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WASHINGTON, DC

WHEN: July 11, 2000, at 9:00 a.m.

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

RESERVATIONS: 202–523–4538

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Rules and Regulations

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

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

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

15 CFR Part 2014

RIN 0350–AA02

Implementation of the Temporary Tariff-Rate Quota for Imports of Lamb Meat

AGENCY: Office of the United States Trade Representative.

ACTION: Final rule.

SUMMARY: The Office of the United States Trade Representative (''USTR'') hereby issues a final rule providing for the establishment of an export certificate procedure to assist in the orderly marketing of lamb meat imports from countries provided a specific import allocation under the temporary tariff-rate quota that the President has imposed on those products.

DATES: The effective date of this final rule is June 29, 2000.

FOR FURTHER INFORMATION CONTACT: Mark Sloan, Director of Agricultural Affairs, Office of the United States Trade Representative, 600 17th Street NW., Washington, DC 20506, (202) 395–6127.

SUPPLEMENTARY INFORMATION: On July 7, 1999, the President issued Proclamation 7208, 64 FR 37387 (July 9, 1999), which established a temporary tariff-rate quota (''TRQ'') and increased duties, effective July 22, 1999, on lamb meat imports to facilitate the domestic industry's adjustment to import competition. In order to provide for the efficient and fair administration of the TRQ, on July 30, 1999, the President issued Proclamation 7214, 64 FR 42265 (Aug. 4, 1999), which delegated authority to administer the TRQ to the United States Trade Representative.

To provide for the efficient and fair administration of the TRQ, USTR has established a procedure under which countries that have been allotted an in-quota allocation under the TRQ may use a system of export certificates to ensure that only those of its lamb meat exports specifically designated for the United States market are counted against the country's in-quota allocation. USTR published an interim rule and request for comments on this subject in the **Federal Register** on October 20, 1999, 64 FR 56429.

Under the final rule, as under the interim rule, a country that was provided a specific in-quota allocation under the TRQ may elect to have the United States Customs Service (''U.S. Customs'') determine which lamb meat imports are to be counted against the country's in-quota allocation, and thus be assessed the lower rate of duty applicable to in-quota imports, based on whether the country has issued (or authorized issuance of) an export certificate for that lamb meat. Two countries, Australia and New Zealand, were provided specific in-quota allocations under the TRQ. Both governments have requested USTR to establish an export certificate procedure to assist in the orderly marketing of their lamb meat exports to the United States while the TRQ is in effect.

A country wishing to avail itself of the export certificate procedure must notify USTR and provide the necessary supporting information. Australia and New Zealand have provided the requisite supporting information, and USTR determine in the **Federal Register** notice for the interim rule that both countries are ''participating countries'' under the export certificate procedure. 64 FR at 56429. USTR will publish a notice in the **Federal Register** if Australia or New Zealand ceases to be a participating country.

U.S. Customs will ensure that no imports of lamb meat from a participating country are counted against that country's in-quota allocation unless the importer declares that there is a valid export certificate for that lamb meat. In the absence of such a declaration, the imports will not be eligible for the in-quota rate of duty.

U.S. Customs will separately issue regulations governing its implementation of this rule.

Comments on the Interim Rule

USTR received comments on the interim rule from representatives of the Australian lamb meat industry (Meat and Livestock Australia, or ''MLA'') and the Embassy of New Zealand.

MLA supported implementation of the export certificate system, and therefore supported the interim rule. MLA had no substantive comments on the interim rule.

The Embassy of New Zealand also supported the export certificate system. However, it recommended the following three changes to the interim rule:

(i) That the wording of § 2014.3(b)(2) be amended by replacing ''calendar year'' with ''quota year;''

(ii) That the wording of § 2014.3(b)(4) be amended by replacing ''in the calendar year'' with ''for quota year;'' and

(iii) That the term ''quota year'' be defined in § 2014.2 as ''the period between 22 July 1999 and 21 July 2000, inclusive, and such subsequent periods as set forth in Presidential Proclamations 7208 (64 FR 37387) and 7214 (64 FR 42265) during which lamb meat is exported.''

USTR has adopted all of the changes suggested by the Embassy of New Zealand, and has amended its interim rule accordingly.

List of Subjects in 15 CFR Part 2014

Export certificates, Imports, Lamb meat, Tariff-rate quotas.

For the reasons set out in the **SUPPLEMENTARY INFORMATION** section of this notice, 15 CFR 2014 is revised to read as follows:

PART 2014—IMPLEMENTATION OF TARIFF-RATE QUOTA FOR IMPORTS OF LAMB MEAT

Sec.
2014.1 Purpose.
2014.2 Definitions.
2014.3 Export certificates.

Authority: 19 U.S.C. 2253(g); Proclamation 7208, 64 FR 37387, July 9, 1999; Proclamation 7214, 64 FR 42265, Aug. 4, 1999.

§ 2014.1 Purpose.

The purpose of this part is to provide for the implementation of the tariff-rate quota for imports of lamb meat established in Proclamation 7208 (64 FR 37387) (July 9, 1999) and modified in Proclamation 7214 (64 FR 42265) (Aug. 4, 1999). In particular, this part provides for the administration of export certificates where a country that has an allocation of the in-quota quantity under

the tariff-rate quota has chosen to use export certificates.

§ 2014.2 Definitions.

Unless the context otherwise requires, for the purpose of this part, the following terms shall have the meanings assigned as follows:

(a) *Lamb meat* means fresh, chilled, or frozen lamb meat, provided for in subheadings 0204.10.00, 0204.22.20, 0204.23.20, 0204.30.00, 0204.42.20, and 0204.43.20 of the HTS.

(b) *In-quota lamb meat* means lamb meat that is entered under the in-quota rate of duty.

(c) *Participating country* means any country to which an allocation of a particular quantity of lamb meat has been assigned under Proclamation 7208 that USTR has determined is, and has notified to the United States Customs Service as being, eligible to use export certificates.

(d) *Enter or Entered* means to enter or withdraw from warehouse for consumption.

(e) *HTS* means the Harmonized Tariff schedule of the United States.

(f) *USTR* means the United States Trade Representative or the designee of the United States Trade Representative.

(g) *Quota Year* means the period between July 22, 1999 and July 21, 2000, inclusive, and such subsequent periods as set forth in Presidential Proclamations 7208 and 7214 during which lamb meat is exported.

§ 2014.3 Export certificates.

(a) In-quota lamb meat may only be entered as a product of a participating country if the United States importer makes a declaration to the United States Customs Service, in the form and manner determined by the United States Customs Service, that a valid export certificate is in effect with respect to that lamb meat product.

(b) To be valid, an export certificate shall:

(1) Be issued by or under the supervision of the government of the participating country;

(2) Specify the name of the exporter, the product description and quantity, and the quota year for which the export certificate is in effect;

(3) Be distinct and uniquely identifiable; and

(4) Be used for the quota year for which it is in effect.

Kenneth P. Freiberg,

Deputy General Counsel, Office of the United States Trade Representative.

[FR Doc. 00–16403 Filed 6–28–00; 8:45 am]

BILLING CODE 3910–01–M

DEPARTMENT OF THE TREASURY

Bureau of Alcohol, Tobacco and Firearms

27 CFR Parts 270, 275 and 295

[T.D. ATF–427; Ref: Notice No. 889]

RIN 1512–AB92

Extension of Package Use-Up Rule for Roll-Your-Own Tobacco Manufacturers and Importers (98R–370P)

AGENCY: Bureau of Alcohol, Tobacco and Firearms (ATF), Department of the Treasury.

ACTION: Temporary rule (Treasury decision).

SUMMARY: In Treasury Decision ATF–424, ATF issued temporary regulations requiring manufacturers and importers to mark packages of roll-your-own tobacco as either ''roll-your-own tobacco'' or ''Tax Class J.'' The temporary regulations provided a use-up period until April 1, 2000 for manufacturers who used packages that did not meet the marking requirements, provided they used the packages before January 1, 2000. In this temporary rule, ATF is extending the date by which manufacturers of roll-your-own tobacco must comply with the package marking requirements. ATF is also adding regulations to provide the same compliance date for importers of roll-your-own tobacco.

DATES: Effective date: June 29, 2000. This temporary rule extends the compliance date for both manufacturers and importers until October 1, 2000.

FOR FURTHER INFORMATION CONTACT: Robert P. Ruhf, Regulations Division, 650 Massachusetts Avenue, NW., Washington, DC 20226; (202) 927–8210; or alctob@atfhq.atf.treas.gov.

SUPPLEMENTARY INFORMATION:

Background

This temporary rule extends the date stated in 27 CFR 270.216b(c) and 295.45c for manufacturers to comply with the requirements that packages be marked as ''roll-your-own tobacco'' or ''Tax Class J'' from April 1, 2000, to October 1, 2000. This temporary rule also adds a new section, 27 CFR 275.72c, that will allow importers to have this same benefit. We are taking this action as a result of comments from the Pipe Tobacco Council, Washington, DC. These comments were received in response to the notice of proposed rulemaking, Notice No. 889 (*64 FR 71935*), issued concurrently with the temporary rule T.D. ATF–424 (64 FR 71929).

The Pipe Tobacco Council submitted written comments concerning the inability of manufacturers and importers of roll-your-own tobacco to comply with the April 1, 2000 deadline. The Pipe Tobacco Council stated that they represented manufacturers and importers who account for more than 90 percent of the roll-your-own tobacco sold in the United States. The Pipe Tobacco Council stated that since there is a long lead time for acquiring new packaging of at least 5 to 6 months, most manufacturers and importers would be unable to meet the April 1, 2000 deadline for marking packages as ''roll-your-own tobacco'' or ''Tax Class J''. In addition, they stated that although manufacturers and importers could place stickers on the packages with ''roll-your-own tobacco'' or ''Tax Class J'' markings, the amount of hand labor involved would make this very costly. The Pipe Tobacco Council requested an extension of the compliance date to October 1, 2000, to allow all manufacturers and importers a reasonable time to comply with this requirement to mark packages ''roll-your-own tobacco'' or ''Tax Class J''.

We have considered the jeopardy to the revenue in extending the compliance date with these package markings and the costs that would be incurred. Since the jeopardy to the revenue is minimal and the costs would be comparatively large for manufacturers and importers to comply, we have decided to extend the use-up date from April 1, 2000, to October 1, 2000.

We note that the Pipe Tobacco Council letter also requested that ''cigarette tobacco,'' be allowed as an alternative marking designation on packages of roll-your-own tobacco. We are not addressing this issue at this time. We will address this issue after we have analyzed all comments received during the 60-day comment period to Notice No. 889 (64 FR 71935), which was issued concurrently with the temporary rule T.D. ATF–424 (64 FR 71929) published December 22, 1999.

Regulatory Flexibility Act

Because no notice of proposed rulemaking is required for this temporary rule, according to the provisions of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) do not apply. Moreover, to give immediate guidance to manufacturers and importers, this temporary rule to extends the date they have to comply with the requirement to mark packages as ''roll-your-own tobacco'' or ''Tax Class J''. The extension of this date does not impose any additional requirements on small

businesses. Pursuant to 26 U.S.C. 7805(f), the temporary rulemaking (T.D. ATF–424 (64 FR 71929)) has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Executive Order 12866

It has been determined that this temporary rule is not a significant regulatory action as defined by Executive Order 12866 because any economic effects flow directly from the underlying statute and not from this rule. Therefore, a regulatory assessment is not required.

Paperwork Reduction Act

This rule does not impose any collection of information as defined in the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(j)). Consequently, this rule is being issued without prior notice and public procedure pursuant to the Administrative Procedure Act (5 U.S.C. 553).

Administrative Procedure Act

Because this document merely extends the date when manufacturers and importers must comply with certain marking requirements, and because immediate guidance is necessary to implement this extension, it is found to be impracticable to issue this Treasury decision with notice and public procedure under 5 U.S.C. 553(b) or subject to the effective date limitation under 5 U.S.C. 553(d).

Drafting Information

The principal author of this document is Robert P. Ruhf, of the Regulations Division, Bureau of Alcohol, Tobacco and Firearms.

List of Subjects

27 CFR Part 270

Administrative practice and procedure, Authority delegations, Cigarette papers and tubes, Claims, Electronic fund transfer, Excise taxes, Labeling, Packaging and containers, Penalties, Reporting requirements, Seizures and forfeitures, Surety bonds, Tobacco products.

27 CFR Part 275

Administrative practice and procedure, Authority delegations, Cigarette papers and tubes, Claims, Electronic fund transfer, Customs duties and inspection, Excise taxes, Imports, Labeling, Packaging and containers, Penalties, Reporting requirements, Seizures and forfeitures, Surety bonds, Tobacco products, U.S. possessions, Warehouses.

27 CFR Part 295

Administrative practice and procedure, Authority delegations, Cigarette papers and tubes, Excise taxes, Labeling, Packaging and containers, Tobacco products.

Authority and Issuance

Accordingly, title 27 of the Code of Federal Regulations is amended as follows:

PART 270—MANUFACTURE OF TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES

Paragraph 1. The authority citation for part 270 continues to read as follows:

Authority: 26 U.S.C. 5142, 5143, 5146, 5701, 5703–5705, 5711–5713, 5721–5723, 5731, 5741, 5751, 5753, 5761–5763, 6061, 6065, 6109, 6151, 6301, 6302, 6311, 6313, 6402, 6404, 6423, 6676, 6806, 7011, 7212, 7325, 7342, 7502, 7503, 7606, 7805, 31 U.S.C. 9301, 9303, 9304, 9306.

Par. 2. Section 270.216c is revised to read as follows:

§ 270.216c Package use-up rule.

(a) A manufacturer must have used such packaging for roll-your-own tobacco before January 1, 2000.

(b) A manufacturer of roll-your-own tobacco may continue to place roll-your-own tobacco in packages that do not meet the marking requirements of §§ 270.212 and 270.216b(b) until April 1, 2000.

(c) A manufacturer of roll-your-tobacco may continue to place roll-your-tobacco in packages that do not meet the requirements of § 270.216b(a) until October 1, 2000.

* * * * *

PART 275—IMPORTATION OF TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES

Par. 4. The authority citation for part 275 continues to read as follows:

Authority: 18 U.S.C. 2342; 26 U.S.C. 5701, 5703–5705, 5708, 5712, 5713, 5722, 5723, 5741, 5754, 5761–5763, 6301, 6302, 6313, 6404, 7101, 7212, 7342, 7606, 7652, 7805; 31 U.S.C. 9301, 9303, 9304, 9306.

Par. 5. A new section 275.72c is added to read as follows:

§ 275.72c Package use-up rule.

(a) An importer must have used such packaging for roll-your-own tobacco before January 1, 2000.

(b) An importer of roll-your-own tobacco may continue to place roll-your-own tobacco in packages that do not meet the marking requirements of § 275.72b(b) until April 1, 2000.

(c) An importer of roll-your-own tobacco may continue to place roll-your-own tobacco in packages that do not meet the requirements of § 275.72b(a) until October 1, 2000.

* * * * *

PART 295—REMOVAL OF TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES, WITHOUT PAYMENT FOR USE OF THE UNITED STATES

Par. 6. The authority citation for part 295 continues to read as follows:

Authority: 26 U.S.C. 5703, 5704, 5705, 5723, 5741, 5751, 5762, 5763, 6313, 7212, 7342, 7606, 7805, 44 U.S.C. 3504(h).

Par. 7. Section 295.45c is revised to read as follows:

§ 295.45c Package use-up rule.

(a) A manufacturer must have used such packaging for roll-your-own tobacco before January 1, 2000.

(b) A manufacturer of roll-your-own tobacco, may continue to place roll-your-own tobacco in packages that do not meet the marking requirements of §§ 270.212 and 270.216b(b) until April 1, 2000.

(c) A manufacturer of roll-your-own tobacco may continue to place roll-your-own tobacco in packages that do not meet the marking requirements of § 270.216b(a) until October 1, 2000.

* * * * *

Signed: March 28, 2000.

Bradley A. Buckles,

Director.

Approved: April 26, 2000.

John P. Simpson,

Deputy Assistant Secretary (Regulatory, Tariff and Trade Enforcement).

[FR Doc. 00–16203 Filed 6–28–00; 8:45 am]

BILLING CODE 4810–31–U

DEPARTMENT OF THE INTERIOR

Minerals Management Service

30 CFR Part 250

RIN 1010–AC55

Oil and Gas and Sulphur Operations in the Outer Continental Shelf—Update of Documents Incorporated by Reference, Correction

AGENCY: Minerals Management Service (MMS), Interior.

ACTION: Correction to final regulations.

SUMMARY: This document corrects the final rule titled ''Update of Documents Incorporated by Reference,'' which was published Tuesday, January 4, 2000 (65

FR 217). We are adding a citation to entries for two American Petroleum Institute (API) Recommended Practices (RP) in the table of Documents Incorporated by Reference and correcting a section of the regulations to incorporate by reference the two documents.

EFFECTIVE DATE: February 3, 2000. The incorporation by reference of publications listed in the regulation is approved by the Director of the **Federal Register** as of February 3, 2000.

FOR FURTHER INFORMATION CONTACT: Alexis London, Rules Processing Team, Engineering and Operations Division, (703) 787–1600.

SUPPLEMENTARY INFORMATION:

Background

The final regulations that are the subject of these corrections updated one API document incorporated by reference (API RP 500) and added a new document incorporated by reference (API RP 505). These regulations affect all operators and lessees on the Outer Continental Shelf.

The regulation at 30 CFR 250.410(e) on safety precautions in mud-handling areas currently incorporates by reference the out-of-date document ''API RP 500B.'' The final regulations should have revised § 250.410(e) to reference ''API RP 500'' or ''API RP 505'' as it did for various other sections of our regulations. The list of citations for API RP 500 and API RP 505 in the table of documents incorporated by reference in § 250.198(e) should have then included § 250.410(e).

Need for Correction

As published, the final regulations contain errors that may prove to be misleading and are in need of clarification.

Correction of Publication

Accordingly, the publication of the final regulations on January 4, 2000, which were the subject of FR Doc. 00–26, is corrected as follows:

§ 250.198 [Corrected]

On pages 218 and 219, in the table for § 250.198(e), the entries for API RP 500 and API RP 505 are corrected to read as follows:

§ 250.198 Documents incorporated by reference.

* * * * *

(e) * * *

Title of document	Incorporated by reference at
* * * *	* * *
API RP 500, Recommended Practice for Classification of Locations for Electrical Installations at Petroleum Facilities Classified as Class I, Division 1 and Division 2, Second Edition, November 1997, API Stock No. C50002.	§ 250.114(a); § 250.410(e); § 250.802(e)(4)(i); § 250.803(b)(9)(i); § 250.1628(b)(3); (d)(4)(i); § 250.1629(b)(4)(i).
API RP 505, Recommended Practice for Classification of Locations for Electrical Installations at Petroleum Facilities Classified as Class I, Zone 0, Zone 1, and Zone 2, First Edition, November 1997, API Stock No. C50501.	§ 250.114(a); § 250.410(e); § 250.802(e)(4)(i); § 250.803(b)(9)(i); § 250.1628(b)(3); (d)(4)(i); § 250.1629(b)(4)(i).
* * * *	* * *

On page 219, in the 3rd column following the amendment to § 250.1629, an amendment to § 250.410 is added as follows:

9. In § 250.410, in paragraph (e), the title of the document incorporated by reference ''API RP 500B'' is revised to read ''API RP 500 or API RP 505''.

Dated: June 19, 2000.

E. P. Danenberger,

Chief, Engineering and Operations Division.

[FR Doc. 00–16250 Filed 6–28–00; 8:45 am]

BILLING CODE 4310–MR–P

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Parts 1, 3, 20, 62, 66, 67, 70, 74, 80, 100, 114, 117, 118, 127, 144, 151, 153, 154, 157, 160, 161, 162, 165, 181, and 183

[USCG–2000–7223]

Technical Amendments; Organizational Changes; Miscellaneous Editorial Changes and Conforming Amendments

AGENCY: Coast Guard, DOT.

ACTION: Final rule.

SUMMARY: This rule makes editorial and technical changes throughout Title 33 of the Code of Federal Regulations (CFR) to update the title before it is recodified on July 1, 2000. It corrects addresses, updates cross-references, makes conforming amendments, and makes other technical corrections. This rule will have no substantive effect on the regulated public.

DATES: This final rule is effective June 30, 2000.

ADDRESSES: Documents as indicated in this preamble are available for inspection or copying at the Docket Management Facility, [USCG–2000–7223], U.S. Department of Transportation, room PL–401, 400 Seventh Street SW., Washington, DC, 20590–0001, 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 rule, contact Ms. Janet Walton, Project Manager, Standards Evaluation and Development Division (G–MSR–2), Coast Guard, telephone 202–267–0257. For questions on viewing, or submitting material to, the docket, contact Dorothy Beard, Chief, Dockets, Department of Transportation, telephone 202–366–9329.

SUPPLEMENTARY INFORMATION:

Discussion of the Rule

Each year Title 33 of the Code of Federal Regulations is recodified on July 1. This rule makes editorial changes throughout the title, corrects addresses, updates cross-references, and makes other technical and editorial corrections to be included in the recodification. Some editorial changes are discussed individually in the following paragraphs. This rule does not change any substantive requirements of existing regulations.

We did not publish a notice of proposed rulemaking (NPRM) for this regulation. Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing an NPRM. This rule consists only of corrections and editorial and conforming amendments to Title 33 of the Code of Federal Regulations. These changes will have no substantive effect on the public and publishing an NPRM and providing an opportunity for public comment is

unnecessary. Under 5 U.S.C. 553(d)(3), the Coast Guard finds that, for the same reasons, good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**.

Section 20.304

The Coast Guard published an Interim Rule, Rules of Practice, Procedure, and Evidence for Administrative Proceedings of the Coast Guard, on May 24, 1999 [USCG–1998–3472] [64 FR 28054]. We published a correction to the Interim Rule, on June 28, 1999, that corrected Table 20.304(D)—How To Serve Filed Documents. With the publication of the July 1, 1999, codification of 33 CFR, we discovered that the table was still printed incorrectly. This rulemaking sets out the table the way it was intended.

Sections 127.611, 127.1511, 154.500, Appendix A, B, and C to Part 154, and Sections 183.114, and 183.516

On December 1, 1999, the Coast Guard published a Direct Final Rule, Update of Standards from the American Society for Testing and Materials (ASTM) [USCG–1999–5151] [64 FR 67170]. On March 1, 2000, we published a confirmation of effective date for the rule [65 FR 10943]. Because we did not change the sections in the CFR where the standard numbers did not contain a year date, we are now adding a cross-reference back to the Incorporation by reference section in each part for each of the sections listed.

Section 151.19

The Frequency of Inspection Final Rule [USCG–1999–4976], published on February 9, 2000 (65 FR 6494), established a 5-year Certificate of Inspection cycle to harmonize the Coast Guard's inspections with internationally required certificates. We published the final rule to establish the frequency of inspection requirements to meet the International Convention for the Safety of Life at Sea, 1974, and the International Convention on Load Line compliance date of February 3, 2000. This rule changes section 151.19 to conform to the February final rule.

Section 153.205

This rule updates the addresses and telephone numbers in Table 1, Addresses and Telephone Numbers of Coast Guard District Offices and EPA Regional Offices.

Section 154.1035

This rule sets out paragraph (e)(3)(iii) with the correct location of the words ''classified'' and ''classification''. The words are reversed in the current codification.

Regulatory Evaluation

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866 and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. It has not been reviewed by the Office of Management and Budget under that Order. It is not significant under the regulatory policies and procedures of the Department of Transportation (DOT) (44 FR 11040; February 26, 1979). We expect the economic impact of this rule to be so minimal that a full Regulatory Evaluation under paragraph 10e of the regulatory policies and procedures of DOT is unnecessary. As this rule involves internal agency practices and procedures, it will not impose any costs on the public.

Collection of Information

This rule calls for no new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

Federalism

We have analyzed this rule under E.O. 13132 and have determined that this rule does not have implications for federalism under that Order.

Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) governs the issuance of Federal regulations that require unfunded mandates. An unfunded mandate is a regulation that requires a State, local, or tribal government or the private sector to incur direct costs without the Federal Government's having first provided the funds to pay those costs. This proposed rule would not impose an unfunded mandate.

Taking of Private Property

This rule will 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 rule meets applicable standards in sections 3(a) and 3(b)(2) of E.O. 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

Protection of Children

We have analyzed this rule under E.O. 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 rule and concluded that, under figure 2–1, paragraph (34)(a) and (b) of Commandant Instruction M16475.lC, this rule is categorically excluded from further environmental documentation. This exclusion is in accordance with paragraphs (34)(a) and (b), concerning regulations that are editorial or procedural and concerning internal agency functions or organization. A ''Categorical Exclusion Determination'' is available in the docket where indicated under **ADDRESSES.**

List of Subjects

33 CFR Part 1

Administrative practice and procedure, Authority delegations (Government agencies), Freedom of information, Penalties.

33 CFR Part 3

Organization and functions (Government agencies).

33 CFR Part 20

Administrative law judges, Administrative practice and procedure, Appeals, Discovery, Evidence, Hearings.

33 CFR Part 62

Navigation (water).

33 CFR Part 66

Intergovernmental relations, Navigation (water), Reporting and recordkeeping requirements.

33 CFR Part 67

Continental shelf, Navigation (water), Reporting and recordkeeping requirements.

33 CFR Part 70

Navigation (water), Penalties.

33 CFR Part 74

Navigation (water).

33 CFR Part 80

Navigation (water), Treaties, Waterways.

33 CFR Part 100

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

33 CFR Part 114

Bridges.

33 CFR Part 117

Bridges.

33 CFR Part 118

Bridges.

33 CFR Part 127

Fire prevention, Harbors, Natural gas, Reporting and recordkeeping requirements, Security measures.

33 CFR Part 144

Continental shelf, Marine safety, Occupational safety and health.

33 CFR Part 151

Administrative practice and procedure, Oil pollution, Penalties, Reporting and recordkeeping requirements, Water pollution control.

33 CFR Part 153

Hazardous substances, Oil pollution, Reporting and recordkeeping requirements, Water pollution control.

33 CFR Part 154

Fire prevention, Hazardous substances, Oil pollution, Reporting and recordkeeping requirements.

33 CFR Part 157

Cargo vessels, Oil pollution, Reporting and recordkeeping requirements.

33 CFR Part 160

Administrative practice and procedure, Harbors, Hazardous materials transportation, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Vessels, Waterways.

33 CFR Part 161

Harbors, Navigation (water), Reporting and recordkeeping requirements, Vessels, Waterways.

33 CFR Part 162

Navigation (water), Waterways.

33 CFR Part 165

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

33 CFR Part 181

Labeling, Marine safety, Reporting and recordkeeping requirements.

33 CFR Part 183

Marine safety.

For the reasons set out in the preamble, the Coast Guard amends 33 CFR parts 1, 3, 20, 62, 66, 67, 70, 74, 80, 100, 114, 117, 118, 127, 144, 151, 153, 154, 157, 160, 161, 162, 165, 181, and 183 as follows:

PART 1—GENERAL PROVISIONS

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

Authority: 14 U.S.C. 633; Sec. 6079(d), Pub. L. 100–690, 102 Stat. 4181; 49 CFR 1.46.

2. In § 1.07–10, in paragraph (a), add after the word ''Commander'' and before the word ''in'' the words ''or other designated official''; and revise paragraph (b) to read as follows:

§ 1.07–10 Reporting and investigation.

* * * * *

(b) Reports of any investigation conducted by the Coast Guard or received from any other agency which indicate that a violation may have occurred may be forwarded to a District Commander or other designated official for further action. This is normally the District Commander of the District in which the violation is believed to have occurred, or the District in which the reporting unit or agency is found. The report is reviewed to determine if there is sufficient evidence to establish a *prima facie* case. If there is insufficient evidence, the case is either returned for further investigation or closed if further action is unwarranted. The case is closed in situations in which the investigation has established that a violation did not occur, the violator is unknown, or there is little likelihood of discovering additional relevant facts. If it is determined that a *prima facie* case does exist, a case file is prepared and forwarded to the Hearing Officer, with a recommended action. A record of any prior violations by the same person or entity, is forwarded with the case file.

PART 3—COAST GUARD AREAS, DISTRICTS, MARINE INSPECTION ZONES, AND CAPTAIN OF THE PORT ZONES

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

Authority: 14 U.S.C. 633; 49 CFR 1.45, 1.46.

§ 3.05–35 [Amended]

4. In § 3.05–35(b), remove the words ''thence proceeds along a line northwesterly to 40°40′ N. latitude, 73°40′ W. longitude'' and add, in their place, the words ''thence proceeds along a line northeasterly to 40°40′ N. latitude, 73°40′ W. longitude''.

PART 20—RULES OF PRACTICE, PROCEDURE, AND EVIDENCE FOR FORMAL ADMINISTRATIVE PROCEEDINGS OF THE COAST GUARD

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

Authority: 33 U.S.C. 1321; 42 U.S.C. 9609; 46 U.S.C. 7701, 7702; 49 CFR 1.46.

6. In § 20.304, in paragraph (d), revise Table 20.304(D) to read as follows:

§ 20.304 Service of documents.

* * * * *

(d) * * *

TABLE 20.304(D).—HOW TO SERVE FILED DOCUMENTS

Type of filed document	Acceptable methods of service
(1) Complaint	(i) Certified mail, return receipt requested. (ii) Personal delivery. (iii) Express-courier service that has receipt capability.
(2) Default Motion	(i) Certified mail, return receipt requested. (ii) Personal delivery. (iii) Express-courier service that has receipt capability.
(3) Answer	(i) Mail. (ii) Personal delivery. (iii) Express-courier service. (iv) Fax.
(4) Any other filed document.	(i) Mail. (ii) Personal delivery. (iii) Express-courier service. (iv) Fax. (v) Other electronic means (at the discretion of the ALJ).

* * * * *

PART 62—UNITED STATES AIDS TO NAVIGATION SYSTEM

7. The authority citation for part 62 continues to read as follows:

Authority: 14 U.S.C. 85; 33 U.S.C. 1233; 43 U.S.C. 1333; 49 CFR 1.46.

§ 62.65 [Amended]

8. In § 62.65(c)(1), remove the words ''listed in Chapter five, Section 500D of Radio Navigational Aids Publication, 117A and 117B'' and add, in their place, the words ''listed in Chapter four of Radio Navigation Aids Publication, 117''; remove paragraph (c)(2); and redesignate paragraph (c)(3) as (c)(2).

PART 66—PRIVATE AIDS TO NAVIGATION

9. The authority citation for part 66 continues to read as follows:

Authority: 14 U.S.C. 83, 85; 43 U.S.C. 1333; 49 CFR 1.46.

10. Revise § 66.05–30(b) to read as follows:

§ 66.05–30 Notice to Mariners.

* * * * *

(b) Notices to Mariners which concern the establishment, disestablishment, or change of State aids to navigation, including regulatory markers, may be published whenever the aids to navigation concerned are covered by navigational charts or maps issued by the U.S. Coast and Geodetic Survey or the U.S. Army Corps of Engineers.

PART 67—AIDS TO NAVIGATION ON ARTIFICIAL ISLANDS AND FIXED STRUCTURES

11. The authority citation for part 67 continues to read as follows:

Authority: 14 U.S.C. 85, 633; 43 U.S.C. 1333; 49 CFR 1.46.

§ 67.50–25 [Amended]

12. In § 67.50–25(e), remove the words ''328 Custom House Building, New Orleans, Louisiana 70130'' and add, in their place, the words ''Hale Boggs Federal Building, 500 Camp Street, New Orleans, LA 70130–3396''.

PART 70—INTERFERENCE WITH OR DAMAGE TO AIDS TO NAVIGATION

13. The authority citation for part 70 continues to read as follows:

Authority: Secs. 14, 16, 30 Stat. 1152, 1153; secs. 84, 86, 92, 633, 642, 63 Stat. 500, 501, 503, 545, 547 (33 U.S.C. 408, 411, 412; 14 U.S.C. 84, 86, 92, 633, 642).

§ 70.05–20 [Amended]

14. In § 70.05–20, remove the authority citation following the section.

PART 74—CHARGES FOR COAST GUARD AIDS TO NAVIGATION WORK

15. The authority citation for part 74 continues to read as follows:

Authority: 14 U.S.C. 81, 85, 86, 92, 93, 141, 633, 642, 647; 49 CFR 1.46(b).

§ 74.20–1 [Amended]

16. In § 74.20–1(a), remove the words ''COMDTNOTE 7310 (series) which is available at the Office of the Comptroller'' and add, in their place the words ''COMDTINST 7310 (series) which is available from the District Budget Office''.

PART 80—COLREGS DEMARCATION LINES

17. The authority citation for part 80 continues to read as follows:

Authority: 14 U.S.C. 2; 14 U.S.C. 633; 33 U.S.C. 151(a); 49 CFR 1.46.

18. In § 80.501, revise paragraph (h) to read as follows:

§ 80.501 Tom's River, NJ to Cape May, NJ.

* * * * *

(h) A line drawn from Cape May Inlet East Jetty Light 4 to Cape May Inlet West Jetty Light 5.

PART 100—MARINE EVENTS

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

Authority: 33 U.S.C. 1233 through 1236; 49 CFR 1.46; 33 CFR 100.35.

20. In § 100.114(a), in the Fireworks Display Table—

a. In the entry for New York: 6.5, remove the word ''years'' and add, in its place, the word ''yards'';

b. In the entry for New York: 10.1, remove the numbers ''6:45 to 8:45'' and add in their place, the numbers ''6:45 p.m. to 8:45 p.m.''; and

c. Revise the entries for Massachusetts: 6.6, Maine: 7.51, Maine: 8.12, New York: 9.8, and Massachusetts: 10.2 as follows:

§ 100.114 Fireworks displays within the First Coast Guard District.

(a) * * *

FIREWORKS DISPLAY TABLE

* * * * * * *		
Massachusetts:		
6.6	Thursday prior to July 4th	Name: Boston Harborfest Fireworks. Sponsor: Harborfest Committee. Time: 9:30 p.m. to 10.30 p.m. Location: Just Off Coast Guard Base, Boston Harbor, MA 42°22′53″ N/71°02′ 56″W (NAD 1983).
* * * * * * *		
Maine:		
7.51	Third Saturday in July	Name: Belfast Fireworks. Sponsor: Belfast Bay Festival Committee. Time: 8:00 p.m. to 10:00 p.m. Location: Belfast Bay, ME.
* * * * * * *		
Maine:		
8.12	A night during Labor day weekend	Name: Camden Fireworks Display. Sponsor: Town of Camden Chamber of Commerce. Time: 8:00 p.m. to 10:00 p.m. Location: Camden Harbor, Camden, ME.
* * * * * * *		
New York:		
9.8	A night during the last two weekends in September.	Name: Cow Harbor Day Fireworks. Sponsor: Village of Northport Harbor. Time: 8:00 p.m. to 10.00 p.m. Location: Sand Pit, Northport Harbor, Northport, NY.

FIREWORKS DISPLAY TABLE—Continued

* * * * * * *		
Massachusetts:		
10.2	A night during the second weekend of October	Name: Yarmouth Seaside Festival Fireworks. Sponsor: Yarmouth Seaside Festival. Time: 8:00 p.m. to 9:00 p.m. Location: Seagull Beach, W. Yarmouth, MA 41°38′06″ N/070°13′ 13″W (NAD 1983).
* * * * * * *		

* * * * *

§ 100.502 [Amended]

21. In § 100.502(a)(2), remove the words ''Cape May'' and add, in their place, the words ''Atlantic City''.

§ 100.507 [Amended]

22. In § 100.507(a)(2), remove the word ''Group'' and add, in its place, the words ''Coast Guard Activities''.

§ 100.511 [Amended]

23. In § 100.511(a)(2), remove the word ''Group'' and add, in its place, the words ''Coast Guard Activities''.

§ 100.515 [Amended]

24. In § 100.515(a)(2), remove the word ''Group'' and add, in its place, the word ''Coast Guard Activities''.

§ 100.517 [Amended]

25. In § 100.517(a)(2), remove the word ''Group'' and add, in its place, the words ''Activities''.

§ 100.518 [Amended]

26. In § 100.518(a)(2), remove the word ''Group'' and add, in its place, the words ''Coast Guard Activities''.

27. In § 100.901(e), in Table 1, under the ''Group Detroit, MI'' remove the entry for Flatsfest, and add, in alphabetical order, an entry for ''Parade of Lights'' to read as follows:

§ 100.901 Great Lakes annual marine events.

* * * * *

(e) * * *

Table 1

* * * * *

Group Detroit, MI:

* * * * *

Parade of Lights

Sponsor: Lake Erie Marine Trade Association (LEMTA).
Date: 3rd or 4th weekend of July.
Location: Cuyahoga River, Conrail Railroad Bridge at Mile 0.8 above the mouth of the river to the Eagle Avenue Bridge, near Cleveland, OH.

* * * * *

PART 114—GENERAL

28. The authority citation for part 114 continues to read as follows:

Authority: 33 U.S.C. 401, 491, 499, 521, 525, and 535; 14 U.S.C. 633; 49 U.S.C. 1655(g); 49 CFR 1.46(c).

§ 114.10 [Amended]

29. In § 114.10, add the word ''for'' immediately before the words ''the reasonable needs of navigation''.

PART 117—DRAWBRIDGE OPERATION REGULATIONS

30. The authority citation for part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 49 CFR 1.46; 33 CFR 1.05–1(g); section 117.255 also issued under the authority of Pub. L. 102–587, 106 Stat. 5039.

§ 117.101 [Amended]

31. In § 117.101(b), remove the words ''Illinois Central'' and add, in their place, the words ''Canadian National/Illinois Central''.

§ 117.123 [Amended]

32. In § 117.123(b)(2), remove the words ''33 CFR 165.203'' and add, in their place, the words ''33 CFR 165.817''.

§ 117.171 [Amended]

33. In § 117.171(b), remove the words ''yardmaster at Stockton'' and add, in their place, the words ''Manager of Structures at San Bernardino''.

§ 117.381 [Amended]

34. In § 117.381, remove the words ''Union Pacific (Camas Prairie)'' and add, in their place, the words ''Camas Prairie''.

§ 117.465 [Amended]

35. In § 117.465(e), remove the words ''The draws of the S649 bridge, mile 66.1, and the new S649 bridge, mile 66.6'' and add, in their place, the words '' The draw of the S649 bridge, mile 66.6''.

§ 117.484 [Amended]

36. In § 117.484 introductory text, remove the words ''Illinois Central'' and add, in their place, the words ''Canadian National/Illinois Central''.

§ 117.686 [Amended]

37. In § 117.686(a), remove the words ''Illinois Central'' and add, in their place, the words ''Canadian National/Illinois Central''.

§ 117.861 [Amended]

38. In § 117.861, remove the words ''Burlington Northern Santa Fe'' and add, in their place, the words ''Portland and Western''.

§ 117.863 [Removed]

39. Remove § 117.863.

§ 117.865 [Amended]

40. In § 117.865, remove the words ''Willamette and Pacific'' and add, in their place, the words ''Portland and Western''.

§ 117.881 [Amended]

41. In § 117.881(a), remove the words ''Willamette and Pacific'' and add, in their place, the words ''Portland and Western''.

42. Revise § 117.1063 to read as follows:

§ 117.1063 Willapa River South Fork.

The draw of the Washington State Parks and Recreation Commission bridge across the South Fork Willapa River, mile 0.3, at Raymond, shall open on signal if at least 24 hours notice is given.

PART 118—BRIDGE LIGHTING AND OTHER SIGNALS

43. The authority citation for part 118 continues to read as follows:

Authority: 33 U.S.C. 494; 14 U.S.C. 85, 633; 49 CFR 1.46(b) and (c)

§ 118.3 [Amended]

44. In § 118.3(b), remove the words ''Office of the Federal Register, Washington, DC 20408 and at U.S. Coast Guard, Room 1410, 2100 Second Street,

SW., Washington, DC 20593'' and add, in their place, the words ''Office of the Federal Register, 800 North Capitol Street NW., suite 700, Washington, DC 20408 and at U.S. Coast Guard Headquarters, Office of Bridge Administration (G-OPT), room 3500, 2100 Second Street SW., Washington, DC 20593–0001''.

PART 127—WATERFRONT FACILITIES HANDLING LIQUEFIED NATURAL GAS AND LIQUEFIED HAZARDOUS GAS

45. The authority citation for part 127 continues to read as follows:

Authority: 33 U.S.C. 1231; 49 CFR 1.46.

§ 127.611 [Amended]

46. In § 127.611, remove the words ''ASTM F–1121'' and add, in their place, the words ''ASTM F 1121 (incorporated by reference, see § 127.003)''.

§ 127.1511 [Amended]

47. In § 127.1511, remove the words ''ASTM F–1121'' and add, in their place, the words ''ASTM F 1121 (incorporated by reference, see § 127.003)''.

PART 144—LIFESAVING APPLIANCES

48. The authority citation for part 144 continues to read as follows:

Authority: 43 U.S.C. 1333d; 46 U.S.C. 3102(a); 46 CFR 1.46.

§ 144.20–5 [Amended]

49. In § 144.20–5(c), remove the words ''46 CFR 160.071'' and add, in their place, the words ''46 CFR 160.171''.

PART 151—VESSELS CARRYING OIL, NOXIOUS LIQUID SUBSTANCES, GARBAGE, MUNICIPAL OR COMMERCIAL WASTE, AND BALLAST WATER

50. The authority citation for part 151, subpart A, continues to read as follows:

Authority: 33 U.S.C. 1321 and 1903; Pub. L. 104–227 (110 Stat. 3034), E.O. 12777, 3 CFR, 1991 Comp. p. 351; 49 CFR 1.46.

51. Revise the introductory text of § 151.19(e) to read as follows:

§ 151.19 International Oil Pollution Prevention (IOPP) Certificates.

* * * * *

(e) The IOPP Certificate for each U.S. inspected ship is valid for a period not to exceed five years from the date of issue, and for each U.S. uninspected ship the IOPP Certificate is valid for a period not to exceed five years from the date of issue, except as follows—

* * * * *

PART 153—CONTROL OF POLLUTION BY OIL AND HAZARDOUS SUBSTANCES, DISCHARGE REMOVAL

52. Revise the authority citation for part 153 to read as follows:

Authority: 14 U.S.C. 633; 33 U.S.C. 1321; 42 U.S.C. 9615; E.O. 12580, 3 CFR, 1987 Comp., p. 193; E.O. 12777, 3 CFR, 1991 Comp., p. 351; 49 CFR 1.45 and 1.46.

53. In § 153.205, revise Table 1 to read as follows:

§ 153.205 Fines.

* * * * *

TABLE 1.—ADDRESSES AND TELEPHONE NUMBERS OF COAST GUARD DISTRICT OFFICES AND EPA REGIONAL OFFICES

	Address	Telephone
EPA Regional Offices		
Region:		
1	1 Congress St., Suite 1100, Boston, MA 02114–2023	617–918–1111
2	290 Broadway, New York, NY 10007–1866	212–637–3000
3	1650 Arch St., Philadelphia, PA 19103–2029	215–814–5000
4	Atlanta Federal Center, 61 Forsyth St., SW, Atlanta, GA 30303–3104	404–562–9900
5	77 West Jackson Boulevard, Chicago, IL 60604–3507	312–353–2000
6	Fountain Place 12th Floor, Suite 1200, 1445 Ross Avenue, Dallas, TX 75202–2733	214–665–2200
7	901 North 5th St., Kansas City, KS 66101	913–551–7003
8	999 18th St., Suite 500, Denver, CO 80202–2466	303–312–6312
9	75 Hawthorne St., San Francisco, CA 94105	415–744–1305
10	1200 Sixth Avenue, Seattle, WA 98101	206–553–1200
Coast Guard District Offices		
District:		
1st	408 Atlantic Avenue, Boston, MA 02210–3350	617–223–8480
5th	Federal Building, 431 Crawford St., Portsmouth, VA 23704–5004	757–398–6638
7th	909 S.E. First Avenue, Miami, FL 33131–3050	305–536–5651
8th	Hale Boggs Federal Bldg., 500 Camp Street, New Orleans, LA 70130–3396	504–589–6901
9th	1240 E. 9th St., Cleveland, OH 44199–2060	216–902–6045
11th	Coast Guard Island, Building 50–6, Alameda, CA 94501–5100	510–437–2940
13th	Jackson Federal Bldg., 915 Second Avenue, Seattle, WA 98174–1067	206–220–7090
14th	Prince PJKK Federal Bldg., Room 9212, 300 Ala Moana Blvd., Honolulu, HI 96850–4982	808–541–2114
17th	P.O. Box 25517, Juneau, AK 99802–5517	907–463–2199

* * * * *

PART 154—FACILITIES TRANSFERRING OIL OR HAZARDOUS MATERIAL IN BULK

54. The authority citation for part 154 continues to read as follows:

Authority: 33 U.S.C. 1231, 1321(j)(1)(C), (j)(5), (j)(6), and (m)(2); sec. 2, E.O. 12777, 56 FR 54757; 49 CFR 1.46. Subpart F is also issued under 33 U.S.C. 2735.

§ 154.500 [Amended]

55. In § 154.500(d)(3), remove the words ''ASTM F–1122'' and add, in their place, the words ''ASTM F 1122 (incorporated by reference, see § 154.106)''.

56. In § 154.1035(e)(3)(iii) introductory text, revise the second sentence to read as follows:

§ 154.1035 Specific requirements for facilities that could reasonably be expected to cause significant and substantial harm to the environment.

* * * * *

(e) * * *

(3) * * *

(iii) * * *

For oil spill removal organization(s) classified by the Coast Guard, the classification must be noted in this section of the plan. * * *

* * * * *

Appendix A to Part 154 [Amended]

57. In Appendix A to part 154—

a. In paragraph 7.1, remove the words ''ASTM F1155'' and add, in their place, the words ''ASTM F 1155 (incorporated by reference, see § 154.106)'';

b. In paragraph 8.4, remove the words ''ASTM F722'' and add, in their place, the words ''ASTM F 722 (incorporated by reference, see § 154.106)'' and remove the words ''ASTM F1155'' and add, in their place, the words ''ASTM F 1155 (incorporated by reference, see § 154.106)''; and

c. In paragraph 8.6, remove the words ''ASTM F722'' and add, in their place, the words ''ASTM F 722 (incorporated by reference, see § 154.106)''.

Appendix B to Part 154 [Amended]

58. In Appendix B to part 154—

a. In paragraph 7.1, remove the words ''ASTM F1155'' and add, in their place, the words ''ASTM F 1155 (incorporated by reference, see § 154.106)'';

b. In paragraph 8.4, remove the words ''ASTM F722'' and add, in their place, the words ''ASTM F 722 (incorporated by reference, see § 154.106)'' and remove the words ''ASTM F1155'' and add, in their place, the words ''ASTM F 1155 (incorporated by reference, see § 154.106)''; and

c. In paragraph 8.6, remove the words ''ASTM F722'' and add, in their place, the words ''ASTM F 722 (incorporated by reference, see § 154.106)''.

Appendix C to Part 154 [Amended]

59. In Appendix C to part 154—

a. In paragraph 2.3.1, remove the words ''ASTM F 715'' and add, in their place, the words ''ASTM F 715 (incorporated by reference, see § 154.106)''; and

b. In paragraph 6.3, remove the words ''ASTM F 631'' and add, in their place, the words ''ASTM F 631 (incorporated by reference, see § 154.106)''.

PART 157—RULES FOR THE PROTECTION OF THE MARINE ENVIRONMENT RELATING TO TANK VESSELS CARRYING OIL IN BULK

60. The authority citation for part 157 continues to read as follows:

Authority: 33 U.S.C. 1903; 46 U.S.C. 3703, 3703a (note); 49 CFR 1.46. Subparts G, H, and I are also issued under section 4115(b), Pub. L. 101–380, 104 Stat. 520; Pub. L. 104–55, 109 Stat. 546.

§ 157.19 [Amended]

61. In § 157.19, remove the cross reference note following the section.

PART 160—PORTS AND WATERWAYS SAFETY—GENERAL

62. The authority citation for part 160 continues to read as follows:

Authority: 33 U.S.C. 1223, 1231; 49 CFR 1.46. Subpart D is also issued under the authority of 33 U.S.C. 1225 AND 46 U.S.C. 3715.

§ 160.201 [Amended]

63. In § 160.201, remove paragraph (c)(6) and redesignate paragraphs (c)(7), (8), and (9) as (c)(6), (7), and (8).

PART 161—VESSEL TRAFFIC MANAGEMENT

64. The authority citation for part 161 continues to read as follows:

Authority: 33 U.S.C. 1231; 33 U.S.C. 1223; 49 CFR 1.46.

65. In Table 161.35(C) in § 161.35, revise the entry for ''P'' to read as follows:

§ 161.35 Vessel Traffic Service Houston/Galveston.

* * * * *

TABLE 161.35(C).—VTS HOUSTON/GALVESTON REPORTING POINTS

Designator	Geographic name	Geographic description	Latitude/longitude	Notes
*	*	*	*	*
P	Bayport Ship Channel	Bayport Ship Channel Lt. 8 and 9.	29° 36.8′ N; 94° 59.5′ W;	Report at the North Land Cut.
*	*	*	*	*

PART 162—INLAND WATERWAYS NAVIGATION REGULATIONS

66. The authority citation for part 162 continues to read as follows:

Authority: 33 U.S.C. 1231; 49 CFR 1.46.

§ 162.65 [Amended]

67. In § 162.65(b)(2)(iv) and (b)(6), remove the words ''Inland Rules and the Pilot Rules for Inland Waters'' and add, in their place, the words ''Navigation Rules, International-Inland, Commandant Instruction M16672.2 (series)''.

§ 162.75 [Amended]

68. In § 162.75(b)(3)(iii) and (b)(7), remove the words ''Inland Rules and the Pilot Rules for Inland Waters'' and add, in their place, the words ''Navigation Rules, International-Inland, Commandant Instruction M16672.2 (series)''.

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

69. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1231; 50 U.S.C. 191, 33 CFR 1.05–1(g), 6.04–1, 6.04–6, 160.5; 49 CFR 1.46.

§ 165.510 [Amended]

70. In § 165.510(f)(5), remove the words ''46 CFR 85.25.55'' and add, in their place, the words ''46 CFR 58.25–70''.

§ 165.514 [Amended]

71. In § 165.514(a), remove the words ''Bogue Sound-New River Light 58'' and add, in their place, the words ''Bogue Sound-New River Daybeacon 58''; and in paragraph (d), remove the words ''or (910) 815–4895''.

72. Revise § 165.804(d) to read as follows:

§ 165.804 Snake Island, Texas City, Texas; mooring and fleeting of vessels-safety zone.

* * * * *

(d) In an emergency, vessels shall advise the Captain of the Port, Houston-

Galveston, of the nature of the emergency via the most rapid means available.

§ 165.903 [Amended]

73. In § 165.903—

a. In paragraph (a)(1), remove the word ''Conrail'' and add, in its place, the words ''Norfolk and Southern'';

b. In paragraph (a)(4) remove the word ''Nicky's'' and add, in its place, the word ''Tiffany's''; and

c. In paragraph (a)(11) remove the words ''Jim's Steak House'' and add, in their place, the words ''The Club Aqua''.

§§ 165.515 and 165.530 [Amended]

74. In addition to the amendments set for above, in 33 CFR part 165, remove the number ''(910) 343–4895'' and add, in its place, the number ''1–800–325–4956'' in the following sections:

(a) Section 165.515(c); and

(b) Section 165.530(b)(1).

PART 181—MANUFACTURER REQUIREMENTS

75. The authority citation for part 181 continues to read as follows:

Authority: 46 U.S.C. 4302 and 4310; 49 CFR 1.46

76. In § 181.4(b), revise the heading and address for ''Underwriters Laboratories, Inc.'' to read as follows:

§ 181.4 Incorporation by reference.

* * * * *

(b) * * *

Underwriters Laboratories, Inc. (UL)

12 Laboratory Drive, Research Triangle Park, NC 27709–3995

* * * * *

PART 183—BOATS AND ASSOCIATED EQUIPMENT

77. The authority citation for part 183 continues to read as follows:

Authority: 46 U.S.C. 4302; 49 CFR 1.46.

78. In § 183.5(b), revise the heading and address for ''Underwriters Laboratories, Inc.'' to read as follows:

§ 183.5 Incorporation by reference.

* * * * *

(b) * * *

Underwriters Laboratories, Inc. (UL)

12 Laboratory Drive, Research Triangle Park, NC 27709–3995

* * * * *

§ 183.114 [Amended]

79. In § 183.114, in paragraphs (b), (c), (d), and (e), remove the words ''ASTM D–471'' and add, in their place, the words ''ASTM D 471 (incorporated by reference, see § 183.5)''; and in paragraph (h), remove the words ''ASTM D–2842'' and add, in their place, the words ''ASTM D 2842 (incorporated by reference, see § 183.5)''.

§ 183.516 [Amended]

80. In § 183.516:

a. In paragraphs (a)(1)(i) and (ii), remove the words ''ASTM D–471'' and add, in their place, the words ''ASTM D 471 (incorporated by reference, see § 183.5)'';

b. In paragraph (b), remove the words ''ASTM D–1621'' and add, in their place, the words ''ASTM D 1621 (incorporated by reference, see § 183.5)''; and

c. In paragraph (c), remove the words ''ASTM D–1622'' and add, in their place, the words ''ASTM D 1622 (incorporated by reference, see § 183.5)''.

81. In § 183.607, in paragraph (a) introductory text, remove the words ''Room 4210, 2100 Second Street, SW., Washington, DC 20593'' and add, in their place, the words ''2100 Second Street, SW., Washington, DC 20593–0001''; and revise paragraphs (a)(2) and (3) to read as follows:

§ 183.607 Incorporation by reference.

* * * * *

(a) * * *

(2) ASTM Standard D 471. American Society for Testing and Materials, 100 Barr Harbor Drive, West Conshohocken, PA 19428–2959.

(3) UL Standard 1128, Underwriters Laboratories, Incorporated, 12 Laboratory Drive, Research Triangle Park, NC 27709–3995.

* * * * *

Dated: June 20, 2000.

Joseph J. Angelo,

Acting Assistant Commandant for Marine Safety and Environmental Protection.

[FR Doc. 00–16078 Filed 6–28–00; 8:45 am]

BILLING CODE 4910–15–U

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 648

[Docket No. 991228354–0078–02; I.D. 062300C]

Fisheries of the Northeastern United States; Atlantic Mackerel, Squid, and Butterfish Fisheries; Closure of Fishery for *Loligo* Squid

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

ACTION: Closure.

SUMMARY: NMFS announces that the directed fishery for *Loligo* squid in the exclusive economic zone (EEZ) will be closed. Vessels issued a Federal permit to harvest *Loligo* squid may not retain or land more than 2,500 lb (1.13 mt) per trip of *Loligo* squid for the remainder of the quota period. This action is necessary to prevent the fishery from exceeding the Period II quota and allow for rebuilding of this overfished stock, while allowing for fishing throughout the year.

DATES: Effective 0001 hours, July 2, 2000, through 0001 hours, September 1, 2000.

FOR FURTHER INFORMATION CONTACT: Allison Ferreira, Fishery Management Specialist, 978–281–9103, fax 978–281–9135, e mail allison.ferreira@noaa.gov.

SUPPLEMENTARY INFORMATION: Regulations governing the *Loligo* squid fishery are found at 50 CFR part 648. The regulations require annual specifications for initial optimum yield as well as the amounts for allowable biological catch, domestic annual harvest (DAH), domestic annual processing, joint venture processing, and total allowable levels of foreign fishing for the species managed under the Atlantic Mackerel, Squid, and Butterfish Fishery Management Plan. The procedures for setting the annual initial specifications are described in § 648.21.

The 2000 specification of DAH for *Loligo* squid was set at 13,000 mt (65 FR 16341, March 28, 2000). This amount is allocated by trimester based on the following table.

TABLE 2.—*Loligo* 4-MONTH PERIOD ALLOCATIONS

4-month Period	Percent	Metric Tons
I (Jan–Apr)	42	5,460
II (May–Aug)	18	2,340
III (Sep–Dec)	40	5,200
Total	100	13,000

Section 648.22 requires the closure of the directed *Loligo* squid fishery in the EEZ when 90 percent of the DAH for *Loligo* squid is harvested in either Period I or II, or 95 percent is harvested in Period III. NMFS is further required to notify, in advance of the closure, the Executive Directors of the Mid-Atlantic, New England, and South Atlantic Fishery Management Councils; mail notification of the closure to all holders of *Loligo* squid permits at least 72 hours

before the effective date of the closure; provide adequate notice of the closure to recreational participants in the fishery; and publish notification of the closure in the **Federal Register**.

The regulations at 50 CFR 648.22 require NMFS to close the *Loligo* squid directed fishery when 90 percent of the Period II quota is harvested. The 2000 Period II quota for *Loligo* squid is 2,340 mt or 5,159,700 lbs (65 FR 16341, March 28, 2000). NMFS has determined, based on landings and other available information, that 90 percent of the DAH for *Loligo* squid in Period II, will be harvested by July 1, 2000. Therefore, effective 0001 hours, July 2, 2000, the directed fishery for *Loligo* squid is closed and vessels issued Federal permits for *Loligo* squid may not retain or land more than 2,500 lb (1.13 mt). The directed fishery will reopen effective 0001 hours, September 1, 2000, which marks the beginning of the Period III quota.

Classification

This action is required by 50 CFR part 648 and is exempt from review under E.O. 12866.

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

Dated: June 26, 2000.

Richard W. Surdi,

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

[FR Doc. 00–16463 Filed 6–26–00; 3:18 pm]

BILLING CODE 3510–22–F

Proposed Rules

Federal Register
Vol. 65, No. 126
Thursday, June 29, 2000

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

FEDERAL RESERVE SYSTEM

12 CFR Part 205

[Regulation E; Docket No. R–1074]

Electronic Fund Transfers

AGENCY: Board of Governors of the Federal Reserve System.

ACTION: Proposed rule; official staff interpretation.

SUMMARY: The Board is publishing for comment a proposal to revise the Official Staff Commentary to Regulation E (Electronic Fund Transfers). The commentary interprets the requirements of Regulation E to facilitate compliance by financial institutions that offer electronic fund transfer services to consumers. The proposed revisions provide guidance on electronic authorization of recurring debits from a consumer's account, Regulation E coverage of electronic check conversion transactions, telephone-initiated fund transfers, and other issues.

DATES: Comments must be received on or before August 31, 2000.

ADDRESSES: Comments, which should refer to Docket No. R–1074, may be mailed to Jennifer J. Johnson, Secretary, Board of Governors of the Federal Reserve System, 20th Street and Constitution Avenue, NW., Washington, DC 20551 or mailed electronically to regs.comments@federalreserve.gov. Comments addressed to Ms. Johnson may also be delivered to the Board's mail room between 8:45 a.m. and 5:15 p.m. weekdays, and to the security control room at all other times. The mail room and the security control room, both in the Board's Eccles Building, are accessible from the courtyard entrance on 20th Street between Constitution Avenue and C Street, NW. Comments may be inspected in room MP–500 in the Board's Martin Building between 9:00 a.m. and 5:00 p.m., pursuant to the Board's Rules Regarding the Availability of Information, 12 CFR part 261.

FOR FURTHER INFORMATION CONTACT: Kyung Cho-Miller, Natalie E. Taylor, or John C. Wood, Counsels, Division of Consumer and Community Affairs, Board of Governors of the Federal Reserve System, Washington, DC 20551, at (202) 452–2412 or (202) 452–3667. For the hearing impaired *only,* contact Janice Simms, Telecommunications Device for the Deaf (TDD), at (202) 872–4984.

SUPPLEMENTARY INFORMATION:

I. Background

The Electronic Fund Transfer Act (EFTA) (15 U.S.C. 1693 *et seq.*), enacted in 1978, provides a basic framework establishing the rights, liabilities, and responsibilities of participants in electronic fund transfer (EFT) systems. The EFTA is implemented by the Board's Regulation E (12 CFR part 205). Types of transfers covered by the act and regulation include transfers initiated through an automated teller machine (ATM), point-of-sale (POS) terminal, automated clearinghouse (ACH), telephone bill-payment plan, or remote banking program. The act and regulation require disclosure of terms and conditions of an EFT service; documentation of electronic transfers by means of terminal receipts and periodic account statements; limitations on consumer liability for unauthorized transfers; procedures for error resolution; and certain rights related to preauthorized electronic transfers. The act and regulation also prescribe restrictions on the unsolicited issuance of ATM cards and other access devices.

The Official Staff Commentary (12 CFR part 205 (Supp. I)) is designed to facilitate compliance and provide protection from civil liability, under § 915(d)(1) of the act, for financial institutions. The commentary is updated periodically, as necessary, to address significant questions that arise.

II. Proposed Revisions

Supplement I—Official Staff Interpretations

Section 205.2—Definitions

2(a) Access Device

Several issues under Regulation E are raised by check conversion programs that allow a merchant to use a consumer's check as a source document to provide the routing, serial, and account numbers used to initiate an EFT. The Board has been asked whether the type of transaction described herein is covered by Regulation E and whether the check is an access device under Regulation E. Such a transaction is generally covered by Regulation E, but proposed comment 2(a)–2 would be added to clarify that a check used as a source document to initiate an EFT is not an access device. Proposed comment 3(b)–1(v) also addresses check conversion programs.

2(h) Electronic Terminal

Comment 2(h)–2 states that a POS terminal that captures data electronically is an electronic terminal if a debit card is used to initiate an EFT. Some have interpreted the provision narrowly to apply only when a debit card is used to initiate an EFT. Comment 2(h)–2 would be revised to reflect that a POS terminal that captures data electronically to initiate electronic transfers is an electronic terminal even if no access device is used to initiate an EFT such as when a check is used as a source document. Thus, the receipt requirements of § 205.9 would apply.

2(k) Preauthorized Electronic Fund Transfer

Section 205.2(k) defines a ''preauthorized electronic fund transfer'' as ''an EFT authorized in advance to recur at substantially regular intervals.'' Beyond that authorization, no further action by the consumer is required to initiate the transfer. Proposed comment 2(k)–1 would be added to clarify the definition.

2(m) Unauthorized Electronic Fund Transfer

Payments such as payroll or government benefits often are made by direct deposit to a consumer's account through the ACH. Rules of the National Automated Clearing House Association (NACHA) permit reversal of payments made in error in limited circumstances. Proposed comment 2(m)–5 would be added to clarify that reversals of certain direct deposits that were made in error are not unauthorized electronic transfers.

Section 205.3—Coverage

3(b) Electronic Fund Transfer

NACHA has established rules for a program in which a merchant may obtain information from a consumer's check to initiate a one-time ACH debit from the consumer's account for

purchases or payments made in person by the consumer. The merchant uses electronic equipment to scan the MICR (Magnetic Ink Character Recognition) encoding on the check for the routing, account, and serial numbers of the check, and enters the amount to be debited from the consumer's account. Other entities have or are planning similar programs. Proposed comment 3(b)–1(v) would be added to clarify that where a check is provided at POS as a source document to initiate an EFT, the resulting transfer is covered by the regulation (see also proposed comment 2(a)–2).

NACHA has also considered rules for a variation on the electronic check conversion program described above in which the consumer provides a check, and the merchant or the merchant's financial institution would retain the check after it had been scanned. NACHA has solicited comment on this ''merchant or financial institution-as-keeper'' type of program, but has not yet approved its use. Some merchants, however, may be conducting electronic check programs of this type.

Regulation E applies where the consumer provides a blank or partially completed check as a source document that is scanned and retained by the merchant or the merchant's financial institution. To clarify the rights and responsibilities of the parties to a transaction where the check used as a source document is completed and signed by the consumer and is scanned and retained by the merchant, the transaction is an EFT and thus subject to Regulation E if the consumer authorizes it as such. (See cf. comment 3b–1(i).) Specific comment is solicited on this position and the extent to which merchants are currently carrying out transactions of the sort described.

NACHA has established rules for a pilot referred to as the ''lock-box'' program in which a merchant converts completed and signed checks received by mail to ACH debits. Consumers are informed of how the check payment will be processed. These transactions would not be covered by Regulation E since transfers originated by check are excluded from coverage. See § 205.3(c)(1).

Proposed comment 3(b)–1(vi) would be added to provide guidance on the regulation's coverage of bill-payment services where a consumer initiates payments via computer and the financial institution carries out the payment by check or draft. The definition of ''electronic fund transfer'' in § 205.3(b) covers these payments unless the terms of the bill-payment service explicitly state that payment by the bill payer will be made solely via check, draft or similar paper instrument.

3(c) Exclusions from Coverage

3(c)(1)—Checks

Proposed comment 3(c)(1)–1 would be added to provide guidance on NACHA's re-presented check entry (RCK) program, in which merchant payees (or their financial institutions or agents) re-present returned checks electronically. Written authorization from the consumer for the RCK debit is not obtained, although, the merchant payee usually has provided notice to the consumer that any returned item may be collected electronically if returned for insufficient or uncollected funds. The comment would clarify that an RCK transaction is not covered by Regulation E because the transfer is originated by check.

In some cases, a payee may impose a fee on the consumer, such as a collection or NSF fee, because the consumer's check was returned. The NACHA rules provide that the RCK debit must be in the amount of the original check. Therefore, the amount of the RCK debit may not be increased to include a fee, and the payee would have to initiate a separate debit to collect the fee electronically. Because an electronically debited fee would not be a part of the RCK debit, and appears to meet the definition of an EFT under Regulation E, it would be covered by the regulation and must be authorized by the consumer.

Proposed comment 3(c)(1)–2 would be added to provide a cross reference to proposed comment 3(b)–1(v), which provides guidance on the regulation's coverage of an EFT at POS where a consumer provides a check as a source document.

3(c)(6)—Telephone-Initiated Transfers

A transfer initiated by telephone is covered by Regulation E if it occurs pursuant to a telephone bill-payment or other written plan. Comment 3(c)(6)–1 would be revised to provide additional guidance on what constitutes a written plan. Proposed comment 3(c)(6)–2(v) would be added to clarify coverage of transfers initiated by audio or voice response telephone systems.

Section 205.6—Liability of Consumer for Unauthorized Transfers

6(b) Limitations on Amount of Liability

6(b)(1)—Timely Notice Given

Section 205.6 provides rules for a consumer's liability for an unauthorized transfer. The limitation on the consumer's liability depends, in part, on whether the unauthorized transfer takes place within or after two business days of the consumer's learning of the loss or theft of the access device. Proposed comment 6(b)(1)–3 would be added to clarify the timing on the two-business-day period.

Section 205.7—Initial Disclosures

7(a) Timing of Disclosures

The regulation generally requires that disclosures be provided at the time the consumer contracts for an EFT service or before the first transfer is made to or from the consumer's account. Comment 7(a)–2 currently provides an exception to the disclosure timing rules when the first EFT is a direct deposit. If the account-holding institution does not have prior notice of a direct deposit arrangement between the consumer and a third party, the institution must provide the Regulation E disclosures as soon as reasonably possible after the first direct deposit.

Comment 7(a)–2 would be revised to clarify that the special timing rules apply both to single and to recurring debits or credits. The account-holding institution may not always receive prior notice of a one-time or recurring credit to or debit from the consumer's account. For example, the consumer may authorize a third party to debit the account (without notifying the institution), and the third party's financial institution may fail to send prior notice to the consumer's institution.

7(b) Content of Disclosures

7(b)(10) Error Resolution

An error resolution notice must be provided as a part of a financial institution's initial disclosures under § 205.7 and annually under § 205.8. Comment 7(b)(10)–2 provides that a financial institution must have disclosed the longer error resolution time periods for resolving errors under § 205.11(c)(3) in order to use the longer times. In September 1998, § 205.11(c)(3) was amended to extend the error resolution time periods for new accounts (63 FR 5211, September 29, 1998). Comment 7(b)(10)–2 would be revised to reflect the amendment to § 205.11(c)(3).

Section 205.8—Change-in-terms Notice; Error Resolution Notice

8(b) Error Resolution Notice

If an institution seeks to use the longer error resolution time periods in § 205.11(c)(3), it must disclose them in the annual error resolution notice. Comment 8(b)–2 would be added to cross reference comment 7(b)(10)–2, which provides this guidance.

Section 205.9—Receipts at Electronic Terminals; Periodic Statements

9(a) Receipts at Electronic Terminals

9(a)(5) Terminal Location

Section 205.9(a)(5) requires that an ATM or POS terminal receipt contain the location of the terminal where the transfer is initiated, or an identification such as a code or terminal number. This section has been interpreted by some institutions to require a full description of the location (such as the street address) rather than simply a code. Comment 9(a)(5)–1 would be revised to clarify that a code may be disclosed. Comments 9(a)(5)(iv)–1 and –2 would be redesignated as comments 9(a)(5)–3 and –4.

9(b) Periodic Statements

Comment 9(b)–4 provides that an institution may permit, but not require, consumers to ''call for'' periodic statements. For clarity, the comment would be revised by changing the reference ''call for'' to ''pick up;'' no substantive change is intended.

9(c) Exceptions to the Periodic Statement Requirements for Certain Accounts

9(c)(1)—Preauthorized Transfers to Accounts

Section 205.9(c) lists the circumstances in which a periodic statement for EFT transactions is not required. Proposed comment 9(c)(1)–1 would be added to provide further guidance on the exceptions to the periodic statement requirements.

Proposed comment 9(c)(1)–2 would be added to clarify that the exceptions in § 205.9(c) apply to reversals of deposits made in error. (See also proposed comment 2(m)–5.)

Section 205.10—Preauthorized Transfers

10(b) Written Authorization for Preauthorized Transfers from Consumer's Account

Section 205.10(b) provides that recurring electronic debits from a consumer's account ''may be authorized only by a writing signed or similarly authenticated by the consumer.'' The phrase ''similarly authenticated'' was added to Regulation E in 1996 (61 FR 19678, May 2, 1996), and was intended to permit electronic authorizations. The supplemental information indicated that the authentication method should provide the same assurance as a signature in a paper-based system, and cited security codes and digital signatures as examples of authentication devices that could meet the requirements of § 205.10(b); and comment 10(b)–5 was added to the staff commentary to provide guidance on electronic authorizations.

The issue of electronic authentication methods has been further discussed in two Regulation E rulemakings in the past two years—first, in a March 1998 rulemaking in which the Board issued an interim rule permitting financial institutions to deliver electronically disclosures that are required to be given in writing (63 FR 14528); and second, in a September 1999 rulemaking in which the Board proposed more comprehensive rules for providing electronic disclosures under Regulation E (64 FR 49699) and certain other Board regulations. In these rulemakings, the Board again gave examples of authentication devices and expressed interest in learning about other electronic authentication methods.

Industry commenters suggested various alternatives for verifying a consumer's identity such as alphanumeric codes (combination of letters and numbers) or combination of unique identifiers (such as account numbers combined with a number representing algorithms of the account numbers). Some commenters requested additional examples of appropriate electronic authentication devices; many stated their concern that limiting the examples to security codes and digital signatures could be viewed as the Board's endorsement of particular methods, which could hinder the development of alternative authentication mechanisms. Other commenters disfavored examples of particular authentication mechanisms; they recommended that the Board defer to general principles set forth in various state and federal laws and legislative proposals. Consumer advocates, on the other hand, suggested that the Board should limit authentication methods to those that prevent documents from being altered without detection after the authentication is affixed, such as digital signatures.

The Congress has passed electronic commerce legislation that addresses, among other things, the use and acceptance of electronic signatures (broadly defined in the legislation) and records for electronic commerce in general. If the legislation becomes law, the ''similarly authenticated'' standard in Regulation E may become unnecessary. In the meantime, to ensure that institutions have flexibility in establishing authentication methods for purposes of § 205.10(b), comment 10(b)–5 would be revised. Any authentication mechanism that provides similar assurance to a paper-based signature (such as a mechanism that identifies the consumer and evidences the consumer's assent to the authorization) will satisfy the ''similarly authenticated'' standard. The word ''text'' is also substituted by ''term,'' no substantive change is intended.

The comment currently states that the person obtaining an electronic authorization from a consumer must make a paper copy of the authorization available to the consumer, either automatically or upon request. For consistency with Board rulemakings permitting the electronic delivery of disclosures, comment 10(b)–5 would also be revised to permit the person obtaining the authorization to provide a copy of the authorization to the consumer either in paper form or electronically.

The supplementary information to the Official Staff Commentary, discussing comment 10(b)–5 at the time of its adoption in 1996, stated that for home-banking systems, a security code used to ''similarly authenticate'' preauthorized transfers pursuant to § 205.10(b) must originate with the paying (account-holding) institution. The Board's position reflected concerns about the potential for increased liability for account-holding institutions associated with unauthorized use when a party other than the institution issued the code. Under NACHA operating rules, however (as well as operating rules of debit card networks), an account-holding institution is permitted to charge back to the payee's financial institution any transaction that was not properly authorized; thus, the payee's institution (or the payee) would bear the liability for unauthorized transfers. Accordingly, it seems unnecessary to require that a security code originate with the paying institution, provided the code meets the general standards for similar authentication discussed above.

Proposed comment 10(b)–7 would be added to address a situation where a consumer authorizes recurring charges against a credit card but in fact provides information for the consumer's debit card, for example, in an on-line transaction or in a telephone conversation with a merchant. Unlike Regulation E, Regulation Z and the Truth in Lending Act (12 CFR part 226) do not require a written, signed or ''similarly authenticated'' authorization for recurring charges to a consumer's credit card account. The proposed comment would clarify that when the consumer's account in fact involves a debit card, the payee is required to obtain an authorization in accordance with § 205.10(b), but may rely on the bona fide error provision in section

915(c) of the EFTA, provided procedures are in place to prevent such errors from occurring.

10(e) Compulsory Use

Section 205.10(e) prohibits a person from requiring a consumer to establish an account with a particular institution to receive electronic transfers, as a condition of employment. Comment 10(e)(2)–1 would be revised to clarify that an employer (including a financial institution) may specify an institution to receive direct deposits provided the employer also gives employees the option to receive their salary by check or cash.

Section 205.11—Procedures for Resolving Errors

11(a) Exception to the Periodic Statement Requirements for Certain Accounts

Comment 11(a)–2 would be revised to provide additional examples of when the error resolution rules are inapplicable because the consumer has not asserted an error.

Section 205.12—Relation to Other Laws

12(a) Relation to Truth in Lending

Comment 12(a)–1 would be revised to distinguish between two types of unauthorized transfers: those where a consumer's access device is used to withdraw funds from a checking account with an overdraft protection feature, and those where the consumer's access device is also a credit card separately used to obtain cash advances. Examples would illustrate how these rules apply in various situations.

Aggregation of Consumer Financial Information

The Board has been asked about the possible application of Regulation E to a service sometimes referred to as ''aggregation'' or ''screen-scraping.'' Aggregation is a service made available to consumers through an Internet web site, in which consumers are able to view their financial information from multiple sources, such as credit card, securities, and deposit accounts at a number of institutions. To enable the service provider (the ''aggregator'') to obtain the information and make it available to the consumer at the aggregator's web site, the consumer may provide the aggregator with account numbers and passwords to access the consumer's accounts. In addition to allowing consumers to view accounts in one location, aggregators may offer consumers EFT services such as bill-payment.

To assist the Board in providing any needed guidance on Regulation E's potential coverage, comment is solicited on how these services that aggregate consumer financial information operate or plan to operate. Are aggregators providing or planning to provide bill-payment or other EFT services (in addition to information services)? To what extent do agreements exist between aggregators and account-holding institutions, governing matters such as procedures for access to information and for electronic transfers?

In addition, comment is solicited on the implications of a determination that aggregators are or are not financial institutions for purposes of Regulation E generally or under § 205.14. Typically, only one access device is contemplated to initiate an EFT to or from a consumer's account. Nevertheless, if a consumer enters a security code issued by the aggregator to access information on the aggregator's web site and the consumer initiates an EFT using a security code provided by the account-holding institution, the security code issued by the aggregator arguably meets the definition of an ''access device.'' Two access codes (the one provided by the aggregator and the other by the account-holding institution) are needed to initiate electronic transfers from the consumer's account from the aggregator's web site. Thus, the aggregator would be a financial institution for purposes of Regulation E.

If the aggregator is not a financial institution and an unauthorized EFT occurs through an aggregator's service, comment 2(m)–2 could be read to suggest that a consumer who has given the aggregator access to the consumer's account assumes liability for the transfers. The guidance in the comment, however, was not originally provided to address this situation.

III. Form of Comment Letters

Comment letters should refer to Docket No. R–1074, and when possible, should use a standard typeface with a type size of 10 or 12 characters per inch. This will enable the Board to convert the text into machine-readable form through electronic scanning, and will facilitate automated retrieval of comments for review. Also, if accompanied by an original document in paper form, comments may be submitted on 3½ inch computer diskettes in any IBM-compatible DOS- or Windows-based format. Alternatively, comments may be mailed electronically to regs.comments@federalreserve.gov.

List of Subjects in 12 CFR Part 205

Consumer protection, Electronic fund transfers, Federal Reserve System, Reporting and recordkeeping requirements.

Text of Proposed Revisions

For the reasons set forth in the preamble, the Board proposes to amend the Official Staff Commentary, 12 CFR part 205, as set forth below. Certain conventions have been used to highlight the proposed changes to the commentary. New language is shown inside bold-faced arrows, while language that would be deleted is set off with bold-faced brackets.

PART 205—ELECTRONIC FUND TRANSFERS (REGULATION E)

1. The authority citation for part 205 would be revised to read as follows:

Authority: 15 U.S.C. 1693b.

2. In Supplement I to Part 205, the following amendments would be made:

a. Under *Section 205.2—Definitions,* under *2(a) Access Device,* a new paragraph 2. would be added;

b. Under *Section 205.2—Definitions,* under *2(h) Electronic Terminal,* paragraph 2. would be revised;

c. Under *Section 205.2—Definitions,* a new heading *2(k) Preauthorized Electronic Fund Transfer,* and a new paragraph 1. would be added;

d. Under *Section 205.2—Definitions,* under *2(m) Unauthorized Electronic Fund Transfer,* a new paragraph 5. would be added;

e. Under *Section 205.3—Coverage,* under *3(b) Electronic Fund Transfer,* new paragraphs 1.v. and 1.vi. would be added;

f. Under *Section 205.3—Coverage,* under *3(c) Exclusions from Coverage,* a new heading ''Paragraph 3(c)(1)—Checks'' would be added;

g. Under *Section 205.3—Coverage,* under *3(c) Exclusions from Coverage,* under newly added heading Paragraph 3(c)(1)—Checks, paragraphs 1. and 2. would be added;

h. Under *Section 205.3—Coverage,* under *3(c) Exclusions from Coverage,* under Paragraph 3(c)(6)—Telephone—Initiated Transfers, paragraph 1. would be revised and paragraph 2.v. would be added;

i. Under *Section 205.6—Liability of Consumer for Unauthorized Transfers,* under *Paragraph 6(b)(1)—Timely Notice Given,* new paragraph 3. would be added;

j. Under *Section 205.7—Initial Disclosures,* under *7(a) Timing of Disclosures,* paragraph 2. would be revised;

k. Under *Section 205.7—Initial Disclosures,* under Paragraph 7(b)(10) Error Resolution, paragraph 2. would be revised;

l. Under *Section 205.8—Change-in-Terms Notice; Error Resolution Notice,* under *8(b) Error Resolution Notice,* a new paragraph 2. would be added;

m. Under *Section 205.9—Receipts at Electronic Terminals; Periodic Statements,* under Paragraph 9(a)(5)—Terminal Location, paragraph 1. would be revised;

n. Under *Section 205.9—Receipts at Electronic Terminals; Periodic Statements,* under Paragraph 9(a)(5)(iv), paragraphs 1. and 2. are redesignated as paragraphs 3. and 4. under paragraph 9(a)(5) and republished;

o. Under *Section 205.9—Receipts at Electronic Terminals; Periodic Statements,* Paragraph 9(a)(5)(iv) would be removed;

p. Under *Section 205.9—Receipts at Electronic Terminals; Periodic Statements,* under *9(b) Periodic Statements,* paragraph 4. would be revised;

q. Under *Section 205.9—Receipts at Electronic Terminals; Periodic Statements,* under *9(c) Exceptions to the Periodic Statement Requirements for Certain Accounts,* a new heading, *Paragraph 9(c)(1)—Preauthorized Transfers to Accounts* would be added and new paragraphs 1. and 2. would be added to the newly designated heading;

r. Under *Section 205.10—Preauthorized Transfers,* under *10(b) Written Authorization for Preauthorized Transfers from Consumer's Account,* paragraph 5. would be revised, and new paragraph 7 would be added;

s. Under *Section 205.10—Preauthorized Transfers,* under *Paragraph 10(e)(2)—Employment or Government Benefit,* paragraph 1. would be revised;

t. Under *Section 205.11—Procedures for Resolving Errors,* under *11(a) Definition of Error,* paragraph 2. would be revised; and

u. Under *Section 205.12—Relation to Other Laws,* under *12(a) Relation to Truth in Lending,* paragraph 1. would be revised.

SUPPLEMENT I TO PART 205—OFFICIAL STAFF INTERPRETATIONS

Section 205.2—Definitions

2(a) Access Device

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►2. *Check used as a source document.* The term ''access device'' does not include a check or draft used as a source document to initiate an EFT. For example, a merchant may use equipment to scan the MICR (Magnetic Ink Character Recognition) encoding on a check (for the serial, account, and routing numbers) to initiate a one-time ACH debit from a consumer's account. The check is not an access device under Regulation E (12 CFR part 205), although the transaction is covered by the regulation (see comment 3(b)–1(v)).◄

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2(h) Electronic Terminal

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2. *POS terminals.* A POS terminal that captures data electronically, for debiting or crediting to a consumer's asset account, is an electronic terminal for purposes of Regulation E [if a debit card] ►even if no access device◄ is used to initiate the transaction. ►(See § 205.9 for receipt requirements.)◄

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►*2(k) Preauthorized Electronic Fund Transfer*

1. *Advance authorization.* A ''preauthorized electronic fund transfer'' under Regulation E is one authorized by the consumer in advance of a transfer which will take place on a recurring basis, at substantially regular intervals, and require no further action by the consumer to initiate the transfer. In a bill-payment system, for example, if the consumer authorizes a financial institution to make monthly payments to a payee, and the payments take place without further action by the consumer, the payments are preauthorized EFTs. In contrast, if the consumer must take action each month to initiate a payment (such as by entering instructions on a touch-tone telephone or home computer), the payments are not preauthorized EFTs.◄

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2(m) Unauthorized Electronic Fund Transfer

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►5. *Reversal of direct deposits.* A reversal of a direct deposit made in error is not an unauthorized EFT when it involves:

i. A credit made to the wrong consumer's account;

ii. A duplicate credit made to a consumer's account; or

iii. A credit in the wrong amount made to a consumer's account (for example, when the amount credited differs from the amount in the transmittal instructions). If, however, there is a dispute whether the account holder is entitled to a certain amount (for example, a salary or a government benefit payment) the reversal may be an unauthorized EFT, depending on the facts and circumstances.◄

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Section 205.3—Coverage

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3(b) Electronic Fund Transfer

1. *Fund transfers covered.* * * *

►v. A transfer from the consumer's account at POS where the merchant uses a consumer's check or draft as a source document to obtain the serial, account, and routing numbers.

vi. A payment made by a bill payer under a bill-payment service available to a consumer via computer or other electronic means, unless the terms of the bill-payment service explicitly state that payment will be solely by check, draft, or similar paper instrument.◄

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3(c) Exclusions from Coverage

►Paragraph 3(c)(1)—Checks

1. *Re-presented checks.* Electronic re-presentment of a returned check is not covered by Regulation E because the transfer originated by check. Regulation E does apply, however, to any fee debited electronically from the consumer's account for re-presenting the check electronically.

2. *Check used as a source document.* See comment 3(b)–1(v) regarding coverage of certain EFTs at POS where a consumer provides a check as a source document.◄

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Paragraph 3(c)(6)—Telephone-Initiated Transfers

1. *Written plan or agreement.* A transfer that the consumer initiates by telephone is covered ►by Regulation E◄ [only] if the transfer is made under a written plan or agreement between the consumer and the financial institution making the transfer. ►A written statement available to the public or to account holders that describes a service allowing a consumer to initiate transfers by telephone constitutes a plan—for example, a brochure, or material included with periodic statements. However, t◄ [T]he following do not, by themselves, constitute a written plan or agreement:

i. A hold-harmless agreement on a signature card that protects the institution if the consumer requests a transfer.

ii. A legend on a signature card, periodic statement, or passbook that limits the number of telephone-initiated transfers the consumer can make from a savings account because of reserve requirements under Regulation D (12 CFR part 204).

iii. An agreement permitting the consumer to approve by telephone the rollover of funds at the maturity of an instrument.

2. *Examples of covered transfers.* * * *

►v. The consumer initiates the transfer using a financial institution's audio response or voice response telephone system.◄

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Section 205.6—Liability of Consumer for Unauthorized Transfers

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6(b) Limitations on Amount of Liability

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Paragraph 6(b)(1)—Timely Notice Given

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►3. *Two-business-day rule.* The two-business-day period runs from midnight of the first business day after the consumer learns of the loss or theft and ends at midnight two business days later. The financial institution's business hours or the hour the consumer learns of the loss or theft does not govern the two-business-day period. For example, a consumer learns of the loss or theft at 6 p.m. on Friday. Assuming that the following Saturday is a business day and Sunday is not, the two-business-day period expires at midnight on Monday.◄

Section 205.7—Initial Disclosures

7(a) Timing of Disclosures

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2. [*Lack of prenotification of direct deposit.* In some instances, before direct deposit of government payments such as Social Security takes place, the consumer and the financial institution both will complete Form 1199A (or a comparable form providing notice to the institution) and the institution can make disclosures at that time. If an institution has not received advance notice that direct deposits are to be made to a consumer's account, the institution must provide the required disclosures as soon as reasonably possible after the first direct deposit is made, unless the institution has previously given disclosures.]►*Lack of advance notice of a transfer.* Where a consumer authorizes a third party to debit or credit the consumer's account, an account-holding institution that has not received advance notice of a transfer or transfers must provide the required disclosures as soon as reasonably possible after the first debit or credit is made, unless the institution has previously given the disclosures.◄

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Paragraph 7(b)(10)—Error Resolution

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2. *Exception from provisional crediting.* To take advantage of the longer time periods for resolving errors under § 205.11(c)(3) (for ►new accounts,◄ transfers initiated outside the United States, or resulting from POS debit-card transactions), a financial institution must have disclosed these longer time periods. Similarly, an institution that relies on the exception from provisional crediting in § 205.11(c)(2) for accounts subject to Regulation T (12 CFR part 220) must disclose accordingly.

Section 205.8—Change-in-Terms Notice; Error Resolution Notice

8(b) Error Resolution Notice

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►2. *Exception from provisional crediting.* See comment 7(b)(10)–2.◄

Section 205.9—Receipts at Electronic Terminals; Periodic Statements

9(a) Receipts at Electronic Terminals

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Paragraph 9(a)(5)—Terminal Location

1. [*Location code*]►*Options for identifying terminal.* The institution may provide either:

(i) The city, state or foreign country, and the information in §§ 205.9(a)(5)(i), (ii), or (iii), or

(ii) A number or a code identifying the terminal. If the institution chooses the second option, the◄ [A] code or terminal number identifying the terminal where the transfer is initiated may be given as part of a transaction code.

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►3. *Omission of a state.* A state may be omitted from the location information on the receipt if:

i. All the terminals owned or operated by the financial institution providing the statement (or by the system in which it participates) are located in that state, or

ii. All transfers occur at terminals located within 50 miles of the financial institution's main office.

4. *Omission of a city and state.* A city and state may be omitted if all the terminals owned or operated by the financial institution providing the statement (or by the system in which it participates) are located in the same city.◄

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9(b) Periodic Statements

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4. ►*Statement*◄[*Customer*] *pickup.* A financial institution may permit, but may not require, consumers to ►pick up◄[call for] their periodic statements ►at the financial institution◄.

* * * * *

9(c) Exceptions to the Periodic Statement Requirements for Certain Accounts

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►Paragraph 9(c)(1)—Preauthorized Transfers to Accounts◄

►1. *Accounts that may be accessed only by preauthorized transfers to the account.* The exception for ''accounts that may be accessed only by preauthorized transfers to the account'' includes accounts that can be accessed by means other than EFTs, such as checks. If, however, an account may be accessed by any EFT other than preauthorized credits to the account, such as preauthorized debits or ATM transactions, the account does not qualify for the exception.

2. *Reversal of direct deposits.* For direct-deposit-only accounts, a financial institution must send a periodic statement at least quarterly. A reversal of a direct deposit to correct an error does not trigger the monthly statement requirement when the error represented a credit to the wrong consumer's account, a duplicate credit to a consumer's account, or a credit in the wrong amount to a consumer's account. (See comment 2(m)–5 for guidance on the reversal of direct deposits and the rules for unauthorized EFTs.)◄

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Section 205.10—Preauthorized Transfers

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10(b) Written Authorization for Preauthorized Transfers from Consumer's Account

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5. *Similarly authenticated.* An example of a consumer's authorization that is not in the form of a signed writing but is instead ''similarly authenticated'' is a consumer's authorization via a home banking system[.]

►or other electronic communication system. An authentication device or procedure satisfies the ''similarly authenticated'' requirement if it provides similar assurance to a written signature (such as a device or procedure that verifies the consumer's identity and evidences the consumer's assent to the authorization). Examples include, but are not limited to, digital signatures and security codes.◄ [To satisfy the requirements of this section, there must be some means to identify the consumer (such as a security code) and to make available a paper copy of the authorization (automatically or upon request).] The [text] ►terms◄ of the electronic authorization would have to be displayed on a computer screen or other visual display which enables the consumer to read the communication. ►The person that obtains the authorization must provide a copy of the terms of the authorization to the consumer.◄ Only the consumer may authorize the transfer and not, for example, a third-party merchant on behalf of the consumer.

* * * * *

►7. *Bona fide error.* Consumers sometimes authorize, by telephone or on-line, third-party payees to submit recurring charges against a credit card account. If the consumer indicates use of a credit card when in fact a debit card is being used, the payee is not in violation of the requirement to obtain a written authorization if the failure to obtain written authorization was not intentional and resulted from a bona fide error, and the payee maintains procedures reasonably adapted to avoid any such error. If the payee is unable to determine whether a credit or debit card number is involved, at the time of the authorization, but later finds that the card used was a debit card, the payee must obtain a written and signed or (where appropriate) a similarly authenticated authorization as soon as reasonably possible, or cease debiting the consumer's account.◄

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10(e) Compulsory Use

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Paragraph 10(e)(2)-Employment or Government Benefit

1. *Payroll.* [A financial institution (as an employer)] ►An employer (including a financial institution)◄ may not require its employees to receive their salary by direct deposit [to that same institution or] to any [other] particular institution. An employer may require direct deposit of salary by electronic means if employees are allowed to choose the institution that will receive the direct deposit. Alternatively, an employer may give employees the choice of having their salary deposited at a particular institution ►(designated by the employer)◄ (, or receiving their salary by another means, such as by check or cash.

Section 205.11—Procedures for Resolving Errors

11(a) Definition of Error

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2. *Verifying* ►*a payment or an*◄ *account deposit.* If the consumer [merely] calls to ascertain ►whether a payment (for example, in a home-banking or bill-payment program) was made electronically or ◄whether a deposit made via ATM, preauthorized transfer, or any other type of EFT was credited to the account, without asserting an error, the error resolution procedures do not apply.

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Section 205.12—Relation to Other Laws

12(a) Relation to Truth in Lending

1. *Determining applicable regulation.* ►i. ◄For transactions involving access devices

that also constitute credit cards, whether Regulation E or Regulation Z (12 CFR part 226) applies, depends on the nature of the transaction. For example, if the transaction [is purely] ► solely involves ◄ an extension of credit, and does not include a debit to a checking account (or other consumer asset account), the liability limitations and error resolution requirements of Regulation Z [(12 CFR part 226)] apply. If the transaction only debits a checking account (with no credit extended), the provisions of Regulation E apply. [Finally, if] ► If ◄ the transaction debits a checking account but also draws on an overdraft line of credit ► attached to the account ◄, [the Regulation E provisions apply, as well as] §§ 226.13(d) and (g) of Regulation Z[.] ► apply, as well as the Regulation E provisions, because there was an extension of credit associated with the overdraft feature on the checking account.

In such a transaction, the liability provisions under Regulation E apply. Finally, if a consumer's access device is also a credit card and the device is used to make unauthorized withdrawals from a checking account, but also is used to obtain unauthorized cash advances directly from a separate line of credit unattached to the checking account, the liability limitations under both Regulation E and Regulation Z apply. In such a transaction, the consumer is potentially liable under Regulation Z for the unauthorized use of the credit card and, in addition, up to $50, $500, or an unlimited amount (not to exceed the amount of the unauthorized transfer) under Regulation E for the unauthorized use of the debit card◄ [In such a transaction, the consumer might be liable for up to $50 under Regulation Z (12 CFR 226) and, in addition, for $50, $500, or an unlimited amount under Regulation E].

► ii. The following examples illustrate these principles:

A. A consumer has a card that can be used either as a credit card or a debit card. When used as a debit card, the card draws on the consumer's checking account. When used as a credit card, the card draws only on a separate line of credit. If the card is stolen and used as a credit card to make purchases or to get cash advances from ATMs, the liability limits and error resolution provisions of Regulation Z apply; Regulation E does not apply.

B. In the same situation, if the card is stolen and is instead used as a debit card to make purchases or to get cash withdrawals from ATMs, the liability limits and error resolution provisions of Regulation E apply; Regulation Z does not apply.

C. In the same situation, the card is stolen and used both as a debit card and as a credit card; for example, the thief makes some purchases using the card as a debit card, and other purchases using the card as a credit card. Here, the liability limits and error resolution provisions of Regulation E apply to the unauthorized transactions in which the card was used as a debit card, and the corresponding provisions of Regulation Z apply to the unauthorized transactions in which the card was used as a credit card.

D. Assume a somewhat different type of card, one that draws on the consumer's checking account and can also draw on an overdraft line of credit attached to the checking account. There is no separate line of credit, other than the overdraft line, associated with the card. In this situation, if the card is stolen and used, the liability limits and the error resolution provisions of Regulation E apply. In addition, if the use of the card has resulted in accessing the overdraft line of credit, the error resolution provisions of § 226.13(d) and (g) of Regulation Z also apply; however, the other error resolution provisions of Regulation Z do not apply. ◄

* * * * *

By order of the Board of Governors of the Federal Reserve System, acting through the Director of the Division of Consumer and Community Affairs under delegated authority, June 22, 2000.

Jennifer J. Johnson,

Secretary of the Board.

[FR Doc. 00–16303 Filed 6–28–00; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF THE TREASURY

Customs Service

19 CFR Part 10

RIN 1515–AC59

Civil Aircraft

AGENCY: Customs Service, Department of the Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document proposes to amend the Customs Regulations concerning the duty-free entry of civil aircraft merchandise to reflect amendments to General Note 6 of the Harmonized Tariff Schedule of the United States made by the Miscellaneous Trade and Technical Corrections Act of 1996. This document invites the public to comment on the proposed changes.

DATES: Comments must be received on or before August 28, 2000.

ADDRESSES: Written comments (preferably in triplicate), regarding both the substantive aspects of the proposed rule and how it may be made easier to understand, may be submitted to and inspected at the Regulations Branch, Office of Regulations and Rulings, U.S. Customs Service, 1300 Pennsylvania Avenue, NW., 3rd Floor, Washington, DC 20229.

FOR FURTHER INFORMATION CONTACT: Ms. Dixie Staple, Office of Field Operations, at (202) 927–1131.

SUPPLEMENTARY INFORMATION:

Background

This document proposes to amend § 10.183 of the Customs Regulations (19 CFR 10.183), which concerns Customs duty-free treatment of civil aircraft merchandise. Section 10.183 implements General Note 6 of the Harmonized Tariff Schedule of the United States (HTSUS) (19 U.S.C. 1202), which implements the Agreement on Trade in Civil Aircraft (Title VI of the Trade Agreements Act of 1979, Pub. L. 96–39, 93 Stat. 144, July 26, 1979), to provide duty-free treatment for qualifying civil aircraft merchandise upon compliance with certain requirements.

General Note 6 of the HTSUS was amended by section 12 of the Miscellaneous Trade and Technical Corrections Act of 1996 (the Act), Pub. L. 104–295, 110 Stat. 3514 (October 11, 1996). Prior to the amendment, General Note 6, HTSUS, required that an importer entering merchandise duty-free thereunder must file with Customs a written statement certifying that the merchandise (i) Is civil aircraft or has been imported for use in civil aircraft, (ii) will be so used, and (iii) has been approved for civil aircraft use by, or an application for approval has been submitted to, the Administrator of the Federal Aviation Administration (FAA) (or has been approved by an airworthiness authority in the country of exportation if such approval is recognized by the FAA). General Note 6 defined the term ''civil aircraft'' as all aircraft other than aircraft purchased for use by the Department of Defense or the United States Coast Guard.

Prior to the amendment of General Note 6, HTSUS, § 10.183 of the Customs Regulations (19 CFR 10.183) provided that the written statement required under General Note 6, HTSUS (referred to in the regulation as a certificate or certification), must be filed with each entry summary or be on file with Customs at the time of entry as a blanket statement at the port where the entry is filed (19 CFR 10.183(c)). The regulation also provided that the statement could not be treated as a missing document for which a bond could be posted pending its later production (under 19 CFR 141.66), and that failure to timely file the statement or to have a valid blanket statement on file at the port would result in a dutiable entry (19 CFR 10.183(c)(2)).

The Act amended General Note 6, HTSUS, to eliminate the statement (certification) filing requirement and to provide that an importer makes a claim for duty-free treatment under the General Note by entering the merchandise under a tariff provision for which the program indicator ''Free (C)'' appears in the ''Special'' subcolumn of the tariff. This is accomplished by

placing the program indicator C'' on the entry summary. This claim, in accordance with General Note 6 as amended by the Act, is deemed the importer's certification that the merchandise being entered is civil aircraft or has been imported for use in civil aircraft and will be so used. Although the amendment eliminated the statement filing requirement, it requires that an importer maintain documentation to support the claim. It also provides that an importer may amend an entry or file a written statement to claim duty-free treatment under General Note 6, HTSUS, any time before the liquidation of the entry becomes final.

These statutory amendments to General Note 6, HTSUS, establish the basis for the amendments to § 10.183 proposed in this document. The proposed amendments to the regulation expand its coverage, eliminate the requirement that supporting documentation be filed with each entry summary, require that supporting documentation be maintained in the importer's records, eliminate the statement (certification) filing requirement, allow an importer to make a claim under General Note 6, HTSUS, after the filing of an entry but before its liquidation becomes final, and provide that no interest attaches to refunds of duty resulting from post-entry claims.

Comments

Before adopting this proposal as a final rule, consideration will be given to any written comments timely submitted to Customs. Comments submitted will be available for public inspection in accordance with the Freedom of Information Act (5 U.S.C. 552), § 1.4 of the Treasury Department Regulations (31 CFR 1.4), and § 103.11(b) of the Customs Regulations (19 CFR 103.11(b)) on regular business days between the hours of 9 a.m. and 4:30 p.m. at the Regulations Branch, Office of Regulations and Rulings, U.S. Customs Service, 1300 Pennsylvania Avenue, NW., 3rd Floor, Washington, DC

Eexcutive Order 12866

This document does not meet the criteria for a ''significant regulatory action'' as specified in E.O. 12866.

Regulatory Flexibility Act

Adoption of the proposed amendments regarding civil aircraft will make importations of such merchandise less burdensome for importers than is the case under current regulations. Accordingly, pursuant to the provisions of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*), it is certified that the proposed amendments to the Customs Regulations, if adopted, will not have a significant economic impact on a substantial number of small entities. The proposed amendments are not subject to the regulatory analysis or other requirements of 5 U.S.C. 603 and 604.

Paperwork Reduction Act

The collection of information contained in this notice has previously been reviewed and approved by the Office of Management and Budget (OMB) under OMB control number 1515–0065 (Entry Summary), 1515–0069 (Immediate Delivery Application), and 1515–0144 (Customs Bond Structure). This rule does not propose any substantive changes to the existing approved information collection.

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.

Drafting Information

The principal author of this document was Bill Conrad, Office of Regulations and Rulings, U.S. Customs Service. However, personnel from other offices contributed in its development.

List of Subjects IN 19 CFR Part 10

Aircraft, Customs duties and inspection, Entry, Reporting and recordkeeping requirements.

Proposed Amendments to the Regulations

For the reasons stated in the preamble, part 10 of the Customs Regulations (19 CFR Part 10) is proposed to be amended as follows:

PART 10—ARTICLES CONDITIONALLY FREE, SUBJECT TO A REDUCED RATE, ETC.

1. The general authority citation for part 10 continues to read, and the specific authority citation for § 10.183 is added, as follows:

Authority: 19 U.S.C. 66, 1202 (General Note 20, Harmonized Tariff Schedule of the United States (HTSUS)), 1321,1481,1484,1498,1508,1623, 1624, 3314;
* * * * *

Section 10.183 also issued under 19 U.S.C. 1202 (General Note 6, HTSUS);
* * * * *

2. Section 10.183 is revised to read as follows:

§ 10.183 Duty-free entry of civil aircraft, aircraft engines, ground flight simulators, parts, components, and subassemblies.

(a) *Applicability.* Except as provided in paragraph (b) of this section, this section applies to aircraft, aircraft engines, and ground flight simulators, including parts, components, and subassemblies thereof, that qualify as civil aircraft under General Note 6 of the Harmonized Tariff Schedule of the United States (HTSUS) by meeting the following requirements:

(1) The aircraft, aircraft engines, ground flight simulators, or parts, components, and subassemblies thereof, are used as original or replacement equipment in the design, development, testing, evaluation, manufacture, repair, maintenance, rebuilding, modification, or conversion of aircraft; and

(2) They are either:

(i) Manufactured or operated pursuant to a certificate issued by the Administrator of the Federal Aviation Administration (FAA) under 49 U.S.C. 44704, or pursuant to the approval of the airworthiness authority in the country of exportation, if such approval is recognized by the FAA as an acceptable substitute for the FAA certificate;

(ii) Covered by an application for such certificate, submitted to and accepted by the FAA, filed by an existing type and production certificate holder pursuant to 49 U.S.C. 44702 and implementing regulations (Federal Aviation Administration Regulations, title 14, Code of Federal Regulations); or

(iii) Covered by an application for such approval or certificate which will be submitted in the future by an existing type and production certificate holder, pending the completion of design or other technical requirements stipulated by the FAA (applicable only to the quantities of parts, components, and subassemblies as are required to meet the stipulation).

(b) *Department of Defense or U.S. Coast Guard use.* If purchased for use by the Department of Defense or the United States Coast Guard, aircraft, aircraft engines, and ground flight simulators, including parts, components, and subassemblies thereof, that qualify as civil aircraft under General Note 6 of the HTSUS are subject to this section only if they are used as original or replacement equipment in the design, development, testing, evaluation, manufacture, repair, maintenance, rebuilding, modification, or conversion of aircraft and meet the requirements of either paragraph (a)(2)(i) or (a)(2)(ii) of this section.

(c) *Claim for admission free of duty.* Merchandise qualifying under paragraph (a) or paragraph (b) of this section is entitled to duty-free admission in accordance with General Note 6, HTSUS, upon meeting the requirements of this section. An

importer makes a claim for duty-free admission under this section and General Note 6, HTSUS, by properly entering qualifying merchandise under a provision for which the rate of duty ''Free (C)'' appears in the ''Special'' subcolumn of the HTSUS and by placing the special indicator ''C'' on the entry summary. The fact that qualifying merchandise has previously been exported with benefit of drawback does not preclude free entry under this section.

(d) *Importer certification.* In making a claim for duty-free admission as provided for under paragraph (c) of this section, the importer is deemed to certify, in accordance with General Note 6(a)(ii), HTSUS, that the imported merchandise is civil aircraft as described in paragraph (a) or paragraph (b) of this section or has been imported for use in civil aircraft and will be so used.

(e) *Documentation.* Each entry summary claiming duty-free admission for imported merchandise in accordance with paragraph (c) of this section must be supported by the written order or contract and any additional documentation Customs may require to verify the claim for duty-free admission, including evidence of compliance with the FAA certification requirement of paragraph (a)(2)(i), (a)(2)(ii), or (a)(2)(iii) of this section. This required documentation need not be filed with the entry summary, but must be maintained in accordance with the recordkeeping provisions of part 163 of this chapter. An importer not in possession of the required supporting documentation at the time of entry may not then claim duty-free admission under this section but may later make a duty-free claim after entry in accordance with paragraph (f) of this section. Customs may request production of supporting documentation at any time to verify the claim for duty-free admission. Proof of end use of the entered merchandise need not be maintained.

(f) *Post-entry claim.* An importer may file a claim for duty-free treatment under General Note 6, HTSUS, after filing an entry that made no such duty-free claim, by filing a written statement with Customs any time prior to liquidation or prior to the liquidation becoming final. When filed, the written statement constitutes the importer's deemed certification. In accordance with General Note 6, HTSUS, any refund resulting from a claim made under this paragraph will be without interest, notwithstanding the provision of 19 U.S.C. 1505(c).

(g) *Verification.* The port director will monitor and periodically audit selected entries made under this section.

Approved: June 7, 2000.

Raymond W. Kelly,

Commissioner of Customs.

John P. Simpson,

Deputy Assistant Secretary of the Treasury.

[FR Doc. 00–16406 Filed 6–28–00; 8:45 am]

BILLING CODE 4820–02–P

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 181

[CGD 92–065]

RIN 2115–AE37

Hull Identification Numbers for Recreational Boats

AGENCY: Coast Guard, DOT.

ACTION: Supplemental notice of proposed rulemaking; termination.

SUMMARY: The Coast Guard is terminating its rulemaking intended to amend its regulations on the identification number placed on the hull of a vessel. There is no consensus on the format for an expanded HIN and the Coast Guard lacks sufficient data to demonstrate that the benefits clearly outweigh the costs and burdens, particularly for small entities and the builders of high-volume, low cost boats.

DATES: This proposed rulemaking is terminated on June 29, 2000.

FOR FURTHER INFORMATION CONTACT: Alston Colihan, Office of Boating Safety, Recreational Boating Product Assurance Division, 202–267–0981.

SUPPLEMENTARY INFORMATION:

Regulatory History

The Coast Guard published a Notice of Proposed Rulemaking in the **Federal Register** (59 FR 23651) on May 6, 1994, proposing to expand the existing 12-character hull identification number (HIN) to include certain vessel-specific information similar to the Vehicle Identification Number (VIN) on an automobile. A check digit in the expanded HIN would make alteration of an HIN more difficult, thereby helping to prevent fraud in the sale of vessels.

Major objections to the proposed 19-character HIN were received based on the increased information collection burdens, particularly on small entities and the builders of high-volume, low cost boats, such as canoes, kayaks, and inflatables. In addition, the International Standards Organization (ISO) had finalized an HIN standard consisting of the existing Coast Guard 12-character HIN format preceded by a 2-character country code and a hyphen. Manufacturers in the U.S. who export to Europe would be using the ISO HIN standard beginning with the 1996 model year. Builders would have to affix HINs in two different formats or know in advance whether a boat would be sold in the U.S. or in Europe.

In consideration of the objections received about information-collection burdens, we published a Supplemental Notice of Proposed Rulemaking (SNPRM) in the **Federal Register** on February 21, 1997 (62 FR 7971) announcing a proposal to align the HIN with the recently adopted ISO 14-character HIN standard. We received 31 comments nearly all of which were opposed to the 14-character ISO HIN format. Some of the comments indicated that, if the Coast Guard were to adopt the ISO format instead of an HIN format consisting of vessel-specific characters and a check digit, some States might refuse to participate in the development of the Vessel Identification System (VIS).

Therefore, in an attempt to gather information to resolve conflicting issues, we published a Request for Comments in the **Federal Register** on November 16, 1998 (63 FR 63638), soliciting comments on: (1) The expected benefits of an expanded HIN with vessel-specific characters and a check digit; (2) the manner in which the Coast Guard should exempt small entities and the builders of high-volume, low cost boats, such as canoes, kayaks, and inflatables; and (3) the estimated burdens and costs to boat manufacturers if the HIN regulations were revised to require vessel-specific characters and a check digit.

We received 31 comments, only one of which contained any economic data which could be used to determine the benefits of a requirement for an expanded HIN containing vessel-specific characters and a check digit. Only four comments were in favor of allowing exceptions for small entities and the builders of high-volume, low cost boats, such as canoes, kayaks, and inflatable boats. None of the comments contained information about the estimated burdens and costs to boat manufacturers.

Withdrawal

This proposed rulemaking is terminated because of (1) the lack of substantive information about the benefits to society with a requirement for an expanded HIN containing vessel-specific characters and a check digit,

and (2) an inability to address issues involving exemptions for small entities and the builders of high-volume, low cost boats, such as canoes, kayaks, and inflatables. For these reasons, we are terminating further rulemaking under docket number CGD 92–065.

We are initiating a study to gather data on the costs and benefits of an expanded HIN format and potential adverse impacts on small entities. We will review the results of the study and decide whether or not to open a new regulatory project in the future.

Dated: June 21 2000.

Terry M. Cross,

Rear Admiral, U.S. Coast Guard, Assistant Commandant for Operations.

[FR Doc. 00–16449 Filed 6–28–00; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF TRANSPORTATION

Saint Lawrence Seaway Development Corporation

33 CFR Part 401

[Docket No. SLSDC 2000–7543]

RIN 2135–AA11

Seaway Regulations and Rules: Miscellaneous Amendments

AGENCY: Saint Lawrence Seaway Development Corporation, DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Saint Lawrence Seaway Development Corporation (SLSDC) and the St. Lawrence Seaway Management Corporation of Canada (SLSMC) publish joint Seaway Regulations. The SLSDC and the SLSMC have determined that a number of existing regulations need to be amended. Only four of the amendments in this proposal are substantive and of applicability in both U.S. and Canadian waters. Accordingly, comments are invited on only these four proposed amendments. (See **SUPPLEMENTARY INFORMATION**.)

The remaining amendments are merely editorial, ministerial, for clarification without substantive change in interpretation, or applicable only in Canada. The Canada Marine Act has abolished the Saint Lawrence Seaway Authority of Canada and replaced it with the SLSMC, made changes in the manner in which the SLSMC conducts or may conduct its operations as compared to the Authority, and made minor changes in some of the terminology used in the Canadian law applicable to the Seaway. Accordingly, most of the amendments in this proposal are strictly editorial, reflect procedures undertaken unilaterally by the SLSMC, or otherwise are applicable only in Canada because of unilateral action by the SLSMC or Canadian law. Accordingly, the SLSDC is not requesting comments on these amendments, even though they appear in this proposal. Other changes are due strictly to Canadian circumstances or unilateral action, such as: removal of reference to bridges that no longer exist; removal of references to the Canadian entity in the rules on detention and sale; and adding provisions that are only applicable on Canadian property. Some minor changes in numbering and lettering also are being made.

DATES: Any party wishing to present views on the proposed amendments may file comments with the Corporation on or before July 31, 2000.

ADDRESSES: Signed, written comments should refer to the docket number appearing at the top of this document and must be submitted to the Docket Clerk, U.S. DOT Dockets, Room PL–401, 400 Seventh Street, SW, Washington, DC 20590–0001. Written comments may also be submitted electronically by using the submission form at *http://dmses.dot.gov/submit/BlankDSS.asp.* All comments received will be available for examination between 9 a.m. and 5 p.m., E.T., Monday through Friday, except federal holidays. Those desiring notification of receipt of comments must include a self-addressed, stamped envelope or postcard.

FOR FURTHER INFORMATION CONTACT: Marc C. Owen, Chief Counsel, Saint Lawrence Seaway Development Corporation, 400 Seventh Street, SW, Washington, DC 20590, (202) 366–6823.

SUPPLEMENTARY INFORMATION: As a result of discussions with the Saint Lawrence Seaway Management Corporation of Canada, the Saint Lawrence Seaway Development Corporation proposes to amend the Seaway Regulations and Rules in 33 CFR part 401 as described in the following summary.

Only four of the amendments in this proposal are substantive and of applicability in both U.S. and Canadian waters. Accordingly, comments are invited on only these four proposed amendments, which are as follows.

Section 401.3, ''Maximum vessel dimensions'', would be amended by revising paragraph (e) to allow a vessel with a beam in excess of 23.2 m, but not more than 23.8 m. and an overall length in excess of 222.5 m, but not more than 225.5 m, to be considered for transit upon application to the SLSMC and SLSDC. This proposal follows successful feasibility testing by both corporations. Section 410.10, ''Mooring lines'', would be amended by adding a new paragraph (a)(2) requiring mooring lines to have a diameter not greater than 28 mm. This is in response to safety concerns for linehandling personnel of both corporations. The larger, heavier mooring lines that have been used by some vessels are difficult to handle and may cause back injuries.

Section 401.13, ''Hand lines'', would be amended by changing the minimum diameter from 12 mm to 15 mm, the maximum diameter from 20 mm to 17 mm, and the minimum length from 35 m to 30 m for similar safety of linehandling personnel reasons. Schedule III, ''Calling-In Table'', would be amended by changing a number of reporting requirements at certain calling-in points. The SLSDC and the SLSMC now share the same computer database, which eliminates the need for vessels to report particulars more than once unless a change has occurred.

The remaining amendments, described in the rest of this preamble, are merely editorial, ministerial, for clarification without substantive change in interpretation, or applicable only in Canada. Some minor changes in numbering and lettering also are being made.

The Canada Marine Act has abolished the Saint Lawrence Seaway Authority of Canada and replaced it with the SLSMC, made changes in the manner in which the SLSMC conducts or may conduct its operations as compared to the Authority, and made minor changes in some of the terminology used in the Canadian law applicable to the Seaway. Accordingly, most of the amendments in this proposal are strictly editorial, reflect procedures undertaken unilaterally by the SLSMC, or otherwise are applicable only in Canada because of unilateral action by the SLSMC or Canadian law. Accordingly, the SLSDC is not requesting comments on these amendments, even though they appear in this proposal. The principal change of this type is wherever the terms ''Saint Lawrence Seaway Authority'', ''Authority'', *etc.* appears, they are replaced with ''Saint Lawrence Seaway Management Corporation'', ''Manager'', etc. Another change is the term ''vessel'' is referred to as ''ship'' in the Canadian Act and the regulations will so note. Similarly, the SLSMC now refers to the ''Tariff of Tolls'' as the ''Schedule of Tolls'' and to ''tolls and charges'' as ''fees'', both of which also are to be noted in the regulations. Finally, the SLSMC now refers to these regulations as ''Practices and Procedures'' and that is so noted.

There are a number of changes that merely reflect current Canadian practice

in their procedures for clearances and tolls collection, and similar matters, such as adding a requirement for 3 copies of applications for preclearance in section 401.24 or the type of bonding they will accept in paragraph 401.26(a)(5). Some administrative provisions, such as paragraphs 401.26(b), 401.54(a), and 401.59(c) and section 401.33, have been rewritten simply for clarity with no substantive change. In addition, where the Canadian SLSMC is solely handling the administrative aspect of the Seaway's operations, such as in section 401.26 for security for tolls, references to the SLSDC are being removed.

Other changes are due strictly to Canadian circumstances or unilateral action include: removal of the reference to Bridges 20 and 21 in paragraph 401.52(b) is removed because the bridges no longer exist; removal of references to the Canadian entity in the rules on detention and sale, sections 401.86, 401.87, and 401.88, which the SLSMC will no longer use, but which remain of current and prospective use by the SLSDC. Finally, new paragraphs (b) and (c) are being added to section 401.90, ''Boarding for inspection'', which are only applicable on Canadian property.

Regulatory Evaluation

This proposed regulation involves a foreign affairs function of the United States, and therefore, Executive Order 12866 does not apply. This proposed regulation has also been evaluated under the Department of Transportation's Regulatory Policies and Procedures and the proposed regulation is not considered significant under those procedures and its economic impact is expected to be so minimal that a full economic evaluation is not warranted.

Regulatory Flexibility Act Determination

The Saint Lawrence Seaway Development Corporation certifies that this proposed regulation, if adopted, would not have a significant economic impact on a substantial number of small entities. The St. Lawrence Seaway Regulations and Rules primarily relate to the activities of commercial users of the Seaway, the vast majority of whom are foreign vessel operators. Therefore, any resulting costs will be borne mostly by foreign vessels.

Environmental Impact

This proposed regulation does not require an environmental impact statement under the National Environmental Policy Act (49 U.S.C. 4321, *et seq.*) because it is not a major federal action significantly affecting the quality of human environment.

Federalism

The Corporation has analyzed this rule under the principles and criteria in Executive Order 13132, Dated August 4, 1999, and has determined that it will not have a substantial, direct effect on the States or on the distribution of power and responsibilities among various levels of government. The rule will not limit the policymaking discretion of the States. Nothing in it would directly preempt any State law or regulation. Because the rule will have no significant effect on State or local governments, no consultations with those governments on this rule were necessary.

Paperwork Reduction Act

This proposal has been analyzed under the Paperwork Reduction Act of 1995 and does not contain new or modified information collection requirements subject to the Office of Management and Budget review.

List of Subjects in 33 CFR Part 401

Hazardous materials transportation, Navigation (water), Radio reporting and record keeping requirements, Vessels, Waterways.

Accordingly, the Saint Lawrence Seaway Development Corporation proposes to amend Part 401—Seaway Regulations and Rules (33 CFR Part 401) as follows:

PART 401—[AMENDED]

1. The authority citation for part 401, subpart A, would be revised to read as follows:

Authority: 33 U.S.C. 983(a) and 984(a)(4), as amended; 49 CFR 1.50a, unless otherwise noted.

§ 401.1 [Amended]

2. Section 401.1 would be amended by adding the parenthetical phrase ''(the Practices and Procedures in Canada)'' after the words ''Seaway Regulations''.

3. Section 401.2 would be amended as follows:

a. Remove paragraph (a).

b. Redesignate paragraphs (b) and (c) as paragraphs (a) and (b).

c. Add a new paragraph (c).

d. Redesignate current paragraphs (m) through (p) as paragraphs (o) and (r).

e. Add new paragraphs (m) and (n).

f. In newly redesignated paragraph (q), add the parenthetical phrase ''('ship' in Canada)'' after the word ''Vessel''.

g. In newly redesignated paragraph (q), add the parenthetical phrase ''('ship traffic controller' in Canada)'' after the word ''controller''.

The additions read as follows:

§ 401.2 Interpretation.

* * * * *

(c) ''Manager'' means the St. Lawrence Seaway Management Corporation;

* * * * *

(m) ''Tariff of Tolls'' means the same as ''Schedule of Tolls in Canada.''

(n) ''Tolls(s)'' or ''tolls and charges'' is included in the definition of ''fees'' in Canada.

* * * * *

4. Section 401.3 would be amended by revising paragraph (e) to read as follows:

§ 401.3 Maximum vessel dimensions.

* * * * *

(e) A vessel having a beam width in excess of 23.2 m, but not more than 23.8 m, and having dimensions that do not exceed the limits set out in the block diagram in appendix I of this part or overall length in excess of 222.5 m, but not more than 225.5 m, shall, on application to the Manager or Corporation, be considered for transit in accordance with directions issued by the Manager and Corporation.

* * * * *

5. Section 401.10 would be amended by redesignating current paragraphs (a)(2), (3), and (4) as paragraphs (a)(3), (4), and (5) and by adding a new paragraph (a)(2) to read as follows:

§ 401.10 Mooring lines.

(a) * * *

(2) Have a diameter not greater than 28mm;

* * * * *

6. Section 401.13 would be amended by revising paragraph (b) to read as follows:

§ 401.13 Hand lines.

* * * * *

(b) Be of uniform thickness and have a diameter of not less than 15 mm and not more than 17 mm and a minimum length of 30 m.

* * * * *

§ 401.22 [Amended]

7. Section 401.22 would be amended by removing the words ''the Corporation or'' the first time they appear in paragraph (a).

§ 401.24 [Amended]

8. Section 401.24 would be amended by adding the parenthetical phrase ''(3 copies)'' after the word ''form''.

§ 401.25 [Amended]

9. Section 401.25 would be amended by removing the words ''in writing'' in paragraph (a).

10. Section 401.26 would be revised to read as follows:

§ 401.26 Security for tolls.

(a) Before transit by a vessel to which the requirement of preclearance applies, security for the payment of tolls in accordance with the ''St. Lawrence Seaway Tariff of Tolls'' as well as security for any other charges, shall be provided by the representative by means of:

(1) A deposit of money with the Manager;

(2) A deposit of money to the credit of the Manager with a bank in the United States or a member of the Canadian Payments Association, a corporation established by section 3 of the Canadian Payments Association Act, or a local cooperative credit society that is a member of a central cooperative credit society having membership in the Canadian Payments Association;

(3) A deposit with the Manager of negotiable bonds of the Government of the United States or the Government of Canada; or

(4) A letter of guarantee to the Manager given by an institution referred to in paragraph (a)(2) of this section.

(5) A letter of guarantee or bond given to the Manager by an acceptable Bonding Company. Bonding companies may be accepted if they:

(i) Appear on the list of acceptable bonding companies as issued by the Treasury Board of Canada; and

(ii) Meet financial soundness requirements as may be defined by the Manager at the time of the request.

(b) The security for the tolls of a vessel shall be sufficient to cover the tolls established in the ''St. Lawrence Seaway Tariff of Tolls'' for *the* gross registered tonnage of the vessel, cargo carried, and lockage tolls as estimated by the Manager.

(c) Where a number of vessels:

(1) For each of which preclearance has been given;

(2) Are owned or controlled by the same individual or company; and

(3) Have the same representative, the security for the tolls is not required if the individual, company, or representative has paid every toll invoice received in the preceding five years within the period set out in § 401.75(a).

(d) Notwithstanding paragraph (c) of this section, where a number of vessels, for each of which a preclearance has been given, are owned or controlled by the same individual or company and have the same representative, the security for tolls may be reduced or eliminated provided the representative has paid every toll invoice received in the preceding five years within the period set out in § 401.75(a). The representative must provide the Manager with a financial statement that meets the requirements established by the Manager.

(e) Where, in the opinion of the Manager, the security provided by the representative is insufficient to secure the tolls and charges incurred or likely to be incurred by a vessel, the Manager may suspend the preclearance of the vessel.

11. Section 401.28 would be amended by revising paragraphs (a) and (b) to read as follows:

§ 401.28 Speed limits.

(a) The maximum speed over the bottom for a vessel of more than 12 m in overall length shall be regulated so as not to adversely affect other vessels or shore property, and in no event shall such a vessel proceeding in any area between the place set out in Column I of an item of Schedule II to this part and a place set out in Column II of that item exceed the speed set out in Column III or Column IV of that item, whichever speed is designated by the Corporation and the Manager in a Seaway Notice from time to time as being appropriate to existing water levels.

(b) Where the Corporation or the Manager designate any speed less than the maximum speeds set out in Schedule II of this part, that speed shall be transmitted as transit instructions referred to in § 401.27.

* * * * *

12. Section 401.29 would be amended by revising paragraph (b) to read as follows:

§ 401.29 Maximum draft.

* * * * *

(b) The draft of a vessel shall not, in any case, exceed 79.2 dm or the maximum permissible draft designated in a Seaway Notice by the Corporation and the Manager for the part of the Seaway in which a vessel is passing.

* * * * *

13. Section 401.33 would be revised to read as follows:

§ 401.33 Special instructions.

No vessel of unusual design, vessel, or part of a vessel under tow, or vessel whose dimensions exceed the maximum vessel dimensions § 401.3 shall transit the Seaway except in accordance with special instructions of the Corporation or the Manager given on the application of the representative of the vessel.

§ 401.37 [Amended]

14. Section 401.37 would be amended by inserting the words ''U.S. Coast Guard or Canadian approved'' after the word ''wear''.

§ 401.52 [Amended]

15. Section 401.52 would be amended by removing the phrase ''or at Bridges 20 and 21 on the Welland Canal''.

§ 401.54 [Amended]

16. Section 401.54 would be amended by removing the words ''moored to'' in paragraph (a) and adding in their place the words ''used as moorings''.

§ 401.59 [Amended]

17. Section 401.59 would be amended by adding the words ''by the vessel'' after the word ''kept'' in paragraph (c).

§ 401.68 [Amended]

18. Section 401.68 would be amended by removing the word ''Authority'' and adding in its place the words ''Management Corporation'' in paragraph (c).

19. Section 401.74 would be amended by revising paragraphs (a), (e), (f) and (g) to read as follows:

§ 401.74 Transit declaration.

(a) A Seaway Transit Declaration Form (Cargo and Passenger) shall be forwarded to the Manager by the representative of a vessel, for each vessel that has an approved preclearance except non-cargo vessels within fourteen days after the vessel enters the Seaway on any upbound or downbound transit. The form may be obtained from the Saint Lawrence Seaway Development Corporation, P.O. Box 520, Massena, New York 13662, or the St. Lawrence Seaway Management Corporation, 202 Pitt Street, Cornwall, Ontario K6J 3P7.

* * * * *

(e) Where a Seaway Transit Declaration Form is found to be inaccurate concerning the destination, cargo or passengers, the representative shall immediately forward to the Manager a revised Declaration Form.

(f) Seaway Transit Declaration Forms shall be used in assessing toll charges in accordance with the St. Lawrence Seaway Tariff of Tolls and toll accounts shall be forwarded in duplicate to the representative or its designated agent.

(g) Where government aid cargo is declared, appropriate Canadian (Revenue Canada Customs and Excise form B–13) or U.S. (Shippers Export Declaration form 7525) customs form or a stamped and signed certification letter from the U.S. or Canada Customs must accompany the transit declaration form.

§ 401.75 [Amended]

20. Section 401.75 would be amended by removing the phrase ''Or American funds, as indicated on the invoice,'' and adding in their place the word ''funds'' in paragraph (a).

21. Section 401.81 would be amended by revising paragraph (a) to read as follows:

§ 401.81 Reporting an accident.

(a) Where a vessel on the Seaway is involved in an accident, the master of the vessel shall report the accident to the nearest Seaway station immediately or as soon as the vessel can make radio contact with the station.

* * * * *

§ 401.84 [Amended]

22. Section 401.84 would be amended by removing the number ''401.21'' and adding in its place the number ''401.19'' in paragraph (c).

§§ 401.86, 401.87, and 401.88 [Amended]

23. In Sections 401.86, 401.87, and 401.88, remove the words ''or the Authority'' wherever they appear in the following places;

a. Section 401.86(a), (b), and (c).

b. Section 401.87(c), (d), and (d)(3).

c. Section 401.88(a)(2) and (b).

§ 401.89 [Amended]

24. Section 401.89 would be amended by removing the number ''401.6'' and adding in its place the number ''401.5'' and removing the number ''401.21'' and adding in its place the number ''401.19'' in paragraph (a)(1).

25. Section 401.90 would be revised to read as follows:

§ 401.90 Boarding for inspections.

(a) For the purpose of enforcing these Regulations in this part in both Canadian and U.S. waters, an officer may board any vessel and:

(1) Examine the vessel and its cargo; and

(2) Determine that the vessel is adequately manned.

(b) In addition to § 401.90(a)(1) and (2) in Canadian waters, a Manager's officer may also:

(1) Require any person appearing to be in charge of the vessel to produce for inspection, or for the purpose of making copies or extracts, any log book, document or paper; and

(2) In carrying out an inspection:

(i) Use or cause to be used any computer system or data processing system on the vessel to examine any data contained in, or available to, the system;

(ii) Reproduce any record, or cause it to be reproduced from the data, in the form of a print-out or other intelligible output and remove the print-out or other output for examination or copying; and

(iii) Use or cause to be used any copying equipment in the vessel to make copies of any books, records, electronic data or other documents.

(c) In Canadian waters, the owner or person who is in possession or control of a vessel that is inspected, and every person who is found on the vessel, shall:

(1) Give the officer all reasonable assistance to enable the officer to carry out the inspection and exercise any power conferred by the Canada Marine Act; and

(2) Provide the officer with any information relevant to the administration of these practices and procedures that the officer may reasonable require.

§ 401.93 [Amended]

26. Section 401.93 would be amended by adding the words ''or its successor'' after the words ''*Shore Traffic Regulations*'' in paragraph (b).

§ 401.94 [Amended]

27. The heading for § 401.94 would be amended by removing the word ''copy'' and adding in its place the word ''copies''.

Schedule III to Subpart A [Amended]

28. Schedule III to subpart A, part 401 would be amended as follows:

a. Amend item 5 by removing items 3, 4, and 5 in the third column, under the heading ''Message Content'', and redesignating item 6 in that column as item 3.

b. Amend item 8 by removing the words ''and call sign'' from item 1 in the third column, under the heading ''Message Content'', by removing items 5 and 6 in that column, and adding a new item 5 in that column to read as follows, ''5. All ports of call''.

c. Amend item 19 by removing items 3, 4, 5, and 6 in the third column, under the heading ''Message Content'', and redesignating item 7 in that column as item 3.

d. Amend item 35 by removing item 3 in the third column, under the heading ''Message Content''.

e. Amend item 36 by removing items 3, 4, and 5 in the third column, under the heading ''Message Content'', and 20 redesignating items 6 and 7 in that column as items 3 and 4.

f. Amend item 40 by removing items 3, 4, and 5 in the third column, under the heading ''Message Content''.

§§ 401.2, 401.12, 401.13, 401.22, 401.24, 401.25, 401.31, 401.34, 401.54, 401.59, 401.66, 401.72, 401.78, 401.91, 401.92, 401.93, 401.96, 401.97, and Schedule II to subpart A [Amended]

PART 401—[AMENDED]

29. In addition to the amendments set forth above, in 33 CFR part 401 remove the word ''Authority'' and add in its place the word ''Manager'' in the following places:

a. Section 401.2(d), (e), (h), (j), and (k);

b. Section 401.12(a)(2) and (a)(4)(ii);

c. Section 401.13(a);

d. Section 401.22(a);

e. Section 401.24;

f. Section 401.25;

g. Section 401.31(b);

h. Section 401.34;

i. Section 401.54(b);

j. Section 401.59(d);

k. Section 401.66(b);

l. Section 401.72(e);

m. Section 401.78(b);

n. Section 401.91;

o. Section 401.92;

p. Section 401.93(a) and (b);

q. Section 401.96(a), (b), (c), and (e);

r. Section 401.97(a), (b)(2), and (d); and

s. Footnote 1 to Schedule II to subpart A, ''Table of Speeds''.

Issued at Washington, D.C. on June 20, 2000.

Saint Lawrence Seaway Development Corporation.

Marc C. Owen,

Chief Counsel.

[FR Doc. 00–16409 Filed 6–28–00; 8:45 am]

BILLING CODE 4910–61–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

RIN 1018–AF32

Endangered and Threatened Wildlife and Plants; Reopening of Comment Period and Notice of Availability of Draft Economic Analysis for Proposed Critical Habitat Determination for the Coastal California Gnatcatcher

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed rule; reopening of comment period and notice of availability of draft economic analysis.

SUMMARY: The U.S. Fish and Wildlife Service announces the availability of the draft economic analysis for the proposed designation of critical habitat for the coastal California gnatcatcher (*Polioptila californica californica*). We are also providing notice of the

reopening of the comment period for the proposal to designate critical habitat for the coastal California gnatcatcher to allow all interested parties to submit written comments on the proposal and on the draft economic analysis. Comments previously submitted need not be resubmitted as they will be incorporated into the public record as a part of this reopened comment period and will be fully considered in the final rule.

DATES: The original comment period on the critical habitat proposal closed on April 7, 2000. The comment period is again reopened and we will accept comments until July 31, 2000. Comments must be received by 5:00 p.m. on the closing date. Any comments that are received after the closing date may not be considered in the final decision on this proposal.

ADDRESSES: Copies of the draft economic analysis are available on the Internet at ''www.r1.fws.gov.'' or by writing to the Field Supervisor, U.S. Fish and Wildlife Service, Carlsbad Fish and Wildlife Office, 2730 Loker Avenue West, Carlsbad, California, 92008. Written comments should be sent to the Field Supervisor at the above address. You may also send comments by electronic mail (e-mail) to ''http://pacific.fws.gov/crithab/cg.'' Please submit electronic comments in ASCII file format and avoid the use of special characters and encryption. Please include ''Attn: [RIN 1018–AF32]'' and your name and return address in your e-mail message. If you do not receive a confirmation from the system that we have received your e-mail message, contact us directly by calling our Carlsbad Fish and Wildlife Office at phone number 760–431–9440. Comments and materials received will be available for public inspection, by appointment, during normal business hours at the above Service address.

FOR FURTHER INFORMATION CONTACT: Douglas Krofta, Fish and Wildlife Biologist, Carlsbad Fish and Wildlife Office, at the above address (telephone 760–431–9440; facsimile 760–431–9624).

SUPPLEMENTARY INFORMATION:

Background

The coastal California gnatcatcher is a small, insect-eating bird with dark blue-gray plumage above and grayish-white plumage below. The tail is mostly black above and below. The male has a distinctive black cap which is absent during the winter. Both sexes have a distinctive white eye-ring. The coastal California gnatcatcher is primarily restricted to sage scrub and scrub habitats found in coastal southern California and northwestern Baja California, Mexico, from Ventura and San Bernardino counties, California, south to approximately El Rosario, Mexico, at about 30° north latitude. The once-common species was federally listed as threatened in March 1993, due to habitat loss and fragmentation resulting from urban and agricultural development, and the cumulative effects of cowbird parasitism and predation (58 FR 16742). On February 7, 2000, we published a determination proposing 323,726 hectares (799,916 acres) of sage scrub and scrub habitats as critical habitat for the coastal California gnatcatcher in the **Federal Register** (65 FR 5946) pursuant to the Endangered Species Act of 1973, as amended (Act). Critical habitat is proposed in Los Angeles, Orange, Riverside, San Bernardino, and San Diego counties, California, as described in the proposed determination.

Section 4(b)(2) of the Act requires that the Secretary shall designate or revise critical habitat based upon the best scientific and commercial data available and after taking into consideration the economic impact of specifying any particular area as critical habitat. Based upon the previously published proposal to designate critical habitat for the coastal California gnatcatcher and comments received during the previous comment period, we have prepared a draft economic analysis of the proposed critical habitat designation, which is available at the above Internet and mailing address. We have reopened the comment period at this time in order to accept the best and most current scientific and commercial data available regarding the proposed critical habitat and the draft economic analysis. We will accept written comments during this reopened comment period. Previously submitted oral or written comments on this critical habitat proposal need not be resubmitted. The current comment period on this proposal closes on July 31, 2000. Written comments may be submitted to the Carlsbad Fish and Wildlife Office in the **ADDRESSES** section.

Author

The primary author of this notice is Douglas Krofta (see **ADDRESSES** section).

Authority: The authority for this action is the Endangered Species Act of 1973 (16 U.S.C. 1531 *et seq.*).

Dated: June 23, 2000.

Michael J. Spear,

Manager, California/Nevada Operations.

[FR Doc. 00–16511 Filed 6–28–00; 8:45 am]

BILLING CODE 4310–55–P

Notices

Federal Register
Vol. 65, No. 126
Thursday, June 29, 2000

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

AGENCY FOR INTERNATIONAL DEVELOPMENT

Notice of Public Information Collections Being Reviewed by the U.S. Agency for International Development; Comments Requested

SUMMARY: U.S. Agency for International Development (USAID) is making efforts to reduce the paperwork burden. USAID invites the general public and other Federal agencies to take this opportunity to comment on the following proposed and/or continuing information collections, as required by the Paperwork Reduction Act for 1995. Comments are requested concerning: (a) Whether the proposed or continuing collections 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 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.

DATES: Submit comments on or before August 28, 2000.

FOR FURTHER INFORMATION CONTACT: Beverly Johnson, Bureau for Management, Office of Administrative Services, Information and Records Division, U.S. Agency for International Development, Room 2.07–106, RRB, Washington, DC, 20523, (202) 712–1365 or via e-mail bjohnson@usaid.gov.

SUPPLEMENTARY INFORMATION:

OMB No.: OMB 0412–0520.

Form No.: AID 1420–17.

Title: Contractor Employee Biographical Data Sheet.

Type of Review: Renewal of Information Collection.

Purpose: USAID is authorized to make contracts with any corporation, international organization, or other body of persons in or outside of the United States in furtherance of the purposes and within limitations of the Foreign Assistance Act (FAA). The information collections requirements placed on the public are published in 48 CFR chapter 7, and include such items as the contractor Employee Biographical Data Sheet and Performance and Progress Reports (AIDAR 752.7026). These are all USAID unique procurement requirements. The pre-award requirements are based on a need for prudent management in the determination that an offeror either has or can obtain the ability to competently manage development assistance programs utilizing public funds. The requirements for information collection requirements during the post-award period are based on the need to administer public funds prudently.

Annual Reporting Burden:

Respondents: 3,679.

Total annual responses: 51,605.

Total annual hours requested: 73,855 hours.

Dated: June 21, 2000.

Joanne Paskar,

Chief, Information and Records Division, Office of Administrative Services, Bureau for Management.

[FR Doc. 00–16457 Filed 6–28–00; 8:45 am]

BILLING CODE 6116–01–M

DEPARTMENT OF AGRICULTURE

Forest Service

Information Collection; Request for Comments; Application for Prospecting Permit

AGENCY: Forest Service, USDA.

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, the Forest Service announces its intention to extend the information collection, FS–2800–14—Application for Prospecting Permit. The collected information enables the Forest Service to effectively and efficiently process oil and gas prospecting permits. Information will be collected from oil and gas companies, lessees, exploration companies, and independent, exploration operators expressing an interest in conducting geophysical operations on National Forest System lands.

EFFECTIVE DATES: Comments must be received in writing on or before August 28, 2000.

ADDRESSES: All comments should be addressed to Director, Minerals and Geology Management Staff, Attn: Mr. W. Dean Crandell, Fluid Minerals Program Manager, Forest Service, USDA, P.O. Box 96090, Washington, D.C. 20090–6090.

Comments also may be submitted via facsimile to (202) 205–1405 or by email to dcrandel@fs.fed.us.

The public may inspect comments received at the Office of the Director, Minerals and Geology Management Staff, Forest Service, USDA, 201 14th Street, S.W., Washington, D.C. 20024. Visitors are encouraged to call ahead to facilitate entrance into the building.

FOR FURTHER INFORMATION CONTACT:

W. Dean Crandell, Minerals and Geology Staff, at (202) 205–1405.

SUPPLEMENTARY INFORMATION:

Background

The Mineral Leasing Act (30 U.S.C. 181, as amended) authorizes the Forest Service to permit oil and gas companies, lessees, exploration companies, and independent, exploration operators to conduct geophysical exploration on or off lease on National Forest System lands.

Three regulations govern geophysical operations on National Forest System lands: (1) Title 36 of the Code of Federal Regulations, Part 251, Subpart E provides direction for geophysical operations on lease (operations within the legal land description of an oil and gas lease); (2) Title 36 of the Code of Federal Regulations, Part 251, Subpart A, § 251.15, provides direction for geophysical operations on reserved mineral rights (operations where the Forest Service manages the surface resources but the mineral resources (subsurface) is owned by someone other than the Federal government); and (3) Title 36 of the Code of Federal Regulations, Part 251, Subpart B, provides authorization for geophysical operations off lease (operations on all Forest Service managed lands not included in the preceding two categories).

Description of Information Collection

The following describes the information collection to be extended:

Title: FS–2800–14, Application for Prospecting Permit.

OMB Number: 0596–0089.

Expiration Date of Approval: August 31, 2000.

Type of Request: Extension of an information collection currently approved by the Office of Management and Budget.

Abstract: Forest Service personnel evaluate the collected information to ensure that oil and gas companies, lessees, exploration companies, or independent, energy exploration operators, applying to conduct geophysical operations on National Forest System lands, comply with the authorizing legislation and regulations described in the **SUPPLEMENTARY INFORMATION** section of this notice and with the National Environmental Policy Act (42 U.S.C. 4521–4347). The National Environmental Protection Act requires all land managers to consider an activity's impact to the environment and to determine the measures required to mitigate those impacts prior to making a decision on the request for a permit.

Oil and gas companies, lessees, exploration companies, or independent, energy exploration operators apply to conduct geophysical operations by completing the form, FS–2800–14, Application for Prospecting Permit, or by supplying the same information in a format of their choice.

Oil and gas companies, lessees, exploration companies, or independent, energy exploration operators are asked to provide information that includes the type and size of the proposed activity, the location of the proposed geophysical operation, the equipment that will be used in the proposed geophysical operation, the timing of the operation, and administrative information, such as the applicant's mailing address, the applicant's telephone number, and the applicant's responsible local operator or company representative.

Data gathered in this information collection are not available from other sources.

Estimate of Annual Burden: 15 minutes.

Type of Respondents: Oil and gas companies, mineral lessees, energy exploration companies, and independent, energy exploration operators.

Estimated Annual Number of Respondents: 20.

Estimated Annual Number of Responses per Respondent: 1.

Estimated Total Annual Burden on Respondents: 5 hours.

Comment is Invited

The agency invites comments on the following: (a) Whether the proposed collection of information is necessary for the stated purposes and the proper performance of the functions of the agency, including whether the information will have practical or scientific utility; (b) 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; (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 the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Use of Comments

All comments received in response to this notice, including names and addresses when provided, will become a matter of public record. Comments will be summarized and included in the request for Office of Management and Budget approval.

Dated: June 21, 2000.

Sally Collins,

Associate Deputy Chief, NFS.

[FR Doc. 00–16507 Filed 6–28–00; 8:45 am]

BILLING CODE 3410–11–P

DEPARTMENT OF AGRICULTURE

Forest Service

Crossroads Project, Mark Twain National Forest, Phelps and Pulaski Counties, Missouri

AGENCY: Forest Service, USDA.

ACTION: Notice; intent to prepare an environmental impact statement.

SUMMARY: The project area is located on Forest Service Lands within the Spring Creek and Lower Big Piney Creek watersheds east of Fort Leonard Wood Military Reservation and Big Piney River, and south and west of Flat, Missouri, T34N, R9W, Sections 4–6; T35N, R9W, Sections 28–34; T35N, R10W, Sections 1–3, 8–17, 21–27, 35, 36; and, T36N, R10W, Sections 34–36, Fifth Principal Meridian.

The Forest Service will prepare an environmental impact statement (EIS) to analyze and disclose the environmental effects of the project.

The primary purpose of this project is to maintain the project area's forest ecosystems ecological structure and function within a natural condition utilizing vegetative management and other restoration activities. The existing condition does not meet the desired future conditions (DFC) described in the Mark Twain National Forest Plan (MTFP) and the projected successional stages are not anticipated to meet the DFC described in the Mark Twain National Forest Plan.

DATES: Initial comments concerning the scope of the analysis should be received on or before July 31, 2000 to receive timely consideration in the preparation of the draft EIS.

ADDRESSES: Send written comments and suggestions on the proposed action or requests to be placed on the project mailing list to: John C. Bisbee, District Ranger, Houston/Rolla/Cedar Creek Ranger District, 108 South Sam Houston Boulevard, Houston, Missouri 65483. E-mail should have a subject line that reads ''NEPA Houston'' and be sent to: mailroom_r9 mark_twain@fs.fed.us

FOR FURTHER INFORMATION CONTACT: Mark Hamel, Project Leader/NEPA Coordinator, Houston/Rolla/Cedar Creek Ranger District, 108 South Sam Houston Boulevard, Houston, Missouri 65483, phone (417) 967–4194.

SUPPLEMENTARY INFORMATION: The following proposed projects would move the Crossroads area towards the desired future condition for the area (Mark Twain Forest Plan pg. IV–115 to IV–123). Note: several activities may occur on the same acre. The Forest Service's proposed action includes the following possible actions: (1) Designate approximately 1,500 acres of old growth, (2) maintain early successional habitat on approximately 650 acres through mechanical means (haying, bush hogging,) and/or grazing, (3) maintain early successional habitat through burning on approximately 1,600 acres, (4) restore and develop savanna habitat on approximately 150 acres through firewood cutting and burning, (5) restore glade habitat on approximately 130 acres through mechanical treatment and burning, (6) restore bottomland riparian habitat by planting hardwoods on approximately 50 acres, (7) for forest health and fuels management, prescribe burn approximately 2,100 acres, (8) plant approximately 50 acres of gamma grass for wildlife habitat, (9) treat approximately 1,400 acres with unevenage management (including group selection and group shelterwood) to meet woodland habitat objectives that exhibit a condition of 20–30 percent forbs, grass and shrub age class requirements, (10) treat approximately 700 acres with regeneration cuts (shelterwood and clearcut) to meet the

0–9 age class woodland habitat, (11) improve existing river access and parking facilities for canoeists, (12) relocate an existing river access site and access road for public safety and watershed concerns, (13) close a range allotment to future cattle grazing for soil and water resource protection, (14) connect several miles of existing unconnected non-motorized trails, (15) enhance habitat for upland game wildlife species on approximately 50 acres by planting food plots, (16) construct approximately 10 miles of temporary roads (which will be closed after use) to facilitate wildlife habitat improvement and the removal of wood products, (17) close approximately 1 mile of existing system road, and (18) rehab approximately 2 miles of old road corridor for watershed protection.

The overall objective is to move Management Area 3.4–18 toward the desired future condition outlined in the Mark Twain Forest Plan.

The scope of this analysis is limited to activities related to the purpose and need and measures necessary to mitigate the effects these activities may have on the environment. The decision will include if, when, how, and where to schedule: wildlife habitat improvement activities, watershed, glade, and savanna improvement activities, temporary road construction and closure, forest habitat treatments, prescribed burning, recreation site improvement and access management, resource protection measures, monitoring, and other follow-up activities.

A project in the same vicinity was originally presented to the public for review and comment (scoping) in April of 1997 (Project Name: MA 3.4–18) prior to undertaking preparation of an Environmental Assessment (EA). In 1999 after modification to the MA 3.4–18 project boundary, the project was presented to the public again (Project Name: Crossroads Projects). Since September 1999, additional changes have been made to the proposal and today the decision has been made to prepare an EIS. Many years of experience implementing similar types of activities in the same vicinity have shown us that the effects are not significant. We therefore do not feel that an EIS is required. However, due to the increase in appeals and litigation over the last few years and for wise fiscal efficiency, we have decided to try a new public participation approach for this particular project and prepare an EIS. This Notice of Intent serves as notice of the intent to prepare an EIS for the Crossroads Project. The comments received as a result of the public participation for the analysis will be brought forward for the EIS.

Preliminary comments made by the public and agencies were considered in the development of the tentative or preliminary issues. These are as follows: effects on Threatened, Endangered, and Sensitive (TES) species and Management Indicator Species (MIS); concern over new road construction, and road closures; concern over motorized recreational access; direct, indirect and cumulative effects; current and designated old growth; forest health, in relation to the current vegetative patterns, structures, and species composition; and, effects of restoration activities to the overall watershed.

Public participation will continue to be an important part of the project, commencing with the EIS initial scoping process (40 CFR 1501.7), which starts with publication of this notice and continues for the next 30 days. In addition, the public is encouraged to visit with Forest Service officials at any time during the analysis and prior to the decision. The Forest Service will be seeking information, comments, and assistance from Federal, State, and local agencies, the Osage Tribe, and other individuals or organizations that may be interested in or affected by the proposed action.

Comments from the public and other agencies will be used in preparation of the draft EIS. The scoping process will be used to: identify potential issues; identify additional alternatives to the proposed action; and, identify potential environmental effects of the proposed action and alternatives (i.e., direct, indirect, and cumulative effects).

While public participation in this analysis is welcome at any time, comments received within 30 days of the publication of this notice will be especially useful in the preparation of the draft EIS, which is expected top be filed with the Environmental Protection Agency and available for public review in August 2000. A 45-day comment period will follow publication of a Notice of Availability of the draft EIS in the **Federal Register**. The comments received will be analyzed and considered in preparation of a final EIS, which we expect to file in October 2000. A Record of Decision will be issued not less than 30 days after publication of a Notice of Availability of the final EIS in the **Federal Register**.

The Forest Service believes it is important at this early stage to give reviews notice of several court rulings related to public participation in the environmental review process. First, reviewers of the draft EIS must structure their participation in the environmental review of the proposal in such a way that it is meaningful and alerts an agency to the reviewer's position and contentions. *Vermont Yankee Nuclear Power Corp.* v. *NRDC,* 435 U.S. 519, 513 (1978). Also, environmental objections that could be raised at the draft EIS stage but that are not raised until after completion of the final EIS may be waived or dismissed by the courts. *City of Angoon* v. *Hodel,* 803 F.2d 1016, 1022 (9th Cir, 1986), and *Wisconsin Heritages Inc.* v. *Harris,* 490 F.Supp. 1334, 1338 (E.D. Wis., 1980). Because of these court rulings, it is very important that those interested in this proposed action participate by the close of the 45-day comment period of the draft EIS in order that substantive comments and objections and available to the Forest Service at a time when it can meaningful consider them and respond to them in the final EIS. To assist the Forest Service in identifying and considering issues and concerns on the proposed action, comments should be as specific as possible. Reviewers may wish to refer to the Council on Environmental Quality Regulations for implementing the procedural provisions of the National Environmental Policy Act at 40 CFR 1503.3 in addressing these points.

The responsible official for this environmental impact statement is Randy Moore, Forest Supervisor, Mark Twain National Forest.

Dated: June 15, 2000.

John C. Bisbee,

District Ranger, Houston/Rolla/Cedar Creek Ranger District, Mark Twain National Forest, 108 South Sam Houston Boulevard, Houston, Missouri 65483.

[FR Doc. 00–16452 Filed 6–28–00; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Natural Resources Conservation Service

Notice of Availability of Proposed Changes to Conservation Practice standards in Section IV of the Field Office Technical Guide of the NRCS in South Dakota for Review and Comment

SUMMARY: It is the intention of the NRCS in South Dakota to issue revised conservation practice standards in Section IV of the FOTG for the practice ''Animal Trails and Walkways.''

DATES: Comments on this notice must be received within 30 days from the publication date in the **Federal Register**.

ADDRESSES: All comments concerning the proposed conservation practice standard changes should be addressed to: Dean Fisher, State Conservationist, NRCS, 200 Fourth Street SW, Huron, South Dakota 57350. A copy of this standard will be made available upon written request.

Dated: June 13, 2000.

Dean Fisher,

State Conservationist, Natural Resources Conservation Service, Huron, South Dakota 57350.

[FR Doc. 00–16408 Filed 6–28–00; 8:45 am]

BILLING CODE 3410–16–U

COMMISSION ON CIVIL RIGHTS

Agenda and Notice of Public Meeting of the Rhode Island Advisory Committee

Notice is hereby given, pursuant to the provisions of the rules and regulations of the U.S. Commission on Civil Rights, that a meeting of the Rhode Island Advisory Committee to the Commission will convene at 9 a.m. and adjourn at 12:30 p.m. on Friday, July 21, 2000, at the Rhode Island State House, Providence, Rhode Island 02601. The Committee will release its report, *The Impact of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 on Legal Immigrants in Rhode Island*. Updated information will be provided by invited civil rights advocates who participated in the original factfinding meeting. The Committee will also plan for future projects.

Persons desiring additional information, or planning a presentation to the Committee, should contact Committee Chairperson Olga Noguera, 401–464–1876, or Ki-Taek Chun, Director of the Eastern Regional Office, 202–376–7533 (TDD 202–376–8116). Hearing-impaired persons who will attend the meeting and require the services of a sign language interpreter should contact the Regional Office at least ten (10) working days before the scheduled date of the meeting.

The meeting will be conducted pursuant to the provisions of the rules and regulations of the Commission.

Dated at Washington, DC, June 23, 2000.

Lisa M. Kelly,

Special Assistant to the Staff Director, Regional Programs Coordination Unit.

[FR Doc. 00–16427 Filed 6–28–00; 8:45 am]

BILLING CODE 6335–01–P

DEPARTMENT OF COMMERCE

Minority Business Development Agency

[Docket No. 000623192–0192–01]

RIN 0640–ZA07

Solicitation of Applications for the Minority Business Capital Access Policy Institute

AGENCY: Minority Business Development Agency, Commerce.

ACTION: Notice.

SUMMARY: The Minority Business Development Agency (MBDA) published a document in the **Federal Register** of June 8, 2000, (65 FR 36411), concerning solicitation of competitive applications from organizations seeking to establish a Minority Business Capital Access Policy Institute (MBCAPI). This document extends the closing date of the award to no later than 5:00 p.m. on July 24, 2000.

DATES: The closing date for receipt of applications has been extended until July 24, 2000.

ADDRESSES: Applicants must submit one signed original plus two (2) copies of the application. Completed application packages must be submitted to: Office of Financial Access, Room 5600, Minority Business Development Agency, U.S. Department of Commerce, 14th & Constitution Avenue, NW, Washington, DC 20230.

FOR FURTHER INFORMATION CONTACT: Jason Everett at (202) 482–1940.

SUPPLEMENTARY INFORMATION: In the **Federal Register** issue of June 8, 2000, in FR Doc. 65–111, on page 36412, in the first column (second paragraph), change the date from July 10, 2000 to July 24, 2000. Applications will be accepted until 5:00 p.m. Eastern Daylight Time.

Glenn Clark,

Financial Management Officer, Minority Business Development Agency.

Juanita E. Berry,

Federal Register Liaison Officer, Minority Business Development Agency.

[FR Doc. 00–16444 Filed 6–28–00; 8:45 am]

BILLING CODE 3510–21–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

DEPARTMENT OF THE INTERIOR

U.S. Fish and Wildlife Service

[I.D. 091799D]

Notice of Additional Public Involvement Opportunities/Re-opening of Comment Period for the Preparation of an Environmental Impact Statement to Allow Incidental Take of Multiple Species by Nonindustrial Private Landowners in Lewis County, WA

AGENCIES: Fish and Wildlife Servce, Interior; National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice to re-open public comment period.

SUMMARY: This notice advises other agencies and the public that the Fish and Wildlife Service (USFWS) and National Marine Fisheries Service (NMFS) (collectively, the Services) are re-opening the initial 30-day public comment period and will hold three additional scoping workshops to assist in gathering information for the preparation of an Environmental Impact Statement (EIS). This EIS pertains to the proposed issuance of Incidental Take Permits by NMFS and USFWS, and Enhancement of Survival Permits by USFWS (collectively, Permits) to nonindustrial forest landowners for forest-management activities conducted in Lewis County, WA. The proposed Permits would authorize take of federally listed species in accordance with the Endangered Species Act of 1973, as amended (Act), and certain other unlisted species should they be listed in the future. As required by the Act, a Conservation Plan is being prepared in voluntary cooperation with interested Lewis County parties. Since the Permits are likely to involve multiple landowners, the Conservation Plan will be developed as a programmatic Plan, titled the Family Forest Conservation Project (Plan). The USFWS will also use additional landowner agreements available under Section 10 of the Act, such as Enhancement of Survival Permits for Safe Harbor Agreements and Candidate Conservation Agreements with Assurances, as appropriate. This notice supplements the notice of intent published in the September 23, 1999, **Federal Register**.

DATES: Written comments regarding the scope of issues and potential alternatives to be included in the EIS should be received on or before September 1, 2000. Public meetings will be held at the following locations and times: Lacey, WA on July 26, 2000, at the USFWS/NMFS office on the St. Martins College Campus at 510 Desmond Drive, SE (Sawyer Hall) from 3:00–5:00 pm and 6:00–8:00 pm; and in Chehalis, WA on August 15, 2000, at the Lewis and Clark State Park from 6:00–8:00 pm. The Lewis and Clark State Park is located 12 miles south of Chehalis on Jackson Highway (4583 Jackson Highway).

ADDRESSES: Written comments, questions, or requests for additional information, including maps for the workshop locations, should be addressed to Mark Ostwald, USFWS, 510 Desmond Drive, SE, Suite 102, Lacey, WA 98503–1273, telephone (360) 753–9564, facsimile (360) 753–9518; or Mike Parton, NMFS, 510 Desmond Drive, SE, Suite 103, Lacey, WA 98503–1273, telephone (360) 753–4650, facsimile (360) 453–9517. Comments received will be available for public inspection by appointment during normal business hours (8:00 am to 5:00 pm, Monday through Friday).

FOR FURTHER INFORMATION CONTACT: See **ADDRESSES.**

SUPPLEMENTARY INFORMATION: Section 9 of the Act prohibits the ''take'' of species listed as threatened or endangered. The term take is defined under the Act to mean harm, harass, pursue, hunt, shoot, wound, kill, trap, capture or collect, or to attempt to engage in any such conduct. Harm is defined to include significant habitat modification or degradation where it actually kills or injures wildlife by significantly impairing essential behavioral patterns, including breeding, spawning, rearing, feeding, and sheltering.

The Services may issue Permits, under limited circumstances, to take listed species incidental to, and not the purpose of, otherwise lawful activities. The USFWS regulations governing Permits for endangered species are promulgated in 50 CFR 17.22 and regulations governing Permits for threatened species are promulgated in 50 CFR 17.32. The NMFS regulations governing Permits for threatened and endangered species are promulgated in 50 CFR 222.22.

Interested parties have held meetings and field visits with the Services. Scoping workshops on this Plan and EIS were held by the Services on September 22 and September 23, 1999, in Olympia and Chehalis, WA, respectively. As a further opportunity for interested persons to comment on this planning effort, the comment period is being re-opened and additional scoping workshops are scheduled as announced above.

Pursuant to the Act, a collaborative planning effort has been initiated in cooperation with the Services involving landowners, landowner associations, state and federal agencies, universities, and environmental groups. As a result, an EIS will be prepared to address this programmatic Plan and the effects of issuing Permits to landowners engaged in forest-management activities. We expect the proposed Plan to include several options available for landowners toward achieving a specified desired future condition in Lewis County and to be utilized to address State Forest Practices, Clean Water Act, and Endangered Species Act concerns. We expect that the proposed Plan and EIS will evaluate the potential take of several listed species that occur in Lewis County. These may include, but are not limited to, the northern spotted owl (*Strix occidentalis caurina*), bald eagle (*Haliaeetus leucocephalus*), steelhead (*Oncorhynchus mykiss*), and chinook salmon (*Oncorhynchus tshawytscha*). The proposed Plan and EIS will address forestry operations within the constraints of: (1) A specified portion of Lewis County; (2) a restricted number of Permits; (3) a specified time frame; and potentially (4) a limited amount of total acreage included under such Permits. Increases to the number of Permits or covered acreage would likely require supplemental analyses. The proposed Plan and EIS will also address the impacts of incidental take of several species, listed and unlisted, which could occur as a result of timber harvest and related activities on subject lands. Some of these species may not occur on the lands currently, but might occur on the subject lands in the future and may at some point be subject to disturbance or other take. This effort is proposed to result in one Plan and EIS addressing the potential issuance of multiple Permits. The Permits issued subsequent to this Plan would not be subject to additional public comment at the time of issuance.

The Services are exploring two options for the ultimate structure of the permitting regime for this project. These are: (1) One single entity (e.g., state or local agency, or organization, etc.) receives the Incidental Take Permit and upon completion and approval by this entity of detailed, site-specific plans that implement the terms of the programmatic Plan, participating landowners will receive permit coverage under section 10(a)(1)(B) of the Act through individual Certificates of Inclusion; or (2) an individual Incidental Take Permit or Enhancement of Survival Permit is issued to each landowner that provides and receives approval by the Services of a detailed, site-specific plan that implements the terms detailed in the programmatic Plan.

The USFWS is considering the use of Incidental Take Permits and Certificates of Inclusion under Section 10(a)(1)(B) of the Endangered Species Act, as well as Enhancement of Survival Permits for Safe Harbor and Candidate Conservation under Section 10(a)(1)(A). The NMFS is considering the use of Incidental Take Permits and Certificates of Inclusion under Section 10(a)(1)(B) of the Act, but is not proposing to utilize Enhancement of Survival Permits for Safe Harbor and/or Candidate Conservation for any of the species under its jurisdiction.

The Services invite comments and suggestions from all interested parties to ensure that the full range of issues related to these proposed actions are addressed and that all significant issues are identified. We request that comments be as specific as possible. In particular, we request comments regarding: the direct, indirect, and cumulative impacts that implementation of the proposal could have on endangered and threatened species and their habitats; other possible alternatives; permitting regime; portions of Lewis County to be included; total acreage covered by each individual, landowner Permit; total number of Permits to be issued; duration of Permits; potential adaptive management and/or monitoring provisions; funding issues; baseline environmental conditions in Lewis County; other plans or projects that might be relevant to this project; and minimization and mitigation efforts. In addition to considering impacts on species and their habitat, the EIS must include information on impacts resulting from the alternatives on other components of the human environment. These other components include, but are not limited to, air quality, water quality and quantity, geology and soils, cultural resources, other fish and wildlife species, social resources, and economic resources.

The environmental review of this project will be conducted in accordance with the requirements of the National Environmental Policy Act of 1969, as amended (42 U.S.C. 4321 et seq.), the Council on Environmental Quality Regulations (40 CFR 1500–1508) and other appropriate Federal laws and

regulations and policies and procedures of the Services for compliance with those regulations. We predict that the draft EIS will be available for public review during the first quarter of 2001.

Dated: June 22, 2000.

Rowan W. Gould,

Regional Director, Region 1, U.S. Fish and Wildlife Service, Portland, Oregon.

Dated: June 23, 2000.

Craig Johnson,

Acting Chief, Endangered Species Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 00–16509 Filed 6–28–00; 8:45 am]

BILLING CODES: 3510–22–F, 4310–55–F

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 061900C]

Gulf of Mexico Fishery Management Council; Public Meetings

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

ACTION: Notice of public meeting; correction.

SUMMARY: The Gulf of Mexico Fishery Management Council published a document in the **Federal Register** of June 23, 2000, concerning convening of public meetings. This document contained insufficient information.

FOR FURTHER INFORMATION CONTACT: Wayne E. Swingle, Executive Director, Gulf of Mexico Fishery Management Council; telephone: 813–228–2815.

Correction

In the **Federal Register** of June 23, 2000, in FR Doc. 00–15974, on page 39132, in the first column, under the heading ''Monday, July 10, 2000,'' first paragraph, last sentence, add the following to read:

''The Committee will hear a NOAA General Counsel legal opinion regarding the stone crab amendment and will discuss possible responses to that legal opinion.''

In the **Federal Register** of June 23, 2000, in FR Doc. 00–15974, on page 39133, in the second column, under the heading ''Tuesday, July 11, 2000,'' revise the last paragraph to read:

3:30 p.m.–5 p.m.—Convene the Habitat Protection Committee to hear a presentation on the Williams Gas Pipeline Project, the Gulfstream Gas Pipeline Project, and a review of the proposed Destination Broadwater Draft EIS.

Dated: June 26, 2000.

Richard W. Surdi,

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

[FR Doc. 00–16508 Filed 6–28–00; 8:45 am]

BILLING CODE 3510–22–F

DEPARTMENT OF COMMERCE

National Telecommunications and Information Administration

[Docket No. [000609173–0173–01]

RIN 0660–XX08

Public Meeting, Request for Comment on All-Hazard Warning Network

AGENCY: National Telecommunications and Information Administration, Department of Commerce.

ACTION: Notice of public meeting, request for public comment.

SUMMARY: The Assistant Secretary for Communications and Information and Administrator of the National Telecommunications and Information Administration (NTIA), Gregory L. Rohde, in cooperation with the All-Hazard Warning Interagency Working Group, will host a roundtable discussion on July 17, 2000 that will be open to the public to explore hazard warning systems. Recent technological advances are fostering new and innovative methods of bringing warning messages to the public. This notice, through a series of questions, requests public comment on issues relating to the means by which government agencies and public and private sectors can work together to ensure that hazard warning systems are developed to save more lives.

DATES: The All-Hazard Warning Roundtable will be held from 9:30–11:30 a.m., Monday, July 17, 2000. Written comments must be filed on or before August 18, 2000. Written reply comments must be filed on or before September 1, 2000.

ADDRESSES: The All-Hazard Warning Roundtable will be held from 9:30–11:30 a.m. on July 17, 2000, at the U.S. Department of Commerce, Room 4830, 1401 Constitution Avenue, NW., Washington, DC 20230. The meeting will be open to the public. For current information on the roundtable, please see NTIA's website at *http://www.ntia.doc.gov.*

The Department invites the public to submit written comments on paper or electronic form. Comments may be mailed to Jeng Mao, Public Safety Program, National Telecommunications and Information Administration (NTIA), U.S. Department of Commerce, Room 4624, 1401 Constitution Avenue, NW., Washington, DC 20230. In the alternative, comments may be submitted in electronic form to the following electronic mail address: <warnings@ntia.doc.gov>.

Submission of Documents

Written Comments

Paper submissions should include three paper copies and a version on a diskette in PDF, ASCII, WordPerfect (please specify version) or Microsoft Word (please specify version) format. Diskettes should be labeled with the name of the party, and the name and version of the word processing program used to create the document. Comments and reply comments submitted via e-mail to <warnings@ntia.doc.gov> should also be submitted in the formats specified above.

All comments and reply comments should be captioned ''All-Hazard Warning—Comment [or Reply Comment], Docket No. 000609173–0173–01.'' Comments and reply comments should be numbered and organized in response to the questions set forth in this Notice.

Comments and reply comments received will be posted on the NTIA web site at *http://www.ntia.doc.gov.*

FOR FURTHER INFORMATION CONTACT: Jeng Mao, Public Safety Program, National Telecommunications and Information Administration at either telephone number (202) 501–0342 or electronic mail <jmao@ntia.doc.gov>.

Media inquiries should be directed to NTIA's Office of Public Affairs at (202) 482–7002.

SUPPLEMENTARY INFORMATION:

Background

In 1998, Vice President Gore's National Partnership for Reinventing Government (NPR) brought together representatives from more than a dozen Federal agencies to form an inter-agency working group to explore ways of improving the Nation's hazard warning systems to save lives. This group is working to do this by finding combined solutions to give people better, faster, and more effective hazard warnings. As a result of its efforts, the inter-agency working group published *Saving Lives With an All-Hazard Warning Network* in December 1999. This report made several important observations about the current warning system and the future needs for effective warnings.

Currently, the National Oceanic and Atmospheric Administration (NOAA) Weather Radio is the most direct way to warn people about all impending

hazards. Recent technological advances, however, have fostered new and innovative methods of bringing hazard warnings to the public. To reach the maximum number of people, we must utilize all available communications technologies—both current and emerging—to deliver better, faster, more affordable, and more effective hazard warnings. Partnerships between government agencies and public and private parties will help to ensure that these life saving hazard warnings are provided through various means of communication available to consumers. These communications technologies include both wireline and wireless telephone services, Internet, paging, broadcast television and radio, both satellite and cable television, and emerging technologies.

Questions for Public Comment

Interested parties are requested to submit written comments on any issue of fact, law, or policy that may inform the U.S. Department of Commerce on hazard warnings. Specifically, comments are requested on the questions below. These questions are designed to assist the public and should not be construed as a limitation on the issues on which public comments may be submitted. Comments should cite the number of the question(s) being addressed. Please provide copies of any studies, research and other empirical data referenced in the comments.

1. Is it technologically feasible today to deliver hazard warnings: to wireless devices, such as cell phones and pagers; over the Internet to users who are online; to standard telephones in the form of a call warning; to broadcast television; to satellite services; to cable television; and to emerging and developing technologies?

2. What are the tradeoffs among technology options?

3. What are the economic impediments, if any, to the use of any of the technologies that might be used to disseminate hazard warnings?

4. What are the legal impediments, if any, to the use of any of the technologies that might be used to disseminate hazard warnings?

5. What legal measures, if any, should be taken to foster the delivery of hazard warnings?

6. What economic and technological policy measures, if any, should be taken to foster the dissemination of hazard warnings?

PUBLIC PARTICIPATION: The All-Hazard Warning Roundtable is open to the public on a first-come, first-served basis and physically accessible to people with disabilities. To facilitate entry into the Department of Commerce building, please have a photo identification available and/or a U.S. Government building pass if applicable. Any member of the public wishing to attend and requiring special services, such as a sign language interpretation or other ancillary aids, should contact Jeng Mao, Public Safety Program, U.S. Department of Commerce, at least five (5) working days prior to the All-Hazard Warning Roundtable, at either telephone number (202) 501–0342 or electronic mail at <jmao@ntia.doc.gov>.

Gregory L. Rohde,

Assistant Secretary for Communications and Information.

[FR Doc. 00–16405 Filed 6–28–00; 8:45 am]

BILLING CODE 3510–60–P

DEPARTMENT OF COMMERCE

National Telecommunications and Information Administration

[Docket No. 000608169–0169–01]

RIN 0660–XX07

Notice of Public Meeting and Request for Comment on Minority Media Ownership

AGENCY: National Telecommunications and Information Administration, U.S. Department of Commerce

ACTION: Notice of public meeting, request for public comment.

SUMMARY: The Assistant Secretary for Communications and Information and Administrator of the National Telecommunications and Information Administration (NTIA), Gregory L. Rohde, will host a roundtable discussion open to the public on minority media ownership in a changing industry. NTIA also requests public comment on ways to preserve diversity in the media. With relaxation of the local broadcast ownership caps and elimination of the national station limit under the Telecommunications Act of 1996, concentration in the broadcasting industry has increased. Although access to investment capital remains a challenge for many minority entrepreneurs seeking to buy broadcast stations, the convergence of traditional broadcasting and new telecommunications technologies may present new opportunities for media ownership. Therefore, the roundtable discussion will also explore ways to improve prospects for minorities to acquire media properties. In addition, this notice will present a series of questions to solicit public comment on these issues.

DATES: NTIA will hold the Minority Media Ownership Roundtable from 9:00 a.m. until 12:45 p.m. on Tuesday, July 18, 2000. The deadline for written comments is July 28, 2000 and the deadline for reply comments is August 8, 2000.

ADDRESSES: NTIA will hold the Minority Media Ownership Roundtable from 9:00 a.m. until 12:45 p.m. on July 18, 2000 at the U.S. Department of Commerce, Room 4830, 1401 Constitution Avenue, NW., Washington, DC 20230. The meeting will be open to the public. For current information on the roundtable, please visit NTIA's website at http://www.ntia.doc.gov/ntiahome/minoritymediaroundtable/.

The Department invites the public to submit written comments in paper or electronic form. Please mail comments to Maureen Lewis, Director, Minority Telecommunications Development Program, National Telecommunications and Information Administration, U.S. Department of Commerce, Room 4720, 1401 Constitution Avenue, NW., Washington, DC 20230. In the alternative, commenters may submit their views electronically to the following electronic mail address: minoritymedia@ntia.doc.gov.

Submission of Documents

Written Comments

Paper submissions should include an original and two paper copies and a version on a 3.5 inch write protected diskette in one of the following formats: PDF, ASCII, Word Perfect (please specify version) or Microsoft Word (please specify version). Please label all diskettes with the name of the party submitting the comments, and the name and version of the word processing program used to create the document. Comments and reply comments submitted by electronic mail to <minoritymedia@ntia.doc.gov> should also be submitted in one of the formats specified above. Caption all comments and reply comments ''Minority Media Ownership—Comment [or Reply Comment], Docket No. 000608169–0169–01'' and organize each submission in response to the questions set forth in this Notice. NTIA will post comments and reply comments to its web site at <http://www.ntia.doc.gov>.

FOR FURTHER INFORMATION CONTACT: Maureen Lewis, Director, Minority Telecommunications Development Program, National Telecommunications and Information Administration; telephone (202) 482–8056; or electronic mail <mlewis@ntia.doc.gov.> The NTIA Office of Public Affairs will answer

media inquiries. Representatives may be contacted at (202) 482–7002.

SUPPLEMENTARY INFORMATION:

Background

In its most recent report on minority media ownership titled ''Minority Commercial Broadcast Ownership in the United States,'' published in August 1998, NTIA found that ''financial barriers, increased competition, and higher station prices, are likely to be significant obstacles to new minority entrants to this marketplace.'' The report also identified increasing media concentration as a factor likely to cause small station owners with less investment capital to exit the industry as they find it more difficult to compete against station group owners. In addition, increased competition from non-minority group owners for syndicated programming, advertising revenues, and station personnel, such as on-air talent and managers, were other challenges some minority station owners described in the 1998 report. NTIA is seeking public comment on whether the trends described in the 1998 report are continuing to affect adversely minority media ownership. NTIA is also requesting suggestions about ways to reverse any such negative trends. Since the 1998 report, multibillion dollar mergers of large radio station groups and unions between cable companies, multimedia conglomerates and telecommunications companies have been announced or consummated. Traditional distinctions between the broadcast, cable and telecommunications industries appear to be disappearing as new technologies, such as digital radio, satellite radio, audio and video streaming over the Internet, and interactive television emerge. Given this, NTIA is also interested in obtaining comments on the viability of these and other new technologies to enhance ownership opportunities for incumbent media owners and new entrants. This topic, and the effect on minority media ownership of media concentration and access to capital will be integral parts of NTIA's roundtable discussion.

Questions for Public Comment

NTIA requests that interested parties submit written comments on any issue of fact, law, or policy that may inform the U.S. Department of Commerce on opportunities for increased minority media ownership. Although the Department specifically seeks information on the questions set forth below, the purpose of these questions is to assist the public. These questions do not, nor should they be construed to, limit the issues on which the public may submit comments. Comments and reply comments should cite the number of the question(s) addressed. Please provide copies of any studies, research, or other empirical data referenced in the comments.

1. What criteria should the federal government use to define minority ownership of broadcast or other media properties?

2. What changes, if any, have occurred in minority broadcast ownership since passage of the Telecommunications Act of 1996?

3. What legal impediments, if any, exist to minority media ownership?

4. What economic impediments, if any, exist to minority media ownership?

5. What policies or programs, if any, should the federal government implement to promote minority media ownership?

6. What legal or regulatory measures would promote minority media ownership?

7. What media ownership opportunities do new technologies offer to minority entrepreneurs?

8. What policies or programs should the federal government implement to promote opportunities for minority entrepreneurs to own ''new media'' ventures, such as webcasting firms or Internet portals?

Information collected in response to this **Federal Register** Notice may be included in the 2000 Minority Commercial Broadcast Ownership Report.

PUBLIC PARTICIPATION: The Minority Media Ownership Roundtable is open to the public on a first-come, first-served basis and is physically accessible to people with disabilities. To facilitate entry into the Department of Commerce building, please have a photo identification available and/or a U.S. Government building pass if applicable. Any member of the public wishing to attend and requiring special services, such as a sign language interpretation or other ancillary aids, should contact Maureen Lewis, Director, Minority Telecommunications Development Program, National Telecommunications and Information Administration at least five (5) working days prior to the Minority Media Ownership Roundtable by telephone at (202) 482–8056, or by electronic mail at <mlewis@ntia.doc.gov.>

Gregory L. Rohde,

Assistant Secretary for Communications and Information.

[FR Doc. 00–16404 Filed 6–28–00; 8:45 am]

BILLING CODE 3510–60–P

COMMODITY FUTURES TRADING COMMISSION

Proposed Amendments to the Maximum Daily Price Fluctuation Limits for the Chicago Board of Trade's Corn, Corn Yield Insurance (Six Contracts), Oats, Rough Rice, Soybeans, Soybean Meal, Soybean Oil, Wheat, Kilo Gold, 100 Ounce Gold, 1000 Ounce Silver, and 5000 Ounce Silver Futures Contracts; Extension of Comment Period

AGENCY: Commodity Futures Trading Commission.

ACTION: Notice of extension of public comment period for the proposed amendments.

SUMMARY: The Chicago Board of Trade (CBT or Exchange) has proposed amendments to the Exchange's corn, corn yield insurance (six contracts), oats, rough rice, soybeans, soybean meal, soybean oil, wheat, kilo gold, 100 ounce gold, 1000 ounce silver, and 5000 ounce silver futures contracts. On June 8, 2000, the Commission published a request for public comment on the proposed amendments for a 15-day comment period ending on June 23, 2000. The Acting Director of the Division of Economic Analysis (Division), acting pursuant to the authority delegated by Commission Regulation 140.96, has determined that extension of the comment period for an additional thirty (30) days is in the public interest, will assist the Commission in considering the views of interested persons, and is consistent with the purposes of the Commodity Exchange Act.

DATES: Comments must be received on or before July 24, 2000.

ADDRESSES: Interested persons should submit their views and comments to Jean A. Webb, Secretary, Commodity Futures Trading Commission, Three Lafayette Centre, 21st Street, NW, Washington, DC 20581. In addition, comments may be sent by facsimile transmission to facsimile number (202) 418–5521, or by electronic mail to secretary@cftc.gov. Reference should be made to the proposed amendments to the maximum daily price fluctuation limits for the CBT's futures contracts.

FOR FURTHER INFORMATION CONTACT: Please contact John Bird of the Division of Economic Analysis, Commodity Futures Trading Commission, Three Lafayette Centre, 21st Street NW, Washington, DC 20581, telephone (202) 418–5274. Facsimile number: (202) 418–5527. Electronic mail: jbird@cftc.gov.

SUPPLEMENTARY INFORMATION: The Acting Director, acting on behalf of the

Commission, has determined to extend the public comment period for the subject notice. The Division believes that an extension of the comment period until July 24, 2000 would permit interested parties to fully evaluate the proposal and to submit comments thereon to the Commission.

Issued in Washington, DC, on June 22, 2000.

John R. Mielke,

Acting Director.

[FR Doc. 00–16411 Filed 6–28–00; 8:45 am]

BILLING CODE 6351–01–M

DEPARTMENT OF DEFENSE

Department of the Air Force

Performance Review Boards List of 2000 Members

Below is a list of individuals who are eligible to serve on the Performance Review Boards for the Department of the Air Force in accordance with the Air Force Senior Executive Appraisal and Awards System.

Secretariat
Mr. Ronald L. Orr
Maj Gen James E. Sherrard III
Mr. Frank Tuck
Mr. Gary M. Erickson
Ms. Susan A. O'Neal
Mr. Harlan G. Wilder
Air Staff and ''Others''
Mr. William A. Davidson
Mr. Gene L. Hathenbruck
Maj Gen Larry Northington
Mr. James C. Barone
Ms. Mary Lou Keener
Mr. Anthony J. DeLuca
Air Force Materiel Command
Lt Gen Charles Coolidge
Maj Gen Claude Bolton
Mr. Harry Schulte
Dr. Donald Daniel
Mr. Pat Zarokiewicz

Janet A. Long,

Air Force Federal Register Liaison Officer.

[FR Doc. 00–16453 Filed 6–28–00; 8:45 am]

BILLING CODE 5001–05–U

DEPARTMENT OF DEFENSE

Department of the Army

Availability for Non-Explosive, Exclusive, or Partially Exclusive Licensing of U.S. Patent Application Concerning a Novel HIV Suppressor Factor Derived From Scrub Typhus

AGENCY: U.S. Army Medical Research and Material Command, Department of the Army, DoD.

ACTION: Notice.

SUMMARY: In accordance with 37 CFR 404.6, announcement is made of the availability for licensing of U.S. Patent Application Serial No. 09/377,743 entitled ''Novel HIV Suppressor Factor Derived from Scrub Typhus,'' filed August 20, 1999. This patent has been assigned to the United States Government as represented by the Secretary of the Army.

ADDRESSES: Commander, U.S. Army Medical Research and Material Command, ATTN: Command Judge Advocate, MCMR–JA, 504 Scott Street, Fort Detrick, Frederick, Maryland 21702–5012.

FOR FURTHER INFORMATION CONTACT: Elizabeth Arwine, Patent Attorney, (301) 619–2065 or telefax (301) 619–5034.

SUPPLEMENTARY INFORMATION: The invention takes advantage of the anti-HIV effects of an inhibitory factor produced during scrub typhus infection. It is the object of the invention to provide a method of inducing an immunogenic response to human immunodeficiency virus (HIV), in particular to HIV–1. It is a further object of the invention to provide a suppressor factor derived from scrub typhus infection in the form of purified sera, plasma, or immunogolobulin which is suitable for administration to patents at rink for , or infected with, HIV either alone or in combination with other agents. It is a particular object of the invention to provide an isolated suppressor factor from sera or plasma taken from patients with scrub typhus which has anti-HIV activity. It is also a further object in the invention to provide peptides from inhibitory strains of scrub typhus, which peptides function as antigens and can be used to produce antibodies effective for the prophylaxis and treatment of HIV infection.

Gregory D. Showalter,

Army Federal Register Liaison Officer.

[FR Doc. 00–16402 Filed 6–28–00; 8:45 am]

BILLING CODE 3710–08–M

DEPARTMENT OF DEFENSE

Department of the Army, Corps of Engineers

Announcement of Public Hearing on a Draft Environmental Impact Statement/ Environmental Impact Report (EIS/EIR) for the Upper Newport Bay Ecosystem Restoration Project, Orange County, California

AGENCY: U.S. Army Corps of Engineers, DoD.

ACTION: Notice (Announcement of Public Hearing Date).

SUMMARY: The Draft EIS/EIR will be released for public review on or about June 30, 2000. The Environmental Protection Agency plans to publish a Notice of Availability of the Draft EIS/EIR in the **Federal Register** on or about June 30, 2000. The public review of the Draft EIS/EIR ends on August 14, 2000.

ADDRESSES: Commander, U.S. Army Corps of Engineers, Los Angeles District, Ecosystem Planning Section, P.O. Box 532711, Los Angeles, CA 90053–2325.

FOR FURTHER INFORMATION CONTACT: Mr. Larry Smith, Technical Manager, phone (213) 452–3846.

SUPPLEMENTARY INFORMATION:

1. Background

The purpose of the Upper Newport Bay Ecosystem Restoration Project is to develop a long-term management plan to control sediment deposition in the Upper Bay to preserve the health of Upper Newport Bay's habitats. Sediment will continue to deposit in the Bay no matter what control measures are implemented in the watershed. Therefore, one of the most important components of this project is to develop a plan to control sediments by designing one or two in-bay basins in which the bulk of the sediment will settle. In addition to developing a plan for sediment control, the Upper Newport Bay Restoration project includes several other measures to improve habitat quality in the Upper Bay.

2. Proposed Action

The proposed project would involve deepening and expanding the existing sediment basins. Additional ecosystem restoration measures would be included to enhance the overall habitat value of Upper Newport Bay.

3. Alternatives

The EIS/EIR evaluates four alternatives carried forward for detailed environmental analysis. In general, the major differences among alternatives are the basin and channel depths. During the Preliminary Engineering Design (PED) phase, modifications to further reduce the loss of intertidal mudflat habitat will be investigated.

No Action: No dredging would occur within the Upper Bay ecological reserve.

Recommended Plan: The recommended plan includes the expansion and deepening of the Unit I/ III basin and the Unit II basin to –20 feet (−6 m) MSL, with an approach channel between the two basins dredged to −14 feet (−4.2 m) MSL; a 100-foot wide approach channel below the Unit II

basin to PCH Bridge, dredged to −14 feet MSL; the removal of the existing 4-acre tern island from the Unit I/III basin and reconstruction of the tern island in the Unit II basin adjacent to the western segment of the salt dike; and habitat restoration measures that include side channels around the small tern island adjacent to the Unit I/III basin, New Island, Middle Island and Shellmaker Island; the capping of the small tern island with clean sand; the removal of old dredge spoil and restoration of the Bullnose area adjacent to the Unit I/III basin, Northstar Beach and Shellmaker Island; the creation of a small channel on Shellmaker Island adjacent to the eastern edge of the restoration area; the segmenting of the main dike to decrease potential terrestrial disturbances; the restoration of eelgrass beds along the southwestern edge of Shellmaker Island; and, the addition of education kiosks along Back Bay Drive and by the interpretive center.

Dredging Methods: Two dredge types were evaluated: hydraulic and clamshell. The contractor will select a dredge type based on availability and cost. Impacts associated with the use of the two dredge types are evaluated in the EIS/R.

4. The USACOE and the County of Orange, the local sponsor, will consider public concerns on the Draft EIS/EIR. Summary of the Public Hearing and written comment letters and responses will be incorporated in the Final EIS/EIR as appropriate.

5. Time and Location

The Public Hearing is scheduled for Tuesday, July 18, 2000, at 7:00 PM, at the Newport Beach City Hall Council Chambers, 3300 Newport Boulevard, Newport Beach, California.

Dated: June 2, 2000.

John P. Carroll,

Colonel, Corps of Engineers, District Engineer.

[FR Doc. 00–16400 Filed 6–28–00; 8:45 am]

BILLING CODE 3710–KF–P

DEPARTMENT OF DEFENSE

Department of the Army, Corps of Engineers

Inland Waterways Users Board

AGENCY: U.S. Army Corps of Engineers, DoD.

ACTION: Notice of open meeting.

SUMMARY: In accordance with 10(a)(2) of the Federal Advisory Committee Act, Public Law (92–463) announcement is made of the next meeting of the Inland Waterways Users Board. The meeting will be held on July 27, 2000, in Portland, Oregon, Doubletree Hotel—Columbia River, 1401 N. Hayden Island Drive (Tel. (503) 283–2111). Registration will begin at 9 a.m. and the meeting is scheduled to adjourn at 4 p.m. The meeting is open to the public. Any interested person may attend, appear before, or file statements with the committee at the time and in the manner permitted by the committee.

FOR FURTHER INFORMATION CONTACT: Mr. Norman T. Edwards, Headquarters, U.S. Army Corps of Engineers, CECW–PF, Washington, DC 20314–1000.

SUPPLEMENTARY INFORMATION: None.

Gregory D. Showalter,

Army Federal Register Liaison Officer.

[FR Doc. 00–16401 Filed 6–28–00; 8:45 am]

BILLING CODE 3710–02–M

DEPARTMENT OF EDUCATION

Notice of Proposed Information Collection Requests

AGENCY: Department of Education.

SUMMARY: The Leader, Regulatory Information Management, Office of the Chief Information Officer, invites comments on the proposed information collection requests as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before August 28, 2000.

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Leader, Regulatory Information Management, Office of the Chief Information Officer, publishes that notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, *e.g.* new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment. The Department of Education is especially interested in public comment addressing the following issues: (1) Is this collection necessary to the proper functions of the Department; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the Department enhance the quality, utility, and clarity of the information to be collected; and (5) how might the Department minimize the burden of this collection on the respondents, including through the use of information technology.

Dated: June 23, 2000.

John Tressler,

Leader, Regulatory Information Management, Office of the Chief Information Officer.

Office of Educational Research and Improvement

Type of Review: Reinstatement, without change, of a previously approved collection for which approval has expired.

Title: National Assessment of Educational Progress (NAEP) Year 2001 Field Test and Year 2002 Main Assessment of Reading and Writing.

Frequency: Annually.

Affected Public:

Businesses or other for-profit (primary).

Not-for-profit institutions.

Reporting and Recordkeeping Hour Burden: Responses: 7250—Burden Hours: 7250.

Abstract: The Congressionally-mandated 2002 National Assessment of Educational Progress will assess writing and reading knowledge among 4th, 8th and 12th graders. To provide contextual information to intrepret the assessment information, relevant background characteristics of the students and their schools and teachers are gathered as well. The clearance package provides all of the background questions and supporting information for the field test and the main study. The results of the main study will be used to provide descriptive information about programs and practices in the teaching of reading and writing; suggest relationships between characteristics and assessment results; serve as a basis for monitoring change over time.

Requests for copies of the proposed information collection request may be accessed from *http://edicsweb.ed.gov,* or should be addressed to Vivian Reese, Department of Education, 400 Maryland Avenue, SW, Room 4050, Regional Office Building 3, Washington, DC 20202–4651. Requests may also be

electronically mailed to the internet address OCIO IMG Issues@ed.gov or faxed to 202–708–9346. Please specify the complete title of the information collection when making your request. Comments regarding burden and/or the collection activity requirements should be directed to Kathy Axt at (703) 426–9692. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

Office of Educational Research and Improvement

Type of Review: Reinstatement, with change, of a previously approved collection for which approval has expired.

Title: State Library Agencies Survey.

Frequency: Annually.

Affected Public: State, Local, or Tribal Gov't, SEAs or LEAs (primary).

Reporting and Recordkeeping Hour Burden: Responses: 51—Burden Hours: 612.

Abstract: State library agencies are the official agencies of each state charged by state law with the extension and development of public library services throughout the state. The purpose of this survey is to provide state and federal policymakers with information about SILAs, including their governance, allied operations, developmental services to libraries and library systems, support of electronic information networks, number and types of outlets, direct services to the public, public service hours, type and size of collections, service and development transactions, staffing patterns, and income and expenditures.

Requests for copies of the proposed information collection request may be accessed from *http://edicsweb.ed.gov,* or should be addressed to Vivian Reese, Department of Education, 400 Maryland Avenue, SW, Room 4050, Regional Office Building 3, Washington, DC 20202–4651. Requests may also be electronically mailed to the internet address OCIO IMG Issues@ed.gov or faxed to 202–708–9346. Please specify the complete title of the information collection when making your request. Comments regarding burden and/or the collection activity requirements should be directed to Kathy Axt at (703) 426–9692. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

[FR Doc. 00–16431 Filed 6–28–00; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP00–391–000]

ANR Pipeline Company; Notice of Petition

June 23, 2000.

Take notice that on June 19, 2000, ANR Pipeline Company, (ANR) petitioned the Commission pursuant to Rule 207 of the Commission's Rules of Practice and Procedure, 18 CFR 385.207 for authorization to reacquire certain firm transportation capacity that it has historically held on Viking Gas Transmission Company (Viking).

In its Petition, ANR explained that the capacity at issue was released/assigned by ANR to its former sales customers at the direction of the Commission as part of the Order No. 636 restructuring process. ANR also advised that, although some of that Viking capacity is no longer desired by those customers, it is still required by ANR to ensure its ability to obtain flowing gas volumes in order to meet its existing firm service requirements in certain parties of western Wisconsin. ANR has requested that the Commission act on its Petition no later than September 1, 2000.

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 on or before June 29, 2000. 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).

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 00–16420 Filed 6–28–00; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER00–2828–000]

Avista Corporation; Notice of Filing

June 23, 2000.

Take notice that on June 14, 2000, Avista Corporation, tendered for filing with the Federal Energy Regulatory Commission pursuant to section 35.12 of the Commissions, 18 CFR 35.12, an executed Netting and Close-Out Agreement with Aquila Energy Marketing Corporation effective June 1, 2000.

Notice of the filing has been served upon Aquila Energy Marketing Corporation.

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 and protests should be filed on or before July 5, 2000. protests will be considered by the Commission to determine 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. This filing may also be viewed on the Internet at http://www.ferc.fed.us/online/rims.htm (call 202–208–2222 for assistance).

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 00–16426 Filed 6–28–00; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP00–390–000]

Columbia Gas Transmission Corporation; Notice of Application for Abandonment Authorization

June 23, 2000.

Take notice that on June 16, 2000, Columbia Gas Transmission Corporation (Columbia), 12801 Fair Lakes Parkway, Fairfax, Virginia 22030–0146, filed an abbreviated application pursuant to section 7(b) of the Natural Gas Act (NGA) requesting the issuance of an

Order granting permission and approval to abandon by removal certain natural gas compression facilities located in Indiana County, Pennsylvania, and known as Columbia's Nolo, Kent and Homer City Compressor Stations, all as more fully set forth in the application which is on file with the Commission and open to public inspection. The application may be viewed on the web at www.ferc.fed.us/online/rims.htm. Call (202) 208–2222 for assistance.

Columbia states that the compressor stations consist of seven compressor units with a cumulative horsepower (hp) rating of 2,900; four dehydration systems; various compressor, office, and auxiliary buildings; 0.5 mile of 6 and 8-inch station piping; and various ancillary systems necessary to support the station operation, as more fully described in the application.

Columbia states that as result of Order Nos. 436 and 636, it has experienced a shift from primarily a merchant function to that of transporter. As a result, Columbia is taking steps to redefine its pipeline system. Columbia further states that the facilities proposed for abandonment are not an integral part of its transmission system and that the long term needs of its customers will be best served through abandonment of assets no longer required to support Columbia's role as a transporter.

Columbia does not propose the abandonment of service to any customer as a result of the facility abandonment, nor does it propose any construction in connection with the abandonment. All ground disturbance will be limited to those activities necessary to abandon the facilities.

Any person desiring to be heard or to protest this application should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426, in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Commission's Regulations under the Natural Gas Act (18 CFR 157.10). All such motions or protests must be filed on or before July 14, 2000. 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 to a proceeding must file a motion to intervene in accordance with the commission's Rules and Regulations. Copies of this application are on file with the Commission and are available for public inspection in the Public Reference Room.

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 Natural Gas Act and the Commission's Rules of Practice and Procedure, a hearing will be held without further notice before the Commission if no intervention or protest is filed within the time frame required herein, if the Commission on its own review of the matter finds that permission and approval for the proposed abandonment are required by the public convenience and necessity. If a motion for leave to intervene is timely filed, or if the Commission on its own motion believes that a formal hearing is required, further notice of such hearing will be duly given.

Under the procedure herein provided for, unless otherwise advised, it will be necessary for Applicant to appear or be represented at the hearing.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 00–16425 Filed 6–28–00; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP00–389–000]

ONEOK WestTex Transmission, Inc.; Notice of Application

June 23, 2000.

Take notice that on June 13, 2000, ONEOK WestTex Transmission, Inc. (WesTex), 100 West Fifth Street, P.O. Box 871, Tulsa, Oklahoma 74102, a Hinshaw pipeline, filed in Docket No. CP00–389–000 an application pursuant to section 284.224(b) of the Commission's regulations, seeking confirmation that it has a blanket certificate, or in the alternative to grant such a blanket certificate. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims,htm* (call 202–208–2222).

Any person desiring to be heard or to make any protest with reference to said application should on or before July 10, 2000, file with the Federal Energy Regulatory Commission, Washington, DC 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Regulations under the Natural Gas Act (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 00–16419 Filed 6–28–00; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP00–392–000]

Stanfield Hub Services, LLC; Notice of Petition

June 23, 2000.

Take notice that on June 19, 2000, Stanfield Hub Services, LLC (Stanfield), 200 S.W. Market Street, Suite 1750, Portland, Oregon 97201, filed in Docket No. CP00–392–000, a petition, pursuant to Rule 207(a)(5) of the Commission's Rules of Practice and Procedure (18 CFR 387.207(a)(5)), and section 7(c)(1)(B) of the Natural Gas Act, seeking approval of a temporary exemption from certificate requirements, all as more fully set forth in this petition which is on file with the Commission and open to public inspection. This filing may be viewed on the web at http://www.ferc.us/online/rims.htm (call 202–208–2222 for assistance). The Stanfield has requested expedited consideration of this Petition.

Specifically, Stanfield seeks authorization to drill up to eight test wells located in Benton County, Washington. Stanfield states that the test wells and related testing and developments are necessary to enable Stanfield to investigate the feasibility of developing an underground natural gas storage project.

Any questions regarding this petition should be directed to Michael C. Dotten or Natalie L. Hocken; Counsel to Stanfield Hub Services, LLC; 200 S.W. Market, Suite 1750, Portland, Oregon 97201–5718 at (508) 227–7400 (Voice) or (503) 241–0950 (FAX).

Any person desiring to be heard or making any protest with reference to said petition should on or before July 14, 2000, 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 385.214 or 385.211) and the Regulations under the Natural

Gas Act (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. The Commission's rules require that protestors provide copies of their protests to the party or person to whom the protests are directed. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Take further notice that, pursuant to the authority contained in and subject to the jurisdiction conferred upon the Federal Energy Regulatory Commission by Sections 7 and 15 of the 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 petition if no motion to intervene is filed within the time required herein, if the Commission on its own review of the matter finds that a grant of the requested exemption is required by the public convenience and necessity. If a motion for leave to intervene is timely filed, of if the Commission on its own motion believes that a formal hearing is required, further notice of such hearing will be duly given.

Under the procedure herein provided for, unless otherwise advised, it will be uncessary for Stanfield to appear or be represented at the hearing.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 00–16421 Filed 6–28–00; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP00–393–000]

Wyoming Interstate Company, LTD.; Notice of Request Under Blanket Authorization

June 23, 2000.

Take notice that on June 20, 2000, Wyoming Interstate Company, LTD. (WIC), Post Office box 1087, Colorado Springs, Colorado 80944, filed a request with the Commission in Docket No. CP00–393–000, pursuant to section 157.205, 157.211 and/or 157.216(b) of the Commission's Regulations under the Natural Gas Act (NGA) for authorization to construct a new meter station for delivery of gas to Coastal Chem, Inc. authorized in blanket certificate issued in Docket No. CP83–22–000, all as more fully set forth in the request 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/rims.htm (call 202–208–2222 for assistance).

WIC states that Coastal Chem, Inc. a manufacturer of nitrogen based fertilizer to provide fuel gas for their processing facility in Laramie County, Wyoming. The proposed WIC delivery facility would consist of an eight-inch meter run with four-inch flow control valve and appurtenant facilities at an estimated cost of $240,000 plus tax gross up. Coastal Chem, Inc. would pay for the facility. The Coastal Chem, Inc. manufacturing facility is currently served by Cheyenne Light, Fuel and Power Company, a local distribution company.

Any person for the Commission's staff may, within 45 days after the Commission has issued this notice, 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. If no protest is filed within the allowed time, 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.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 00–16422 Filed 6–28–00; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. EC98–40–006, et al.]

American Electric Power Company, et al.; Electric Rate and Corporate Regulation Filings

June 21, 2000.

Take notice that the following filings have been made with the Commission:

1. American Electric Power Company and Central and South West Corporation

[Docket Nos. EC98–40–006, ER98–2770–007, and ER98–2786–007]

Take notice that on June 15, 2000, American Electric Power Company and Central and South West Corporation made their compliance filing as required under Ordering Paragraph (A) of the Commission's May 31, 2000 order in the referenced dockets.

Comment date: July 17, 2000, in accordance with Standard Paragraph E at the end of this notice.

2. The United Illuminating Company and Quinnipiac Energy, LLC

[Docket No. EC00–101–000]

Take notice that on June 13, 2000, The United Illuminating Company (UI) and Quinnipiac Energy, LLC (Quinnipiac Energy) (the Applicants) jointly submitted for filing, pursuant to section 203 of the Federal Power Act, and Part 33 of the Commission's regulations, an application for the disposition of certain transmission facilities in connection with the sale by UI of its currently non-operating, oil-fired generating facility known as English Station, located in New Haven, Connecticut, to Quinnipiac Energy, pursuant to a Purchase and Sale Agreement dated March 2, 2000. Copies of the entire filing have been served on the Connecticut Department of Public Utility Control.

Comment date: July 11, 2000, in accordance with Standard Paragraph E at the end of this notice.

3. Newark Bay Cogeneration Partnership, L.P.

[Docket No. EG00–178–000]

Take notice that on June 19, 2000, Newark Bay Cogeneration Partnership, L.P. (NBCP), 414–462 Avenue P, Newark, New Jersey, 07105, filed with the Federal Energy Regulatory Commission (Commission) an Application for Determination of Exempt Wholesale Generator Status pursuant to part 365 of the Commission's Regulations and Section 32 of the Public Utility Holding Company Act, as amended (the Application).

The Application seeks a determination that NBCP qualified for Exempt Wholesale Generator status. NBCP is a Delaware limited partnership that owns and operates a gas-fired combined cycle cogeneration facility rated at 123 MW summer and 147 MW winter capacity. NBCP historically has engaged in the sale of electricity to Public Service Electric and Gas Company (PSE&G) as a Qualifying Facility (QF) under the Public Utility Regulatory Policies Act of 1978 (PURPA). Upon NBCP's determination as an EWG, the facility will be used for the generation of electricity exclusively for sale at wholesale.

Copies of the application have been served upon the New Jersey Board of

Public Utilities and Energy and the Securities and Exchange Commission.

Comment date: July 12, 2000, 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.

4. Dighton Power Associates Limited Partnership et al. v. ISO New England Inc.

[Docket No. EL00–40–002]

Take notice that on June 16, 2000, ISO New England Inc. (the ISO) filed a Report of Compliance pursuant to the Federal Energy Regulatory Commission's (Commission) order issued on May 19, 2000 in the above-referenced proceeding.

Copies of said filing have been served on all parties to this proceeding.

Comment date: July 17, 2000, in accordance with Standard Paragraph E at the end of this notice.

5. PJM Interconnection, L.L.C.

[Docket No. ES00–47–000]

Take notice that on June 19, 2000, PJM Interconnection, L.L.C. (PJM), submitted an application pursuant to section 204 of the Federal Power Act seeking authorization to issue securities in an amount not to exceed $191 million.

PJM also requests a waiver from the Commission's competitive bidding and negotiated placement requirements in 18 CFR 34.2.

Comment date: July 12, 2000, in accordance with Standard Paragraph E at the end of this notice.

6. Mid-Continent Area Power Pool

[Docket Nos. OA97–163–010, ER97–1162–009 and OA97–658–010]

Take notice that on June 16, 2000, the Mid-Continent Area Power Pool (MAPP) notified the Commission of certain procedural changes regarding MAPP Schedule F to the Restated Agreement.

A copy of the notification was served on all parties in the above-referenced proceedings and the state public service commissions located in the MAPP region.

Comment date: July 12, 2000, in accordance with Standard Paragraph E at the end of this notice.

7. Southwestern Public Service Company

[Docket No. ER00–2565–001]

Take notice that on June 16, 2000, New Century Services, Inc. (NCS), on behalf of Southwestern Public Service Company (SPS), tendered for filing executed Network Integration Transmission Service and Network Operating Agreements between Golden Spread Electric Cooperative, Inc. and SPS. NCS also submitted executed Network Integration Transmission Service and Network Operating Agreements between South Plains Electric Cooperative, Inc. and SPS.

NCS has requested that all of the agreements become effective on April 20, 2000.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

8. Milford Power Limited Partnership

[Docket No. ER00–2592–001]

Take notice that on June 16, 2000, Milford Power Limited Partnership tendered for filing an amendment to its petition filed in the above referenced dockets on May 23, 2000. The amendment serves to amend the Revised FERC Electric Tariff No.1 attached as Appendix A to the petition to provide that Milford will not sell energy or capacity to any affiliate with a franchised service area pursuant to such rate schedule, and will only engage in such sales pursuant to a separate filing approved by the Commission under Section 205 of the Federal Power Act.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

9. Midwest Independent Transmission System Operator, Inc.

[Docket No. ER00–2863–000]

Take notice that on June 16, 2000, Midwest Independent Transmission System Operator, Inc., tendered for filing an executed signature pages to the ''Agreement of the Transmission Facilities Owners to Organize the Midwest Independent Transmission System Operator, Inc., A Delaware Non-Stock Corporation,'' and the ''Agency Agreement for Open Access Transmission Service Offered by the Midwest ISO for Nontransferred Transmission Facilities' executed by Northern States Power Company-Minnesota and Northern States Power Company-Wisconsin were filed with the Commission.

A copy of this filing was served on all affected state commission.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

10. Illinois Power Company

[Docket No. ER00–2864–000]

Take notice that on June 16, 2000, Illinois Power Company (Illinois Power), 500 South 27th Street, Decatur, Illinois 62526, tendered for filing firm and non-firm transmission agreements under which British Columbia Power Exchange Corporation will take transmission service pursuant to its open access transmission tariff. The agreements are based on the Form of Service Agreement in Illinois Power's tariff.

Illinois Power has requested an effective date of June 15, 2000.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

11. Allegheny Energy Service Corporation on behalf of Allegheny Energy Supply Company, LLC

[Docket No. ER00–2865–000]

Take notice that on June 16, 2000, Allegheny Energy Service Corporation on behalf of Allegheny Energy Supply Company, LLC (Allegheny Energy Supply), tendered for filing Service Agreement No. 76 to add one (1) new Customer to the Market Rate Tariff under which Allegheny Energy Supply offers generation services.

Allegheny Energy Supply requests a waiver of notice requirements to make service available as of May 17, 2000 to East Kentucky Power Cooperative, Inc.

Copies of the filing have been provided to the Public Utilities Commission of Ohio, the Pennsylvania Public Utility Commission, the Maryland Public Service Commission, the Virginia State Corporation Commission, the West Virginia Public Service Commission, and all parties of record.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

12. Pacific Gas and Electric Company

[Docket No. ER00–2866–000]

Take notice that on June 16, 2000, Pacific Gas and Electric Company (PGandE Company), tendered for filing the Emergency Demand Relief Service Agreement between Pacific Gas and Electric Company and City and County of San Francisco (CCSF). This agreement is intended to facilitate CCSF's participation in the California Independent System Operator (CAISO) Demand Relief Program to support reliability of the electric grid in California this summer. Under this agreement, PGandE Company will provide information to the CAISO regarding curtailment of loads designated by CCSF when requested by CAISO to meet reserve and reliability requirements, and pass through payments from CAISO to CCSF.

PGandE Company has requested certain waivers.

Copies of this filing have been served upon City, the CAISO, The California Electricity Oversight Board, the CPUC and the Service List for Docket No. EL00–75–000.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

13. Virginia Electric and Power Company

[Docket No. ER00–2867–000]

Take notice that on June 16, 2000, Virginia Electric and Power Company (Virginia Power), tendered for filing a Network Integration Transmission Service and Network Operating Agreement with The Wholesale Power Group under the Company's Open Access Transmission Tariff to Eligible Purchasers dated July 14, 1997. Under the tendered agreements, Virginia Power will provide network integration transmission service in accordance with the rates, terms and conditions of the Open Access Transmission Tariff.

Virginia Power requests an effective date of June 1, 2000, the date service was first provided to the customer.

Copies of the filing were served upon The Wholesale Power Group, the Virginia State Corporation Commission and the North Carolina Utilities Commission.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

14. Wisconsin Public Service Corporation

[Docket No. ER00–2868–000]

Take notice that on June 16, 2000, Wisconsin Public Service Corporation tendered for filing an executed service agreement with Enron Power Marketing, Inc. (EPMI) under its Market-Based Rate Tariff, FERC Electric Tariff Volume No. 10.

Copies of this filing were served upon EPMI, the Public Service Commission of Wisconsin and the Michigan Public Service Commission.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

15. Cook Inlet Energy Supply L.L.C.

[Docket No. ER00–2871–000]

Take notice that on June 16, 2000, Cook Inlet Energy Supply L.L.C., tendered for filing a Notice of Change in Status related to a change in its ownership.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

16. Consumers Energy Company

[Docket No. ER00–2872–000]

Take notice that on June 16, 2000, Consumers Energy Company (Consumers), tendered for filing a Facility Engineering Authorization Agreement Between Consumers and Covert Generating Company, L.L.C. [Covert] (Agreement), dated May 26, 2000 (Agreement). Under the Agreement, Consumers is to perform engineering and other preliminary work associated with providing an electrical connection between Consumers' transmission system and a generating plant to be built by Covert.

Consumers requested that the Agreement be allowed to become effective May 26, 2000.

Copies of the filing were served upon Covert and the Michigan Public Service Commission.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

17. Duke Energy Vermillion, LLC

[Docket No. ER00–2873–000]

Take notice that on June 16, 2000, Duke Energy Vermillion, LLC (Duke Vermillion), tendered for filing a Service Agreement with Duke Energy Trenton, LLC and Cincap VIII, LLC pursuant to Duke Vermillion's Market-Based Rate Tariff.

Duke Vermillion requests an effective date for the Service Agreement of May 15, 2000.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

18. Duke Energy Madison, LLC

[Docket No. ER00–2874–000]

Take notice that on June 16, 2000, Duke Energy Madison, LLC (Duke Madison), tendered for filing a Service Agreement with Duke Energy Trenton, LLC and Cincap VIII, LLC pursuant to Duke Madison's Market-Based Rate Tariff.

Duke Madison requests an effective date for the Service Agreement of May 29, 2000.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

19. Calcasieu Power, LLC

[Docket No. ER00–2875–000]

Take notice that on June 16, 2000, Calcasieu Power, LLC, tendered for filing an unexecuted Power Sales Agreement for short-term transactions between Calcasieu Power, LLC and Entergy Services, Inc. (as agent Entergy Gulf States, Inc.) to be in effect as of May 17, 2000.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

20. Consumers Energy Company

[Docket No. ER00–2876–000]

Take notice that on June 16, 2000, Consumers Energy Company (Consumers) tendered for filing a Facilities Agreement Between Consumers Energy Company and CMS Distributed Power, L.L.C., (Facilities Agreement). Under the Facilities Agreement, Consumers is to construct, operate and maintain various interconnection facilities. The Facilities Agreement is dated May 31, 2000.

Consumers requested that the Agreements be allowed to become effective by May 31, 2000.

Copies of the filing were served upon CMS Distributed Power, L.L.C. and upon the Michigan Public Service Commission.

Comment date: July 7, 2000, in accordance with Standard Paragraph E at the end of this notice.

21. Otter Tail Power Company

[Docket No. ER00–2877–000]

Take notice that on June 16, 2000, Otter Tail Power Company (Otter Tail), tendered for filing a letter notifying the Federal Energy Regulatory Commission that Otter Tail proposes to modify its open access transmission tariff as of May 1, 2000, to incorporate the Mid-Continent Power Pool's Line Loading Relief (LLR) procedures as required by the Commission's May 26, 2000 Order in the same docket.

Comment date: July 7, 2000, 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).

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 00–16418 Filed 6–28–00; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 1494–197, Oklahoma]

Grand River Dam Authority; Notice of Availability of Environmental Assessment

June 23, 2000.

An environmental assessment (EA) is available for public review. The EA analyzes the environmental impacts of Grand River Dam Authority's (GRDA) application to grant a permit to John W. Mayes (applicant) to install 9 boat docks with 84 slips in Grand Lake O' The Cherokees (Grand Lake), the reservoir for the Pensacola Hydroelectric Project. GRDA's proposed permit would also allow the applicant to dredge about 33,557 cubic yards of sediment to improve boat access from the docks to Grand Lake. The Pensacola Project is on the Grand (Nesho) River in Craig, Delaware, Mayes, and Ottawa Counties, Oklahoma.

The EA was written by staff in the Office of Energy Projects, Federal Energy Regulatory Commission. In the EA, Commission staff conclude that approving GRDA's application to grant the permit would not constitute a major federal action significantly affecting the quality of the human environment. Copies of the EA can be viewed on the web at *www.ferc.fed.us/online/rims.htm.* Call (202) 208–2222 for assistance. Copies are also 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.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 00–16424 Filed 6–28–00; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Notice of Scoping Meetings and Site Visit and Soliciting Scoping Comments

June 23, 2000.

Take notice that the following hydroelectric applications have been filed with Commission and are available for public inspection:

a. Type of Applications: New Major Licenses.

b. Projects: Soda Project No. 20–019, Grace-Cove Project No. 2401–007, and Oneida Project No. 472–017.

c. Date filed: September 27, 1999.

d. Applicant: PacifiCorp.

e. Location: On the Bear River in Caribou and Franklin Counties, Idaho. The projects are partially on United States lands administered by the Bureau of Land Management.

f. Filed Pursuant to: Federal Power Act, 16 USC 791(a)–825(r).

g. Applicant Contact: Randy Landolt, Director, Hydro Resources, PacifiCorp, 825 N.E. Multnomah Street, Suite 1500, Portland, OR 97232, (503) 813–6650, or, Thomas H. Nelson, 825 Multnomah Street, Suite 925, Portland, OR 97232, (503) 813–5890.

h. FERC Contact: Susan O'Brien, susan.obrien@ferc.fed.us, (202) 219–2840.

i. Deadline for filing scoping comments: September 14, 2000.

All documents (original and eight copies) should be filed with: David P. Boergers, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE, Washington, DC 20426.

The Commission's Rules of Practice and Procedure require all interveners filing documents with the Commission to serve a copy of that document on each person on the official service list for the project. Further, if an intervener files comments or documents with the Commission relating to the merits of an issue that may affect the responsibilities of a particular resource agency, they must also serve a copy of the document on that resource agency.

j. This application is not ready for environmental analysis at this time.

k. The existing Soda Project consists of: (1) the 103-foot-high and 433-foot-long concrete gravity Soda Dam with a 114-foot-long spillway section; (2) the Soda Reservoir with a surface area of 1,100 acres, an active storage capacity of 16,300 acre-feet, and a maximum water elevation of 5,720 feet; (3) the Soda Powerhouse containing two units with a total installed capacity of 14 megawatts (MW); and (4) other appurtenances.

The existing Grace Development consists of: (1) a 51-foot-high and 180-foot-long rock filled timber crib dam that creates a 250 acre-feet usable storage capacity forebay; (2) a 26,000-foot-long flowline and surge tanks; and (3) a powerhouse with three units with total installed capacity of 33 MW. The Cove Development consists of: (1) a 26.5-foot-high and 141-foot-long concrete dam creating a 60-acre-foot forebay; (2) a 6,125-foot-long concrete and wood flume; (3) a 500-foot-long steel penstock; and (4) a powerhouse with a 7.5-MW unit.

The existing Oneida Project consists of: (1) the 111-foot-high and 456-foot-long concrete gravity Oneida Dam; (2) the Oneida Reservoir with an active storage of 10,880 acre-feet and a surface area of 480 acres; (3) an 16-foot-diameter, 2,240-foot-long flowline; (4) a surge tank; (5) three 12-foot-diameter, 120-foot-diameter, 120-foot-long steel penstocks; (6) the Oneida Powerhouse with three units with a total installed capacity of 30 MW; and (7) other appurtenances.

l. 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. The application may be viewed on http://www.ferc.fed.us/rims.htm (call (202) 208–2222 for assistance). A copy is also available for inspection and reproduction at the address in item g above.

m. Scoping Process

The Commission intends to prepare an Environmental Impact Statement (EIS) on the project in accordance with the National Environmental Policy Act. The EIS will consider both site-specific and cumulative environmental impacts and reasonable alternatives to the proposed action.

Scoping Meetings and Site Visit

A scoping meeting will be held on Tuesday, August 14, 2000 from 7:00 p.m. until 10 p.m. at the Caribou County Senior Citizens Center, 60 South Main Street, Soda Springs, Idaho. A project site visit will be scheduled for Tuesday, August 14, 2000 at 9 am, if there is any interest. If you would like to attend, please call Susan O'Brien, FERC Team Leader, at (202) 219–2840, no later than Thursday, July 27, 2000.

Copies of the Scoping Document (SDI) outlining the subject areas to be addressed in the EIS were distributed to the parties on the Commission's mailing list. Copies of the SDI will be available at the scoping meeting in August or may be viewed on http://www.ferc.fed.us/

rims.htm (call (202) 208–2222 for assistance).

The Commission held scoping meetings, one in the daytime and one in the evening, to help identify the scope of issues to be addressed in the EIS. The daytime scoping meeting was held on June 15, 2000 at the Holiday Inn, 1399 Bench Road, Pocatello, Idaho, and focused on resource agency concerns. The evening scoping meeting was held on June 14, 2000 at the Caribou County Senior Citizens Center, 60 South Main Street, Soda Spring, Idaho, and was primarily for public input. The applicant and Commission staff also conducted a project site visit on Friday, June 16, 2000.

It was the Commission's intent that all interested individuals, organizations, and agencies be invited to attend one or both of the meetings and the site visit, and to assist the staff in identifying the scope of the environmental issues that should be analyzed in the EIS. These meetings and site visit were not noticed in the **Federal Register** or the local newspapers. For that reason, the subject scoping meeting and site visit are being scheduled. Transcripts of the June meetings will be available shortly and can be viewed on http://www.ferc.fed.us/rims.htm (call (202) 208–2222 for assistance). Transcripts of the August meeting will also become available shortly after that meeting.

The scoping comment period will be extended from July 16, 2000 until September 14, 2000. Please follow procedures in item i. above.

Objectives

Individuals, organizations, and agencies with environmental expertise and concerns are encouraged to attend the meeting and to assist the staff in defining and clarifying the issues to be addressed in the EIS.

At the scoping meetings, the staff will: (1) Summarize the environmental issues tentatively identified for analysis in the EIS; (2) solicit from the meeting participants all available information, especially quantifiable data, on the resources at issue; (3) encourage statememts from experts and the public on issues that should be analyzed in the EIS, including viewpoints in opposition to, or in support of, the staff's preliminary views; (4) determine the resource issues to be addressed in the EIS; and (5) identify those issues that require a detailed analysis, as well as those issues that do not require a detailed analysis.

Procedures

The meetings are recorded by a stenographer and become part of the formal record of the Commission proceeding on the project.

Linwood A. Watson, Jr.,

Acting Secretary.

[FR Doc. 00–16423 Filed 6–28–00; 8:45 am]

BILLING CODE 6717–01–M

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6726–6]

Agency Information Collection Activities: Submission for OMB Review; Comment Request; National Emission Standards for Air Pollutants for Source Categories: Flexible Polyurethane Foam Production—MACT

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this document announces that the following Information Collection Request (ICR) has been forwarded to the Office of Management and Budget (OMB) for review and approval: MACT, Subpart III, National Emission Standards for Air Pollutants for Flexible Polyurethane Foam Production. OMB Control Number 2060–0357, expiration date 8/31/00. The ICR describes the nature of the information collection and its expected burden and cost; where appropriate, it includes the actual data collection instrument.

DATES: Comments must be submitted on or before July 31, 2000.

FOR FURTHER INFORMATION CONTACT: For a copy of the ICR contact Sandy Farmer at EPA by phone at (202) 260–2740, by E-Mail at Farmer.Sandy@epamail.epa.gov or download off the Internet at *http://www.epa.gov/icr* and refer to EPA ICR No. 1783.02. For technical questions about the ICR contact Greg Fried at EPA by phone at (202) 564–7016 or by email at *fried.gregory@epa.gov*.

SUPPLEMENTARY INFORMATION:

Title: ICR for MACT Subpart III—National Emission Standards for Hazardous Air Pollutants for Flexible Polyurethane Foam Production, OMB Control Number 2060–0357, EPA ICR No. 1783.02, expiration date 8/31/00. This is a request for extension of a currently approved collection.

Abstract: This standard applies to owners or operators of new and existing facilities that engage in the manufacture of flexible polyurethane foam products. This includes facilities making slabstock flexible polyurethane foam (''slabstock''), rebond flexible polyurethane foam (''rebond''), and/or molded flexible polyurethane foam (''molded foam'').

For slabstock foam producers, these requirements include an initial notification, notification of compliance status, and semiannual reports thereafter. In addition, respondents are required to submit a pre-compliance report that describes the HAP compliance procedures, and recordkeeping procedures. Respondents electing to comply with the slabstock foam emission limitation using recovery devices must measure and record emissions as specified in section 63.1297 of the final rule. Molded and rebond foam producers have only to submit a notification of compliance status report.

Owners or operators of slabstock flexible polyurethane foam production facilities must maintain a copy of all HAP usage records onsite for a minimum of five years. All reports are to be submitted upon request to EPA or the enforcement authority by EPA. The information is used to determine whether or not all sources subject to the MACT are achieving the 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 OMB control numbers for EPA's regulations are listed in 40 CFR part 9 and 48 CFR Chapter 15. The **Federal Register** document required under 5 CFR 1320.8(d), soliciting comments on this collection of information was published on April 18, 2000; no comments were received.

Burden Statement: The annual burden for this collection of information is estimated to average 45 hours over the next three years. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

Respondents/Affected Entities: Flexible Polyurethane Foam Production Plants.

Estimated Number of Respondents: 143.

Frequency of Response: Initial and semiannual.

Estimated Total Annual Hour Burden: 6,400 hours.

Estimated Total Annualized Capital O&M Cost Burden: $0.

Send comments on the Agency's need for this information, the accuracy of the provided burden estimates, and any suggested methods for minimizing respondent burden, including through the use of automated collection techniques to the following addresses. Please refer to EPA ICR No.1783.02 and OMB Control No. 2060–0357 in any correspondence.

Ms. Sandy Farmer, U.S. Environmental Protection Agency, Office of Environmental Information, Collection Strategies Division (2822), 1200 Pennsylvania Ave, NW, Washington, DC 20460;

and

Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: Desk Officer for EPA, 725 17th Street, NW, Washington, DC 20503.

Dated: June 20, 2000.

Oscar Morales,

Director, Collection Strategies Division.

[FR Doc. 00–16516 Filed 6–28–00; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6726–7]

Agency Information Collection Activities; Submission for OMB Review; Comment Request; EPA ICR #1249.06

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this document announces that the following Information Collection Request (ICR) has been forwarded to the Office of Management and Budget (OMB) for review and approval: Recordkeeping Requirements For Certified Applicators Using 1080 Collars For Livestock Protection, (EPA ICR No. 1249.06, OMB No. 2070–0074). The ICR, which is abstracted below and expires on June 30, 2000, describes the nature of the information collection and its estimated cost and burden. The Agency is requesting that OMB renew approval of the ICR for a three year period. The **Federal Register** document required under 5 CFR 1320.8(d), soliciting comments on this collection of information, published on December 29, 1999 (64 FR 73042). EPA received a single comment, which was considered in finalizing this ICR for submission to OMB.

DATES: Additional comments may be submitted on or before July 31, 2000.

FOR FURTHER INFORMATION CONTACT: Sandy Farmer by phone at 202–260–2740, or via e-mail at ''farmer.sandy@epa.gov'', or using the address indicated below. Please refer to EPA ICR No. 1249.06. and OMB Control No. 2070–0074.

ADDRESSES: Send comments, referencing EPA ICR No. 1249.06 and OMB Control No. 2070–0074, to the following addresses: Ms. Sandy Farmer, U.S. Environmental Protection Agency, Collection Strategies Division (2822), 1200 Pennsylvania Avenue, NW., Washington, DC 20460; and to: Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), Attention: Desk Officer for EPA, 725 17th Street, NW., Washington, DC 20503.

SUPPLEMENTARY INFORMATION:

Review Requested: The Agency is requesting that OMB renew approval of this ICR for a three year period.

ICR Numbers: EPA ICR No. 1249.06 and OMB Control No. 2070–0074.

Current Expiration Date: June 30, 2000.

Title: Recordkeeping Requirements for Certified Applicators Using 1080 Collars for Livestock Protection.

Abstract: This ICR affects approximately 75 Certified Pesticide Applicators, who utilize 1080 toxic collars for livestock protection. Four states (Montana, New Mexico, South Dakota, and Wyoming) monitor the program, and five pesticide registrants are required to keep records of: (a) Number of collars purchased; (b) number of collars placed on livestock; (c) number of collars punctured or ruptured; (d) apparent cause of puncture or rupture; (e) number of collars lost or unrecovered; (f) number of collars in use and in storage; and (g) location and species data on each animal poisoned as an apparent result of the toxic collar.

Applicators maintain records, and the registrants/lead agencies do monitoring studies and submit the reports. These records are monitored by either the: (a) State lead agencies; (b) EPA regional offices; or (c) the registrants. The Environmental Protection Agency (EPA, the Agency) receives annual monitoring reports from registrants or State lead agencies. 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.

Burden Statement: The data that certified Livestock Protection Collar applicators are required to record and maintain were outlined in the Initial Decision of the Administrative Law Judge in the 1080 Predacide Hearings. Pursuant to that decision, the EPA requires certified Livestock Protection Collar applicators to keep and report no records other than those prescribed by USE RESTRICTIONS 5 and 6. The ICR provides a detailed explanation of this estimate. The annual public burden for the Recordkeeping Requirements for Certified Applicators using 1080 Collars for Livestock Protection is estimated to average 40 hours per certified applicator, 77 hour per state, and 9 hours per registrant. The following is a summary of the estimates taken from the ICR:

Respondents/Affected Entities: Certified applicators, States and Registrants.

Estimated Total Number of Respondents: 84.

Frequency of Response: Annually.

Estimated total number of responses for each respondent: 1.

Estimated Total Annual Burden: 3,353.

Estimated Total Annualized Non-labor Costs: $0.

Changes in Burden Estimates: The Agency reduced its estimate of the number of certified applicators based on the number of annual participants during the past three years, and reduced the number of registrants because one registrant is no longer participating in the program. This resulted in a total adjustment in the total burden of –3,086 burden hours.

According to the procedures prescribed in 5 CFR 1320.12, EPA has submitted this ICR to OMB for review and approval. Any comments related to the renewal of this ICR should be submitted within 30 days of this document, as described above.

Dated: June 20, 2000.

Oscar Morales,

Director, Collection Strategies Division.

[FR Doc. 00–16519 Filed 6–28–00; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[KY119–200023; FRL–6726–8]

Adequacy Status of the Northern Kentucky Submitted Ozone Redesignation Request and Maintenance State Implementation Plan for Transportation Conformity Purposes

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of adequacy.

SUMMARY: In this document, EPA is notifying the public that we have found that the motor vehicle emissions budgets for oxides of nitrogen and volatile organic compounds for the year 2010 in the Ozone Redesignation Request and Maintenance State Implementation Plan (SIP) submitted by the Commonwealth of Kentucky for Northern Kentucky are adequate for transportation conformity purposes. On March 2, 1999, the D.C. Circuit Court ruled that submitted SIPs cannot be used for conformity determinations until EPA has affirmatively found them adequate. As a result of our finding, the motor vehicle emissions budgets in the submitted Northern Kentucky Ozone Redesignation Request and Maintenance SIP must be used for future conformity determinations.

DATES: These budgets are effective July 14, 2000.

FOR FURTHER INFORMATION CONTACT: The finding will be available at EPA's conformity website: *http://www.epa.gov/oms/traq,* (once there, click on the ''Conformity'' button, then look for ''Adequacy Review of SIP Submissions for Conformity'').

The SIP is available for public viewing at the United States Environmental Protection Agency, 61 Forsyth Street, SW., Atlanta, Georgia 30303. You can request a copy of the SIP submission by contacting Dr. Robert W. Goodwin, Regulatory Planning Section, United States Environmental Protection Agency, 61 Forsyth Street, SW., Atlanta, Georgia 30303, Phone: (404) 562–9044, Fax: (404) 562–9019, E-smail: Goodwin.Robert@EPA.gov.

SUPPLEMENTARY INFORMATION:

Background

Today's document is simply an announcement of a finding that we have already made. EPA Region 4 sent a letter to the Kentucky Division for Air Quality on May 24, 2000, stating that the motor vehicle emissions budgets in the submitted Northern Kentucky Ozone Redesignation Request and Maintenance SIP for the year 2010 are adequate. This finding will also be announced on EPA's conformity website: *http://www.epa.gov/oms/traq,* (once there, click on the ''Conformity'' button, then look for ''Adequacy Review of SIP Submissions for Conformity'').

Transportation conformity is required by section 176(c) of the Clean Air Act. EPA's conformity rule requires that transportation plans, programs, and projects conform to state air quality implementation plans (SIPs) and establishes the criteria and procedures for determining whether or not they do. Conformity to a SIP means that transportation activities will not produce new air quality violations, worsen existing violations, or delay timely attainment of the national ambient air quality standards.

The criteria by which we determine whether a SIP's motor vehicle emission budgets are adequate for conformity purposes are outlined in 40 CFR 93.118(e)(4). We've described our process for determining the adequacy of submitted SIP budgets in guidance (May 14, 1999 memo titled ''Conformity Guidance on Implementation of March 2, 1999 Conformity Court Decision''). We followed this guidance in making our adequacy determination.

Authority: 42 U.S.C. 7401–7671q.

Dated: June 21, 2000.

A. Stanley Meiburg,

Acting Regional Administrator, Region 4.

[FR Doc. 00–16517 Filed 6–28–00; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6726–9]

Landia Chemical Company Site/ Lakeland, Florida; Notice of Proposed Settlement

AGENCY: Environmental Protection Agency.

ACTION: Notice of proposed settlement.

SUMMARY: Under sections 104, 106(a), 107 and 122 of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), Agrico Chemical Company and PCS Joint Venture, Ltd. (Respondents) entered into an Administrative Order on Consent (AOC) with the Environmental Protection Agency (EPA), whereby Respondents agreed to perform response activities at the Landia Chemical Company Site (Site) located in Lakeland, Florida. Section VII of the AOC provides for the reimbursement of EPA's past response costs by Respondents. Under the terms of the AOC, section VII is subject to section 122(i) of CERCLA, which requires EPA to publish notice of the proposed settlement in the **Federal Register** for a thirty (30) day public comment period. EPA will consider public comments on section VII of the AOC for thirty days. EPA may withhold consent to all or part of section VII of the AOC if comments received disclose facts or considerations which indicate that section VII of the AOC is inappropriate, improper, or inadequate. Copies of the proposed settlement are available from: Ms. Paula V. Batchelor, U.S. Environmental Protection Agency, Region IV, CERCLA Program Services Branch, Waste Management Division, 61 Forsyth Street, SW., Atlanta, Georgia 30303, (404) 562–8887.

Written comment may be submitted to Mr. Greg Armstrong at the above address within 30 days of the date of publication.

Dated: June 15, 2000.

Franklin E. Hill,

Chief, CERCLA Program Services Branch, Waste Management Division.

[FR Doc. 00–16518 Filed 6–28–00; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

Public Information Collections Approved by Office of Management and Budget

June 23, 2000.

The Federal Communications Commission (FCC) has received Office of Management and Budget (OMB) approval for the following public information collections pursuant to the Paperwork Reduction Act of 1995, Public Law 104–13. An agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid control number. For further information contact Shoko B. Hair, Federal Communications Commission, (202) 418–1379.

Federal Communications Commission

OMB Control No.: 3060–0943
Expiration Date: 12/31/2000
Title: 47 CFR Section 54.809, Carrier Certification
Form No.: N/A
Respondents: Business or other for-profit.
Estimated Annual Burden: 27 respondents; 1.5 hours per response (avg.).; 40.5 total annual burden hours.
Estimated Annual Reporting and Recordkeeping Cost Burden: $0.

Frequency of Response: Annually.

Description: Section 54.809 of the Commission's rules requires each price cap or competitive local exchange carrier that wishes to receive universal service support to file an annual certification with the Universal Service Administrative Company (USAC) and the Commission. The certification must state that the carrier will use its interstate access universal service support only for the provision, maintenance, and upgrading of facilities and service for which the support is intended. The Commission and USAC will use the certifications to ensure that carriers comply with section 254(e) of the Telecommunications Act by using the interstate access universal service support only for the provision, maintenance, and upgrading of facilities and service for which the support is intended. Obligation to respond: Required to obtain or retain benefits.

OMB Control No.: 3060–0463

Expiration Date: 06/30/2003

Title: Telecommunications Services for Individuals with Hearing and Speech Disabilities and the Americans with Disabilities Act of 1990, 47 CFR Part 64 (Sections 64.601–64.605).

Form No.: N/A.

Respondents: Business or other for profit; State, Local or Tribal Government.

Estimated Annual Burden: 5052 respondents; 5.31 hours per response (avg). 26,832 total annual burden hours.

Estimated Annual Reporting and Recordkeeping Cost Burden: $0.

Frequency of Response: On occasion; Annually; Every five years; Recordkeeping; Third Party Disclosure.

Description: In a Report and Order issued in CC Docket 98–67, released March 6, 2000, the Commission amended the rules governing the delivery of telecommunications relay services (TRS) to expand the kinds of relay services available to consumers and to improve the quality of relay services. The Commission clarified some of the requirements in an Order on Reconsideration issued in CC Docket 98–67, released June 5, 2000. Title IV of the Americans with Disabilities Act of 1990 (ADA), which is codified at section 225 of the Communications Act of 1934, as amended requires the Commission to ensure that TRS is available, to the extent possible and in the most efficient manner, to individuals with hearing and speech disabilities in the United States. Section 225 defines relay service to be a telephone transmission service that provides the ability for an individual with a hearing or speech disability to engage in communication by wire or radio with a hearing individual in a manner functionally equivalent to someone without such a disability. Section 225 requires the Commission to ensure that interstate and intrastate relay services are available throughout the country and to establish regulations to ensure the quality of relay service. To fulfill this mandate, the Commission first issued rules in 1991. The rules are found at 47 CFR 64.601–64.605. Following are the information collection requirements contained in the rules approved by OMB.

Section 64.604(c)(1) requires states to maintain a log of consumer complaints including all complaints about TRS in the state, whether filed with the TRS provider or the State, and must retain the log until the next application for certification is granted. The log shall include, at a minimum, the date the complaint was filed, the nature of the complaint, the date of resolution, and an explanation of the resolution. Summaries of logs must be submitted annually to the Commission. (No. of respondents: 52 respondents; hours per response: 2 hours; total annual burden: 104 hours). Pursuant to Section 64.604(c)(2) states must submit to the Commission a contact person or office for TRS consumer information and complaints about intrastate TRS. Providers of interstate TRS must submit to the Commission a contact person or office for TRS consumer information and complaints about the provider's service. This submission must include, at a minimum, the name and address of the office that receives complaints, grievances, inquiries and suggestions, voice and TTY telephone numbers, fax number, e-mail address, and physical address to which correspondence should be sent. (No. of respondents: 52 respondents; hours per response: 1 hour; total annual burden: 52 hours). Pursuant to 47 CFR 64.604(b)(2) TRS providers must answer 85% of all relay calls within 10 seconds by a CA prepared to place the TRS call at the time. The calculation of whether a provider is in compliance with the ''85–10 rule'' must be performed on at least a daily basis. (No. of respondents: 31 respondents; hours per response: 365 hours; total annual burden: 11,315 hours). Pursuant to 47 CFR 64.604(a)(2), STS CAs may retain information from a particular call in order to facilitate the completion of consecutive calls, at the request of the user. The CA may retain the information only for as long as it takes to complete the subsequent calls. Relay providers must offer STS users the option to maintain at the relay center a list of names and telephone numbers which the STS users call. When the STS users requests one of these names, the CA must repeat the name and state the telephone number to the STS users. See 47 CFR 64.604(a)(7). Pursuant to Section 64.604(b)(6), relay providers shall electronically capture recorded messages and retain them for the length of the call. See 47 CFR 64.604(b)(6). (No. of respondents: 31; hours per response: 1 hour; total annual burden: 31 hours). 47 CFR 64.604(c)(3) requires carriers, through publications in their directories, periodic billing inserts, placement of TRS instructions in telephone directories, through directory assistance services, and incorporation of TTY numbers in telephone directories, shall assure that callers in their service areas are aware of the availability and use of all forms of TRS. (No. of respondents: 5,000 respondents: hours per response: 1 hour; total annual burden: 5,000 hours). 47 CFR 64.604(c)(iii)(5)(C) requires TRS providers to provide the administrator with true and adequate data necessary to determine TRS fund revenue requirements and payments. TRS providers must provide the following: total TRS minutes of use, total interstate TRS minutes of use, total TRS operating expenses and total TRS investment in general accordance with Part 32 and other historical or projected information reasonably requested by the administrator for purposes of computing payments and revenue requirements. (No. of respondents: 13; hours per response: 3 hours; total annual burden; 39 hours). Pursuant to 47 CFR 64.604(c)(iii)(5)(E), in addition to the data required under paragraph (c)(5)(ii)(C) all TRS providers, including providers who are not interexchange carriers, local exchange carriers, or certified state relay providers, must submit reports of interstate TRS minutes of use to the administrator in order to receive payments. TRS providers receiving payments shall file a form prescribed by the administrator. (No. of respondents: 13; hours per response: 4 hours; total annual burden: 52 hours). 47 CFR 64.604(c)(iii)(5)(F) lists TRS providers who are eligible for receiving payments from the TRS fund. These providers must notify the administrator of their intent to participate in the TRS Fund thirty days prior to submitting reports of TRS interstate minutes of use in order to receive payment settlements for interstate TRS. Failure to file may exclude the TRS provider from eligibility for the year. (See 47 CFR 64.604(c)(iii)(5)(G)). Payments will only be made to eligible TRS providers operating in compliance with the mandatory minimum standards set forth

in section 64.604. (No. of respondents: 13; hours per response: .166 hours; total annual burden: 2.16 hours). 47 CFR 64.604(c)(6)(v)(3) requires TRS providers to file with the Commission a statement designating an agent or agents whose principal responsibility will be to receive all complaints, inquiries, orders, decisions, and notices and other pronouncements forwarded by the Commission. Such designation shall include a name or department designation, business address, telephone number (voice and TTY), facsimile number and, if available, internet e-mail address. (No. of respondents: 32; hours per response: .50 hours; total annual burden: 16 hours). 47 CFR 64.604(c)(7) requires that all future contracts between the TRS administrator and the TRS vendor shall provide for the transfer of TRS customer profile data from the outgoing TRS vendor to the incoming TRS vendor. Such data must be disclosed in usable form at least 60 days prior to the provider's last day of service provision. (No. of respondents: 31 respondents; hours per response: 1 hour; total annual burden: 31 hours). 47 CFR 64.604(c)(6) establishes complaint procedures for TRS. The Commission modified its TRS complaints procedures by adopting informal complaint process for TRS complaints. The principal objective of the informal mechanism is to afford consumers and affected companies non-adversarial opportunities to resolve issues or concerns without expending the time, effort and money typically associated with our formal adjudicatory proceedings. The Commission retains its existing TRS complaint procedures as an option for consumers desiring formal adjudication of a complaint. (No. of respondents: 22; hours per response 5 hours; total annual burden: 110 hours). 47 CFR 64.605 describes the state certification procedures by which states may apply to assert jurisdiction over the provisions of intrastate TRS. States desiring to establish such jurisdiction are required to submit to the Commission documentation describing the program and the procedures and remedies available for enforcing any requirements imposed by that state program. The request must be submitted in narrative form, by the office of the governor or other delegated executive office of the state empowered to provide TRS. States applying for certification must submit documentation which: (1) Establishes that they meet or exceed all operational, technical, and functional minimum standards contained in Section 64.604; (2) establishes that the program makes available adequate procedures and remedies for enforcing the requirements of the state program; and (3) where a state program exceeds the mandatory minimum standards, the state must establish that its program in no way conflicts with federal law. Initial TRS certifications were issued on July 26, 1993. State certification remains in effect for five years, unless the certification is suspended or revoked (see 47 CFR 64.605). One year prior to the expiration of certification, a state may apply for renewal of its certification. (No. of respondents: 50; hours per response: 160 hours; total annual burden: 8000 hours). States are required to send written notification of substantive changes within 60 days of when they occur. A substantive change includes the replacement of the state program's TRS vendor, the opening of the state program to allow multiple vendors, any change in the underlying state statutes or regulations governing the state TRS program, and any change in the state program's current technology to provide TRS. (No. of respondents: 52; hours per response: 40 hours; total annual burden: 2080 hours). All the collections of information are promulgated pursuant to section 225 of the ADA which requires that the Commission ensures that telecommunications relay services are available to persons with hearing and speech disabilities in the United States. Information submitted to notify the Commission of substantive change to a certified state program will be used to determine whether the program is still certifiable under federal requirements. Also, as a condition of certification, the Commission will review the information submitted to notify the Commission of state's complaint procedures. These submissions address the concerns from TRS users that state programs are not providing sufficient information to consumers on their complaint and grievance options. The information submitted in the complaint logs will substantially help consumers and the Commission monitor the service quality of the relay service providers and the effectiveness of the state TRS programs by enabling the Commission to begin a dialogue with a particular state on particular issues or problems and enabling states to communicate with one another to learn how similar complaints have been resolved by other states. Obligation to respond: Mandatory.

OMB Control No.: 3060–0370

Expiration Date: 06/30/2003

Title: Part 32—Uniform System of Accounts for Telecommunications Companies

Form No.: N/A

Respondents: Business or other for profit.

Estimated Annual Burden: 239 respondents; 9540 hours per response (avg.); 2,280,080 total annual burden hours.

Estimated Annual Reporting and Recordkeeping Cost Burden: $0.

Frequency of Response: On occasion; Recordkeeping.

Description: The Uniform System of Accounts is a historical financial accounting system which reports the results of operational and financial events in a manner which enables both management and regulators to assess these results within a specified accounting period. Subject respondents are telecommunications companies. Entities having annual revenues from regulatory telecommunications operations of less than $100 million are designated as Class B and are subject to a less detailed accounting system than those designated as Class A companies. Section 220 of the Communications Act of 1934, as amended allows the Commission, in its discretion, to prescribe the forms of any and all accounts, records, and memoranda to be kept by carriers subject to this Act, including the accounts, records and memoranda of the movement of traffic, as well as of the receipts and expenditures of moneys. Section 219(b) authorizes the Commission by general or special orders to require any carrier subject to this Act to file monthly reports of earnings and expenses and to file periodical and/or special reports concerning any matters with respect to which the Commission is authorized or required by law to act. The information recorded in Part 32 accounts is used by the Commission to ensure that carriers meet a host of regulatory reporting requirements that depend on the consistent and accurate recordkeeping and reporting of accounting information. Obligation to respond: Mandatory.

OMB Control No.: 3060–0168

Expiration Date: 06/30/2003

Title: Reports of Proposed Changes in Depreciation Rates—Section 43.43.

Form No.: N/A

Respondents: Businesses or other for profit.

Estimated Annual Burden: 10 respondents; 4000 hours per response (avg.); 40,000 total annual burden hours.

Estimated Annual Reporting and Recordkeeping Cost Burden: $0.

Frequency of Response: On occasion; Recordkeeping.

Description: Section 220(b) of the Communications Act of 1934, as amended, states that the Commission may prescribe depreciation charges for

the subject carriers. Section 219 of the Act requires annual and other reports from the carriers. Section 43.43 of the Commission's Rules establishes the reporting requirements for the depreciation prescription purposes. Communication common carriers with annual operating revenues of $112 million or more that the Commission has found to be dominant must file information specified in section 43.43 before making any change in the depreciation rates applicable to their operating plant. Section 220 also allows the Commission, in its discretion, to prescribe the forms of any and all accounts, records, and memoranda to be kept by carriers subject to the Act, including the accounts, records, and memoranda of the movement of traffic, as well as receipts and expenditures of moneys. In CC Docket No. 98–137, released December 30, 1999, the Commission streamlined the depreciation requirements for price cap incumbent local exchange carriers. For example, carriers will be required to file four summary exhibits, along with the underlying data used to generate them, and must provide the depreciation factors (i.e., life, salvage, curve shape, depreciation reserve) required to verify the calculation of the carriers' depreciation reserve. Mid-sized carriers are no longer required to file theoretical reserve studies. Certain price cap incumbent LECs in certain instances may request a waiver of the depreciation prescription process. The Commission also issued a Further Notice of Proposed Rulemaking in which it solicited public comment on additional changes to the depreciation requirements that could be eliminated for price-cap carriers in a manner that serves the public interest. The information filed is used by the Commission to establish proper depreciation rates to be charged by the carriers, pursuant to section 220(b) of the Act. The information serves as the basis for depreciation analyses made by the Common Carrier Bureau in establishing the depreciation rates. Obligation to respond: Mandatory.

OMB Control No.: 3060–0734

Expiration Date: 06/30/2003

Title: Accounting Safeguards, CC Docket No. 96–150 (47 USC Sections 260, 271–276 and 47 CFR Sections 53.209, 53.211 and 53.213)

Form No.: SEC 10-K

Respondents: Businesses or other for profit.

Estimated Annual Burden: 27 respondents; 6391 hours per response (avg.); 172,560 total annual burden hours.

Estimated Annual Reporting and Recordkeeping Cost Burden: $632,500.

Frequency of Response: On occasion; Biennially; Annually; Recordkeeping; Third Party Disclosure.

Description: In a Report and Order issued in CC Docket No. 96–150, the Commission addressed the accounting safeguards necessary to satisfy the requirements of Sections 260 and 271 through 276 of the Telecommunications Act of 1996. The Report and Order prescribed the way incumbent local exchange carriers (ILECs), including the Bell Operating Companies (BOCs), must account for transactions with affiliates involving, and allocate costs incurred in the provision of, both regulated telecommunications services and nonregulated services, including telemessaging, interLATA telecommunications and information services, telecommunications equipment and CPE manufacturing and others. The Commission concluded that when an electronic publishing separated affiliate already files a Form 10–K with the SEC, the separated affiliate may file the same Form 10–K with the Commission within 90 days after the end of the separated affiliate's fiscal year to satisfy section 274(f) of the 1996 Act. For each separated affiliate not subject to the SEC's Form 10–K requirement, the Commission concludes that the separated affiliate must also file a Form 10–K following the same filing requirements. In CC Docket No. 98–81, released June 30, 1999, the Commission modified the holding in the Report and Order and concluded that the information contained in the limited version of the SEC Form 10–K, with certain modifications, is sufficient to enable the Commission to monitor electronic publishing affiliates' compliance with the section 274 requirements. The Commission modified the limited Form 10–K filing requirements to exclude Item 5 and include Item 10. The required information enables the Commission to ensure that the subscribers to regulated telecommunications services to not bear the costs of these new nonregulated services and that transactions between affiliates and carriers will be at prices that do not ultimately result in unfair rates being charged to ratepayers. Obligation to respond: Mandatory.

OMB Control No.: 3060–0395

Expiration Date: 6/30/2003

Title: The ARMIS USOA Report; The ARMIS Service Quality Report; and The ARMIS Infrastructure Report.

Form Nos.: FCC 43–02; FCC 43–05; FCC 43–07.

Respondents: Business or other for profit.

Estimated Annual Burden: 50 respondents; 587.3 hours per response (avg.).; 29,366 total annual burden hours.

Estimated Annual Reporting and Recordkeeping Cost Burden: $0.

Frequency of Response: Annually.

Description: The USOA Report provides the annual results of the carriers' activities for each account of the Uniform System of Accounts. (No. of respondents: 50 respondents; hours per response: 295.4 hours; total annual burden: 14,770 hours). The Service Quality Report provides service quality information in the areas of interexchange access service, installation and repair intervals, local service installation and repair intervals, trunk blockage, and total switch downtime for price cap companies. (Recordkeeping requirement—No. of respondents: 12; hours per response: 844 hours; total annual hours: 10,128 hours. Reporting requirement: No. of respondents: 12; hours per response: 5.7 hours; total annual burden: 68.4 hours). The Infrastructure Report provides switch deployment and capabilities data. (No. of respondents: 8; hours per response: 550 hours; total annual burden: 4400 hours). Section 220 of the Communications Act of 1934, as amended, allows the Commission, at its discretion, to prescribe the forms of any and all accounts, records and memoranda to be kept by carriers subject to this Act, including the accounts, records and memoranda of the movement of traffic, as well as the receipts and expenditures of moneys. Section 219(b) authorizes the Commission by a general or special order to require any carrier subject to this Act to file monthly reports concerning any matters for which the Commission is authorized, or required by law, to act. The information collected in the reports provides the necessary detail to enable this Commission to fulfill its regulatory responsibilities. Automated reporting of these data greatly enhances the Commission's ability to process and analyze the extensive amounts of data it needs to administer its rules. ARMIS facilities the timely and efficient analysis of revenue requirements, rates of return and price caps, and provides an improved basis for auditing and other oversight functions. It also enhances the Commission's ability to quantify the effects of policy proposals. Obligation to respond: Mandatory. Public reporting burden for the collection of information is as noted above. Send comments regarding the burden estimate or any other aspect of the collections of information, including suggestions for reducing the burden to Performance

Evaluation and Records Management, Washington, DC 20554.

Federal Communications Commission.

Magalie Roman Salas,

Secretary.

[FR Doc. 00–16525 Filed 6–28–00; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL RESERVE SYSTEM

Notice of Proposals to Engage in Permissible Nonbanking Activities or To Acquire Companies that are Engaged in Permissible Nonbanking Activities

The companies listed in this notice have given notice under section 4 of the Bank Holding Company Act (12 U.S.C. 1843) (BHC Act) and Regulation Y, (12 CFR part 225) to engage de novo, or to acquire or control voting securities or assets of a company, including the companies listed below, that engages either directly or through a subsidiary or other company, in a nonbanking activity that is listed in § 225.28 of Regulation Y (12 CFR 225.28) or that the Board has determined by Order to be closely related to banking and permissible for bank holding companies. Unless otherwise noted, these activities will be conducted throughout the United States.

Each notice is available for inspection at the Federal Reserve Bank indicated. The notice also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether the proposal complies with the standards of section 4 of the BHC Act. Additional information on all bank holding companies may be obtained from the National Information Center website at www.ffiec.gov/nic/.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than July 14, 2000.

A. Federal Reserve Bank of Chicago (Phillip Jackson, Applications Officer) 230 South LaSalle Street, Chicago, Illinois 60690–1414:

1. Byron Bancshares, Inc., Byron, Illinois; to continue to engage de novo through its subsidiary, Byron Bank Financial Services, Byron, Illinois, in the sale of mutual funds pursuant to § 225.28(b)(7)(i) of Regulation Y.

Board of Governors of the Federal Reserve System, June 23, 2000.

Jennifer J. Johnson,

Secretary of the Board.

[FR Doc. 00–16410 Filed 6–28–00; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30DAY–44–00]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 639–7090. Send written comments to CDC, Desk Officer; Human Resources and Housing Branch, New Executive Office Building, Room 10235; Washington, DC 20503. Written comments should be received within 30 days of this notice.

Proposed Projects

1. National Ambulatory Medical Care Survey—(0920–0234)—Revision—(NCHS)—The National Ambulatory Medical Care Survey (NAMCS) was conducted annually from 1973 to 1981, again in 1985, and resumed as an annual survey in 1989. It is directed by the Division of Health Care Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention. The purpose of NAMCS is to meet the needs and demands for statistical information about the provision of ambulatory medical care services in the United States. Ambulatory services are rendered in a wide variety of settings, including physicians' offices and hospital outpatient and emergency departments. The NAMCS target population consists of all office visits within the United States made by ambulatory patients to non-Federal, office-based physicians (excluding those in the specialties of anesthesiology, radiology, and pathology) who are engaged in direct patient care. Since more than 80 percent of all direct ambulatory medical care visits occur in physicians' offices, the NAMCS provides data on the majority of ambulatory medical care services. To complement these data, in 1992 NCHS initiated the National Hospital Ambulatory Medical Care Survey (NHAMCS, OMB No. 0920–0278) to provide data concerning patient visits to hospital outpatient and emergency departments. The NAMCS, together with the NHAMCS, constitute the ambulatory component of the National Health Care Survey (NHCS) and will provide coverage of more than 90 percent of ambulatory medical care.

The NAMCS provides a range of baseline data on the characteristics of the users and providers of ambulatory medical care. Data collected include the patients' demographic characteristics and reason(s) for visit, and the physicians' diagnosis(es) and diagnostic services, medications and disposition. These data, together with trend data, may be used to monitor the effects of change in the health care system, provide new insights into ambulatory medical care, and stimulate further research on the use, organization, and delivery of ambulatory care.

Users of NAMCS data include, but are not limited to, congressional and other federal government agencies such as NIH and FDA, state and local governments, medical schools, schools of public health, colleges and universities, private businesses, nonprofit foundations and corporations, professional associations, as well as individual practitioners, researchers, administrators and health planners. Uses vary from the inclusion of a few selected statistics in a large research effort, to an in-depth analysis of the entire NAMCS data set covering several years.

To calculate the burden hours, the number of respondents for NAMCS is based on a sample of 6,000 physicians with a 50 percent participation rate (this includes physicians who are out-of-scope as well as those who refuse). The total annualized burden is estimated to be 11,225 hours.

Respondents	No. of respondents	No. of responses/respondent	Avg. burden per response (in hours)	Total burden (in hours)
Induction—eligible	4,500	1	20/60	1,500
Induction—ineligible	1,500	1	5/60	125
Patient Record	4,500	30	4/60	9,000

Respondents	No. of respondents	No. of responses/respondent	Avg. burden per response (in hours)	Total burden (in hours)
Nonresponse Studies	600	1	60/60	600
Total				11,225

Dated: June 23, 2000.

Nancy Cheal,

Acting Associate Director for Policy, Planning and Evaluation, Centers for Disease Control and Prevention (CDC).

[FR Doc. 00–16435 Filed 6–28–00; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30DAY–45–00]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 639–7090. Send written comments to CDC, Desk Officer; Human Resources and Housing Branch, New Executive Office Building, Room 10235; Washington, DC 20503. Written comments should be received within 30 days of this notice.

Proposed Projects

1. Survey of Laboratory Practices for Nucleic Acid Amplification Tests for Mycobacterium tuberculosis (M.tb NAA)—New—As part of the continuing effort to support public health objectives of treatment, disease prevention and surveillance programs, the Public Health Practice Program Office (PHPPO), Centers for Disease Control and Prevention (CDC) seeks to collect information from both public health and private sector laboratories performing nucleic acid amplification tests for Mycobacterium tuberculosis. Mycobacterium tuberculosis (TB) infection has reemerged as a significant public health concern in the United States. Since TB is easily transmitted, early detection of infection is imperative for control and prevention. CDC guidelines have advocated the use of the acid-fast bacilli smear (AFB), followed by culture, to confirm a diagnosis of tuberculosis. However, research and development have led to the design and marketing of nucleic acid amplification-based methods for the rapid detection of Mycobacterium tuberculosis (M.tb) directly from clinical sputum specimens. Since the FDA approval of two commercial M.tb NAA, CDC has become keenly interested in the analytic accuracy and clinical utility of these tests, especially from the standpoint of early detection and control of tuberculosis.

Literature reports indicate variability in sensitivities, specificities, and predictive values for M.tb NAA, depending on the experimental design, the population being studied, and the test methodology. Overall, both sensitivity and specificity are reported to be relatively high compared with AFB smear and culture results. However, there are several important potential sources of error including contamination problems inherent to nucleic acid technology, cross-contamination with other mycobacteria, sub-optimal laboratory practices, and unknown factors. The use of M.tb NAA tests for rapidly diagnosis may be useful for controlling TB, particularly in high prevalence populations. However, the clinical utility and efficacy of M.tb NAA tests remains in question. Because of the uncertainty surrounding the analytical accuracy and clinical validity of the tests, the potential sources of error, and the subsequent potential expense of incorrect treatment.

The goal of the proposed project is to collect laboratory practice data, in conjunction with performance data, through a survey administered to current participants in the CDC's M.tb NAA Performance Evaluation Program, to determine if laboratory practices are associated with the risk of errors in these tests. Information collected in the survey will be on test methods, quality assurance, quality control and reporting practices, and test utilization. The survey will also collect demographic information regarding the types of laboratories where testing is performed. CDC will use this data as a primary source of critical information to develop laboratory guidelines and recommendations for performance and utilization of M.tb NAA tests. The benefit of this data and the subsequent recommendations to public health will be the utilization of enhanced testing practices in the control and elimination of M. tuberculosis infection in the United States. The total annualized burden is estimated to be 55 hours.

Respondents	No. of respondents	No. of responses/respondent	Avg. burden per response (in hours)	Total burden (in hours)
Laboratories	110	1	30/60	55
Total				55

Dated: June 23, 2000.

Nancy Cheal,

Acting Associate Director for Policy, Planning and Evaluation, Centers for Disease Control and Prevention (CDC).

[FR Doc. 00–16436 Filed 6–28–00; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement Number 00064]

Notice of Availability of Funds; Announcement of a Cooperative Agreement With the Minority Health Professions Foundation To Enhance Professional Education, Research Infrastructure, and Community Service in the Areas of Health Promotion and Disease Prevention Partnering With African American Institutions

A. Purpose

The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) announce the availability of fiscal year (FY) 2000 funds for a cooperative agreement program with the Minority Health Professions Foundation (MHPF). The purpose of the program is to assist the Minority Health Professions Foundation in the following manner:

1. To improve the practice of public health at member schools by strengthening their public health infrastructure;

2. To enhance the quantitative and qualitative analytic research infrastructure of the participating institutions;

3. To strengthen the educational and professional development of minority health professionals and educators;

4. To support student training initiatives, in order to introduce public health to minority students;

5. To provide health education and outreach for decreasing the needs of the poor, minority, and under-served populations; and

6. To enhance the interactions between the Minority Health Professions Foundation schools, the historically black colleges and universities and public health institutions.

This program addresses the commitments of the CDC and ATSDR in achieving the health promotion and disease prevention objectives of ''Healthy People 2010'', a national activity to reduce morbidity and mortality, while improving the quality of life. This announcement is related to the 2010 objectives, which specify improving the health of groups of people bearing a disproportionate burden of poor health, as compared to the total population. The framework of ''Healthy People 2010'' consists of two broad goals which are to:

1. Increase quality and years of healthy life; and

2. Eliminate health disparities.

The goals of ''Healthy People 2010'' have been established as the Nation's prevention goals and as a scorecard for monitoring health status. The nations goals and objectives established in ''Healthy People 2010'' will build upon the foundation for establishing a small set of leading health indicators that could be presented to the general public and non-health professionals as an introduction to ''Healthy People''. ''Healthy People 2010'' will be a tool for monitoring America's health. For the conference copy of ''Health People 2010'' visit the internet site: <http://www.health.gov/healthypeople>.

Eliminating disparities by the year 2010 will require new knowledge about the determinants of disease and effective interventions for prevention and treatment. It will also require improved access for all to the resources that influence health. Reaching this goal will necessitate improved collection and use of standardized data to correctly identify all high-risk populations and monitor the effectiveness of health interventions targeting these groups. Research dedicated to a better understanding of the relationships between health status and income, education, race and ethnicity, cultural influences, environment, and access to quality medical services will help us acquire new insights into eliminating the disparities and developing new ways to apply our existing knowledge toward this goal. Improving access to quality health care and the delivery of preventive and treatment services will require working more closely with communities to identify culturally sensitive implementation strategies.

While the nation has made remarkable progress in understanding the causes and risks for developing diseases that have important implications for the health of all Americans, the health status of the nation's minority and poor lag considerably behind that of White Americans. The contributing factors for many disparities include inadequate family incomes, lack of access to medical care, and environmental hazards. The greatest opportunities for improvement and the greatest threats to the future health status of the Nation reside in the population groups that have historically been disadvantaged economically, educationally and politically. In partnering with different racial and ethnic groups, the CDC can work closely with institutions, organizations, and communities to help eliminate disparities in health while meeting the goals of ''Healthy People 2010''.

B. Eligible Applicants

Assistance will be provided only to the Minority Health Professions Foundation (MHPF). No other applications are solicited.

The MHPF is the most appropriate and qualified organization to provide services specified under this cooperative agreement because:

1. The MHPF is dedicated to supporting the organizational growth of minority health professional schools to ensure the advancement of specific research in minority health, the education and professional development of minority health care professionals and educators, and the continuing provision of health services in minority and poor communities;

2. The MHPF represents twelve member institutions which include medical, dental, pharmacy, and veterinary medicine schools in historically African-American colleges and universities. Collectively, these institutions have trained one out of every two African American physicians, dentists, and pharmacists; and three out of every four African American veterinarians. The member institutions have also trained a substantial number of other minority and non-minority health professionals;

3. The MHPF member institutions are comprised of the Historically Black Colleges and Universities (HBCUs) that not only house the health professions schools, but three of which house schools of public health;

4. The primary objective of the MHPF and the nine Historically Black Colleges and Universities is to address the health needs of African American and other minority population groups;

5. The MHPF institutional members have significantly fostered and advanced dramatic growth and expansion of its member institution's collaborative efforts, bolstered and supported considerable increase in public health, medical and scientific research, and assisted in amplifying minority health community education and outreach nationally;

6. The MHPF and its member schools have the capacity to conduct basic sciences and clinical research, and are attacking the various diseases and conditions that disproportionately

impact minority and disadvantaged citizens in America; and

7. The MHPF member institutions were founded specifically to improve the health status of medically underserved African Americans and other ethnic minority groups, and play a critical role in building the nation's health care workforce.

C. Availability of Funds

Approximately $200,000 is available in FY 2000 to fund this cooperative agreement. Sub-awards will be funded through CDC and ATSDR. A cumulative award of approximately $2,000,000 to the MHPF is expected during FY 2000. Subawards will range from $25,000 to $450,000. It is expected that the awards will begin on September 30, 2000. Funding estimates may vary and are subject to change. Continuation awards within the project period will be made on the basis of satisfactory progress and the availability of funds.

Applications that exceed the funding cap of $450,000 will be excluded from the competition and returned to the applicant.

D. Where To Obtain Additional Information

A complete program description and information on application procedures are contained in the application package. Business management technical assistance may be obtained from Sheri Disler, Senior Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 2920 Brandywine Road, Room 3000, MS E–15, Koger Center, Colgate Building, Atlanta, Georgia 30341–3724. Telephone 770–488–2756. E-mail address sjd9@cdc.gov.

Program technical assistance may be obtained from Karen E. Harris, Senior Advisor for Research Projects, Office of the Associate Director for Minority Health, Office of the Director, Centers for Disease Control and Prevention, 1600 Clifton Road, Northeast, Mailstop D–39, Atlanta, Georgia 30333. Telephone (404) 639–4313, E-mail address keh2@cdc.gov.

Dated: June 23, 2000.

John L. Williams,

Director, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC).

[FR Doc. 00–16437 Filed 6–28–00; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 00N–0914]

Agency Information Collection Activities; Submission for OMB Review; Comment Request; Importer's Entry Notice

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that the proposed collection of information listed below has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Submit written comments on the collection of information by July 31, 2000.

ADDRESSES: Submit written comments on the collection of information to the Office of Information and Regulatory Affairs, OMB, New Executive Office Bldg., 725 17th St. NW., rm. 10235, Washington, DC 20503, Attn: Wendy Taylor, Desk Officer for FDA.

FOR FURTHER INFORMATION CONTACT: JonnaLynn P. Capezutto, Office of Information Resources Management (HFA–250), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–4659.

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

Importer's Entry Notice (OMB Control Number 0910–0046)—Extension

Section 801 of the Federal Food, Drug, and Cosmetic Act (the act) (21 U.S.C. 381) charges FDA with the following responsibilities: (1) Ensuring that foreign-origin FDA-regulated foods, drugs, cosmetics, medical devices, and radiological health products offered for import into the United States meet the same requirements of the act as do domestic products; and (2) preventing shipments from entering the country if they are not in compliance.

The information collected by FDA consists of the following: (1) Product code, an alpha-numeric series of characters that identifies each product FDA regulates; (2) FDA country of origin, the country where the FDA-registered or FDA-responsible firm is located; (3) FDA manufacturer, the party who manufactured, grew, assembled, or otherwise processed the goods (if more than one, the last party who substantially transformed the product); (4) shipper, the party responsible for packing, consolidating, or arranging the shipment of the goods to their final destination; (5) quantity and value of the shipment; and (6) if appropriate, affirmation of compliance, a code that conveys specific FDA information, such as registration number, foreign government certification, etc. This information is collected electronically by the entry filer via the U.S. Customs Service's Automated Commercial System at the same time he/she files an entry for import with the U.S. Customs Service. FDA uses the information to make admissibility decisions about FDA-regulated products offered for import into the United States.

The annual reporting burden is derived from the basic processes and procedures used in fiscal year (FY) 1995. The total number of entries submitted to the automated system in FY 1999 was 5,077,493. The total number of entries less the disclaimer entries will represent the total FDA products entered into the automated system. A total of 51 percent of all entries entered into the automated system were entries dealing with FDA-regulated products. The number of respondents is a count of filers who submit entry data for foreign-origin FDA-regulated products. The estimated reporting burden is based on information obtained by FDA contacting some potential respondents. Disclaimer entries are not FDA commodities.

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN [1]

No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours
3,886	652	2,533,355	.14	354,669

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

In the**Federal Register** of March 22, 2000 (65 FR 15340), the agency requested comments on the proposed collections of information. No comments were received.

Dated: June 22, 2000.

William K. Hubbard,

Senior Associate Commissioner for Policy, Planning, and Legislation.

[FR Doc. 00–16396 Filed 6–28–00; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 00N–0836]

Agency Information Collection Activities; Submission for OMB Review; Comment Request; Environmental Impact Considerations

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that the proposed collection of information listed below has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Submit written comments on the collection of information by July 31, 2000.

ADDRESSES: Submit written comments on the collection of information to the Office of Information and Regulatory Affairs, OMB, New Executive Office Bldg., 725 17th St. NW., rm. 10235, Washington, DC 20503, Attn: Wendy Taylor, Desk Officer for FDA.

FOR FURTHER INFORMATION CONTACT: Karen L. Nelson, Office of Information Resources Management (HFA–250), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–1482.

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

Environmental Impact Considerations—Part 25 (21 CFR Part 25)—(OMB Control Number 0910–0322)—Extension

FDA is requesting OMB approval for the reporting requirements contained in FDA's regulation ''Environmental Impact Considerations'' (part 25).

The National Environmental Policy Act (NEPA) (42 U.S.C. 4321–4347) states national environmental objectives and imposes upon each Federal agency the duty to consider the environmental effects of its actions. Section 102(2)(C) of NEPA requires the preparation of an environmental impact statement (EIS) for every major Federal action that will significantly affect the quality of the human environment.

FDA's NEPA regulations are at part 25. All applications or petitions requesting agency action require the submission of an Environmental Assessment (EA) or a claim of categorical exclusion. Section 25.15(a) and (d) specify the procedures for submitting to FDA a claim for a categorical exclusion (certain classes of FDA-regulated actions have little or no potential to cause significant environmental effects and are excluded from the requirements to prepare an EA or EIS). Section 25.40(a) and (c) specify the content requirements for EA's for nonexcluded actions.

This collection of information is used by FDA to assess the environmental impact of agency actions and to ensure that the public is informed of environmental analyses. Firms wishing to manufacture and market substances regulated under statutes for which FDA is responsible must, in most instances, submit applications requesting approval. Environmental information must be included in such applications (when not eligible for categorical exclusion) for the purpose of determining whether the proposed action may have a significant impact on the environment. Where significant adverse effects cannot be avoided, the agency uses the submitted information as the basis for preparing and circulating to the public an EIS, made available through a **Federal Register** notice also filed for comment at the Environmental Protection Agency. The final EIS including the comments received is reviewed by the agency to weigh environmental costs and benefits in determining whether to pursue the proposed action or some alternative that would reduce expected environmental impact. When the agency finds that no significant environmental effects are expected, the agency prepares a finding of no significant impact (FONSI).

I. Estimated Annual Reporting Burden for Human Drugs

Under 21 CFR 312.23(a)(7)(iv)(*e*), 21 CFR 314.50(d)(1)(iii), and 21 CFR 314.94(a)(9)(i), each investigational new drug application (IND), new drug application (NDA), and abbreviated new drug application (ANDA) must contain a claim for categorical exclusion under § 25.30 or § 25.31 or an EA under § 25.40. In 1998, FDA received 2,427 IND's from 1,874 sponsors, 129 NDA's from 80 applicants, 2,500 supplements to NDA's from 238 applicants, 345 ANDA's from 101 applicants, and 3,713 supplements to ANDA's from 165 applicants. FDA estimates that it receives approximately 9,094 claims for categorical exclusions as required under § 25.15(a) and (d), and 20 EA's as required under § 25.40(a) and (c). Based on information provided by the pharmaceutical industry, FDA estimates that it takes sponsors or applicants approximately 8 hours to prepare a claim for a categorical exclusion and approximately 3,400 hours to prepare an EA.

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN FOR HUMAN DRUGS [1]

21 CFR Section	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Burden Hours
25.15(a) and (d)	2,039	4.46	9,094	8	72,752
25.40(a) and (c)	20	1	20	3,400	68,000
Total					140,752

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

II. Estimated Annual Reporting Burden for Human Foods

Under 21 CFR 71.1, 170.39, and 171.1, food additive petitions, color additive petitions, and requests for exemption from regulation as a food additive must contain a claim of categorical exclusion under § 25.30 or § 25.32 or an EA under § 25.40. In 1998, FDA received 57 food additive petitions, 9 color additive petitions, and 26 threshold of regulation exemption requests. FDA estimates that it received approximately 80 claims of categorical exclusions as required under § 25.15(a) and (d), and 12 EA's as required under § 25.40(a) and (c). FDA estimates that it takes petitioners or requesters approximately 8 hours to prepare a claim of categorical exclusion and approximately 210 hours to prepare an EA.

TABLE 2.—ESTIMATED ANNUAL REPORTING BURDEN FOR HUMAN FOODS [1]

21 CFR Section	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Burden Hours
25.15(a) and (d)	44	1.8	8.0	8	640
25.40(a) and (c)	11	1.1	12	210	2,520
Total					3,160

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

The Food and Drug Administration Modernization Act of 1997 (Public Law 105–115) amended section 409 of the Federal Food, Drug, and Cosmetic Act (the act) (21 U.S.C. 348) to establish a premarket notification process as the primary method for authorizing a new use of a food additive that is a food contact substance. Section 409(h)(6) of the act defines a food contact substance as any substance intended for use as a component of materials used in manufacturing, packing, packaging, transporting, or holding food if such use is not intended to have any technical effect in food. Under the notification process, FDA must be notified at least 120 days prior to the marketing of a food contact substance. If FDA does not object within 120 days to the use of a food contact substance that is the subject of a notification, the substance may be legally marketed for the notified use. FDA expects that the majority of new uses of food contact substances that will be the subject of premarket notifications would previously have been regulated under the food additive petition process or exempted from the requirement of a regulation under the threshold of regulation process. FDA has provided in a separate **Federal Register** notice an opportunity for public comment on the collection of information associated with the premarket notification program, including environmental information requirements (64 FR 61648, November 12, 1999).

III. Estimated Annual Reporting Burden for Medical Devices

Under 21 CFR part 814, premarket approvals (original PMA's and supplementals) must contain a claim for categorical exclusion under § 25.30 or § 25.31 or an EA under § 25.40. In 1998, FDA received 568 claims (original PMA's and supplementals) for categorical exclusions as required under § 25.15(a) and (d), and 0 (zero) EA's as required under § 25.40(a) and (c). Based on information provided by less than 10 sponsors, FDA estimates that it takes approximately less than 1 hour to prepare a claim for a categorical exclusion and an unknown number of hours to prepare an EA.

TABLE 3.—ESTIMATED ANNUAL REPORTING BURDEN FOR MEDICAL DEVICES [1]

21 CFR Section	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Burden Hours
25.15(a) and (d)	94	6	568	1	568
25.40(a) and (c)	0	0	0	0	0
Total					568

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

IV. Estimated Annual Reporting Burden for Biological Products

Under 21 CFR 312(a)(7)(iv)(*c*) and 601.2(a), IND and biologics license applications must contain a claim for categorical exclusion under § 25.30 or § 25.31 or an EA under § 25.40. In 1998, FDA received 492 IND's from 278 sponsors, 78 license applications from 20 applicants, and 903 supplements to license applications from 190 applicants. FDA estimates that approximately 10 percent of these supplements would be submitted with a claim for categorical exclusion or an EA.

FDA estimates that it receives approximately 660 claims for categorical exclusion as required under § 25.15(a) and (d), and 2 EA's as required under § 25.40(a) and (c). Based on information provided by industry, FDA estimates that it takes sponsors and applicants approximately 8 hours to prepare a claim for categorical exclusion and approximately 3,400 hours to prepare an EA.

TABLE 4.—ESTIMATED ANNUAL REPORTING BURDEN FOR BIOLOGICAL PRODUCTS [1]

21 CFR Section	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Burden Hours
25.15(a) and (d)	317	2	660	8	5,280
25.40(a) and (c)	2	1	2	3,400	6,800
Total					12,080

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

V. Estimated Annual Reporting Burden for Animal Drugs

Under 21 CFR 514.1(b)(14) new animal drug applications (NADA's) and abbreviated new animal drug application (ANADA), 514.8(a)(1) supplemental NADA's and ANADA's, 511.1(b)(10) investigational new animal drug applications, 570.35(c)(1)(viii) generally recognized as safe, affirmation petitions, and 571.1(c) food additive petitions must contain a claim for categorical exclusion under § 25.30 or § 25.31 or an EA under § 25.40. Since the last OMB approval of the subject collections of information, the Center for Veterinary Medicine has received approximately 545 claims for categorical exclusions as required under § 25.15(a) and (d), and 32 EA's as required under § 25.40(a) and (c). Based on information provided by industry, FDA estimates that it takes sponsors/applicants approximately 8 hours to prepare a claim for a categorical exclusion and approximately 2,160 hours to prepare an EA.

TABLE 5.—ESTIMATED ANNUAL REPORTING BURDEN FOR ANIMAL DRUGS [1]

21 CFR Section	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Burden Hours
25.15(a) and (d)	194	2.8	545	8	4,360
25.40(a) and (c)	29	1.1	32	2,160	69,120
Total					73,480

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

Based on information provided by industry, FDA estimates that the combined burden for the Environmental Impact Considerations—Part 25 are as follows:

TABLE 6.—ESTIMATED ANNUAL REPORTING BURDEN FOR ALL CENTERS [1]

21 CFR Section	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Burden Hours
25.15(a) and (d)	2,688	17.06	10,875	33	83,600
25.40(a) and (c)	62	4.02	66	9,170	146,440
Total	2,750	21.08	10,941	9,203	230,040

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

In the **Federal Register** of March 13, 2000 (65 FR 13405), the agency requested comments on the proposed collections of information. No comments were received.

Dated: June 22, 2000.

William K. Hubbard,

Senior Associate Commissioner for Policy, Planning, and Legislation.

[FR Doc. 00–16398 Filed 6–28–00; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Pharmacy Compounding Advisory Committee; Notice of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). The meeting will be open to the public.

Name of Committee: Pharmacy Compounding Advisory Committee.

General Function of the Committee: To provide advice and recommendations to the agency on FDA's regulatory issues.

Date and Time: The meeting will be held on July 13 and 14, 2000, 8:30 a.m. to 5 p.m.

Location: CDER Advisory Committee conference room 1066, 5630 Fishers Lane, Rockville, MD.

Contact Person: Jayne E. Peterson or Tony A. Slater, Jr., Center for Drug Evaluation and Research (CDER) (HFD–21), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–7001, e-mail: PETERSONJ@CDER.FDA.GOV, or FDA Advisory Committee Information Line, 1–800–741–8138 (301–443–0572 in the Washington, DC area), code 12440. Please call the Information Line for up-to-date information on this meeting.

Agenda: On July 13, 2000, the committee will review five drug products for inclusion on a list of drug products that cannot be compounded because they have been withdrawn or removed from the market because such drug products or components of such drug products have been found to be unsafe or not effective (see 21 CFR 216.24 (64 FR 10944, March 8, 1999)) whereby FDA amended its regulations to include such a list of drug products). In the **Federal Register** of January 4, 2000 (65 FR 256), FDA published a proposed rule amending these regulations to add two drug products to the list: (1) Aminopyrine (all drug products containing aminopyrine) and (2) astemizole (all drug products containing astemizole). In addition to these two drug products, the committee will review the following three drug products: (1) Grepafloxacin (all drug products containing grepafloxacin), (2) troglitazone (all drug products containing troglitazone), and (3) cisapride (all drug products containing cisapride). Beginning at approximately 10 a.m., and continuing on July 14, 2000, at approximately 8:30 a.m., the committee will discuss and provide FDA with advice about drug products that present demonstrable difficulties for compounding that reasonably demonstrate an adverse effect on the safety or effectiveness of those drug products.

Procedure: Interested persons may present data, information, or views, orally or in writing on issues pending before the committee. Written submissions may be made to the contact person by July 3, 2000. On July 13, 2000, oral presentations from the public will be scheduled between approximately 1 p.m. and 2 p.m. On July 14, 2000, oral presentations from the public will be scheduled between approximately 8:30 a.m. and 9:30 a.m. Time allotted for each presentation may be limited. Those desiring to make formal oral presentations should notify the contact person before July 3, 2000, and submit a brief statement of the general nature of the evidence or arguments they wish to present, the names and addresses of proposed participants, and an indication of the approximate time requested to make their presentation.

FDA regrets that it was unable to publish this notice 15 days prior to the July 13 and 14, 2000, Pharmacy Compounding Advisory Committee meeting. Because the agency believes there is some urgency to bring these issues to public discussion and qualified members of the Pharmacy Compounding Advisory Compounding Advisory Committee meeting were available at this time, the Commissioner of Food and Drugs concluded that it was in the public interest to hold this meeting even if there was not sufficient time for the customary 15-day public notice.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. app. 2).

Dated: June 20, 2000.

Linda A. Suydam,

Senior Associate Commissioner.

[FR Doc. 00–16397 Filed 6–28–00; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 00D–1313]

Draft Guidance for Industry on How to Use E–Mail to Submit a Notice of Final Disposition of Animals Not Intended for Immediate Slaughter; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of the draft guidance for industry (#86) entitled ''How to Use E–Mail to Submit a Notice of Final Disposition of Animals Not Intended for Immediate Slaughter'' in the Center for Veterinary Medicine (CVM). This draft guidance is neither final nor is it in effect at this time. The draft guidance document is intended to provide guidance to new animal drug sponsors (sponsors) on how to submit a notice of final disposition of animals not intended for immediate slaughter (NFDA) as an e-mail attachment by Internet. These electronic submissions are part of CVM's ongoing initiative to provide a method for paperless submissions. This draft guidance implements provisions of the Government Paperwork Elimination Act (GPEA).

DATES: Submit written comments on the draft guidance at any time, however, comments should be submitted by August 28, 2000 to ensure their adequate consideration in preparation of the final document. Submit written comments on the information collection requirements by August 28, 2000.

ADDRESSES: Submit written comments on the draft guidance to the Dockets Management Branch (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Comments should be identified with the full title of the draft guidance document and the docket number found in brackets in the heading of this document.

Copies of the draft guidance document entitled ''How to Use E–Mail to Submit a Notice of Final Disposition of Animals Not Intended for Immediate Slaughter'' may be obtained on the

Internet from the CVM home page at http://www.fda.gov/cvm/. Persons without Internet access may submit written requests for single copies of the draft guidance to the Communications Staff (HFV–12), Center for Veterinary Medicine, Food and Drug Administration, 7500 Standish Pl., Rockville, MD 20855. Send one self-addressed adhesive label to assist that office in processing your requests.

Submit written comments on the collection of information requirements to the Dockets Management Branch (address above). Comments should be identified with the docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Janis R. Messenheimer, Center for Veterinary Medicine (HFV–135), Food and Drug Administration, 7500 Standish Pl., Rockville, MD 20855, 301–827–7578, e-mail: jmessenh@cvm.fda.gov.

SUPPLEMENTARY INFORMATION:

I. Background

In the **Federal Register** of March 20, 1997 (62 FR 13430), FDA published the electronic records and electronic signatures final regulation. This regulation (21 CFR part 11) provides for the voluntary submission of parts or all of regulatory records in electronic format without an accompanying paper copy. This rule also established public docket number 92S–0251 to provide a permanent location for a list of the documents or parts of documents that are acceptable for submission in electronic form without paper records and the agency units to which such submissions may be made. CVM will identify in this public docket the types of documents that may be submitted in electronic form as those documents are identified in final guidance or regulations. This docket is accessible on the Internet at http://www.fda.gov/ohrms/dockets/dockets/92s0251.92s0251.htm.

The electronic submission of NFDA's is part of CVM's ongoing initiative to provide a method for paperless submissions. It reflects the principles behind the GPEA. The GPEA of 1998 (Public Law 105–277) requires Federal agencies, by October 21, 2003, to provide: (1) For the option of the electronic maintenance, submission, or disclosure of information, if practicable, as a substitute for paper; and (2) for the use and acceptance of electronic signatures, when practicable.

In order to submit NFDA's by e-mail, sponsors should first register and follow the instructions in draft guidance for industry (#108) entitled ''How to Use E–Mail to Submit Information to the Center for Veterinary Medicine'' when it becomes final.

CVM monitors the final disposition of food animals treated with investigational new animal drugs in situations where the treated animals do not enter the human food chain immediately at the completion of the investigational study. Monitoring of the final disposition of such food animals is consistent with its responsibility to protect the public health under the Federal Food, Drug, and Cosmetic Act (the act). In addition, acceptable standards of study conduct such as those set out in § 514.117 (21 CFR 514.117) would include sponsors accounting for the disposition of all animals treated with investigational new animal drugs. Furthermore, CVM requests this information because some animals are held for 30 days after the investigational drug withdrawal period ends and CVM does not request a notice of intent to slaughter for human food purposes for these animals. Animals held for this period may still be sent for slaughter, however. CVM issues a slaughter authorization letter to investigational new animal drug sponsors that sets the terms under which animals treated with investigational new animal drugs may be slaughtered (§ 511.1(b)(5) (21 CFR 511.1(b)(5))). Also in this letter, CVM requests that sponsors submit NFDA's for animals that are treated with investigational new animal drugs and are not intended for immediate slaughter. NFDA's have historically been submitted to CVM on paper. This draft guidance will give sponsors the option to submit an NFDA as an e-mail attachment to CVM via the Internet.

II. Significance of Guidance

This Level 1 draft guidance is being issued consistent with FDA's good guidance practices (62 FR 8961, February 27, 1997). The draft guidance represents the agency's current thinking about using e-mail to submit an NFDA. It does not create or confer any rights for or on any person and will not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statutes, regulations, or both.

III. Paperwork Reduction Act of 1995

Under the Paperwork Reduction Act of 1995 (the 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 or sponsor. ''Collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information before submitting the collection to OMB for approval. To comply with this requirement, FDA is publishing a notice of the proposed collection of information set forth in this document.

With respect to the following collection of information, FDA invites comments on: (1) Whether the proposed collection of information is necessary for the proper performance of FDA's functions, including whether the information will have practical utility; (2) the accuracy of FDA'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 minimize the burden of the collection of information on respondents, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

Title: How to Use E–Mail to Submit a Notice of Final Disposition of Animals Not Intended for Immediate Slaughter.

Description: CVM monitors the final disposition of food animals treated with investigational new animal drugs in situations where the treated animals do not enter the human food chain immediately at the completion of the investigational study. CVM believes that monitoring of the final disposition of such food animals is consistent with its responsibility to protect the public health under the act. In addition, CVM believes that acceptable standards of study conduct such as those set out in § 514.117 would include sponsors accounting for the disposition of all animals treated with investigational new animal drugs. Furthermore, CVM requests this information because some animals are held for 30 days after the investigational drug withdrawal period ends and CVM does not request a notice of intent to slaughter for human food purposes for these animals. Animals held for this period may still be sent for slaughter, however.

The draft guidance document describes the procedures for persons who are sponsors of new animal drugs who wish to file an NFDA electronically on FDA Form #3487. The information sponsors should include on the form includes the sponsor's name and

address, and information about the treated animals. The likely respondents to this collection of information are new animal drug sponsors who have conducted clinical investigations under § 511.1(b).

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN [1]

FDA Form No.	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours
3487	190	1.7	324	0.81	262

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

The estimates in Table 1 of this document resulted from discussions with new animal drug sponsors. The estimated burden includes NFDA's submitted on paper and by e-mail.

IV. Comments

This draft guidance document is being distributed for comment purposes only and is not intended for implementation at this time. Interested persons may submit to the Dockets Management Branch (address above) written comments regarding this draft guidance document. Submit written comments by August 28, 2000, to ensure adequate consideration in preparation of the final document. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document.

Submit written comments concerning the information collection requirements to the Dockets Management Branch by August 28, 2000. A copy of the document and received comments may be seen in the Dockets Management Branch between 9 a.m. and 4 p.m., Monday through Friday.

Dated: June 16, 2000.

Margaret M. Dotzel,

Associate Commissioner for Policy.

[FR Doc. 00–16392 Filed 6–26–00; 10:07 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 00D–1314]

Draft Guidance for Industry on How to Use E–Mail to Submit a Notice of Intent to Slaughter for Human Food Purposes; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of the draft guidance for industry (#87) entitled ''How to Use E–Mail to Submit a Notice of Intent to Slaughter for Human Food Purposes'' in the Center for Veterinary Medicine (CVM) and U.S. Department of Agriculture (USDA). This draft guidance is neither final nor is it in effect at this time. The purpose of this draft guidance document is to provide guidance to new animal drug sponsors (sponsors) on how to submit a notice of intent to slaughter for human food purposes (slaughter notices) as an e-mail attachment by Internet. This electronic submission is part of CVM's ongoing initiative to provide a method for paperless submissions. This draft guidance implements provisions of the Government Paperwork Elimination Act (GPEA).

DATES: Submit written comments on the draft guidance at any time, however, comments should be submitted by August 28, 2000 to ensure their adequate consideration in preparation of the final document. Submit written comments on the collection of information requirements by August 28, 2000.

ADDRESSES: Submit written comments on the draft guidance to the Dockets Management Branch (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Comments should be identified with the full title of the draft guidance and the docket number found in brackets in the heading of this document.

Copies of the draft guidance document entitled ''How to Use E–Mail to Submit a Notice of Intent to Slaughter for Human Food Purposes'' may be obtained on the Internet from the CVM home page at http://www.fda.gov/cvm. Persons without Internet access may submit written requests for single copies of the draft guidance to the Communications Staff (HFV–12), Center for Veterinary Medicine, Food and Drug Administration, 7500 Standish Pl., Rockville, MD 20855. Send one self-addressed adhesive label to assist that office in processing your requests.

Submit written comments on the collection of information requirements to the Dockets Management Branch (address above). Comments should be identified with the docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Janis R. Messenheimer, Center for Veterinary Medicine (HFV–135), Food and Drug Administration, 7500 Standish Pl., Rockville, MD 20855, 301–827–7578, e-mail: jmessenh@cvm.fda.gov.

SUPPLEMENTARY INFORMATION:

I. Background

In the **Federal Register** of March 20, 1997 (62 FR 13430), FDA published the Electronic Records; Electronic Signatures final regulation. This regulation (21 CFR part 11) provides for the voluntary submission of parts or all of regulatory records in electronic format without an accompanying paper copy. This rule also established public docket number 92S–0251 to provide a permanent location for a list of the documents or parts of documents that are acceptable for submission in electronic form without paper records and the agency units to which such submissions may be made. CVM will identify in this public docket the types of documents that may be submitted in electronic form as those documents that are identified in final guidances or regulations. This docket is accessible on the Internet at http://www.fda.gov/ohrms/dockets/dockets/92s0251/92s0251.htm.

The electronic submission of slaughter notices is part of CVM's ongoing initiative to provide a method for paperless submissions. The draft guidance implements provisions of the GPEA. The GPEA of 1998 (Public Law 105–277) requires Federal agencies, by October 21, 2003, to provide for: (1) The option of the electronic maintenance, submission, or disclosure of information, if practicable, as a substitute for paper; and (2) the use and acceptance of electronic signatures, when practicable. In order to submit slaughter notices by e-mail, sponsors should first register and follow the instructions in draft guidance for industry (#108) ''How to Use E–Mail to Submit Information to the Center for

Veterinary Medicine'' when it becomes final.

Section 512(j) of the Federal Food, Drug, and Cosmetic Act (the act) (21 U.S.C. 360b(j)) gives FDA the authority to issue regulations setting out conditions for marketing animals treated with investigational new animal drugs for food use. Under this authority, FDA issued § 511.1(b)(4) (21 CFR 511.1(b)(4)) that requires that sponsor obtain authorization to slaughter these animals for food. Under § 511.1(b)(5), CVM issues a slaughter authorization letter to sponsors that sets the terms under which the animals treated with investigational new animal drugs may be slaughtered. USDA also monitors the slaughter of animals treated with investigational new animal drugs under the authority of the Meat Inspection Act (21 U.S.C. 601–95). To assist CVM and USDA with this monitoring, the slaughter authorization states that sponsors must submit slaughter notices each time such animals are to be slaughtered unless CVM waives the notice in the authorization letter. Currently, slaughter notices are submitted to CVM on paper. This guidance will give sponsors the option to submit a slaughter notice as an e-mail attachment to CVM and USDA by the Internet.

II. Significance of Guidance

This Level 1 draft guidance is being issued consistent with FDA's good guidance practices (62 FR 8961, February 27, 1997). The draft guidance represents the agency's current thinking about using e-mail to submit a slaughter notice. It does not create or confer any rights for or on any person and will not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statute, regulations, or both.

III. Paperwork Reduction Act of 1995

Under the Paperwork Reduction Act of 1995 (the 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 or sponsor. ''Collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information before submitting the collection to OMB for approval. To comply with this requirement, FDA is publishing a notice of the proposed collection of information set forth in this document.

With respect to the following collection of information, FDA invites comments on: (1) Whether the proposed collection of information is necessary for the proper performance of FDA's functions, including whether the information will have practical utility; (2) the accuracy of FDA'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 minimize the burden of the collection of information on respondents, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

Title: How to Use E–Mail to Submit a Notice of Intent to Slaughter for Human Food Purposes.

Description: Under § 511.1(b)(5), CVM issues slaughter authorizations for food animals treated with investigational new animal drugs. To assist CVM with the monitoring of the slaughter of food animals treated with investigational new animal drugs, the slaughter authorization letter CVM sends to sponsors states that they must submit slaughter notices each time such animals are to be slaughtered unless the authorization letter waives that notice. Currently, slaughter notices are submitted to CVM on paper (OMB Control No. 0910–0117). This draft guidance will give sponsors the option to submit a slaughter notice as an e-mail attachment to CVM by the Internet.

The draft guidance describes the procedures for persons who are sponsors of new animal drugs and who wish to file a slaughter notice on FDA Form No. 3488 by e-mail. The information that should be filed on the form includes: Identify the sponsor, the animals to be slaughtered, and the compound used to treat the animals. The likely respondents to this collection of information are sponsors who have conducted clinical investigations under § 511.1(b).

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN [1]

FDA Form No.	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours
3488	190	0.35	66	0.41	27

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

Submitting a slaughter notice electronically represents a new medium for submission of information currently submitted on paper. The reporting burden for compilation and submission of this information on paper is included in OMB clearance of the information collection provisions of § 511.1 (OMB Control No. 0910–0117). The estimates in table 1 of this document reflect the burden associated with putting the same information on FDA Form No. 3488 and resulted from discussions with sponsors about the time necessary to complete this form.

IV. Comments

This draft guidance document is being distributed for comment purposes only and is not intended for implementation at this time. Interested persons may submit to the Dockets Management Branch (address above) written comments regarding this draft guidance. Submit written comments by August 28, 2000, to ensure adequate consideration in preparation of the final guidance. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. Written comments concerning the information collection requirements must be received by August 28, 2000. A copy of the draft guidance and received comments are available for public examination in the Dockets Management Branch between 9 a.m. and 4 p.m., Monday through Friday.

Dated: June 16, 2000.

Margaret M. Dotzel,

Associate Commissioner for Policy.

[FR Doc. 00–16393 Filed 6–26–00; 10:07 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 00D–1316]

Draft Guidance for Industry on How to Use E–Mail to Submit a Request for a Meeting or Teleconference to the Office of New Animal Drug Evaluation; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of the draft guidance for industry (#88) entitled ''How to Use E–Mail to Submit a Request for a Meeting or Teleconference to the Office of New Animal Drug Evaluation'' in the Center for Veterinary Medicine (CVM). This draft guidance is neither final nor is it in effect at this time. The purpose of this draft guidance document is to provide guidance to new animal drug sponsors (sponsors) on how to submit a request for a meeting or teleconference about a new animal drug submission as an e-mail attachment by Internet. These electronic submissions are part of CVM's ongoing initiative to provide a method for paperless submissions. This draft guidance implements provisions of the Government Paperwork Elimination Act (GPEA).

DATES: Submit written comments on the draft guidance at any time, however, comments should be submitted by August 28, 2000, to ensure their adequate consideration in preparation of the final document. Submit written comments on the collection of information requirements by August 28, 2000.

ADDRESSES: Submit written comments on the draft guidance to the Dockets Management Branch (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Comments should be identified with the full title of the draft guidance and the docket number found in brackets in the heading of this document.

Copies of the draft guidance document entitled ''How to Use E–Mail to Submit a Request for a Meeting or Teleconference to the Office of New Animal Drug Evaluation'' may be obtained on the Internet from the CVM home page at http://www.fda.gov/cvm/. Persons without Internet access may submit written requests for single copies of the draft guidance to the Communications Staff (HFV–12), Center for Veterinary Medicine, Food and Drug Administration, 7500 Standish Pl., Rockville, MD 20855. Send one self-addressed adhesive label to assist that office in processing your requests.

Submit written comments on the collection of information requirements to the Dockets Management Branch (address above). Comments should be identified with the docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Janis R. Messenheimer, Center for Veterinary Medicine (HFV–135), Food and Drug Administration, 7500 Standish Pl., Rockville, MD 20855, 301–827–7578, e-mail: jmessenh@cvm.fda.gov.

SUPPLEMENTARY INFORMATION:

I. Background

In the **Federal Register** of March 20, 1997 (62 FR 13430), FDA published the Electronic Records; Electronic Signatures final regulation. This regulation (part 11 (21 CFR part 11)) provides for the voluntary submission of parts or all of regulatory records in electronic format without an accompanying paper copy. This rule also established public docket number 92S–0251 to provide a permanent location for a list of the documents or parts of documents that are acceptable for submission in electronic form without paper records and the agency units to which such submissions may be made. CVM will identify in this public docket the types of documents that may be submitted in electronic form as those documents that are identified in final guidances or regulations. This docket is accessible on the Internet at http://www.fda.gov/ohrms/dockets/dockets/92s0251/92s0251.htm.

The electronic submission of requests for meetings and teleconferences is part of CVM's ongoing initiative to provide a method for paperless submissions. The draft guidance implements provisions of the GPEA. The GPEA of 1998 (Public Law 105–277) requires Federal agencies, by October 21, 2003, to provide for: (1) The option of the electronic maintenance, submission, or disclosure of information, if practicable, as a substitute for paper; and (2) the use and acceptance of electronic signatures, when practicable.

In order to submit requests for meetings or teleconferences by e-mail, sponsors should first register and follow the instructions in draft guidance for industry (#108) ''How to Use E–Mail to Submit Information to CVM'' when it becomes final.

On request, CVM will hold meetings and/or teleconferences to assist sponsors with new animal drug submissions and general questions. Currently, meeting and teleconference requests are submitted to CVM on paper. CVM would like to allow sponsors to request meetings and teleconferences in a manner more efficient and time saving to them. This draft guidance will give sponsors the option to submit a request for a meeting or teleconference as an e-mail attachment by the Internet.

II. Significance of Guidance

This Level 1 draft guidance is being issued consistent with FDA's good guidance practices (62 FR 8961, February 27, 1997). The draft guidance represents the agency's current thinking on submitting a request for a meeting or teleconference about new animal drug submissions by e-mail. It does not create or confer any rights for or on any person and will not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statute, regulations, or both.

III. Paperwork Reduction Act of 1995

Under the Paperwork Reduction Act of 1995 (the 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 or sponsor. ''Collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information before submitting the collection to OMB for approval. To comply with this requirement, FDA is publishing a notice of the proposed collection of information set forth in this document.

With respect to the following collection of information, FDA invites comments on: (1) Whether the proposed collection of information is necessary for the proper performance of FDA's functions, including whether the information will have practical utility; (2) the accuracy of FDA'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 minimize the burden of the collection of information on respondents, including through the use of automated collection techniques,

when appropriate, and other forms of information technology.

Title: How to Use E–Mail to Submit a Request for a Meeting or Teleconference to the Office of New Animal Drug Evaluation.

Description: As part of new animal drug development, sponsors often meet with CVM scientists to formulate a rational approach to studies to be conducted and to discuss how to meet the statutory requirements for new animal drug approval under section 512 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360b). Requests for meetings and teleconferences about NAD submissions are currently submitted on paper to CVM. CVM is responsible for developing and administering a guidance that explains how to adhere to the Electronic Records; Electronic Signatures regulations (part 11). These regulations provide for the voluntary submission of parts or all of regulatory records in electronic format without an accompanying paper copy and complies with the GPEA. The GPEA requires Federal agencies, by October 21, 2003, to give persons who are required to maintain, submit, or disclose information the option of doing so electronically when practicable as a substitute for paper.

This draft guidance describes the procedure for persons who are new animal drug sponsors to submit a request for a meeting or teleconference to the Office of New Animal Drug Evaluation by e-mail on FDA Form No. 3489. The information of the sponsors should include on the form: The sponsor's name and address, a list of requested participants, an indication of audio-visual needs, and an agenda. The likely respondents to this collection of information are sponsors who will be conducting clinical investigations under 21 CFR 511.1(b).

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN[1]

FDA Form No.	No. of Respondents	Annual Frequency per Respondent	Total Annual Responses	Hours per Response	Total Hours
3489	190	.88	168	0.69	116

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

The estimates in table 1 of this document resulted from discussions with new animal drug sponsors. The estimated burden includes requests for meetings or teleconferences submitted by e-mail and on paper.

IV. Comments

This draft guidance document is being distributed for comment purposes only and is not intended for implementation at this time. Interested persons may submit to the Dockets Management Branch (address above) written comments regarding this draft guidance document. Submit written comments by August 28, 2000, to ensure adequate consideration in preparation of the final guidance. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. Written comments concerning the information collection requirements must be received by August 28, 2000. A copy of the draft guidance and received comments are available for public examination in the Dockets Management Branch between 9 a.m. and 4 p.m., Monday through Friday.

Dated: June 16, 2000.

Margaret M. Dotzel,

Associate Commissioner for Policy.

[FR Doc. 00–16394 Filed 6–26–00;10:07 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 00D–1315]

Draft Guidance for Industry on How to Use E-Mail to Submit Information to the Center for Veterinary Medicine; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of the draft guidance for industry (#108) entitled ''How to Use E-Mail to Submit Information to the Center for Veterinary Medicine.'' This draft guidance is neither final nor is it in effect at this time. The draft guidance document is intended to provide guidance on how to submit information to the Center for Veterinary Medicine (CVM) as an e-mail attachment by Internet. These electronic submissions are part of CVM's ongoing initiative to provide a method for paperless submissions. This draft guidance implements provisions of the Government Paperwork Elimination Act (GPEA).

DATES: Submit written comments on the draft guidance at any time, however, comments should be submitted by August 28, 2000, to ensure their adequate consideration in preparation of the final document. Submit written comments on the information collection requirements by August 28, 2000.

ADDRESSES: Submit written comments on the draft guidance to the Dockets Management Branch (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Comments should be identified with the full title of the draft guidance document and the docket number found in brackets in the heading of this document.

Copies of the draft guidance document entitled ''How to Use E-Mail to Submit Information to the Center for Veterinary Medicine'' may be obtained on the Internet from the CVM home page at http://www.fda.gov/cvm/. Persons without Internet access may submit written requests for single copies of the draft guidance to the Communications Staff (HFV–12), Center for Veterinary Medicine, Food and Drug Administration, 7500 Standish Pl., Rockville, MD 20855. Send one self-addressed adhesive label to assist that office in processing your requests.

Submit written comments on the collection of information requirements to the Dockets Management Branch (address above). Comments should be identified with the docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Janis R. Messenheimer, Center for Veterinary Medicine (HFV–135), Food and Drug Administration, 7500 Standish Pl., Rockville, MD 20855, 301–827–7578, e-mail: jmessenh@cvm.fda.gov.

SUPPLEMENTARY INFORMATION:

I. Background

In the **Federal Register** of March 20, 1997 (62 FR 13430), FDA published the electronic records and electronic signatures final regulation. This regulation (part 11 (21 CFR part 11)) provides for the voluntary submission of parts or all of regulatory records in electronic format without an accompanying paper copy. This rule also established public docket number 92S–0251 to provide a permanent location for a list of the documents or parts of documents that are acceptable for submission in electronic form without paper records and the agency units to which such submissions may be made. CVM will identify in this public docket the types of documents which may be submitted in electronic form as those documents are identified in final guidance or regulations. This docket is accessible on the Internet at http://www.fda.gov/ohrms/dockets/dockets/92s0251/92s0251.htm. The GPEA of 1998 (Public Law 105–277) requires Federal agencies, by October 21, 2003, to provide: (1) For the option of the electronic maintenance, submission, or disclosure of information, if practicable, as a substitute for paper; and (2) for the use and acceptance of electronic signatures, when practicable.

CVM accepts certain types of submissions by e-mail with no requirement for a paper copy. These types of documents are listed in public docket number 92S–0251 as required by § 11.2. CVM's ability to receive and process information submitted electronically is limited by its current information technology capabilities and the requirements of the electronic records and electronic signatures regulation. This guidance outlines general standards which should be used for the submission of any information by e-mail.

II. Significance of Guidance

This Level 1 draft guidance is being issued consistent with FDA's good guidance practices (62 FR 8961, February 27, 1997). The draft guidance represent's the agency's current thinking about using e-mail to submit information electronically. It does not create or confer any rights for or on any person and will not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statute, regulation, or both.

III. Paperwork Reduction Act of 1995

Under the Paperwork Reduction Act of 1995 (the 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 or sponsor. ''Collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, before submitting the collection to OMB for approval. To comply with this requirement, FDA is publishing notice of the proposed collection of information set forth in this document.

With respect to the following collection of information, FDA invites comments on: (1) Whether the proposed collection of information is necessary for the proper performance of FDA's functions, including whether the information will have practical utility; (2) the accuracy of FDA'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 minimize the burden of the collection of information on respondents, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

Title: How to Use E-Mail to Submit Information to the Center for Veterinary Medicine.

Description: CVM is responsible for developing and administering guidances that explain how to adhere to the electronic records and electronic signatures regulations (part 11). The electronic records and electronic signatures regulations provide for the voluntary submission of parts or all of regulatory records in electronic format without an accompanying paper copy. These regulations comply with the GPEA. The GPEA requires Federal agencies, by October 21, 2003, to give persons who are required to maintain, submit, or disclose information the option of doing so electronically when practicable as a substitute for paper.

The draft guidance document describes the procedures for persons who are sponsors of new animal drugs who wish to file submissions by e-mail. The draft guidance instructs those who wish to submit information to CVM by e-mail to first register with them. Registration entails sending a letter to CVM with a sponsor password and the names, phone numbers, and mail and e-mail addresses of a sponsor coordinator and any person who will submit information electronically to CVM. This letter is sent on paper and electronically. Other information collection provisions described in the guidance are the submission of e-mails with the individual passwords of those who submit information electronically and e-mails with any changes to the sponsor's registration. CVM will use all the information submitted to process electronic submissions.

Description of Respondents: The likely respondents to this collection of information are new animal drug sponsors.

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN [1]

No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours
190	0.74	140	1	140

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

The estimates in table 1 of this document resulted from discussions with new animal drug sponsors.

IV. Comments

The draft guidance document is being distributed for comment purposes only and is not intended for implementation at this time. Interested persons may submit to the Dockets Management Branch (address above) written comments regarding this draft guidance document. Submit written comments by August 28, 2000, to ensure adequate consideration in preparation of the final document. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document.

Submit written comments concerning the information collection requirements to the Dockets Management Branch by August 28, 2000. A copy of the document and received comments are available for public examination in the Dockets Management Branch between 9 a.m. and 4 p.m., Monday through Friday.

Dated: June 16, 2000.

Margaret M. Dotzel,

Associate Commissioner for Policy.

[FR Doc. 00–16395 Filed 6–26–00; 10:07 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration, HHS.

[Document Identifier: HCFA–10012]

Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB)

AGENCY: Health Care Financing Administration, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

We are, however, requesting an emergency review of the Information collections referenced below. In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we have submitted to the Office of Management and Budget (OMB) the following requirements for emergency review. We are requesting an emergency review because the collection of this information is needed prior to the expiration of the normal time limits under OMB's regulations at 5 CFR part 1320. This collection of information will be used to test the effectiveness of three possible Medicare smoking cessation benefits and to make inferences that are generalizable to the Medicare program. Using a comparison trial with restricted randomization of study locales, this study will compare three variations in a potential Medicare smoking cessation benefit on smoking cessation and abstinence rates. Smoking cessation for seniors is currently receiving attention from Congress and the White House. Senator Graham (D–FL) has proposed a smoking cessation Medicare benefit, while the White House provides for a smoking cessation demonstration in the *President's Plan to Modernize and Strengthen Medicare for the 21st Century.* In response to this White House initiative, HCFA is launching this demonstration to test smoking cessation as a possible covered benefit under the Medicare program. If this information is not collected, public harm is likely to occur. Considerable evidence indicates that much greater improvement in health status could be accomplished if currently existing, effective and commonly available preventative practices and services were implemented more widely; therefore, this demonstration could help improve the health of the Medicare population.

HCFA is requesting OMB review and approval of this collection by July 5, 2000, with a 180-day approval period. Written comments and recommendations will be accepted from the public if received by the individuals designated below by July 3, 2000. During this 180-day period, we will publish a separate **Federal Register** notice announcing the initiation of an extensive 60-day agency review and public comment period on these requirements. We will submit the requirements for OMB review and an extension of this emergency approval.

Type of Information Collection Request: New Collection;

Title of Information Collection: Healthy Aging Smoking Cessation Demonstration;

Form No.: HCFA–10012 (OMB no. 0938–NEW);

Use: The goals of the Healthy Aging Project are to test the effectiveness of three possible Medicare smoking cessation benefits and to make inferences that are generalizable to the Medicare program. Using a comparison trial with restricted randomization of study locales, this study will compare three variations in a potential Medicare smoking cessation benefit on smoking cessation and abstinence rates.;

Frequency: Semi-annually;

Affected Public: Individuals or Households;

Number of Respondents: 43,500;

Total Annual Responses: 130,500;

Total Annual Hours: 58,000.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access HCFA's Web Site address at http://www.hcfa.gov/regs/prdact95.htm, or E-mail your request, including your address, phone number, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326.

Interested persons are invited to send comments regarding the burden or any other aspect of these collections of Information requirements. However, as noted above, comments on these Information collection and recordkeeping requirements must be mailed and/or faxed to the designees referenced below, by July 3, 2000: Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards Attention: Dawn Willinghan, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Fax Number: (202) 395–6974 or (202) 395–5167, Attn: Allison Herron Eydt, HCFA Desk Officer.

Dated: June 1, 2000.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

[FR Doc. 00–16455 Filed 6–28–00; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[Document Identifier: HCFA–901–1]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Health Care Financing Administration, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send

comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Type of Information Collection Request: Revision of a currently approved collection;

Title of Information Collection: Qualification Application and Supporting Regulations in 42 CFR 417.408 and 417.143;

Form No.: HCFA–901–1 (OMB# 0938–0470);

Use: Prepaid health plans must meet certain regulatory requirements to be federally qualified health maintenance organizations. This application is the collection form used to obtain the information from health plans that allow HCFA staff to determine compliance with the regulations.;

Frequency: Other: One-time;

Affected Public: Business or other for-profit, Not-for-profit institutions, and State, Local, or Tribal Government;

Number of Respondents: 35;

Total Annual Responses: 35;

Total Annual Hours: 3,500.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access HCFA's Web Site address at http://www.hcfa.gov/regs/prdact95.htm, or E-mail your request, including your address, phone number, OMB number, and HCFA document identifier, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the HCFA Paperwork Clearance Officer designated at the following address: HCFA, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Attention: Dawn Willinghan, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: June 16, 2000.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

[FR Doc. 00–16456 Filed 6–28–00; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–1030–N]

Medicare Program; Medicare+Choice Deeming Authority

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

ACTION: Notice.

SUMMARY: This notice announces that 30 days after the publication of the Medicare+Choice (M+C) final rule, we will begin to accept applications from private accrediting organizations who seek M+C deeming authority.

EFFECTIVE DATE: This notice is effective on July 31, 2000.

FOR FURTHER INFORMATION CONTACT: Patricia Kurtz, (410) 786–4670.

SUPPLEMENTARY INFORMATION:

Background

Section 4001 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1987, added section 1852(e)(4) to the Social Security Act (the Act), which gives us the authority to determine that a Medicare+Choice Organization (M+CO) is ''deemed'' to be in compliance with certain Medicare requirements if the M+CO has been accredited (and is periodically reaccredited) by an accrediting organization that we have determined applies and enforces requirements at least as stringent as those the M+CO would be deemed to meet. Section 518 of the Balance Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), enacted on November 29, 1999, amended section 1852(e)(4) of the Act to expand the scope of deeming from two to six areas. Accrediting organizations may seek authority for any of the categories. The BBRA specified that we cannot require an accrediting entity to be able to certify plans for all the deeming categories. It also required us to determine, within 210 days from the day the application is determined to be complete, the eligibilty of the accrediting organizations to be granted deeming authority. Conditions and procedures for granting deeming authority to accrediting organizations are outlined in § 422.157 and § 422.158 of title 42 of the Code of Federal Regulations.

Applications

This notice announces that 30 days after the publication of the M+C final rule, we will begin to accept applications from national private accrediting organizations who seek M+C deeming authority. To receive an application packet, please contact Patricia Kurtz at (410) 786–4670 or via e-mail at pkurtz@hcfa.gov or mail your inquires to: Patricia Kurtz, Health Care Financing Administration, Health Plan Administration Group, Room C4–24–04, 7500 Security Blvd., Baltimore, MD. 21244.

Authority: Section 1852(e)(4) of the Social Security Act (42 U.S.C. 1395w–22(e)(4)) (Catalog of Federal Domestic Assistance Program No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 19, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

[FR Doc. 00–16058 Filed 6–28–00; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Request to Office of Management and Budget for Reinstatement of Agency Information Collection for Indian Self-Determination and Education Assistance Contracts

AGENCIES: Bureau of Indian Affairs, DOI and Indian Health Service, DHHS.

ACTION: 30-Day Notice of Submission to OMB.

SUMMARY: The Department of the Interior and the Department of Health and Human Services announce submission to the Office of Management and Budget (OMB) of a request for reinstatement of information collection, OMB #1076–0136, ''Indian Self-Determination and Education Assistance Act Programs.'' The information collection will be used to process contracts, grants or cooperative agreements for award by the Bureau of Indian Affairs and the Indian Health Service as authorized by the Indian Self-Determination and Education Assistance Act as amended and set forth

in 25 CFR part 900. The Department of the Interior and the Department of Health and Human Services invite you to submit comments to the OMB on the information collection described below.

DATES: Interested persons are invited to submit comments on or before July 31, 2000.

ADDRESSES: If you wish to comment, you may submit your comments to Attn: Desk Officer for Department of the Interior, Office of Information and Regulatory Affairs, Office of Management and Budget, Docket Library, Room 10102, 725 17th Street NW, Washington, DC 20503. Please send copy of comments to James Thomas, Office of Tribal Services, Bureau of Indian Affairs, Department of the Interior, 1849 C Street NW, MS 4660 MIB, Washington, DC 20240.

FOR FURTHER INFORMATION CONTACT: James Thomas, Office of Tribal Services, Bureau of Indian Affairs, Department of the Interior, 1849 C Street NW, MS 4660 MIB, Washington, DC 20240, or (202) 208–5727.

SUPPLEMENTARY INFORMATION: Representatives of the Department of the Interior, the Department of Health and Human Services and the tribes developed a joint rule, 25 CFR part 900, to implement section 107 of the Indian Self-Determination and Education Assistance Act, as amended by, Public Law 103–413, the Indian Self-Determination Contract Reform Act of 1994. Section 107(a)(2)(A)(ii) of the Indian Self-Determination Contract Reform Act requires the joint rule to permit contracts and grants be awarded to Indian tribes without the unnecessary burden or confusion associated with two sets of rules and information collection requirements when there is a single program legislation involved. The burden hours for this collection have been reduced as a result of tribes contracting multiple programs under a single contract, as authorized under 25 CFR 900.8, tribes administering 'mature' contracts which require fewer reports and, tribes entering into Self-Governance 'compacts,' under which Self-Governance tribes may combine all programs under a single self-governance compact.

The information requirements for this joint rule represent significant differences from other agencies in several respects. Both the Bureau of Indian Affairs and the Indian Health Service let contracts for multiple programs whereas other agencies usually award single grants to tribes. Under the Indian Self-Determination and Education Assistance Act, as amended by the Indian Self-Determination Contract Reform Act of 1994, tribes are entitled to contract and may renew contracts annually where other agencies provide grants on a discretionary/competitive basis.

The proposal and other supporting documentation identified in this information collection is used by the Department of the Interior and the Department of Health and Human Services to determine applicant eligibility, evaluate applicant capabilities, protect the service population, safeguard Federal funds and other resources, and permit the Federal agencies to administer and evaluate contract programs. Tribal governments or tribal organizations provide the information by submitting Public Law 93–638 contract or grant proposals to the appropriate Federal agency. No third party notification or public disclosure burden is associated with this collection.

Request for Comments: The Department of the Interior and the Department of Health and Human Services request comments on this information collection particularly concerning: (1) The necessity of the information collection for the proper performance of the agencies' functions; (2) whether this information collection duplicates a collection elsewhere by the Federal Government; (3) whether the burden estimate is accurate or could be reduced using technology available to all respondents; (4) if the quality of the information requested ensures its usefulness to the agency(ies); (5) if the instructions are clear and easily understood, leading to the least burden on the respondents. A Federal 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.

Please submit any comments to the contact in the **ADDRESSES** section. Please submit a copy of comments on this information collection to the Bureau of Indian Affairs by telefax to (202) 208–5113. You may also hand deliver written comments or view comments at the address found in ''**FOR FURTHER INFORMATION CONTACT**.'' You may obtain a copy of this information collection document and the OMB submission at no charge by a written request to the same address, by telefaxing a request to the above number, or by calling (202) 208–5727. Please identify the information collection by, OMB #1076–0136. We make the comments and names and addresses of commentators available for public review during regular business hours. If you wish us to withhold your name and address, you must state this prominently at the beginning of your comments. We will honor your request to the extent allowable by law.

Burden Statement: Respondents may be required to respond from 1 to 12 times per year, depending upon the number of programs they contract from the Bureau of Indian Affairs and the Indian Health Service. In addition, each Subpart concerns different parts of the contracting process. For example, Subpart C relates to provisions of initial contract proposal contents. The burden associated with this would not be used when contracts are renewed. Subpart F describes minimum standards for the management systems used by Indian tribes or tribal organizations under these contracts. Subpart G addresses the negotiability of all reporting and data requirements in the contract.

Total annual burden: 238,992 hours.

Total number of respondents: 550.

Total number of responses: 5,507.

Dated: June 21, 2000.

Kevin Gover,

Assistant Secretary—Indian Affairs, Department of the Interior.

Dated: April 26, 2000.

Michael H. Trujillo,

Assistant Surgeon General, Director, Indian Health Service, Department of Health and Human Services.

[FR Doc. 00–16429 Filed 6–28–00; 8:45 am]

BILLING CODE 4310–02–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Information Collection Submitted to the Office of Management and Budget for Renewal Under the Paperwork Reduction Act

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice.

SUMMARY: We have submitted the information collection requirements to renew approval of the collection of information for special use permit applications on national wildlife refuges in Alaska to OMB for approval under the provisions of the Paperwork Reduction Act of 1995.

DATES: Submit comments on or before July 31, 2000.

ADDRESSES: Send comments and suggestions on specific requirements directly to the Office of Management and Budget, Office of Information and Regulatory Affairs, Attention: Department of the Interior Desk Officer, 725 17th Street, NW, Washington, DC

20503; and a copy to our Information Collection Clearance Officer, U.S. Fish and Wildlife Service [MS 222 ARLSQ], 1849 C Street, NW, Washington, DC 20240.

FOR FURTHER INFORMATION CONTACT: Leslie Marler, Management Analyst, Branch of Policy and Planning, Division of Refuges, (703) 358–2397; or Tony Booth, Refuge Program Specialist, Division of Refuges, Anchorage, AK (907) 786–3384.

SUPPLEMENTARY INFORMATION: We submitted the following proposed information collection clearance requirement to OMB for review and approval under the Paperwork Reduction Act of 1995 (Pub. L. 104–13). OMB has up to 60 days to approve or disapprove information collection. To ensure maximum consideration, OMB should receive public comments by July 31, 2000. We may not conduct or sponsor a collection of information, and a person is not required to respond to a request for information unless it displays a currently valid OMB control number. We previously published a 60-day notice inviting public comment on this information collection in the **Federal Register** on February 9, 2000 (65 FR 6388). We received no comments.

We invite comments on: (1) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) the accuracy of the agency's estimate of burden, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information 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.

The National Wildlife Refuge System Improvement Act of 1997 (Pub. L. 105–57) that amends the National Wildlife Refuge Administration Act of 1966 (16 U.S.C. 668 dd-ee) requires that we authorize economic or other special privileges on any national wildlife refuge by permit only when we determine the activity will be compatible with the purposes for which the refuge was established and the mission of the National Wildlife Refuge System. The Alaska National Interest Lands Conservation Act (ANILCA) (16 U.S.C. 3101 *et seq.*) provides for the disposition and use of national wildlife refuges and other federally owned lands in Alaska. Title III of ANILCA identifies the purposes for each Alaska refuge and requires that all uses we authorize on them first be found to be compatible with the refuge purposes. Section 1307 of ANILCA contains two provisions concerning persons and entities who we are to give special rights and preferences with respect to providing ''visitor services'' on national wildlife refuges in Alaska and certain other Federal lands. Other sections of ANILCA allow us to permit uses on national wildlife refuges in Alaska under certain conditions.

We will provide the permit applications as requested by interested Alaska citizens. We will use information provided on the required written forms and/or verbal applications to determine if the proposed activity is compatible with refuge purposes and ensure that the applicant is eligible for a permit. In the case of competitively awarded permits, we will use the information to determine the most qualified applicant to receive benefits of a refuge permit. In the case of ''1307'' permits, we will use the information to determine whether the applicant is: A member of a Native Corporation; a local resident; engaged in adequately providing visitors services on or before January 1, 1979; or eligible to receive Cook Inlet Region rights.

We make provision in our general refuge regulations for public entry for specialized purposes, including economic activities such as the operation of guiding and other visitor services on refuges by concessionaires or cooperators under appropriate contracts or legal agreements (found in 50 CFR 25.61) or special use permits (found in 50 CFR 26.22(b), 26.25, 36.37, and 36.41). These rules provide the authorities and procedures for selecting permittees on Alaska refuges, the vast majority of which are providers of services and facilities to the public. We will issue permits for a specific period as determined by the type and location of the use or visitor service provided.

We are making several minor modifications to the Special Use Permit application form:

1. On page one, Part 1 of the form, we changed cc:mail address to e-mail address.

2. On page two, Part 2 of the form, we eliminated Aleutian Islands Unit/Alaska Maritime NWR from the list of National Wildlife Refuge Code Acronyms because there is no need for separate entry for the Aleutian Islands Unit of the refuge.

3. On page two, Part 2 of the form, we also revised the list of Activity Codes to provide more effective and clearer identification of the types of commercial visitor service uses that we most commonly permit on Alaska refuges. We changed the activity codes from two-letter codes to three-letter codes.

4. On page three, Part 4 of the form, we revised the instructions that state, ''List the MAKE, MODEL, WHEEL/FLOAT/SKI, COLOR and TAIL NUMBER of all the aircraft you own/lease/operate:'' We added to this statement the phrase, ''* * * that you will use in your proposed activity:'' to clarify that we only need information about aircraft the applicant will use for activities permitted on the refuge.

5. In addition to the revisions identified above, we made several minor editorial changes on the application form for clarification and plain language requirements. The editorial revisions do not affect information requirements of the application.

Title: Special Use Permit Applications on National Wildlife Refuges in Alaska.

OMB form number: 1018–0014—Service form number: 3–2001.

Frequency of collection: On occasion.

Description of the respondents: Individuals and households; business and other.

Number of respondents: 212.

Estimated completion time: 8.6 hours (average time for competitive and non-competitive respondents).

Burden estimate: 1,820 hours.

BILLING CODE 4310–55–P

U.S. DEPARTMENT OF THE INTERIOR

U.S. FISH & WILDLIFE SERVICE, ALASKA REGION

SPECIAL USE PERMIT APPLICATION

OFFICE USE:
SUP # _____

NOTICE: In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501, et seq.) and the Privacy Act of 1974 (5 U.S.C. 552a) please be advised that:

1. The permitting of compatible economic and public uses on lands of the National Wildlife Refuge System is authorized by: (a) the National Wildlife Refuge System Improvement Act of 1997 (Pub. L. 105-57); (b) the National Wildlife Refuge System Administration Act (16 U.S.C. 668dd-ee); (c) the Refuge Recreation Act (16 U.S.C. 460k-n); (d) Bald Eagle Protection Act (16 U.S.C. 663a); (e) Endangered Species Act of 1973 (16 U.S.C. 1539); (f) Migratory Bird Treaty Act (16 U.S.C. 703-711); (g) Marine Mammal Protection Act of 1972 (16 U.S.C. 1371-1383); (g) Lacey Act (18 U.S.C. 42 and 44); and (h) Tariff Classification Act of 1962 (19 U.S.C. 1202).

2. Public and economic uses of national wildlife refuges may be authorized upon a determination that such uses are compatible with the purpose(s) for which the refuge was established, and the mission of the National Wildlife Refuge System. The action also must be in accordance with provisions of all laws applicable to the area, consistent with the principles of sound fish and wildlife management and otherwise in the public interest.

3. The application form will be used by Service personnel to evaluate the qualifications and conclude the eligibility of the applicant. Applicants are not required to disclose their social security number.

4. Routine use disclosures may also be made (1) to the U.S. Department of Justice when related to litigation or anticipated litigation; (2) of information indicating a violation or potential violation of a statute, regulation, rule, order or license to appropriate Federal, State, local or foreign agencies responsible for investigating or prosecuting the violation or for enforcing or implementing the statute, rule, regulation, order or license; (3) from the record of an individual in response to an inquiry from a Congressional office made at the request of that individual (42 FR 19083; April 11, 1977)

5. Information requested in this form is purely voluntary, but failure to answer questions may jeopardize eligibility to receive permits. Response is not required unless a currently valid Office of Management and Budget (OMB) control number is displayed.

6. The public reporting burden for this information collection varies based on the specific refuge use being requested. The relevant burden estimate ranges from 1.5 hours for each non-competitively bid permit, to 30 hours for each competitively awarded permit, to 40 hours for each 1307 permit being requested. This burden estimate includes time for reviewing instructions, gathering and maintaining data, and completing and reviewing the form. Direct comments regarding the burden estimate or any other aspect of the form to the Service Information Collection Clearance Officer, Fish and Wildlife Service, Mail Stop 224, Arlington Square, U.S. Department of the Interior, 1849 C Street, N.W., Washington, D.C. 20240, and to the Office of Information and Regulatory Affairs, OME, Attention: Desk Officer for the Interior Department (1018-0014), Washington, D.C. 20503.

REVISED 4/00
USFWS Form 3-2001

OMB Approval No 1018-0014
Approval Expires __/__/03

OFFICE USE:
SUP # _____

1) Please type or print in ink. Answer all questions completely or mark "N/A" if not applicable.

APPLICANT NAME: _____

SOCIAL SECURITY NUMBER _____

BUSINESS NAME _____

PRIMARY ADDRESS _____
(Business Address)

_____

_____

ALTERNATE ADDRESS _____

_____

_____

PRIMARY PHONE NUMBER _____

FAX NUMBER _____

ALTERNATE PHONE NUMBER _____

E - MAIL ADDRESS _____

AS AN APPLICANT, ARE YOU: (Mark one box with "X")

{ } INDIVIDUAL
{ } CORPORATION
{ } PARTNERSHIP/ASSOCIATION
{ } GOVERNMENT/STATE AGENCY

{ } OTHER_____

If you are an INDIVIDUAL or PARTNERSHIP, are you also a citizen(s) of the United States?

YES_____NO_____

2) **SPECIAL USE PERMIT ACTIVITIES**

Use the code listing below to select the refuge and commercial activity(ies) to complete this section.
Be as specific as you can (Example: ARC-ATX means Arctic National Wildlife Refuge - Air Taxi Operations).

NATIONAL WILDLIFE REFUGE CODE ACRONYMS

AKM = Alaska Maritime NWR
APB = Alaska Peninsula/Becharof NWR
ARC = Arctic NWR
INN = Innoko NWR
IZM = Izembek NWR
KAN = Kanuti NWR
KEN = Kenai NWR
KOD = Kodiak NWR
KOY = Koyukuk/Nowitna NWR
SEL = Selawik NWR
TET = Tetlin NWR
TOG = Togiak NWR
YKD = Yukon Delta NWR
YKF = Yukon Flats NWR

ACTIVITY CODES

GBG = Guiding - Big Game Hunting
GSG = Guiding - Hunting Other than Big Game; specify type of wildlife hunted (e.g., migratory birds, small game, etc.)
GSF = Guiding - Sport Fishing
GRT = Guiding - River Trips; specify type of boat and if motorized or non-motorized
GOT = Outfitting; specify type of activities guided (e.g., hiking, wildlife viewing, sight seeing, photography, etc.)
OUT = Outfitting; specify type of equipment and activity you are outfitting
ATX = Air Taxi - FAA certified, point to point aircraft transportation on refuge lands/waters
AFS = Flightseeing - only if you will be landing on refuge lands/waters
TRP = Transporting; specify mode of transport provided (e.g., horse, boat, snowmachine, etc.)
PHO = Commercial Photography
OTH = Other, please specify in detail, on a separate sheet, the activity you propose

REFUGE CODE	ACTIVITY CODE (specify additional details if applicable - you may use additional sheets)	AREA(S) OF USE (delineate on USGS Topo maps if applicable)	CLIENT #S - Specify anticipated average and maximum number of clients per day

3). What are the estimated starting and ending dates of your proposed activity?_____

4). Will your business be operating aircraft (not hiring air taxis) on refuge lands/waters?

YES _____NO _____. If so, will your business be operating aircraft under:
(check one)_____FAA Regulations Part 91 (incidental Air) _____FAA Regulations Part 135 (Air Taxi)

(PLEASE PROVIDE A COPY OF YOUR FAA CERTIFICATION.)

Name of Air Taxi(s) you plan to use _____

_____

_____

List the MAKE, MODEL, WHEEL/FLOAT/SKI, COLOR and TAIL NUMBER of all aircraft you own/lease/operate that you will use in your proposed activity:

MAKE	MODEL	WHEEL (✓)	SKI (✓)	FLOAT (✓)	COLOR	TAIL NUMBER

5) We require you to carry liability insurance to provide protection for visitors you serve on refuges. You must name the U.S. Government as an additional insured. Do you have current liability insurance? YES _____ NO _____ (Attach a copy of the insurance certificate.)

Applicants must obtain liability coverage BEFORE we can issue a Special Use Permit. Refer to the enclosed Insurance Information Sheet for required minimum coverage amounts.

6) List the type of vessel(s) or vehicle(s) and the maximum passenger capacity of the vehicles and/or vessels (not aircraft) you plan to use within refuge boundaries.

VESSEL/VEHICLE	MAXIMUM CAPACITY	REGISTRATION NUMBER

7) Within the past 5 years, have the company (entity) or any of the owners of the business been convicted, pled nolo contendere, or forfeited collateral for any violations of State, Federal, or local law or regulations related to fish and wildlife or permit activities? YES _____ NO _____

8) Are the company (entity) or any of the owners of the business now under charges for any violation of State, Federal, or local law or regulations related to fish and wildlife or permit activities? YES _____ NO _____

9) Within the past 5 years, have any of your current or proposed employees been convicted, pled nolo contendere, or forfeited collateral for any State, Federal or local law or regulations related to fish and wildlife or permit activities: OR are they now under charges for any violation of state, federal or local law or regulations related to fish and wildlife or permit activities? YES _____ NO _____

10) IF YOU ANSWERED "YES" TO QUESTIONS # 7, 8 OR 9, PLEASE GIVE DETAILS IN THE SPACE BELOW. FOR EACH VIOLATION, PROVIDE THE: 1) Individual's Name, 2) Date, 3) Charge, 4) Place, 5) Court, and 6) Action Taken.

ITEM #	INDIVIDUAL'S NAME	DATE	CHARGE	PLACE	COURT	ACTION

REVISED 4/00
USFWS Form 3-2001

OMB Approval No. 1018-0014
Approval Expires __/__/03

11) If you check the following blank _____, or if this application is in response to a prospectus for a competitively awarded permit, please provide a detailed response which addresses, at a minimum, the following factors: proposed operations plan; complete above history of violation related questions 7, 8, and 9 for the past 10 years; safety record, training and proposed safety plan; documentation of experience and knowledge applicable to both the proposed activity and delineated use area or general geographical area; complete list and description of property, equipment and accessories; and complete list of clients for same or similar activities during the past three years. (Use separate sheets to complete this question.)

12) Provide a complete list of names, addresses and phone numbers of employees who will be assisting with permit activities on the refuge. Also indicate in what capacity they will be operating (e.g., guide, pilot, camp cook, etc.) For any employee, including the applicant, who will be operating a vehicle, aircraft, or vessel while carrying clients, please provide their State drivers license number, pilot certificate number, or applicable vessel operating license number and indicate whether they have had any such licenses suspended or revoked, or have been convicted for driving while under the influence of alcohol or drugs during the past five years. Please use separate sheet to provide this information.

13) False, fictitious or fraudulent statements or representations made in this application may be grounds for revocation of the Special Use Permit and may be punishable by fine or imprisonment (18 U.S.C. 1001). We will consider all information you provide in reviewing this application.

14) Please attach a copy of your State business license and any applicable State or Federal licenses/certifications (e.g., State Big Game Guiding License, State Transporter license, U.S. Coast Guard License, etc.).

_____ _____ _____

SIGNATURE OF OWNER/AGENT (Attach proof of Agent) **PRINTED NAME** **DATE**

****

FOR OFFICE USE ONLY				
Check #	Check Amount:	Overpayment:	Additional Amount Needed:	Fee Not enclosed

WERE THESE DOCUMENTS ENCLOSED WITH APPLICATION?

AIRCRAFT INSURANCE: YES NO GENERAL LIABILITY INSURANCE: YES NO
STATE BUSINESS LICENSE: YES NO OTHER LICENSES/CERTIFICATIONS: YES NO

MISSING DOCUMENTATION _____

REVISED 4/00
USFWS Form 3-2001

OMB Approval No. 1018-0014
Approval Expires __/__/03

Dated: April 12, 2000.
Paul R. Schmidt,
Assistant Director for Refuges and Wildlife.
[FR Doc. 00–16371 Filed 6–28–00; 8:45 am]
BILLING CODE 4310–55–C

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Endangered and Threatened Species Permit Applications

ACTION: Notice of Receipt of Applications.

SUMMARY: The following applicants have applied for a permit to conduct certain activities with endangered species. This notice is provided pursuant to section 10(a) of the Endangered Species Act of 1973, as amended (16 U.S.C. 1531, *et seq.*).

Permit No. TE–827367

Applicant: Bureau of Land Management, Lake Havasu City, Arizona.

Applicant requests authorization for recovery purposes to conduct activities for the southwestern willow flycatcher (*Empidonax traillii extimus*), Yuma clapper rail (*Rallus longirostris yumanensis*), and Mohave Desert tortoise (*Gopherus agassizii*) in Arizona.

Permit No. TE–839505

Applicant: Aaron D. Flesch, Tucson, Arizona.

Applicant requests authorization for recovery purposes to conduct presence/absence surveys for the southwestern willow flycatcher (*Empidonax traillii extimus*) in Arizona and New Mexico.

Permit No. TE–26700

Applicant: John A. Kugler, Sonoita, Arizona.

Applicant requests authorization for recovery purposes to conduct presence/absence surveys for the Gila topminnow (*Poeciliopsis occidentalis*), and desert pupfish (*Cyprinodon macularius*) in Santa Cruz, Cochise, Graham, Pima, Maricopa, and Yuma Counties, Arizona.

Permit No. TE–28362

Applicant: Bureau of Land Management, Arizona Strip Field Office, St. George, Utah.

Applicant requests authorization for recovery purposes to conduct presence/absence surveys for the Mexican spotted owl (*Strix occidentalis lucida*), southwestern willow flycatcher (*Empidonax traillii extimus*), woundfin (*Plagopterus argentissimus*), Virgin River chub (Gila seminuda) and the California condor (*Gymnogyps Californianus*) in Mohave and Coconino counties, north of the Colorado River, and the Virgin River in Arizona.

Permit No. TE–28652

Applicant: Jean Krejca, Austin, Texas.

Applicant requests authorization for scientific research and recovery purposes to collect the following endangered or threatened species in Texas:

Peck's Cave amphipod (*Stygobromus pecki*)
Coffin Cave Mold beetle (*Batrisodes texanus*)
Kretschmarr Cave Mold beetle (*Texamaurops reddelli*)
Tooth Cave ground beetle (*Rhadine persephone*)
Tooth Cave Pseudoscorpion (*Tartarocreagris texana*)
Bee Creek Cave harvestman (*Texella reddelli*)
Bone Cave harvestman (*Texella reyesi*)
Tooth Cave spider (*Neoleptoneta myopica*)
Texas blind salamander (*Typhlomolge rathbuni*)
Mexican long-nosed bat (*Leptonycteris nivalis*)
Barton Springs salamander (*Eurycea sosorum*)

The following species will not be collected but potentially impacted.

San Marcos salamander (*Eurycea nana*)
fountain darter (*Etheostoma fonticola*)
Big Bend gambusia (*Gambusia gaigei*)
Clear Creek gambusia (*Gambusia heterochir*)
Pecos gambusia (*Gambusia nobilis*)
San Marcos gambusia (*Gambusia georgei*)
Comanche Springs pupfish (*Cyprinodon elegans*)
Leon Springs pupfish (*Cyprinodon bovinus*)
Comal Springs dryopid beetle (*Stygoparnus comalensis*)
Comal Springs riffle beetle (*Heterelmis comalensis*)
Texas wild rice (*Zizania texana*)

Permit No. TE–28649

Applicant: Chris Thibodaux, Austin, Texas.

Applicant requests authorization for scientific research and recovery purposes to collect the following endangered or threatened species in Texas:

Peck's Cave amphipod (*Stygobromus pecki*)
Coffin Cave Mold beetle (*Batrisodes texanus*)
Kretschmarr Cave Mold beetle (*Texamaurops reddelli*)
Tooth Cave ground beetle (*Rhadine persephone*)
Tooth Cave Pseudoscorpion (*Tartarocreagris texana*)
Bee Creek Cave harvestman (*Texella reddelli*)
Bone Cave harvestman (*Texella reyesi*)
Tooth Cave spider (*Neoleptoneta myopica*)
Texas blind salamander (*Typhlomolge rathbuni*)
Mexican long-nosed bat (*Leptonycteris nivalis*)
Barton Springs salamander (*Eurycea sosorum*)

The following species will not be collected but potentially impacted.

San Marcos salamander (*Eurycea nana*)
fountain darter (*Etheostoma fonticola*)
Big Bend gambusia (*Gambusia gaigei*)
Clear Creek gambusia (*Gambusia heterochir*)
Pecos gambusia (*Gambusia nobilis*)
San Marcos gambusia (*Gambusia georgei*)
Comanche Springs pupfish (*Cyprinodon elegans*)
Leon Springs pupfish (*Cyprinodon bovinus*)
Comal Springs dryopid beetle (*Stygoparnus comalensis*)
Comal Springs riffle beetle (*Heterelmis comalensis*)
Texas wild rice (*Zizania texana*)

Permit No. TE–28986

Applicant: Arizona Department of Transportation—Environmental Planning Group, Phoenix, Arizona.

Applicant requests authorization for recovery purposes to conduct presence/absence surveys for the following endangered and threatened species in various counties in Arizona:

southwestern willow flycatcher (*Empidonax traillii extimus*)
cactus ferruginous pygmy-owl (*Glaucidium brasilianum cactorum*)
Gila trout (*Oncorhynchus gilae*)
Gila topminnow (*Poeciliopsis occidentalis occidentalis*)
Colorado pikeminnow (*Ptychocheilus lucius*)
razorback sucker (*Xyrauchen texanus*)
spikedace (*Meda fulgida*)
loach minnow (*Rhinichthys* (=*Tiaroga*) cobitis)
Little Colorado spinedace (*Lepidomeda vittata*)
Arizona agave (*Agave arizonica*)
Arizona cliffrose (*Purshia subintegra*)
Arizona hedgehog cactus (*Echinocereus triglochidiatus arizonicus*)
Pima pineapple cactus (*Coryphantha scheeri robustispina*)

DATES: Written comments on these permit applications must be received on or before July 31, 2000.

ADDRESSES: Written data or comments should be submitted to the Legal Instruments Examiner, Division of Endangered Species/Permits, Ecological Services, P.O. Box 1306, Albuquerque, New Mexico 87103. Please refer to the respective permit number for each application when submitting comments. All comments received, including names and addresses, will become part of the official administrative record and may be made available to the public.

FOR FURTHER INFORMATION CONTACT: The U.S. Fish and Wildlife Service, Ecological Services, Division of Endangered Species/Permits, P.O. Box 1306, Albuquerque, New Mexico 87103. Please refer to the respective permit number for each application when requesting copies of documents. Documents and other information submitted with these applications are available for review, subject to the requirements of the Privacy Act and Freedom of Information Act, by any party who submits a written request for a copy of such documents within 30 days of the date of publication of this notice, to the address above.

Steven M. Chambers,

Assistant Regional Director, Ecological Services, Region 2, Albuquerque, New Mexico.

[FR Doc. 00–16438 Filed 6–28–00; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Notice of Receipt of Applications for Permit

The following applicants have applied for a permit to conduct certain activities with endangered species. This notice is provided pursuant to Section 10© of the Endangered Species Act of 1973, *as amended* (16 U.S.C. 1531, *et seq.*):

Applicant: Detroit Zoological Institute, Royal Oak, MI, PRT–028855.

The applicant requests a permit to import one captive-born male mandrill (*Mandrillus sphinx*) from the Toronto Zoo, Canada, for the purpose of enhancement of the survival of the species through propagation.

Applicant: Alfred Rordame, Salt Lake City, UT PRT–028978.

The applicant requests a permit to import the sport-hunted trophy of one male bontebok (*Damaliscus pygargus dorcas*) culled from a captive herd maintained under the management program of the Republic of South Africa, for the purpose of enhancement of the survival of the species.

Applicant: Joe B. Finley, Belton, SC, PRT–028593

The applicant requests a permit to import the sport-hunted trophy of one male bontebok (*Damaliscus pygargus dorcas*) culled from a captive herd maintained under the management program of the Republic of South Africa, for the purpose of enhancement of the survival of the species.

Applicant: Haines T. Lowell, Columbia Falls, MT, PRT–029139.

The applicant requests a permit to import the sport-hunted trophy of one male bontebok (*Damaliscus pygargus dorcas*) culled from a captive herd maintained under the management program of the Republic of South Africa, for the purpose of enhancement of the survival of the species.

Applicant: Stephen Fullmer, Salt Lake City, UT PRT–029359.

The applicant requests a permit to import the sport-hunted trophy of one male bontebok (*Damaliscus pygargus dorcas*) culled from a captive herd maintained under the management program of the Republic of South Africa, for the purpose of enhancement of the survival of the species.

Applicant: Zoological Society of San Diego, Escondido, CA, PRT–027118.

The applicant requests a permit to import three male and three female Chinese Dhole (*Cuon alpinus lepturus*) as the beginning of a captive propagation program for the species.

Applicant: Tulsa Zoo, Tulsa, OK PRT–027871

The applicant requests a permit to import two female Jaguars (*Panthera onca*) for the purpose of enhancement of the survival of the species through propagation.

Marine Mammal

Applicant: Ross Zimmerman, Winnermucca, NV, PRT–028902.

The applicant requests a permit to import a polar bear (*Ursus maritimus*) sport-hunted from the Lancaster Sound polar bear population, Northwest Territories, Canada for personal use.

Written data or comments should be submitted to the Director, U.S. Fish and Wildlife Service, Office of Management Authority, 4401 North Fairfax Drive, Room 700, Arlington, Virginia 22203 and must be received by the Director within 30 days of the date of this publication.

Documents and other information submitted with these applications are available for review, *subject to the requirements of the Privacy Act and Freedom of Information Act*, by any party who submits a written request for a copy of such documents to the following office within 30 days of the date of publication of this notice: U.S. Fish and Wildlife Service, Office of Management Authority, 4401 North Fairfax Drive, Room 700, Arlington, Virginia 22203. Phone: (703/358-2104); FAX: (703/358–2281).

Dated: June 23, 2000.

Kristen Nelson,

Chief, Branch of Permits, Office of Management Authority.

[FR Doc. 00–16441 Filed 6–28–00; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Tribal Consultation on Indian Education Topics

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: The Bureau of Indian Affairs (BIA) is announcing that it will conduct tribal consultation meetings to obtain oral and written comments concerning potential issues in Indian Education Programs. This notice announces the dates and locations of the consultation meetings.

DATES: Written comments must be received on or before August 18, 2000. The consultation meetings will be held on July 11, 13, 18, 20, and 21, 2000. Several dates and locations were scheduled to coincide with meetings of various Indian education organizations. All meetings will begin at 9 a.m. and continue until 3 p.m. (local time) or until all meeting participants have had an opportunity to make comments.

ADDRESSES: Send written comments to the Bureau of Indian Affairs, Office of Indian Education Programs, Attention: Mr. William Mehojah, Jr., MS–3512–MIB, OIE–32, 1849 C Street, NW, Washington, DC 20240, or you may hand-deliver them to Room 3512 at the same address. Comments may also be telefaxed to 202–208–3312. See **SUPPLEMENTARY INFORMATION** for locations of the consultation meetings.

FOR FURTHER INFORMATION CONTACT: Mr. Kenneth Whitehorn or Georgia Braun, 202–208–4976.

SUPPLEMENTARY INFORMATION: The meetings are a follow-up to similar meetings conducted by the Office of Indian Education Programs since 1990. The purpose of the consultation, as required by 25 U.S.C. 2010(b), is to provide Indian tribes, school boards, parents, Indian organizations, and other interested parties an opportunity to comment on potential issues raised during previous consultation meetings or issues being considered by the BIA regarding Indian education programs.

The potential issues which will be set forth in a tribal consultation booklet to be issued prior to the meetings are as follows:

(1) Charter Schools;

(2) Program Management Funding for Facilities;

(3) Transfer Facilities Construction Project Management Funds from the Office of Facilities Management and Construction to the Office of Indian Education Programs;

(4) Other Consultation Items;
(5) Form a Separate Rental Receipts Account in the Federal Finance System;
(6) ''Open Season'' for All New Facilities Space Activities;
(7) Comprehensive Federal Indian Draft Policy; and (8) Indian Student Equalization Program.

A consultation booklet for the July meetings is being distributed to federally-recognized Indian tribes, Bureau Regional and Agency Offices, and Bureau-funded schools. The booklets will also be available from local contact persons at each meeting.

Consultations

We will hold consultations at the following locations on the dates specified:

Date	Location	Local contact	Phone numbers
July 11, 2000	Espanola, NM	Ed Parisian	(505) 753–1465
July 11, 2000	Spokane, WA	LaVonne French	(406) 247–7953
		John Reimer	(503) 872–2743
July 13, 2000	Fort Yates, ND	Cherie Farlee	(605) 964–8722
July 13, 2000	Collinsville, IL	LaVonna Weller	(703) 235–3233
July 13, 2000	Green Bay, IL	Terry Portra	(612) 713–4400
July 18, 2000	Mesa, AZ	Robert Chiago	(602) 379–3944
July 20, 2000	Gallup, NM	Larry Holman	(505) 786–6150
July 21, 2000	Oklahoma City, OK	Joy Martin	(405) 605–6051
July 21, 2000	Anchorage, AK	Robert Pringle	(907) 271–4120
July 21, 2000	San Diego, CA	Fayetta Babby	(916) 978–6057

Written Comments

Comments, including names, street addresses, and other contact information of respondents, will be available for public review at the address listed under **ADDRESSES** section during regular business hours (7:45 a.m. to 4:15 p.m. EST), Monday through Friday, except Federal holidays. Individual respondents may request confidentiality. If you wish us to withhold your name, street address, and other contact information (such as fax or phone number) from public review or from disclosure under the Freedom of Information Act, you must state this prominently at the beginning of your comment. We will honor your request to the extent allowable by law. We will make available for public inspection in their entirety all submissions from organizations or businesses, and from individuals identifying themselves as representatives or officials of organizations or businesses.

This notice is published in accordance with the authority delegated by the Secretary of the Interior to the Assistant Secretary—Indian Affairs by 209 DM 8.

Dated: June 23, 2000.

Kevin Gover,

Assistant Secretary—Indian Affairs.

[FR Doc. 00–16447 Filed 6–28–00; 8:45 am]

BILLING CODE 4310–02–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[WY–920–00–1320–EL, WYW141435]

Horse Creek Coal Lease Application, Wyoming

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of Availability (NOA) of Record of Decision.

SUMMARY: The Bureau of Land Management (BLM) announces the availability of the Record of Decision (ROD) for the Environmental Impact Statement (EIS) for the Horse Creek Coal Lease Application. That EIS analyzes the potential impacts of leasing and mining Federal coal on lands in Campbell County, Wyoming. BLM's decision was to approve the Selected Alternative, which analyzed the impacts of offering for competitive lease sale approximately 2,819 acres containing approximately 356 million tons of in-place Federal coal.

BLM received 13 written comments during the two scoping periods on the Horse Creek lease application. These comments are on file in the Casper and Cheyenne offices of the BLM. Nine written comments were received on the draft EIS, and these were included, with written responses, in the final EIS. The transcript of the formal hearing is on file in the Casper and Cheyenne Offices of the BLM. One written comment was received on the final EIS. All comments that were received during the process were considered in the preparation of the draft and final EIS's, and in the ROD.

BLM NOAs for the draft EIS and for the final EIS for this project were published in the **Federal Register** on November 12, 1999 (64 FR 61635), and on May 19, 2000 (65 FR 31898), respectively.

DATES: The ROD was signed by the Associate State Director on June 23, 2000. Parties in interest have the right to appeal that decision pursuant to 43 CFR part 4, within 30 days from the date of publication of this NOA in the **Federal Register**. The ROD contains instructions on taking appeals to the Interior Board of Land Appeals.

FOR FURTHER INFORMATION CONTACT: Melvin Schlagel, 307–775–6257. Copies of the ROD may be obtained from the following BLM offices: Casper Field Office, 2987 Prospector Drive, Casper, Wyoming 82604, 307–261–7600 and Wyoming State Office, 5353 Yellowstone Road, Cheyenne, Wyoming 82009, 307–775–6256.

Dated: June 23, 2000.

Phil Perlewitz,

Acting Deputy State Director, Minerals and Lands Authorization.

[FR Doc. 00–16439 Filed 6–28–00; 8:45 am]

BILLING CODE 4310–22–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CO–930–1430–ET; COC–28584]

Public Land Order No. 7453; Opening of Land Under Section 24 of the Federal Power Act; Colorado

AGENCY: Bureau of Land Management, Interior.

ACTION: Public Land Order.

SUMMARY: This order opens, subject to the provisions of Section 24 of the Federal Power Act, 40 acres of public land withdrawn by an Executive order which established Bureau of Land Management Power Site Reserve No. 92. This action will permit consummation of a pending land exchange and retain the power rights to the United States. The land has been and will remain open to mineral leasing and, under the provisions of the Mining Claims Rights Restoration Act of 1955, to mining.

EFFECTIVE DATE: September 28, 2000.

FOR FURTHER INFORMATION CONTACT: Doris E. Chelius, BLM Colorado State Office, 2850 Youngfield Street, Lakewood, Colorado 80215–7093, 303–239–3706.

By virtue of the authority vested in the Secretary of the Interior by the Act of June 10, 1920, Section 24, as amended, 16 U.S.C. 818 (1994), and pursuant to the determination of the Federal Energy Regulatory Commission in DVCO–556–000, it is ordered as follows:

1. At 9 a.m. on September 28, 2000, the following described public land withdrawn by the Executive Order dated July 2, 1910, which established Power Site Reserve No. 92, will be opened to disposal subject to the provisions of Section 24 of the Federal Power Act as specified by the Federal Energy Regulatory Commission determination DVCO–556–000, and subject to valid existing rights, the provisions of existing withdrawals, other segregations of record, and the requirements of applicable law:

Sixth Principal Meridian

T. 15 S., R. 78 W.,
Sec. 10, NW¼NE¼.

The area described contains 40 acres in Chaffee County.

2. The State of Colorado has a preference right for public highway rights-of-way or material sites for a period of 90 days from the date of publication of this order and any location, entry, selection, or subsequent patent shall be subject to any rights granted the State as provided by the Act of June 10, 1920, Section 24, as amended, 16 U.S.C. 818 (1994).

Dated: June 2, 2000.

Sylvia V. Baca,

Assistant Secretary of the Interior.

[FR Doc. 00–16460 Filed 6–28–00; 8:45 am]

BILLING CODE 4310–JB–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[ID–933–1430–ET; IDI–33168]

Public Land Order No. 7456; Withdrawal for the Burley Administrative Site; Idaho

AGENCY: Bureau of Land Management, Interior.

ACTION: Public land order.

SUMMARY: This order withdraws 19.09 acres of public land from surface entry and mining for a period of 20 years to protect the Bureau of Land Management's Burley Administrative Site. The land has been and will remain open to mineral leasing.

EFFECTIVE DATE: June 29, 2000.

FOR FURTHER INFORMATION CONTACT: Jackie Simmons, BLM Idaho State Office, 1387 S. Vinnell Way, Boise, Idaho 83709, 208–373–3867.

By virtue of the authority vested in the Secretary of the Interior by Section 204 of the Federal Land Policy and Management Act of 1976, 43 U.S.C. 1714 (1994), it is ordered as follows:

1. Subject to valid existing rights, the following described public land is hereby withdrawn from settlement, sale, location, or entry, under the general land laws, including the United States mining laws (30 U.S.C., Ch. 2 (1994)), but not from leasing under the mineral leasing laws, to protect the Bureau of Land Management's Burley Administrative Site:

Boise Meridian

A parcel of land lying in the E½SW¼ of sec 32, T. 10 S., R. 23 E., the said parcel being more particularly described as follows:

Beginning at a point 1500.4 feet north and 33.0 feet west of the quarter section corner common to sec. 32, T. 10 S., R. 23 E., and sec. 5, T. 11 S., R. 23 E., said point being on the west right-of-way line of State Highway No. 27; thence N. 0°22′03″ E. along the highway right-of-way a distance of 515.12 feet; thence N. 89°27′57″ W. a distance 1184.19 feet to the centerline of the U.S.R.S. ''H'' Canal; thence S. 35°17′24″ W. along the canal centerline a distance of 80.64 feet; thence S. 21°20′41″ W. along the canal centerline a distance of 89.13 feet; thence S. 11°08′55″ W. along the canal centerline a distance of 221.23 feet to the west quarter section boundary of said sec. 23; thence S. 0°18′27″ E. along the quarter section boundary 501.81 feet; thence S.89°26′03″ E. a distance of 496.15 feet ; thence N. 0°36′56″ E. a distance of 355.45 feet; thence S.89°21′29″ E. a distance of 800 feet to the point of beginning.

The area described contains 19.09 acres, more or less, in Cassia County.

2. The withdrawal made by this order does not alter the applicability of those public land laws governing the use of the land under lease, license, or permit, or governing the disposal of the mineral or vegetable resources other than under the mining laws.

3. This withdrawal will expire 20 years from the effective date of this order, unless as a result of a review conducted before the expiration date pursuant to section 204(f) of the Federal Land Policy and Management Act of 1976, 43 U.S.C. 1714(f) (1994), the Secretary determines that the withdrawal shall be extended.

Dated: June 7, 2000.

Sylvia V. Baca,

Assistant Secretary of the Interior.

[FR Doc. 00–16458 Filed 6–28–00; 8:45 am]

BILLING CODE 4310–GG–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[ID–933–1430–01; IDI–15518, IDI 15557]

Public Land Order No. 7454; Partial Revocation of Secretarial Orders dated September 27, 1909 and August 12, 1912; Idaho

AGENCY: Bureau of Land Management, Interior.

ACTION: Public land order.

SUMMARY: This order partially revokes two Secretarial orders insofar as they affect 7.5 acres of land withdrawn for use by the Bureau of Reclamation for the Minidoka Reclamation Project. The land is no longer needed for the purpose for which it was withdrawn. The land has been conveyed out of Federal ownership pursuant to Public Law 105–351. This action is for record clearing purposes only.

EFFECTIVE DATE: June 29, 2000.

FOR FURTHER INFORMATION CONTACT: Jackie Simmons, BLM Idaho State Office, 1387 S. Vinnell Way, Boise, Idaho 83709, 208–373–3867.

By virtue of the authority vested in the Secretary of the Interior by Section 204 of the Federal Land Policy and Management Act of 1976, 43 U.S.C. 1714 (1994), it is ordered as follows:

1. Secretarial Orders dated September 27, 1909 and August 12, 1912, which withdrew public land for the Minidoka Reclamation Project, are hereby revoked insofar as they affect the following described land:

Boise Meridian

T. 10 S., R. 25 E.,
Sec. 30, S½S½SW¼NE¼NW¼ and N½NW¼SE¼NW¼.

The area described aggregates 7.5 acres in Cassia County.

Dated: June 2, 2000.

Sylvia V. Baca,

Assistant Secretary of the Interior.

[FR Doc. 00–16459 Filed 6–28–00; 8:45 am]

BILLING CODE 4310–GG–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CA–160–1220–AF]

Notice of Proposed Supplementary Rules for Public Land in Eastern Tulare County

AGENCY: Bureau of Land Management, Interior.

ACTION: Proposed supplementary rules.

SUMMARY: The Bureau of Land Management (BLM), Bakersfield (California) Field Office proposes the rules listed below to protect natural resources and provide for the safety of visitors, and property on public land located in eastern Tulare County adjacent to the towns of Three Rivers and Hammond, California. These supplementary rules will be posted on public land in the applicable areas and made available at the Bakersfield Field Office. The policy of the Department of Interior is, whenever practicable, to afford the public an opportunity to participate in the rulemaking process. Accordingly, BLM invites interested persons to submit written comments, suggestions, or objections regarding the proposed supplementary rules to the location identified in the **ADDRESSES** section of this preamble.

ADDRESSES: Mail or hand deliver comments to Field Office Manager, Bureau of Land Management, Bakersfield Field Office, 3801 Pegasus Drive, Bakersfield, CA 93308; telephone (661) 391–6120.

Supplementary Rules

Pursuant to 43 CFR 8365.1–6 (Supplementary Rules), 43 CFR 8364.1 (Closure and restriction orders), and 8341.2 (Special rules) the following supplementary rules are in effect on public land managed by the BLM within Case Mountain/Milk Ranch Peak area defined as: Township 17 South, Range 29 East, MDB&M and Township 18 South, Range 29 East, MDB&M or the North Fork of the Kaweah Special Management Area defined as: Township 15 South, Range 28 East, MDB&M; Township 16 South, Range 28 East, MDB&M; and, Township 17 South, Range 28 East, MDB&M.

A. Target shooting is permitted within the Case Mountain/Milk Ranch Peak area provided that the firearm is discharged toward a proper backstop sufficient to stop the projectile's forward progress beyond the intended target. Target shooting may not occur within one mile of any private residence or occupied structure. Targets shall be constructed of cardboard and paper or similar non-breakable materials. All targets must be removed and properly discarded after use. No projectile may be intentionally fired into any tree.

B. All roads, trails, and routes of travel on public land within the North Fork of the Kaweah Special Management Area are closed to off-highway vehicles registered or identified under Section 38020 of the California Vehicle Code except as permitted by the Authorized Officer.

C. All roads, trails, and routes of travel within the Case Mountain/Milk Ranch Peak area are closed to the operation of any motor vehicle, except for access to private real estate by property owners or persons they designate as having access to their property, public employees, public agency volunteers in the course of their duties, or such access as authorized under permit, easement, or lease by the authorized officer.

D. The operation of motor vehicles within the North Fork of the Kaweah Special Management Area is limited to designated roads. Designated roads include roads maintained by federal, state, or local government, roads leading to parking areas created by the BLM, Shepherd's Saddle Road, and Overlook Road. Overlook Road extends west from Shepherd's Saddle Road 0.8 miles from the intersection of Shepherd's Saddle Road and North Fork Drive. Designated roads may not be used for off-highway vehicle free-play. Vehicles may not be parked in a way which restricts the flow of traffic through parking areas or on roads. Vehicles parked in a way which obstructs other passenger vehicles or fire vehicles may be towed and stored at the owner's expense.

E. Within the Case Mountain/Milk Ranch Peak area, and the North Fork of the Kaweah Special Management Area, property may not be left unattended for more than three days without the prior approval of the Authorized Officer. Any such unattended property will be considered abandoned, and may be removed and stored by law enforcement personnel at the owner's expense.

F. Within the Case Mountain/Milk Ranch Peak area, and the North Fork of the Kaweah Special Management Area, all litter, trash, and refuse must be kept within a container or receptacle and removed when leaving public land. Litter, waste, or refuse may not be thrown onto or stored on the ground.

G. Within the Case Mountain/Milk Ranch Peak area, and the North Fork of the Kaweah Special Management Area, a permit or written authorization from BLM shall be required for all research activities which involve the taking, or placement of, any natural or man-made object, thing, plant, or animal on these lands. A permit or written authorization shall also be required if the research involves the disturbance of any animal, plant, cultural or historic resource, soil, or federal property. Restrictions regarding the disturbance of animal and plant resources do not apply to the California Department of Fish and Game or the U.S. Fish and Wildlife Service as long as the activities are in accordance with their trustee responsibilities for managing wildlife resources. Leisure activities such as astronomy, or bird watching are not intended to be covered by this supplementary rule.

H. Within the Case Mountain/Milk Ranch Peak area, a state of California Fire Permit is required for any camping, cooking, or warming fire ignited on these lands. Portable gas or propane stoves are exempted from this requirements. If any more restrictive fire provisions are established by any governing authority or public officer having jurisdiction, then persons must comply with these.

I. Within the Case Mountain/Milk Ranch Peak area, and the North Fork of the Kaweah Special Management Area, all laws of the State of California applicable to the possession, use, or distribution of controlled substances and/or the protection of persons or property are in effect. These laws may not be violated by any person.

J. Within the Case Mountain/Milk Branch Peak area and the North Fork of the Kaweah Special Management Area, no person may be under the influence of a controlled substance. No person may be under the influence of alcohol to the extent that their ability to be responsible for their own safety is impaired.

SUPPLEMENTARY INFORMATION: The above supplementary rules are being implemented for the following purposes: The above defined lands contain valuable watershed resources, groves of Sequois Trees, and regionally significant recreational resources. Improved public access through acquired easements has increased visitation. These supplementary rules are effected to maintain the area's traditional uses consistent with hiking, bicycle riding, equestrian use, and other low impact recreational activities. The concerns of local residents and property

owners are also addressed by these supplementary rules.

This order is in no way intended to affect the rights or existing privileges of private land owners or their interests within the defined public land. Existing public easements, county roads, state highways, private lanes or driveways, and private real estate is exempt from these supplementary rules. Further, this order does not infer any Bureau of Land Management jurisdiction over private or state owned lands. These supplementary rules will be in effect until replaced by a more comprehensive recreational management plan for the areas. These supplementary rules are in compliance with the Caliente Resource Management Plan of May 1997.

Federal, State, and local law enforcement officers and California peace officers, as defined in Chapter 4.5 of the California Penal Code, are exempt from these supplementary rules in the course of their official duties. Limitations upon the use of motorized vehicles do not apply to emergency vehicles, fire suppression and rescue vehicles, law enforcement vehicles, and other vehicles performing official duties, or as approved by an authorized officer of the BLM.

These supplementary rules will take effect following review of public comment, and publication as final supplementary rule making in the **Federal Register**.

Penalties

The authorities for these closures and supplementary rules are 43 CFR 8341.2, 8364.1, and 8365.1–6. Violations of these supplementary rules are punishable by fines of up to $1,000 and/or imprisonment not to exceed 12 months as well as the penalties provided under State law.

FOR MORE INFORMATION CONTACT. Ronald D. Fellows, Bureau of Land Management, Bakersfield Field Officer Manager, 3801 Pegasus Drive, Bakersfield, CA 93308

Dated: June 23, 2000.

Ron Fellows,

Field Office Manager, Bakersfield Field Office.

[FR Doc. 00–16462 Filed 6–28–00; 8:45 am]

BILLING CODE 4310–40–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CO–930; COC–60653]

Notice of Meeting on Proposed Withdrawal; Spanish Peaks Planning Area; Colorado

June 20, 2000.

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of public meeting.

SUMMARY: This notice sets forth the schedule and agenda for a forthcoming meeting on the Forest Service withdrawal application for the Spanish Peaks Planning Area for the protection of natural resources. This meeting will provide the opportunity for public involvement in this proposed action as required by regulation. All comments will be considered when a final determination is made on whether this land should be withdrawn.

DATES: Meeting will be held on September 12, 2000, at 7:00 p.m. All comments or requests to be heard should be received by close of business on September 7, 2000, at the Colorado State Office.

ADDRESSES: The meeting will be held at the Walsenburg Community Center, Walsenburg, Colorado, 81089.

FOR FURTHER INFORMATION CONTACT: Doris E. Chelius, BLM Colorado State Office, (303) 239–3706.

SUPPLEMENTARY INFORMATION: The Notice of Proposed Withdrawal for the Spanish Peaks Planning Area which was published in the **Federal Register** on June 20, 1997, (62 FR 33675), is hereby modified to schedule a public meeting as provided by 43 U.S.C. 1714, and 43 CFR 2310.

This meeting will be open to all interested persons; those who desire to be heard in person and those who desire to submit written comments on this subject. All comments and requests to be heard should be submitted to the Colorado State Director, Bureau of Land Management, 2850 Youngfield Street, Lakewood, Colorado 80215–7093, by September 7, 2000.

Herbert K. Olson,

Acting Realty Officer.

[FR Doc. 00–16464 Filed 6–28–00; 8:45 am]

BILLING CODE 3410–11–P

DEPARTMENT OF THE INTERIOR

National Park Service

60 Day Notice of Intention To Request Clearance of Collection of Information; Opportunity for Public Comment

AGENCY: Department of the Interior, National Park Service, Urban and Adjacent Parks.

ACTION: Notice and request for comments.

SUMMARY: The National Park Service (NPS) is proposing in 2000 and 2001 to conduct surveys of persons living in the metropolitan areas of Boston, MA, Los Angeles, CA, Miami, FL, and New Orleans, LA where the following urban national parks are located: Boston African-American National Historic Site, Santa Monica Mountains National Recreation Area, Biscayne National Park, and Jean Lafitte National Historical Park and Preserve. In these surveys, persons will be asked about their knowledge of the urban national park located in their metropolitan area, and their familiarity with community outreach efforts that the urban national park has instituted.

URBAN NATIONAL PARK COMMUNITY OUTREACH SURVEY

Estimated numbers of	
Responses	Burden hours
400	200

Under provisions of the Paperwork Reduction Act of 1995 and 5 CFR part 1320, Reporting and Recordkeeping Requirements, the National Park Service is soliciting comments on the need for gathering the information in the proposed surveys. The NPS also is asking for comments on the practical utility of the information being gathered; the accuracy of the burden hour estimate; ways to enhance the quality, utility, and clarity of the information to be collected; and ways to minimize the burden to respondents, including use of automated information collection techniques or other forms of information technology.

The NPS goal in conducting these surveys is to assess the effectiveness of community outreach programs of urban national parks to residents within selected metropolitan areas

DATES: Public comments will be accepted on or before August 28, 2000.

SEND COMMENTS TO: Ronald J. Vogel, Nelson Mandela School of Public Policy, Higgins Hall, Southern

University, Baton Rouge, LA 70813–0400.

FOR FURTHER INFORMATION CONTACT: Ronald J. Vogel. Voice: 225–771–3103, e-mail: *ron@idsmail.com*.

SUPPLEMENTARY INFORMATION:

Titles: NPS Urban and Adjacent Parks: Assessment and Development of Community Outreach

Bureau Form Number: None.

OMB Number: To be requested.

Expiration date: To be requested.

Type of request: Request for new clearance.

Description of need: The National Park Service needs information to assess the effectives of community outreach programs in reaching residents who live near urban national parks.

Automated data collection: At the present time, there is no automated way to gather this information because it includes asking residents for determinations on effectiveness and awareness of select programs developed by individual parks.

Description of respondents: Persons residing in the metropolitan areas of Boston, MA, Los Angeles, CA, Miami, FL and New Orleans LA.

Estimated average number of respondents: 400 (100 per above metropolitan area).

Estimated average number of responses: Each respondent will respond only one time, so the number of responses will be the same as the number of respondents.

Estimated average burden hours per response: 30 minutes.

Frequency of response: 1 time per respondent.

Estimated annual reporting burden: 200 hours.

Dated: June 23, 2000.

Betsy Chittenden,

Information Collection Clearance Officer, WASO Administrative Program Center, National Park Service.

[FR Doc. 00–16521 Filed 6–28–00; 8:45 am]

BILLING CODE 4310–70–M

INTERNATIONAL TRADE COMMISSION

[Investigation No. 731–TA–856 (Final)]

Certain Ammonium Nitrate From Russia

AGENCY: United States International Trade Commission.

ACTION: Suspension of investigation.

SUMMARY: On June 16, 2000, the Department of Commerce published notice in the **Federal Register** of the suspension of its antidumping investigation on certain ammonium nitrate from Russia (65 FR 37759). The basis for the suspension is an agreement between the Department of Commerce and the Ministry of Trade of the Russian Federation accounting for substantially all imports of ammonium nitrate from Russia, wherein the Ministry of Trade has agreed to restrict exports of ammonium nitrate from all Russian producers/exporters to the United States and to ensure that such exports are sold at or above the agreed reference price. Accordingly, the U.S. International Trade Commission gives notice of the suspension of its antidumping investigation involving imports from Russia of certain ammonium nitrate, provided for in subheading 3102.30.00 of the Harmonized Tariff Schedule of the United States.

EFFECTIVE DATE: June 16, 2000.

FOR FURTHER INFORMATION CONTACT: Karen Taylor (202–708–4101), Office of Investigations, U.S. International Trade Commission, 500 E Street SW, Washington, DC 20436. Hearing-impaired individuals are advised that information on this matter can be obtained by contacting the Commission's TDD terminal on 202–205–1810. Persons with mobility impairments who will need special assistance in gaining access to the Commission should contact the Office of the Secretary at 202–205–2000. General information concerning the Commission may also be obtained by accessing its internet server (http://www.usitc.gov).

Authority: This investigation is being suspended under authority of title VII of the Tariff Act of 1930; this notice is published pursuant to section 207.40 of the Commission's rules (19 CFR 207.40).

Issued: June 23, 2000.

By order of the Commission.

Donna R. Koehnke,

Secretary.

[FR Doc. 00–16524 Filed 6–28–00; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Pursuant to the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as Amended

In accordance with Departmental policy, 28 CFR 50.7, 38 FR 19029, and 42 U.S.C. 9622(d), notice is hereby given that on June 14, 2000, a proposed Consent Decree (''Decree'') in the consolidated cases entitled *United States* v. *Western Publishing Co., Inc., et al.,* Civil Action No. 94–CV–1247 and *State of New York* v. *F.I.C.A. a/k/a Dutchess Sanitation Services, Inc., et al.,* Civil Action No. 86–CV–1136 (LEK/DNH) was lodged with the United States District Court for the Northern District of New York. The proposed Consent Decree will resolve the United States' claims, on behalf of the U.S. Environmental Protection Agency (''EPA''), and the claims of the State of New York (''State'') under the Comprehensive Environmental Response, Compensation, and Liability Act (''CERCLA''), 42 U.S.C. 9601 *et seq.,* against defendants F.I.C.A. and the Estate of Joseph Fiorillo, Sr., as well as potential claims against Joseph Fiorillo, Jr., relating to response costs incurred and to be incurred in connection with the Hertel Landfill Superfund Site (''Site''), located in the Hamlet of Clintondale, Town of Plattekill, Ulster County, New York. The United States and the State of New York alleged in their Complaints that the defendants are liable as successors in interest to Dutchess Sanitation Services, Inc., as owners and/or operators of the Site and as transporters of hazardous substances to the Site pursuant to Section 107(a) of CERCLA, 42 U.S.C. 9607(a).

Under the terms of the Decree, the settling parties will make a cash payment of $50,000, to be divided equally between the United States and certain prior settling parties currently performing EPA's selected remedy at the Site (''performing parties''), within 5 days of execution of the Decree by the United States. The F.I.C.A. settling parties shall also permit and cooperate in the sale of various parcels of real property owned by the F.I.C.A. partnership, proceeds from which are to be paid, after deduction of real estate closing costs and satisfaction of back property taxes, equally to the United States and the performing parties. Terms of the sales of the properties are subject to the approval of the United States and the performing parties. The Decree further provides that the United States shall designate $60,000 of its share of the proceeds to be applied as a civil penalty and punitive damages, pursuant to sections 106(b)(1) and 107(c)(3) of CERCLA, 42 U.S.C. 9606(b)(1) and 9607(c)(3), in satisfaction of the United States' claim that F.I.C.A. failed or refused to comply with Administrative Order No. II CERCLA–20217 in connection with the Site. Within 30 days of entry of the Decree, F.I.C.A. will pay the State $2,000 in satisfaction of the State's claim for reimbursement of its response costs at the Site. The

proposed partial consent decree provides the settling defendants with releases for civil liability under sections 106 and 107(a) of CERCLA relating to the Site through construction of the landfill cap as consideration for the payments to be made.

The Department of Justice will receive, for a period of thirty (30) days from the date of this publication, comments relating to the proposed Decree. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, U.S. Department of Justice, Washington, DC 20530, and should refer to *United States* v. *Western Publishing Co., Inc., et al.,* Civil Action No. 94–CV–1247 and *State of New York* v. *F.I.C.A. a/k/a Dutchess Sanitation Services, Inc., et al.,* Civil Action No. 86–CV–1136 (LEK/DNH) (N.D.N.Y.), DOJ Ref. No. 90–11–2–767a.

The proposed Decree may be examined at the Office of the United States Attorney, 445 Broadway, Room 231, Albany, New York 12207 and at the Region II Office of the Environmental Protection Agency, 290 Broadway, New York, New York 10007–1866. A copy of the Decree may also be obtained by mail from the Consent Decree Library, Department of Justice, P.O. Box 7611, Washington, DC 20044–7611. In requesting a copy, please refer to the referenced case and enclose a check in the amount of $11.00 (25 cents per page reproduction costs) made payable to Consent Decree Library.

Bruce S. Gelber,

Deputy Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 00–16466 Filed 6–28–00; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Antitrust Division

Notice Pursuant to the National Cooperative Research and Production Act of 1993—AAF Association, Inc.

Notice is hereby given that, on March 28, 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''), AAF Association, Inc. 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 Avid Technology, Tewksbury, MA; British Broadcasting Corporation, Tadworth, Surrey, UNITED KINGDOM; CNN/Turner Broadcasting Systems, Atlanta, GA; Discreet Logic, Montreal, CANADA; Matrox, Quebec, CANADA; Microsoft Corporation, Playa Del Rey, CA; Sony Corporation, San Jose, CA; Pinnacle, Mountain View, CA; Quantel, Newbury, Berkshire, UNITED KINGDOM; U.S. National Imaging & Mapping Agency, Reston, VA; and 4MC, Burbank, CA. The nature and objectives of the venture are to promote the development and adoption of open, accessible standards and specifications relating to file interchange formats, including initially the Advanced Authoring Format (collectively, the ''Specifications''); to promote such Specifications worldwide; to provide for testing and conformity assessment of implementations in order to ensure compliance with Specifications; to create and own distinctive trademarks; if advisable, to operate a branding program to create high customer awareness of, demand for, and confidence in products designed in compliance with Specifications; and to undertake such other activities as may from time to time be appropriate to further the purposes and achieve the goals set forth above.

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16467 Filed 6–28–00; 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—Application Service Provider Industry Consortium, Inc.

Notice is hereby given that, on January 19, 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''), Application Service Provider Industry Consortium, Inc. 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, NightFire Software, Inc., Berkeley, CA; access-esolutions.com, Pittsburgh, PA; Campio Communications, Inc., Milpitas, CA; Concord Communications, Inc., Marlboro, MA; iRenaissance Inc., Research Triangle Park, NC; Allied Riser Communications (ARC), Dallas, TX; Novell, Orem, UT; Universal, Marlton, NJ; Cyrus Intersoft, Inc., Minneapolis, MN; Teleias, Toronto, ONTARIO, CANADA; ezCRM.com, Ramat Gan, ISRAEL; Mindbridge.com, Fort Washington, PA; PubNETics, Inc., Denver, CO; Oracle Corporation, Redwood Shores, CA; Rhythms NetConnections, Englewood, CO; Fujitsu Siemens Computers, Paderborn, GERMANY; Corel Corporation, Ottawa, CANADA; TEKsystems, Inc., Hanover, MD; PSINet, Herndon, VA; ASP Industry Consortium Japan, Minato-Ku Tokyo, JAPAN; Instinctive Technology, Inc., Cambridge, MA; Wyzdom Solutions, Inc., San Francisco, CA; Inprise Borland, Scotts Valley, CA; Encentris Corporation, Dallas, TX; HydraWEB Technologies, New York, NY; Paramount Technologies, Inc., Southfield, MI; XOR Network Engineering, Boulder, CO; Intelligroup, Inc., Edison, NJ; AccTrak21 Inc., Santa Clara, CA; Paradigm 3, San Jose, CA; MDIS Group plc, Hemel Hempstead, Hertfordshire, UNITED KINGDOM; enCommerce, Santa Clara, CA; Computer Associates' interBiz Financial Group, Fort Lee, NJ; 2WAY Corporation, Seattle, WA; aspective, Huntingdon, Cambridgeshire, UNITED KINGDOM; Raymond James & Associates, St. Petersburg, FL; Candle Corporation, El Segundo, CA; casecentral.com, Inc., San Francisco, CA; CobWeb, Inc., Issaquah, WA; Eftia OSS Solutions, Ottawa, CANADA; Optika, Inc., Colorado Springs, CO; Sideware Systems Inc., North Vancouver, British Columbia, CANADA; Quest Software, Irvine, CA; Thintelectron Service Laboratories, Ormond Beach, FL; Managed Object Solutions, Inc., Fairfax, VA; Infinium, Hyannis, MA; CITEC, Brisbane, Queensland, AUSTRALIA; Nextron Communications, San Jose, CA; Push Computing, Inc., Santa Barbara, CA; Conference Plus, Inc., Schaumberg, IL; EINSTEINet AG, Elmshorn, GERMANY; Netegrity, Waltham, MA; Vertical Networks, Sunnyvale, CA; Seven Mountains Software, Inc., San Mateo, CA; Micronpc.com, Nampa, ID; NTT Software Corporation, Palo Alto, CA; PlaceWare, Inc., Mountain View, CA; LASON, Inc., Troy, MI; Sterling Commerce-MSD, Atlanta, GA; LearnLinc Corporation, Troy, NY; APELDORN'S Communication & Information Tech GmbH, Bad Homburg, GERMANY; apps4biz.com, Andover,

MA; TRW, Reston, VA; The viaLink Company, Edmond, OK; Portal Software, Inc., Cupertino, CA; Excalibur Technologies Corp., Vienna, VA; Illuminet, Olympia, WA; Personable.com Inc., Fountain Valley, CA; MSHOW.com, Littleton, CO; DSL.net, Inc., New Haven, CT; CrossKeys, Kanata, Ontario, CANADA; TexSys RD, Irving, TX; Network-1 Security Solutions, Inc., Waltham, MA; ThinRetail, Inc., Seattle, WA; Network Integration Solutions, Inc., Seattle, WA; Orcom Solutions, Inc., Bend, OR; Who?Vision, Lake Forest, CA; InfoCast Corporation, Toronto, Ontario, CANADA; CWHKT, Sheung Wan, HONG KONG; Objective Systems Integrators, Inc., Folsom, CA; REL-TEK Systems & Design, Inc., Rockville, MD; Exclaim Technologies, Inc., San Jose, CA; Science Applications International Corp., San Diego, CA; NetToll, Issy les Moulineaux, Cedex, France; Voyant Technologies, Westminster, CO; BusinessEdge Solutions, Edison, NJ; Eltrax Systems Inc., Atlanta, GA; Top Layer Networks, Westboro, MA; Canopy International, Newton, MA; ZLand.com, Aliso Viejo, CA; InfoCure, Atlanta, GA; Commtouch Software, Inc., Santa Clara, CA; appe-e.com, Laval, Quebec, CANADA; InsynQ, Inc., Tacoma, WA; Eprise Corporation, Framingham, MA; SOFTRAX Corporation, Canton, MA; InterClient, Co Dublin, IRELAND; JSB Corporation, Scotts Valley, CA; Newmoon.com, San Jose, CA; eNABLE Solutions, Irvine, CA; NetNation Communications Inc., Vancouver, British Columbia, CANADA; Response Networks, Inc., Alexandria, VA; RDS srl, Parma, ITALY; SilverBack Technologies, Inc., Billerica, MA; Intesa, Caracas, VENEZUELA; Teleglobe Communications, Reston, VA; Rackspace.com, San Antonio, TX; Atreus Systems Corporation, Ottawa, Ontario, CANADA; City Reach International, London, UNITED KINGDOM; Aplion Networks, Piscataway, NJ; Cosaweb Inc., Downer's Grove, IL; Modus Novo, Lod, ISRAEL; JurisdictionUSA, Phoenix, AZ; Remedy Corporation, Mountain View, CA; cMeRun Corp, Kirkland, WA; AppStream, Inc., Mountain view, CA; Zantaz.com, Pleasanton, CA; Nexus Technology Inc., Des Plaines, IL; ObjectSwitch, San Rafael, CA; ASPEC 2000, Atlanta, GA; FirstWorld, Greenwood Village, CO; Marathon Technologies Corporation, Boxborough, MA; @mobile.com, Bellevue, WA; Cabletron Systems, Inc., Rochester, NH; Center7, Inc., Lindon, UT; Chell.com, Calgary, Alberta, CANADA; Maxspeed Corporation, Palo Alto, CA; Active Software, Santa Clara, CA; CinApps, division of Cincom Systems, Inc., Cincinnati, OH; Computron Software, Inc., Rutherford, NJ; Deltek Systems, Inc., McLean, VA; eGain Communications Corp., Sunnyvale, CA; Informative, Inc., S. San Francisco, CA; International Software Solutions, Inc., Herndon, VA; and New Edge Networks, Vancouver, WA have been added as parties to this venture. Also, the following members have changed their corporate names: SPG to Spirian Technologies, Inc., Chicago, IL; and NexBase to diCarta, Inc., Redwood City, CA.

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 Application Service Provider Industry Consortium, Inc. intends to file additional written notification disclosing all changes in membership.

On July 28, 1999, Application Service Provider Industry Consortium, Inc. filed its original notification pursuant to section 6(a) of the Act. A notice has not yet been published in the **Federal Register**.

The last notification was filed with the Department on October 21, 1999. A notice has not yet been published in the **Federal Register**.

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16470 Filed 6–28–00; 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—CommerceNet Consortium, Inc.

Notice is hereby given that, on March 31, 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''), CommerceNet Consortium, Inc. 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, Wyzdom Solutions, Inc., San Francisco, CA; Woodside Labs, Inc., Redwood City, CA; Enigma, Inc., Burlington, MA; Electron Economy, Cupertino, CA; and RAM Consulting Services, Poolesville, MD have joined the Consortium as Portfolio members.

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 CommerceNet Consortium, Inc. intends to file additional written notification disclosing all changes in membership.

On June 13, 1994, CommerceNet Consortium, Inc. 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 31, 1994 (59 FR 45012).

The last notification was filed with the Department on February 4, 2000. A notice has not yet been published in the **Federal Register.**

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16476 Filed 6–28–00; 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—CommerceNet Consortium, Inc.

Notice is hereby given that, on January 14, 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''), CommerceNet Consortium, Inc. (the ''Consortium'') 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, EComXML, Inc., Washington Crossing, PA; and FabLink.com, Colorado Springs, CO have joined the Consortium as Core members. TIBCO Software, Inc., Palo Alto, CA has joined the Consortium as a Portfolio member. Also, Trusted Information Systems, Inc., Glenwood, MD; Marshall Industries, San Diego, CA; ChannelPoint, Inc., Colorado Springs, CO; Keynote Systems, Inc., San Mateo, CA; CompuCom Systems, Dallas, TX; Allaire Corporation, Cambridge, MA; and American Power Conversion, West Kingston, RI 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. Memership in this group research project remains open, and CommerceNet Consortium, Inc. intends to file additional written notification disclosing all changes in membership.

On June 13, 1994, CommerceNet Consortium, Inc. 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 31, 1994 (59 FR 45012).

The last notification was filed with the Department on December 2, 1999. A notice has not yet been published in the **Federal Register**.

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16485 Filed 6–28–00; 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—Corporation for National Research Initiatives: Cross Industry Working Team (''XIWT'') Project

Notice is hereby given that, on January 12, 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''), Corporation For National Research Initiatives: Cross Industry Working Team (''XIWT'') 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, AT&T Laboratories, Florham Park, NJ; CitiGroup, New York, NY; MCI Worldcom, Reston, VA; Telecordia Technologies, Inc., Morristown, NJ; Enron Broadband Services, Inc., Portland, OR; US West, Inc., Boulder, CO; and Virtual Networks, Sunnyvale, CA have been added as parties to this venture. Also, Citicorp, New York, NY; MCI Communications, Richardson, TX; US West Communications, Boulder, CO; Inverse Network Technologies, Sunnyvale, CA AT&T Communications, Florham Park, NJ; Bellcore, Morristown, NJ; Sun Microsystems, Mountain View, CA; Texas Instruments, Dallas, TX; Ameritech, Chicago, IL; Bell Atlantic, Philadelphia, PA; Novell, Provo, UT; Southwestern Bell, St. Louis, MO; CyberCash, Reston, VA; Houston Associates, Silver Spring, MD; InterTrust Technologies, Sunnyvale, CA; Pitney Bowes, Stanford, CT; and The New York Times, New York, NY 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 Corporation For National Research Initiatives: Cross Industry Working Team (''XIWT'') intends to file additional written notification disclosing all changes in membership.

On September 28, 1993, the Corporation For National Research Initiatives: Cross Industry Working Team (''XIWT'') 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 December 17, 1993 (58 FR 66022).

The last notification was filed with the Department on January 20, 1999. A notice was published in the **Federal Register** pursuant to Section 6(b) of the Act on May 20, 1999 (64 FR 27603).

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16479 Filed 6–28–00; 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—Die Products Consortium (DPC)

Notice is hereby given that, on March 31, 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''), Die Products Consortium (DPC) 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, Agilent Technologies, Inc., Palo Alto, CA; and IBM, Armonk, NY 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 Die Products Consortium (DPC) intends to file additional written notification disclosing all changes in membership.

On November 15, 1999, Die Products Consortium (DPC) filed its original notification pursuant to section 6(a) of the Act. A notice has not yet been published in the **Federal Register**.

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16480 Filed 6–28–00; 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, Inc.

Notice is hereby given that, on February 11, 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, Inc. 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, Flashpoint Technology, Inc., San Jose, CA; Nuwave Technologies, Inc., Fairfield, NJ; Kaidan Incorporated, Feasterville, PA; MSlide, Inc., Sausalito, CA; printQuick.com, Carlsbad, CA; ImageID, Ltd., Coral Gables, FL; KB Gear Interactive, Minneapolis, MN; Future Image, San Mateo, CA; Adobe Systems Incorporated, San Jose, CA; and University of California at Berkeley, Berkeley, CA have been added as parties to this venture. Also, busybox.com, Inc., San Francisco, CA; Skrudland Photo, Inc., Austin, TX; Questra Corporation, Rochester, NY; Be Here Corporation, Cupertino, CA; Thomas Public Relations, Inc., Huntington, NY; and Microsoft Corporation, Redmond, WA 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, Inc. intends to file additional written notification disclosing all changes in membership.

On September 25, 1997, Digital Imaging Group, Inc. 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 December 2, 1999. A notice was published in the **Federal Register** pursuant to section 6(b) of the Act on April 28, 2000 (65 FR 24982).

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16482 Filed 6–28–00; 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 (''ECTF'')

Notice is hereby given that, on October 21, 1999, 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 Telephony Form (''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, Bosch Telecom GmbH, Frankfort, GERMANY; Telesoft Design, Inc., Dorset, ENGLAND; Cyberlog International, Inc., San Antonio, TX; SI Logic Limitd, Aldermaston, ENGLAND; Digi International, Minnetonka, MN; and Nokia Networks, Helsinki, FINLAND have been added as Principal Members. Sail Labs GesmbH, Vienna, AUSTRIA; RadiSys Corporation, Houston, TX; and 8×8, Inc., Santa Clara, CA have been added as Auditing Members. Also, Nokia Telecommunications, Helsinki, FINLAND has been dropped as a Principal Member; and Texas MicroSystems, Houston, TX has been dropped as an Auditing Member 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 Enterprise Computer Telephony Form (''ECTF'') intends to file additional written notification disclosing all changes in membership.

On February 20, 1996, Enterprise Computer Telephony Forum (''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 222074).

The last notification was filed with the Department on July 8, 1999. A notice has not yet been published in the **Federal Register**.

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16478 Filed 6–28–00; 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—Microelectronics and Computer Technology Corporation (''MCC'')

Notice is hereby given that, on March 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''), Microelectronics and Computer Technology Corporation (''MCC'') has filed written notification simultaneously with the Attorney General and the Federal Trade Commission disclosing changes in its membership status and planned activities. 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, Nokia Research Center, Helsinki, FINLAND; Schlumberger, San Jose, CA; Southwestern Bell, St. Louis, MO; and Telefonica, Madrid, SPAIN 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 Microelectronics and Computer Technology Corporation (''MCC'') intends to file additional written notification disclosing all changes in membership.

On December 21, 1984, Microelectronics and Computer Technology Corporation (''MCC'') 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 January 17, 1985 (50 FR 2633).

The last notification was filed with the Department on June 16, 1999. A notice was published in the **Federal Register** pursuant to Section 6(b) of the Act on December 2, 1999 (64 FR 67590).

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16474 Filed 6–28–00; 8:45 am]

BILLING CODE 4401–11–M

DEPARTMENT OF JUSTICE

Antitrust Division

Notice Pursuant to the National Cooperative Research and Production Act of 1993—National Center for Manufacturing Sciences. Inc. (''NCMS'')

Notice is hereby given that, on November 12, 1999, pursuant to Section 6(a) of the National Cooperative Research and Production Act of 1993, 15 U.S.C. 4301 *et seq.* (''the Act''), National Center for Manufacturing Sciences, Inc. (''NCMS'') 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 circumstance. Specifically, ASPSecure.com Corporation, San Jose, CA; Benchmark Electronics-Hudson Company, Hudson, NH; Ethereal Technologies, Inc., Grosse Ile, MI; Faraday Technology, Inc., Clayton, OH; Information Transport Associates, Inc., Annapolis, MD; and Precision Optical Manufacturing Company, Plymouth, MI have joined the National Center for Manufacturing Sciences, Inc. (''NCMS'') as Active members. Ohio Aerospace Institute, Cleveland, OH; and the University of New Orleans, New Orleans, LA have joined the National Center for Manufacturing Sciences, Inc. (''NCMS'') as Affiliate members. By way of unanimous written consent, the following companies have been accepted for Affiliate membership in the National Center for Manufacturing Sciences, Inc. (''NCMS''): ASM International, Materials Park, OH and Minnesota Technology, Inc., Minneapolis, MN.

Also, Applied Intelligent Systems, Inc., Ann Arbor, MI; Deneb Robotics Inc., Auburn Hills, MI; Diffracto, Windsor, Ontario, CANADA; Cardell Corporation, Auburn Hills, MI; Circo Craft Company, Pointe-Claire, Quebec, CANADA; Concentra Corporation, Burlington, MA; Giddings & Lewis, Inc.,

Fond du lac, WI; Imation Corporation, Oakdale, MN; Midwest Brake and Bond Company, Warren, MI; OG Technology, Inc., Ann Arbor, MI; Progressive Technologies, Inc., Grand Rapids, MI; RES Corporation, Milwaukee, WI; RWD Technologies, Inc., Auburn Hills, MI; Strategic Business Management Company, Villa Park, IL; TYCOM Corporation, Irvine, CA; Universal Flow Monitors, Hazel Park, MI; and Wizdom Systems, Naperville, IL have been dropped as Active members to this venture. Agility Forum, Bethlehem, PA; Materials Technology Laboratory, CANMET, Natural Resources Canada, Ottawa, Ontario, CANADA; National Center for Tooling & Precision Components, Toledo, OH; and ORTECH Corporation, Mississauga, Ontario, CANADA have been dropped as parties to this venture.

Active Touch Systems, Inc., has changed its name to Web Ex, Inc., Santa Clara, CA; Flavors Technology, Inc., has changed its name to R. Morley, Inc., Milford, NH; The MacNealSchwendler Corporation has changed its name to MSC.Software Corporation, Costa Mesa, CA; Ramtech Group, Inc., has changed its name to Bencym West, LLC, North Highlands, CA; and Industrial Technology Institute has changed its name to Michigan Manufacturing Technology Center, Ann Arbor, MI. Chrysler Corporation merged with Daimler–Benz AG and is now known as DaimlerChrysler AG, Auburn Hills, MI.

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 National Center for Manufacturing Sciences, Inc. (''NCMS'') intends to file additional written notification disclosing all changes in membership.

On February 20, 1987, National Center for Manufacturing Sciences, Inc. (''NCMS'') 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 March 17, 1987 (52 FR 8375).

The last notification was filed with the Department on April 1, 1999. A notice was published in the **Federal Register** pursuant to Section 6(b) of the Act on May 26, 1999 (64 FR 28519).

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16473 Filed 6–28–00; 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—National Electronics Manufacturing Initiative (''NEMI'')

Notice is hereby given that, on January 14, 2000, pursuant to section 6(a) of the National Cooperative Research Production Act of 1993, 15 U.S.C. 4301 *et seq.* (''the Act''), National Electronics Manufacturing Initiative (''NEMI'') 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 plantiffs to actual damages under specified circumstances. Specifically, Agile Software Corporation, Armonk, NY; AMR Research, Inc., Boston MA; ChipPCA Inc., Santa Clara, CA; Indium Corporation of America, Clinton, NY; Johnson Manufacturing Company, Princeton, IA; Nortel Networks, Research Triangle Park, NC; Newbridge Networks Corporation, Kanata, Ontario, CANADA; and Netfish, Technologies, Inc., Santa Clara, CA have been added as parties to this venture. The following members have changed their names: Unicam, Inc. to Tecnomatix-Unicam, Inc. Portsmouth, NH; and Morton Electronics to Shipley Ronal, Tustin, CA. Also, Industrial Computer Corporation (ICC), Atlanta, GA; Micro Module Systems, Cupertino, CA; and Hughes Electronics Coporation, El Segundo, 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 NEMI intends to file additional written notification disclosing all changes in membership.

On June 6, 1996, NEMI 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 June 28, 1996 (61 FR 33774).

The last notification was filed with the Department on October 8, 1998. A notice was published in the **Federal Register** pursuant to section 6(b) of the Act on January 29, 1999 (64 FR 4708).

Constance K. Robinson,

Director of Operations Antitrust Division.

[FR Doc. 00–16469 Filed 6–28–00; 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—National Starch & Chemical Company

Notice is hereby given that, on March 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''), National Starch & Chemical Company has filed written notifications simultaneously with the Attorney General and the Federal Trade Commission disclosing (1) The identifies 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 National Starch & Chemical Company, Bridgewater, NJ; and International Business Machines, Yorktown Heights, NY. The nature and objectives of the venture are to develop novel, wafer level, high performance underfill technology.

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16477 Filed 6–28–00; 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—OBI Consortium, Inc.

Notice is hereby given that, on March 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''), OBI Consortium, Inc. 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, i2 Technologies, Dallas, TX; Internet Operations Center, Southfield, MI; NetPlanet LLC, Troy, MI; and Yantra Corporation, Action, MA 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 OBI Consortium, Inc. intends to file additional written notification disclosing all changes in membership.

On September 10, 1997, OBI Consortium, Inc. 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 60531).

The last notification was filed with the Department on November 26, 1999. A notice was published in the **Federal Register** pursuant to Section 6(b) of the Act on April 28, 2000 (65 FR 24983).

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16483 Filed 6–28–00; 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—Salutation Consortium, Inc.

Notice is hereby given that, on March 20, 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''), Salutation Consortium, Inc. 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, Wenching Liou, Taipei, TAIWAN; Richard G. Golden, III, New Orleans, LA; Kaspar Hellden, Ostergotland, SWEDEN: WalletWare, Inc., Irvine, CA; Continental Automated Buildings Association, Ontario, CANADA; Heath Westover, Marysville, WA; AOL, Irvine, CA; Roger deBry, Orem, UT; and Pistachio, Inc., Portland, OR 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 Salutation Consortium, Inc. intends to file additional written notification disclosing all changes in membership.

On March 30, 1995, Salutation Consortium, Inc. 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 June 27, 1995 (60 FR 33233).

The last notification was filed with the Department on December 6, 1999. A notice was published in the **Federal Register** pursuant to section 6(b) of the Act on April 28, 2000 (65 FR 24984).

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16481 Filed 6–28–00; 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—Southwest Research Institute (''SwRI''): Clean Diesel III

Notice is hereby given that, on April 26, 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''), Southwest Research Institute (''SwRI''): Clean Diesel III 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, EMITEC GmgH, Lohmar, Germany; and Isuzu Motors Limited, Fujiasawa-shi, Japan 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 Southwest Research Institute (''SwRI''): Clean Diesel III intends to file additional written notification disclosing all changes in membership.

On January 12, 2000, Southwest Research Institute (''SwRI''): Clean Diesel III filed its original notification pursuant to section 6(a) of the Act. A notice has not yet been published in the **Federal Register**.

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16471 Filed 6–28–00; 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—Telematics Suppliers Consortium, Inc.

Notice is hereby given that, on January 28, 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''), Telematics Suppliers Consortium, Inc. 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, The Automobile Association, Basingstoke, UNITED KINGDOM 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 Telematics Suppliers Consortium, Inc. intends to file additional written notification disclosing all changes in membership.

On March 12, 1999, Telematics Suppliers Consortium, Inc. filed its original notification pursuant to Section 6(a) of the Act. The Department of Justice has not yet published a notice in the **Federal Register**.

The last notification was filed with the Department on November 3, 1999. A notice was published in the **Federal Register** pursuant to Section 6(b) of the Act on December 14, 1999 (64 FR 69801).

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16468 Filed 6–28–00; 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—Telematics Suppliers Consortium, Inc.

Notice is hereby given that, on March 12, 1999, pursuant to section 6(a) of the National Cooperative Research and Production Act of 1993, 15 U.S.C. 4301 *et seq.* (''the Act''), Telematics Suppliers Consortium, Inc. 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 objective 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 Alpine Electronics of America, Inc., Torrance, CA; AMP Inc., Harrisburg, PA; Cellport Labors Inc., Boulder, CO; Ford Motor Company, Dearborn, MI; Kenwood Corp., Tokyo, JAPAN; and Motorola Inc., Schaumburg, IL. The nature and objectives of the venture are to promote the development and adoption of open, accessible, secure, end to end technical specification (''Telematics Specifications'') permitting the transaction of data to and from, as well as within, automobiles and other vehicles; to promote such specifications and solutions worldwide to ensure that a broad spectrum of goods and services is developed and are available to provide for testing and conformity assessment of network components in order to ensure robust system operation; to create and own distinctive trademarks; and to operate a branding program based upon distinctive trademarks to create high customer awareness of, demand for, and confidence in products designed in compliance with Telematics Specification.

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16484 Filed 6–28–00; 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—Wireless Application Protocol Forum, Ltd. (''The WAP Forum''

Notice is hereby given that, on October 5, 1999, pursuant to section 6(a) of the National Cooperative Research and Production Act of 1993, 15 U.S.C. 4301 *et seq.* (''the Act''), Wireless Application Protocol Forum, Ltd. (''The WAP 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, 724 Solutions, Toronto, Ontario, Canada; Adera, Gothenburg, Sweden; Aether Systems, Inc., Owings Mills, MD; Agency.com, London, United Kingdom; Airtel Movil, S.A., Madrid, Spain; Akumiitti Ltd, Helsinki, Finland; AltaWave Inc., Cupertino, CA; Angelica Wireless, Vanlose, Denmark; Argot Interactive Ltd., Chichester, West Sussex, United Kingdom; Aspiro, Malmo, Sweden; At Home Corporation, Redwood City, CA; AtMotion, Incorporated, Redwood Shores, CA; Avenir ASA, Oslo, Norway; BEA Systems, San Francisco, CA; Bul CP8, Louveciennes, France; Centre for Wireless Communications, Singapore, Singapore; Cerulean Technology, Inc., Marlboro, MA; Charles Schwab & Co., Inc., San Francisco, CA; CoCoNet Global Interchange GmbH, Erkrath, Germany; Concis Consulting, Stockholm, Sweden; Cyber-COMM, Paris, France; CycleLogic, Miami, FL; Data on Air, Inc., Orlando, FL; Digital Bridges Limited, Fife, Scotland, United Kingdom; Diversinet Corp., Toronto, Ontario, Canada; Eircell, Dublin, Ireland; Entra Data AB, Stockholm, Sweden; Entrust Technologies Inc., Ottawa, Ontario, Canada; Evolving Systems, Inc., Englewood, CO; FarEasTone Telecommunications Co., Taipei, Hsien, Taiwan; Fidelity Investments, Boston, MA; Framtidsfabriken AB, Stockholm, Sweden; FusionOne, Inc., Los Gatos, CA; Globalaccess Internet Ltd., London, United Kingdom; Hyperwave, Graz, Austria; Icon Medialab International, Tampere, Finland; ILICO Limited, Covent Garden, United Kingdom; Infinite Technologies, Owings Mills, MD; Information Highway AB, Sundbyberg, Sweden; Information Mechanics, Inc., Englewood, CO; Infowave Softwave, Inc., Burnaby, British Columbia, Canada; Intelligent Information Inc., Stamford, CT; Intershop Communications GmbH, Hamburg, Germany; Jinny Software Ltd., Dublin, Ireland; LG TeleCom, Ltd, Seoul, South Korea; LPG Innovations Ltd., Helsinki, Finland; MasterCard International Inc., Purchase, NY; MAZ Mikroelektronik, Hamburg, Germany; Melody Interactive Solutions AB, Stockholm, Sweden; Myalertcom, SA, Madrid, Spain; NEC Corporation, Yokohama, Kanagawa, Japan; Nedecon-Network Development, Espoo, Finland; Novo Meridian Oy, Espoo, Finland; Palm Computing Inc., Santa Clara, CA; pc-plus Computing, Munich, Germany; PCS Innovations Inc., Brossard, Quebec, Canada; Pioneer Corporation, Saitama-ken, Japan; Portal Software, Incorporated, Cupertino, CA; RTS Networks Finland Oy, Espoo, Finland; Sanoma-WSOY Oyj, Helsinki, Finland; screamingmedia.com, San Diego, CA; Setec Oy, Vantaa, Finland; Sharp Corporation, Hiroshima, Japan; SmartServ Online, Inc., Stamford, CT; space2go.com GmbH & Co., Berlin, Germany; STMicroelectronics, Inc., San Jose, CA; Telocity, Inc., Cupertino, CA; Turkcell Iletisim Hizmetleri A.S., Istanbul, Turkey; Ubiguity S.R.L., Milan, Italy; Universal Communication Platform, Vienna, Austria; VeriSign, Inc., Wakefield, MA; VIAGA Interkom GmbH & Co., Muenchen, Germany; Vicinity Corporation, Palo Alto, CA; Virtual, Inc., Taipei, Taiwan; VISA International, Foster City, CA; Webraska Mobile Technologies, Poissy Cedex, France; and Zillion AG, Zurich, Switzerland have been added as parties to this venture. Also, BEA WebXpress, San Francisco, CA 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 Wireless Application Protocol Forum, Ltd. (''The WAP Forum'') intends to file additional written notification disclosing all changes in membership.

On March 18, 1998, Wireless Application Protocol Forum, Ltd. (''The WAP 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 December 31, 1998 (63 FR 72333).

The last notification was filed with the Department on July 9, 1999. A notice was published in the **Federal Register** pursuant to section 6(b) of the Act on April 28, 2000 (65 FR 24985).

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16472 Filed 6–28–00; 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—Wireless Application Protocol Forum, Ltd. (''The WAP Forum'')

Notice is hereby given that, on January 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''),

Wireless Application Protocol Forum, Ltd. (''the WAP 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, Allaire Corporation, Cambridge, MA; Amazon.com, Seattle, WA; Amdocs Ltd., Ra'anana, ISRAEL; AOL Europe, London, UNITED KINGSDOM; Art Technology Group, Cambridge, MA; Arthur Andersen LLP, Atlanta, GA; AU-System AB, Lund, SWEDEN; AvantGo, Inc., San Mateo, CA; Barnes and Noble.com, New York, NY; Brightpoint, Inc., Indianapolis, IN; Cable & Wireless Optus, Ltd., North Sydney, New South Wales, AUSTRALIA; CellPoint Systems AB, Sollentuna, SWEDEN; Conduit Software Ltd, Dublin, IRELAND; Consafe Infotech, Malmo, SWEDEN; Datenwerk, Vienna, AUSTRIA; DCI Gmbh, Starnberg, GERMANY; Dennotai Co., Ltd., Tokyo, JAPAN; Detencon, Bonn, GERMANY; Deutsche Bank AG, Eschborn, GERMANY; Earthport.com Plc, London, UNITED KINGDOM; Edify Corporation, Santa Clara, CA; EnCommerce, Inc., Santa Clara, CA; Everypath.Com, Inc., Santa clara, CA; eWare, Ltd., Dublin, IRELAND; eXaLink Ltd, Kfar Sava, ISRAEL; FST Fabbrica Servizi Telematici, Sarroch, ITALY; Fujitsu Limited, Yokohama, JAPAN; Gohead Software, Bellevue, WA; Guide Konsult, Solna, SWEDEN; GWcom Shangai, Santa Clara, CA; HiQ International, Stockholm, SWEDEN; InfoCell, Amman, JORDAN; INFOCOMM Inc., Taipei, TAIWAN; Infovention, Stockholm, SWEDEN; Interleaf Inc., Waltham, MA; Intrinsic Technology Limited (Shanghai), Shanghai, PEOPLE'S REPUBLIC OF CHINA; KG Telecommunications Co., Ltd., Taipei, TAIWAN; MicroStrategy Incorporated, Vienna, VA; Millenium Information Technologies, Colombo, SRI LANKA; Mitsui & Co., Ltd., Tokyo, JAPAN; @mobile Corp., Bellevue, WA; Mobilephone Telecommunications, Tokyo, JAPAN; Mobilesoft Pty Limited, Sydney, AUSTRALIA; NavaraSoft Ltd, Shannon, County Clare, IRELAND; Neomar, San Francisco, CA; Netegrity, Inc., Waltham, WA; Nettech Systems, Inc., Princeton, NJ; New Media Science/Linne Group, Oslo, NORWAY; NoTime Wireless, Halifax, Nova Scotia, CANADA; NTRU Cryptosystems, Inc., Boston, MA; Ogilvy Interactive Worldwide, New York, NY; OpenGrid Inc., Santa Clara, CA; Opt[e]way, Paris la Defense Cedex, FRANCE; Palm Reach, Stockholm, SWEDEN; ParaRede Technologies, Lisboa, PORTUGAL; Pixo, Inc., Cupertino, CA; Proteus, Inc., Washington, DC; Psion Computers Plc, London, UNITED KINGDOM; Quinary, Milan, ITALY; Real Names Corp., San Carlos, CA; Riverbed Technologies, Inc., Vienna, VA; Santama Interactive, Helsinki, FINLAND; ShopNow.com. Seattle, WA; Sigma AB, Malmo, SWEDEN; SignalSoft Corp., Boulder, CO; SinnerSchrader, Hamburg, GERMANY; Software AG, Darmstadt, GERMANY; Solid Information Technology, Ltd., Helsinki, FINLAND; Sybase, Inc., Waterloo, Ontario, CANADA; TD Waterhouse Group, Inc., New York, NY; ThinAirApps, New York, NY; TIBCO Software Inc., Palo Alto, CA; Time/system International, Allerod, DENMARK; VAST Solutions, Inc., Addison, TX; VeriFone, Santa Clara, CA; Vignette Corporation, Austin, TX; Visma ASA, Oslo, NORWAY; WIPRO Technologies—Global R&D, Bangalore, INDIA; Wireless Data Services, Ltd., Dorset, UNITED KINGDOM; Wysdom Inc., Richmond Hill, Ontario, CANDA; Xircom, Inc., Thousand Oaks, CA; Yamaha Corporation, Hamamatsu, JAPAN; and Zi Corporation, Hong Kong, PEOPLE'S REPUBLIC OF CHINA 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 Wireless Application Protocol Forum, Ltd. (''The WAP Forum'') intends to file additional written notification disclosing all changes in membership.

On March 18, 1998, Wireless Application Portocol Forum, Ltd. (''The WAP 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 December 31, 1998 (63 FR 72333).

The last notification was filed with the Department on October 5, 1999. A notice has not yet been published in the **Federal Register**.

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 00–16475 Filed 6–28–00; 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 Adjustment 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 June, 2000.

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 or 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 indicated that increased imports did not contribute importantly to worker separations at the firm.

TA–W–37,395; Honeywell, Inc., Formerly D/B/A Allied Signal-Johnson Matthey Electronics, Chippewa Falls, WI

TA–W–37,574; Illinois Tool Works Co., Mechanicsburg, PA

TA–W–37,454; Corson Manufacturing Co., Lockport, NY

TA–W–37,673; Dana Corp., Marion Forge Div., Marion, OH

TA–W–37,304; Nova Bus, Inc., Transit Bus Div., Roswell, NM

TA–W–37,617; Troutman Foundry, Inc., Statesville, NY

In the following cases, the investigation revealed that the criteria for eligibility have not been met for the reasons specified.

TA–W–37,689; Agri Sales, Saginaw, MI

TA–W–37,755; Schlegel Construction, Inc., Kalispell, MT

TA–W–37,716; Brunswick Bicycles, Balmorhea, TX
TA–W–37,620; Jo Hanna York, Inc., New York, NY
TA–W–37,614; Imation Corp., Woodbury, MN
TA–W–37,722; Pro-Emp Solutions, Inc., Odessa, TX
TA–W–37,649; San Manuel Health Care Center, San Manuel, AZ
TA–W–37,585; MAMIYE/MESPO Umbrella Co., Hollis, NY
TA–W–37,646; Fairway Foods of Michigan, Menominee, MI

The workers firm does not produce an article as required for certification under Section 222 of the Trade Act of 1974.

TA–W–37,740; Compair Leroi, Independence, VA
TA–W–37,731; Cupples Rubber Co., St. Louis, MO
TA–W–37,732; Choctaw Maid Farms Hatchery, Embrex Dept., Newton, MS
TA–W–37,562, A, B, C, D, E, F, G, H, I, J, K, L, M, N; The Beloit Corp., Beloit Nashua, Nashua, NH, Beloit Lenox, Lenox, MA, Beloit Northeast Regional office, Rochester, NH, Beloit South Regional Office, Hattiesburg, MS, Beloit Southeastern Regional Office, Kennesaw, GA, Beloit Midwest Regional office, Kimberly, WI, Beloit West Regional Office, Portland, OR, Beloit Millpro Service Center, Hattiesburg, MS, Beloit Millpro Service Center, Otego, MI, Beloit Corp Office, Wheeling, IL, Beloit Manhattan, Neenah, WI, Beloit Manhattan, Clark Summit, PA, Beloit Manhattan, Aiken, SC, Beloit Manhattan, Columbus, MS and Beloit Manhattan, Federal Way, OR
TA–W–37,383; Philadelphia Gear Corp., King of Prussia, PA
TA–W–37,419; Compaq Computer Corp., Houston, TX
TA–W–37,487; Alta Gold Co., Olenghouse Mine, Fernley, NV
TA–W–37,566; Bigsby Accessories, Inc., Kalamazoo, MI
TA–W–37,661; RHI Refractories America, Farber, MO
TA–W–37,733; L. Peter Larson Co., Olney, MT
TA–W–37,664; Hutchinson Technology, Inc., Eau Claire, WI
TA–W–37,653; Frontier Foundry, Inc., Titusville, PA
TA–W–37,603; A. Schulman, Inc., Dispersion Div., Orange, TX
TA–W–37,635; MSX International, Workers Employed at U.F.E., El Paso, TX
TA–W–37,425; SKF USA, Inc., Hub Bearing Unit Div., Glasgow, KY
TA–W–37,583; Trinity Industries, Inc., Butler, PA
TA–W–37,660; Go/Dan Industries, Houston, TX
TA–W–37,628; Hutchinson Technology, Inc., Sioux Falls, SD

Increased imports did not contribute importantly to worker separations at the firm.

TA–W–37,519; Air Products and Chemicals, Inc., Pace, FL

The investigation revealed that criteria (2) and criteria (3) have not been met. Sales or production did not decline during the relevant period as required for certification. Increases of imports of articles like or directly competitive with articles produced by the firm or an appropriate subdivision have not contributed importantly to the separations of threat thereof, and the absolute decline in sales or production.

TA–W–37,608; Concord Fabrics, Inc., New York, New York

The investigation revealed that criteria (2) has not been met. Sales or production did not decline during the relevant period 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–37,534; Hartwell Sports (Auburn Sportswear), Tylertown, MS: March 22, 1999.
TA–W–37,588; Coloplast Amotex Plant, Centre, AL: March 27, 1999.
TA–W–37,672; Total Rental Tool and Manufacturing Co., Inc., Rush Springs, OK: April 26, 1999.
TA–W–37,579; Chicago Steel, Gadsden, AL: April 3, 1999.
TA–W–37,565; Philips Electronics North America Corp., Philips Components Div., Saugerties, NY: March 20, 1999.
TA–W–37,426; Leather Specialty Co/ Howe Industries, Sanford, FL: February 22, 1999.
TA–W–37,496; Zin Plas Corp., Grand Rapids, MI: March 10, 1999.
TA–W–37,547 & A; Donnkenny Apparel, Inc., Floyd, VA and Independence, VA: March 16, 1999.
TA–W–37,590; NGK Metals Corp., Reading, PA: April 5, 1999.
TA–W–37,568; Oregon Manufacturing Services, Inc., Klamath Falls, OR: March 24, 1999.
TA–W–37,651; Nortel Networks, Santa Clara, CA: April 20, 1999.
TA–W–37,592; Macedonia Fashions Knitting, Inc., Brooklyn, NY: March 27, 1999.
TA–W–37,668; Pope and Talbot, Inc., Newcastle Plant, Newcastle, WY: May 11, 1999.
TA–W–37,604; Coho Energy, Inc., d/b/a Coho Resources, Inc., Dallas, TX: April 6, 1999.
TA–W–37,645; Lind Shoe Co., Somerset, WI: April 20, 1999.
TA–W–37,671; Hillsville Apparel, Inc., Hillsville, VA: May 22, 1999.
TA–W–37,571; Rugged Sportswear, Siver City, NC: March 31, 1999.
TA–W–37,681; PJC Sportswear, Inc., Brooklyn, NY: May 9, 1999.
TA–W–37,698; Grayson Enterprises, Inc., Eaton, IN: April 26, 1999.
TA–W–37,376; Oneida Limited Silversmith, Sherrill, NY: February 4, 1999.
TA–W–37,712; Rite Industries, Inc., High Point, NC: May 17, 1999.
TA–W–37,707; Oliver Rubber Co., Export, PA: May 9, 1999.
TA–W–37,293; Ironton Iron, Inc., Ironton, OH: January 19, 1999.
TA–W–37,578; Vanity Fair Intimates, Inc., Jackson Sewing, Jackson, AL: March 24, 1999.
TA–W–37,258; IPM Service Corp., Mini Tune Div., Dallas, TX: December 20, 1998.
TA–W–37,747; Thomson 60 Case, LLC, Lancaster, PA: May 25, 1999.
TA–W–37,666; Jensports, New Kensington, PA: April 28, 1999.
TA–W–37,624; PMC Specialties Group, Fords, NJ: March 28, 1999.
TA–W–37,648; Olympia Limited, Inc., Hoboken, NJ: April 4, 1999.
TA–W–37,729; Biljo, Inc., Dublin, GA: February 21, 2000.
TA–W–37,626; Thomason Electronics, Inc., Indianapolis, IN: April 10, 1999.
TA–W–37,524; Gaudette Leather Goods, Inc., North Atleboro, MA: March 14, 1999.
TA–W–37,520; Althin Medical, Inc., Miami Lakes, FL: March 2, 1999.
TA–W–37,476; Triten Leathergoods, Johnson City, TN: March 6, 1999.
TA–W–37,743; Tandycrafts, Inc., Tandyarts, Inc/Impulse Design, Pinnacle Art and Frame Div., Van Nuys, CA: May 23, 1999.
TA–W–37,718; Robertson Transformer Co., Rochester, IN: May 12, 1999.
TA–W–37,625; Thatcher Summit, Inc., d/b/a Ultimate Direction, Rexburg, ID: April 19, 1999.
TA–W–37,611; T and S Sewing, Inc., Hialeah Gardens, FL: April 4, 1999.
TA–W–37,532; The Berne Apparel Co., Berne, IN: March 16, 1999.
TA–W–37,499; Lenox China, Inc., Pomona, NJ: March 3, 1999.

TA–W–37,599 & A; United States Enrichment Corp. (USEC), Paducah Gaseous Diffusion Plant, Paducah, KY, and Portsmouth Gaseous Diffusion Plant, Piketon, OH: April 10, 1999.

TA–W–37,741; Nestle USA, Friskies Petcare Div., Elizabeth City, NC: May 23, 1999.

TA–W–37,708; The Stanley Works, Shelbyville Plant of Hand Tools Div., Shelbyville, TN: May 9, 1999.

TA–W–37,702; Spencer's Inc., Mt. Airy, NC: April 27, 1999.

TA–W–37,696; Parker Hannifin, Batesville, MS: May 4, 1999.

TA–W–37,726; Zebco, a Div. of Brunswick Corp., Tulsa, OK: May 4, 1999.

TA–W–37,687; Xantech Corp., Sylmar, CA: May 10, 1999.

TA–W–37,613; Sandvik Milford, Branford, CT: April 4, 1999.

TA–W–37,761; American Industrial Container Corp. A Div. of Lenworth Metal Products Limited, Meadville, PA: May 28, 1999.

TA–W–37,701; Oregon Woodworking Co & Temporary Workers from Mid-Oregon Labor Contractors & Express Personnel Services, Bend, OR: May 5, 1999.

TA–W–37,577; Electro-Tec Corp., Blacksburg, VA: April 3, 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 June, 2000.

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 is a significant number or 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–03868; Frontier Foundry, Inc., Titusville, PA

NAFTA–TAA–03907; Go/Dan Industries, Inc., Houston, TX

NAFTA–TAA–03683; Nova Bus, Inc., Transit Bus Div., Roswell, NM

NAFTA–TAA–03906; RHI Refractories America, Farber, MO

NAFTA–TAA–03879; Dana Corp., Marion Forge Div., Marion, OH

NAFTA–TAA–03908; Invensys Appliance Controls, Independence, VA

NAFTA–TAA–03911; Hutchinson Technoligy, Inc., Eau Claire, WI

NAFTA–TAA–03852; Troutman Foundry, Inc., Statesville, NC

NAFTA–TAA–03943; L. Peter Larson Co., Olney, MT

NAFTA–TAA–03923; Butteville Lumber Co., Onalaska, WA

NAFTA–TAA–03895; Zebco, A Div. of Brunswick Corp., Tulsa, OK

NAFTA–TAA–03837; K and D Clothing Manufacturing Co., Philadelphia, PA

NAFTA–TAA–03909; Beloit Corp., Manhattan Div., Neenah, WI

NAFTA–TAA–03733; Langenberg Hat Co., Inc., New Haven, MO

NAFTA–TAA–03941; PCS Nitrogen, Camanche, IA

The investigation revealed that the criteria for eligibility have not been met for the reasons specified.

NAFTA–TAA–03834; Seagate Tehcnology, Inc., Customer Service Operations and Research and Design Center, Oklahoma City, OK

NAFTA–TAA–03915; Los Angeles Department of Water and Power, Sun Valley, CA

NAFTA–TAA–03938; Schlegel Construction, Inc., Kalispell, MT

NAFTA–TAA–03949; Agri Sales, Saginaw, MI

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–03651; IPM Service Corp., Mini Tune Div., Dallas, TX: December 20, 1998.

NAFTA–TAA–03917; Biljo, Inc., Dublin, GA: February 21, 2000.

NAFTA–TAA–03844; Thomson Consumer Electronics, Inc., Indianapolis, IN: April 10, 1999.

NAFTA–TAA–03887; Vanity Fair Intimates, Inc., Jackson Sewing, Jackson, AL: April 27, 1999.

NAFTA–TAA–03880; Ranco North America, Plain City, OH: May 1, 1999.

NAFTA–TAA–03928; T&S Sewing, Inc., Hialeah Gardens, FL: April 4, 1999.

NAFTA–TAA–03935; Lefever Plastics, Inc., Huntsville, OH: May 5, 1999.

NAFTA–TAA–03934; Thomson 60 Case, LLC, Lancaster, PA: May 25, 1999.

NAFTA–TAA–03918; Robertson Transformer Co., Rochester, IN: May 12, 1999.

NAFTA–TAA–03930; Cupples Rubber Co., St. Louis, MO: May 17, 1999.

NAFTA–TAA–03939; The Stanley Works, Shelbyville Plant of Hand Rools Div., Shelbyville, TN: May 29, 1999.

NAFTA–TAA–03946; Nestle USA, Friskies Petcare Div., Elizabeth City, NC: May 23, 1999.

NAFTA–TAA–03932; Condor D.C. Power Supplies, Inc., The Todd Products Group, McAllen, TX: May 17, 1999.

NAFTA–TAA–03962; Texas Instruments, Inc., Versailles, KY: May 26, 1999.

NAFTA–TAA–03967; Alco Controls, Wytheville, VA: May 26, 1999.

NAFTA–TAA–03853; Hatch, Inc., El Paso, TX: April 4, 1999.

NAFTA–TAA–03963; Sagaz Industries, Inc., Miami, FL: March 21, 1999.

NAFTA–TAA–03914; Seton Co., El Paso Cutting Plan, El Paso, TX May 18, 1999.

NAFTA–TAA–03874; Long Handle Shirts, Inc., Monroe, NC: April 17, 1999.

I hereby certify that the aforementioned determinations were issued during the month of June 2000. Copies of these determinations are available for inspection in Room C–4318, U.Ss. 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: June 22, 2000.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

[FR Doc. 00–16493 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–37,621 and NAFTA–03863]

Westwood Lighting, El Paso, TX; Dismissal of Application for Reconsideration

Pursuant to 29 CFR 90.18(C) an application for administrative reconsideration was filed with the Director of the Division of Trade Adjustment Assistance for workers at Westwood Lighting, El Paso, Texas. The application contained no new substantial information which would bear importantly on the Department's determination. Therefore, dismissal of the application was issued.

TA–W–37,621 and NAFTA–03863; Westwood Lighting, El Paso, Texas (June 8, 2000)

Signed at Washington, DC this 12th day of June, 2000.

Grant D. Beale,

Program Manager, Division of Trade Adjustment Assistance.

[FR Doc. 00–16503 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–37,251 and TA–W–37,703]

Beloit Millpro Service Center, Hattiesburg, MS and Beloit Manhattan, Neenah, WI; Notice of Termination of Investigation

Pursuant to Section 221 of the Trade Act of 1974, investigations were initiated on January 18, 2000 and May 22, 2000, in response to a worker petitions which were filed on behalf of workers at Beloit Millpro Service Center, Hattiesburg, Mississippi (TA–W–37,251) and Beloit Manhattan, Neenah, Wisconsin (TA–W–37,703), respectively.

During the investigations, it was discovered that both facilities are under existing investigations. The workers are currently under the following investigations: Beloit Millpro Service Center, Hattiesburg, Mississippi (TA–W–37,562G) and Beloit Manhattan, Neenah, Wisconsin (TA–W–37,562J).

Consequently further investigations in these cases (TA–W–37,251 and TA–W–37,703) would serve no purpose, and the investigations have been terminated.

Signed in Washington, DC this 15th day of June, 2000.

Grant D. Beale,

Program Manager, Division of Trade Adjustment Assistance.

[FR Doc. 00–16495 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–37,616]

Chavez Signs, Incorporated, El Paso, Texas; Notice of Termination of Investigation

Pursuant to section 221 of the Trade Act of 1974, an investigation was initiated on April 24, 2000, in response to a petition filed by a company official on behalf of workers at Chavez Signs, Incorporated, El Paso, Texas.

The company official submitting the petition 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 13th day of June, 2000.

Grant D. Beale,

Program Manager, Division of Trade Adjustment Assistance.

[FR Doc. 00–16498 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–37,680]

Chick Orchards, Inc., Chic-A-Dee Packing Corporation, Monmouth, Maine; Notice of Termination of Investigation

Pursuant to Section 221 of the Trade Act of 1974, an investigation was initiated on May 15, 2000, in response to a petition filed on the same date on behalf of workers at Chick Orchards, Inc., Chic-A-Dee Packing Corporation, Monmouth, Maine.

The company official submitting the petition 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 6th day of June, 2000.

Grant D. Beale,

Program Manager, Division of Trade Adjustment Assistance.

[FR Doc. 00–16501 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

Investigations Regarding Certifications of Eligibility To Apply for Worker Adjustment Assistance

Petitions have been filed with the Secretary of Labor under section 221(a) of the Trade Act of 1974 (''the Act'') and are identified in the Appendix to this notice. Upon receipt of these petitions, the Director of the Division of Trade Adjustment Assistance, Employment and Training Administration, has instituted investigations pursuant to section 221(a) of the Act.

The purpose of each of the investigations is to determine whether the workers are eligible to apply for adjustment assistance under Title II, Chapter 2, of the Act. The investigations will further relate, as appropriate, to the determination of the date on which total or partial separations began or threatened to begin and the subdivision of the firm involved.

The petitioners or any other persons showing a substantial interest in the subject matter of the investigations may request a public hearing, provided such request is filed in writing with the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than July 10, 2000.

Interested persons are invited to submit written comments regarding the subject matter of the investigations to the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than July 10, 2000.

The petitions filed in this case are available for inspection at the Office of the Director, Division of Trade Adjustment Assistance, Employment and Training Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

Dated: Signed at Washington, DC this 12th day of June, 2000.

Grant D. Beale,

Program Manager, Division of Trade Adjustment Assistance.

APPENDIX

[Petitions Instituted on 06/12/00]

TA–W	Subject firm (petitions)	Location	Date of petition	Product(s)
37,752	Hamilton Sundstrand (Comp)	Denver, CO	05/30/00	Fuel Pump Gears.
37,753	Nova Yarns (Wrks)	Eden, NC	05/25/00	Single and 2 Ply Yarn.
37,754	Rexworks, Inc. (USWA)	Milwaukee, WI	05/26/00	Front & Rear Frames, Chute, Hoppers.
37,755	Schlegel Construction (Comp)	Kalispell, MT	05/22/00	Transportation of Wood By-Products.
37,756	NRV Manufacturing Co (UNITE)	Carrollton, AL	05/27/00	Ladies' Jackets.
37,757	Eaton Corp. (IAMAW)	Milwaukee, WI	05/24/00	Rail Road Resistors.
37,758	Federal Mogul Corp (Comp)	Milan, MI	05/23/00	Automotive Seals.
37,759	Interstate Dyeing (UNITE)	Passaic, NJ	05/19/00	Dyeing and Finishing Fabrics.
37,760	Marijon Dyeing & Finish (UNITE)	East Rutherford, NJ	05/18/00	Dyeing and Finishing Fabrics.
37,761	American Industrial (UE)	Meadville, PA	05/28/00	Steel Shipping Containers.
37,762	Hearst Entertainment (Wrks)	Los Angeles, CA	05/24/00	Movies for Television.
37,763	Destination Films (Wrks)	Santa Monica, CA	05/24/00	Major Motion Pictures.
37,764	Masco Tech Forming Tech. (SMWI)	Ypsilanti, MI	05/25/00	Bolts and Screws.
37,765	Cuba Specialty Mfg Co. (Comp)	Fillmore, NY	05/26/00	Minnow Traps, Crab Nets.
37,766	Condor DC Power (Comp)	McAllen, TX	05/25/00	Switching Power Supplies.
37,767	Ingersoll-Rand Co. (Comp)	Roanoke, VA	05/26/00	Crawler Rock Drills.
37,768	Big B Valve Repair (Wrks)	Laurel, MS	05/22/00	Well Head Equipment and Accessories.
37,769	Rosebud Mining Co, LLC (Comp)	Winnemucca, NV	05/25/00	Gold and Silver Ore.
37,770	H.H. Rosinsky and Co (Wrks)	Philadelphia, PA	05/30/00	Ladies' Clothing.
37,771	Dallco Industries, Inc (Comp)	York, PA	05/31/00	Ladies' and Girls' Clothing.
37,772	Goodyear Tire and Rubber (USWA)	Akron, OH	06/05/00	Bias Race Tires.
37,773	Alfa Laval Separation (IUE)	Warminster, PA	06/01/00	Centrifuges.
37,774	Caporale Engraving, Inc (UNITE)	Hackensack, NJ	05/25/00	Engraving and Screens for Textiles.
37,775	Ceng, Inc. (Comp)	Dexter, GA	05/30/00	Ladies', Mens' & Boys' Slacks & Uniforms.
37,776	American Case Co (Comp)	Ann Arbor, MI	05/30/00	Musical Instrument Cases.
37,777	Pearl Brewing Co (Wrks)	San Antonio, TX	06/01/00	Beer.
37,778	Shepherd Operating, Inc (Comp)	Midland, TX	06/02/00	Oilwell Maintenance.
37,779	Alco Controls (Comp)	Wytheville, VA	05/26/00	Reversing Valves for A/C.
37,780	Memphis Chair (Wrks)	Gainesboro, TN	06/01/00	Chairs.
37,781	Raleigh Co. (The) (Comp)	Raleigh, MS	05/22/00	Men's & Ladies' Jeans and Shorts.
37,782	Emag Solutions LLC (Wrks)	Graham, TX	05/30/00	Magnetic Tape and Cartridges.
37,783	UFE, Inc (UNITE)	El Paso, TX	05/26/00	Gears for Copiers, Fax Machines.
37,784	Thermos Co (The) (Comp)	Batesville, MS	06/01/00	Foam Insulated Ice Chests.
37,785	J–F Sportswear (UNITE)	Scranton, PA	05/31/00	Men's Sport and Suit Coats.
37,786	Andover Togs (Wrks)	Pisgah, AL	06/02/00	Childrens Clothing.
37,787	Shorewood Packaging Corp (Wrks)	Andalusia, AL	06/02/00	Paperboard Packaging.
37,788	Aztec Finishing, Inc (Wrks)	Commerce, CA	06/01/00	Finishing Garments.

[FR Doc. 00–16494 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–37,268 and TA–W–37,268A]

Hampton Industries, Inc, Warrenton, North Carolina and Hampton Industries, Inc., Washington, North Carolina; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with Section 223 of the Trade Act of 1974 (19 U.S.C. 2273) the Department of Labor issued a Certification of Eligibility to Apply for Worker Adjustment Assistance on February 1, 2000, applicable to workers of Hampton Industries, Inc., Warrenton, North Carolina. The notice was published in the **Federal Register** on February 15, 2000 (65 FR 7563).

At the request of the company, the Department reviewed the certification for workers of the subject firm. New findings show that worker separations will occur at Hampton Industries' Washington, North Carolina facility when it closes in August, 2000. The workers are engaged in the production of men's and boys' casual shirts.

Accordingly, the Department is amending the certification to cover workers at Hampton Industries, Inc., Washington, North Carolina. The intent of the Department's certification is to include all workers of Hampton Industries, Inc. adversely affected by increased imports.

The amended notice applicable to TA–W–37,268 is hereby issued as follows:

''All workers of Hampton Industries, Inc., Warrenton, North Carolina (TA–W–37,268) and Washington, North Carolina (TA–W–37,268A) who became totally or partially separated from employment on or after January 24, 1999 through February 1, 2002 are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974.''

Signed at Washington DC this 20th day of June, 2000.

Grant D. Beale,

Program Manager, Division of Trade Adjustment Assistance.

[FR Doc. 00–16497 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–37,697]

Scientific Research Company, Portland, Oregon; Notice of Termination of Investigation

Pursuant to section 221 of the Trade Act of 1974, an investigation was initiated on May 22, 2000, in response to a petition filed by a company official on behalf of workers at Scientific Research Company, Portland, Oregon.

The company official submitting the petition 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 2nd day of June, 2000.

Grant D. Beale,

Program Manager, Division of Trade Adjustment Assistance.

[FR Doc. 00–16496 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–37, 314]

Shell Chemical Company, Point Pleasant Polyester Plant, Apple Grove, West Virginia; Dismissal of Application for Reconsideration

Pursuant to 29 CFR 90.18(C) an application for administrative reconsideration was filed with the Director of the Division of Trade Adjustment Assistance for workers at Shell Chemical Company, Point Pleasant Polyester Plant, Apple Grove, West Virginia. The application contained no new substantial information which would bear importantly on the Department's determination. Therefore, dismissal of the application was issued.

TA–W–37, 314; Shell Chemical Company, Point Pleasant Polyester Plant, Apple Grove, West Virginia (June 12, 2000).

Signed at Washington, DC this 12th day of June, 2000.

Grant D. Beale,

Program Manager, Division of Trade Adjustment Assistance.

[FR Doc. 00–16502 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

Investigations Regarding Certification 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 July 10, 2000.

Interested persons are invited to submit written comments regarding the subject matter of the investigations to the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than July 10, 2000.

The petitions filed in this case are available for inspection at the Office of the Director, Division of Trade Adjustment Assistance, Employment and Training Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

Signed at Washington, DC this 5th day of June, 2000.

Grant D. Beale,

Program Manager, Division of Trade Adjustment Assistance.

APPENDIX

[Petitions instituted on 06/05/2000]

TA–W	Subject firm (petitioners)	Location	Date of petition	Product(s)
37,736	Transsouthern Leasing (Wkrs)	Selma, AL	05/15/2000	Overals, jackets and tote bags.
37,737	Union Special Corp (Wkrs)	Huntley, IL	05/01/2000	Industrial sewing machines.
37,738	Goodyear Tire & Rubber (USWA)	Green, OH	05/24/2000	Rubber air springs—auto, trucks trains.
37,739	Applied Sewing Resources (Wkrs)	Orland, CA	05/20/2000	Sew luggage and carry bags.
37,740	Compair Leroi (Wkrs)	Independence, VA	05/19/2000	Recipricating air compressors.
37,741	Nestle USA—Friskie (Co.)	Elizabeth City, NC	05/23/2000	Cat, dog treats.
37,742	Key Industries (Co.)	Fort Scott, KS	05/22/2000	Bib overalls (work clothing).
37,743	Impulse Design (Wkrs)	Van Nuys, CA	05/23/2000	Framed art, mirrors.
37,744	Sommers, Inc (Co.)	Stroudsburg, PA	05/23/2000	Narrow fabrics.
37,745	Louisiana Pacific (Wkrs)	Ketchikan, AK	05/19/2000	Lumber and chips.
37,746	N.N. Apparel, Inc (UNITE)	Mt. Vernon, NY	05/23/2000	Day and evening dresses.
37,747	Thomson 60 Case, LLC (USWA)	Lancaster, PA	05/25/2000	Steel shafting.
37,748	Coats North America (Wkrs)	Anniston, AL	05/23/2000	Sewing thread.
37,749	Cast Alloys, Inc (Wkrs)	Northridge, CA	05/23/2000	Metals.
37,750	Acme Steel Co. (USWA)	Riverdale, IL	05/19/2000	Hot rolled, cold rolled sheet and strip.
37,751	Hoff Forest Products (Co.)	Merridian, ID	05/24/2000	Wood mouldings.

[FR Doc. 00–16499 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA—3866]

Furniture Crafters, Grants Pass, Oregon; Notice of Termination of Investigation

Pursuant to section 221 of the Trade Act of 1974, an investigation was initiated on April 24, 2000, in response to a worker petition which was filed by a company official on behalf of its workers at Furniture Crafters, Grants Pass, Oregon.

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 9th day of June, 2000.

Grant D. Beale,

Program Manager, Division of Trade Adjustment Assistance.

[FR Doc. 00–16500 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA—03881]

Johnson Controls, Incorporated, Goshen, Indiana; 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 D, Chapter 2, Title II, of the Trade Act of 1974, as amended (19 U.S.C. 2273), an investigation was initiated on May 1, 2000 in response to a petition filed on behalf of workers at Johnson Controls, Incorporated, Goshen, Georgia.

In a letter dated May 31, 2000, the petitioners requested that the petition for NAFTA–TAA be withdrawn. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed at Washington, DC, this 12th day of June 2000.

Grant D. Beale,

Program Manager, Division of Trade Adjustment Assistance.

[FR Doc. 00–16504 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Mine Safety and Health Administration

Petitions for Modification

The following party has filed petitions to modify the application of the existing safety standard under section 101(c) of the Federal Mine Safety and Health Act of 1977.

1. Anthracite Underground Rescue, Inc.

[Docket Nos. M–2000–057–C through M–2000–083–C]

Anthracite Underground Rescue, Inc., 44 Crescent Street, Tremont, Pennsylvania 17981 has filed petitions to modify the application of 30 CFR 49.2 (availability of mine rescue teams) on behalf of the following Anthracite Underground Mines: (1) M & H Coal Co., (I.D. No. 36–01920), Docket No. M–2000–057–C; (2) UAE Coalcorp Assoc. (I.D. No. 36–07838), Docket No. M–2000–058–C; (3) M & M Coal Company (I.D. No. 36–08744), Docket No. M–2000–059–C; (4) H & R Coal Company (I.D. No. 36–08288), Docket No. M–2000–060–C; (5) AL Coal Company (I.D. No. 36–07018), Docket No. M–2000–061–C; (6) West End Coal Company (I.D. No. 36–07859), Docket No. M–2000–062–C; (7) Three W–M Coal Company (I.D. No. 36–08806), Docket No. M–2000–063–C); (8) Summit Anthracite, Inc., (I.D. No. 36–07328), Docket No. M–2000–064–C; (9) Snyder Rattling Run (I.D. No. 36–08713), Docket No. M–2000–065–C; (10) Snyder Coal Company, N&L Slope (I.D. No. 36–02203), Docket No. M–2000–066–C; (11) S & M Coal Company (I.D. No. 36–02022), Docket No. M–2000–067–C; (12) R S & W Coal Company (I.D. No. 36–01818), Docket No. M–2000–068–C; (13) Rhen Coal Company (I.D. No. 36–08031), Docket No. M–2000–069–C; (14) R & D Coal Company (I.D. No. 36–02053), Docket No. M–2000–070–C); (15) Primrose Coal Company (I.D. No. 36–08698), Docket No. M–2000–071–C; (16) Nowacki Coal Company (I.D. No. 36–07592), Docket No. M–2000–072–C; (17) Morgan Run Coal Company (I.D. No. 36–08559), Docket No. M–2000–073–C; (18) Little Rock Coal Company (I.D. No. 36–08320), Docket No. M–2000–074–C; (19) Little Buck Coal Company (I.D. No. 36–08568), Docket No. M–2000–075–C; (20) Jordan Coal Company (I.D. No. 36–07681), Docket No. M–2000–076–C; (21) Joliett Coal Company (I.D. No. 36–08702), Docket No. M–2000–077–C; (22) H L & W Coal Company (I.D. No. 36–07269), Docket No. M–2000–078–C; (23) B & L Coal Company (I.D. No. 36–08498), Docket No. M–2000–079–C; (24) FKZ Coal Company (I.D. No. 36–08637), Docket No. M–2000–080–C; (25) DJT Coal Company (I.D. No. 36–08454), Docket No. M–2000–081–C; (26) D & D (I.D. No. 36–08341), Docket No. M–2000–082–C; and (27) Chestnut Coal Company (I.D. No. 36–07059), Docket No. M–2000–083–C. The petitioner requests a modification of the standard to permit the reduction of two mine rescue teams with five members and one alternate each, to two mine rescue teams of three members with one alternate for either team for the Anthracite Underground Mines listed above. The petitioner asserts that application of the existing standard would result in a diminution of safety to the miners and that the proposed alternative method would provide at least the same measure of protection as the existing standard.

Request for Comments

Persons interested in these petitions are encouraged to submit comments via e-mail to ''comments@msha.gov,'' or on a computer disk along with an original hard copy to the Office of Standards, Regulations, and Variances, Mine Safety and Health Administration, 4015 Wilson Boulevard, Room 627, Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before July 31, 2000. Copies of these petitions are available for inspection at that address.

Dated: June 23, 2000.

Carol J. Jones,

Director, Office of Standards, Regulations, and Variances.

[FR Doc. 00–16465 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–43–P

DEPARTMENT OF LABOR

Mine Safety and Health Administration

Petitions for Modification

The following parties have filed petitions to modify the application of existing safety standards under section 101(c) of the Federal Mine Safety and Health Act of 1977.

1. Plateau Mining Company

[Docket No. M–2000–046–C]

Plateau Mining Company, One Oxford Centre, 301 Grant Street, 20th Floor,

Pittsburgh, Pennsylvania 15219–1410 has filed a petition to modify the application of 30 CFR 75.364(b)(2) (weekly examination) to its Star Point No. 2 Mine (I.D. No. 42–00171) located in Carbon County, Utah. Due to deteriorating roof and rib conditions in a portion of the Star Point No. 2 Mine, the petitioner proposes to establish check points to examine the affected area instead of traveling the area in its entirety, and to evaluate the evaluation points on a weekly basis. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard and that application of the existing standard would result in a diminution of safety to the miners.

2. Bowie Resources, Ltd.

[Docket No. M–2000–047–C]

Bowie Resources, Ltd., P.O. Box 1488, 1720 4010 Drive, Paonia, Colorado 81428 has filed a petition to modify the application of 30 CFR 75.701 (grounding metallic frames, casings, and other enclosures of electric equipment) to its Bowie Mine (I.D. No. 05–04591) located in Delta County, Colorado. The petitioner proposes to use a 460 KW, 480 volt, wye connected diesel powered generator for utility power and to move electrically powered mining equipment throughout the mine. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard.

3. Bowie Resources, Ltd.

[Docket No. M–2000–048–C]

Bowie Resources, Ltd., P.O. Box 1488, 1720 4010 Drive, Paonia, Colorado 81428 has filed a petition to modify the application of 30 CFR 75.901(a) (protection of low-and medium-voltage three-phase circuits used underground) to its Bowie Mine (I.D. No. 05–04591) located in Delta County, Colorado. The petitioner proposes to use a 460 KW, 480 volt, wye connected diesel powered generator to move and operate electrically powered mobile equipment and stationary equipment throughout the mine. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard.

4. Bowie Resources, Ltd.

[Docket No. M–2000–049–C]

Bowie Resources, Ltd., P.O. Box 1488, 1720 4010 Drive, Paonia, Colorado 81428 has filed a petition to modify the application of 30 CFR 75.500(d) (permissible electric equipment) to its Bowie Mine (I.D. No. 05–04591) located in Delta County, Colorado. The petitioner proposes to use the following nonpermissible low-voltage or battery powered electronic testing and diagnostic equipment inby the last open crosscut: lap top computers, oscilloscopes, vibration analysis machines, cable fault detectors, point temperature probes, infrared temperature devices, resistance measurement devices, recorders, pressure and flow measurement devices, current measurement devices, signal analyzer devices, thickness gauges, power analyzers, component testers, electronic tachometers, and volt ohm meters. The petitioner has listed in this petition for modification specific procedures that would be followed when using this equipment. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard.

5. Bowie Resources, Ltd.

[Docket No. M–2000–050–C]

Bowie Resources, Ltd., P.O. Box 1488, 1720 4010 Drive, Paonia, Colorado 81428 has filed a petition to modify the application of 30 CFR 75.1002–1(a) (location of trolley wires, trolley feeder wires, high-voltage cables and transformers) to its Bowie Mine (I.D. No. 05–04591) located in Delta County, Colorado. The petitioner proposes to use the following nonpermissible low-voltage or battery powered electronic testing and diagnostic equipment inby the last open crosscut: lap top computers, oscilloscopes, vibration analysis machines, cable fault detectors, point temperature probes, infrared temperature devices, resistance measurement devices, recorders, pressure and flow measurement devices, current measurement devices, signal analyzer devices, thickness gauges, power analyzers, component testers, electronic tachometers, and volt ohm meters. The petitioner has listed in this petition for modification specific procedures that would be followed when using this equipment. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard.

6. Alex Energy, Inc.

[Docket No. M–2000–051–C]

Alex Energy, Inc., P.O. Box 857, Summersville, West Virginia 26651 has filed a petition to modify the application of 30 CFR 75.1002 (location of trolley wires, trolley feeder wires, high-voltage cables and transformers) to its Jerry Fork Eagle Mine (I.D. No. 46–08787) located in Nicholas County, West Virginia. The petitioner proposes to use high-voltage longwall mining equipment, with the nominal voltage of the longwall power circuits not to exceed 4,160 volts. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard.

7. Perry County Coal Corporation

[Docket No. M–2000–052–C]

Perry County Coal Corporation, P.O. Box 5001, Hazard, Kentucky 41702 has filed a petition to modify the application of 30 CFR 75.1911(d) (fire suppression systems for diesel-powered equipment and fuel transportation units) to its Eas #1 Mine (I.D. No. 15–02085) located in Perry County, Kentucky. The petitioner proposes to use either manual fire suppression actuators or the automatic fire suppression system, without the automatic engine shut-down portion, on the 35 ton locomotives and the 12 ton locomotives which haul coal and empty mine cars for all rail haulage. The petitioner asserts that if the diesel locomotive engines were to shut down, the brakes would lock up, causing the coal cars to create a train reaction and derail the locomotive causing injury to the locomotive operator. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard.

8. Rustler Coal Company

[Docket No. M–2000–053–C]

Rustler Coal Company, 66 South Tremont Street, Zerbe, Pennsylvania 17981 has filed a petition to modify the application of 30 CFR 49.2(b) (availability of mine rescue teams) to its Orchard Slope Mine (I.D. No. 36–08346) located in Schuylkill County, Pennsylvania. The petitioner requests a modification of the standard to permit the reduction of two mine rescue teams with five members and one alternate each, to two mine rescue teams of three members with one alternate for either team. The petitioner asserts that application of the existing standard would result in a diminution of safety to the miners and members of the rescue team and that the proposed alternative method would provide at least the same measure of protection as the existing standard.

9. Wayne Processing, Inc.

[Docket No. M–2000–054–C]

Wayne Processing, Inc., 22 Hampton Road, Buckhannon, West Virginia 26201

has filed a petition to modify the application of 30 CFR 75.350 (air courses and belt haulage entries) to its Spruce Fork Mine No. 1 (I.D. No. 46–08622) located in Upshur County, West Virginia. The petitioner requests a modification of the standard to allow air coursed through belt haulage entries to be used to ventilate active working places. The petitioner proposes to install a low-level carbon monoxide detection system in all belt entries at certain locations as an early warning fire detection system. The petitioner also proposes to adhere to other conditions. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard.

10. RAG Cumberland Resources LP

[Docket No. M–2000–055–C]

RAG Cumberland Resources LP, One Oxford Centre, 301 Grant Street, 20th Floor, Pittsburgh, Pennsylvania 15219–1410 has filed a petition to modify the application of 30 CFR 75.1002 (location of trolley wires, trolley feeder wires, high-voltage cables and transformers) to its Cumberland Mine (I.D. No. 36–05018) located in Greene County, Pennsylvania. The petitioner requests that the Proposed Decision and Order (PDO) for its previously granted petition, docket number M–92–99–C, be amended. The petitioner requests that Item #29 of the PDO be amended to allow the widths and lengths of its panels to be increased, and that Item #31 of the PDO be amended to read as follows: A primary escapeway maintained in accordance with 30 CFR 75.380 shall be provided on the headgate end of all longwall panels. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard.

11. Dominion Coal Corporation

[Docket No. M–2000–056–C]

Dominion Coal Corporation, P.O. Box 70, Vansant, Virginia 24656 has filed a petition to modify the application of 30 CFR 77.214(a) (refuse piles; general) to its Dominion Mine No. 22 (I.D. No. 44–06645) located in Buchanan County, Virginia. The petitioner requests a modification of the existing standard to allow abandoned mine openings to be covered with coarse refuse material for the Dominion Mine No. 22, MSHA Site ID #1211–VA5–0335–01. The petitioner proposes to construct a refuse bench fill in abandoned mine openings using the specific plans and procedures outlined in this petition for modification. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard.

12. Basic Mining Corp.

[Docket No. M–2000–084–C]

Basic Mining Corp., P.O. Box 1197, Vansant, Virginia 24656 has filed a petition to modify the application of 30 CFR 75.1710–1(a) (canopies or cabs; self-propelled diesel-powered and electric face equipment; installation requirements) to its Mine No. 2 (I.D. No. 44–05032) located in Dickenson County, Virginia. The petitioner requests a modification of the existing standard to permit its Joy 21 SC Shuttle Cars, Joy 14CM Miners, and Long Airdox LRB15A Roof Drills to be operated without canopies. The petitioner asserts that application of the existing standard would result in a diminution of safety of the miners and that the proposed alternative method would provide at least the same measure of protection as the existing standard.

13. FMC Corporation

[Docket No. M–2000–003–M]

FMC Corporation, P.O. Box 872, Green River, Wyoming 82935 has filed a petition to modify the application of 30 CFR 57.22305 (approved Equipment (III mines)) to its Westvaco Mine (I.D. No. 48–00152) located in Sweetwater County, Wyoming. The petitioner proposes to use a cordless drill or other equivalent drills to install surveying spads in the mine roof to minimize the potential of developing cumulative trauma disorders in the wrists, elbows, and shoulders of the surveyors. The petitioner states that methane will be tested before using the drills and if one percent or more of methane is found, drilling will not begin and that drilling will cease if one percent or more of methane is found during drilling. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard.

14. Greer Industries, Inc., d/b/a Deckers Creek Limestone Company and Green Limestone Company

[Docket No. M–2000–004–M]

Greer Industries, Inc., P.O. Box 1900, Morgantown, West Virginia 26507–1900 has filed a petition to modify the application of 30 CFR part 48 (training and retraining of miners working at surface mines and surface areas of underground mines) to the Deckers Creek Limestone Company, Deckers Creek Mine (I.D. No. 46–00029) and the Greer Limestone Company, Greer Mine and Mill (I.D. No. 46–00016) both located in Monongalia County, West Virginia. The petitioner requests a modification of the existing standard to allow over-the-road contracted delivery trucks used to ship limestone material to go to an underground stockpile area to be loaded for a limited time and purpose. The petitioner states that the truck drivers would not be allowed out of their trucks at any time while receiving their load, the Greer Industries alternative safety plan would provide adequate protection to ensure the safety of all contracted delivery trucks drivers, and that all delivery truck drivers would receive site specific hazard training. The petitioner asserts that the proposed alternative method would provide at least the same measure of protection as the existing standard.

15. Frontier-Kemper Constructors, Inc. [Docket No. M–2000–005-M]

Frontier-Kemper Constructors, Inc., P.O. Box 460, Kearny, Arizona 85237 has filed a petition to modify the application of 30 CFR 57.9360 (shelter holes) to the Asarco Mineral Creek Water Diversion Tunnel at the Asarco Ray Complex (I.D. No. 02–00150), P.O. Box 8, Hayden, Arizona 85236, located in Pinal County, Arizona. The petitioner proposes to construct a tunnel 18 feet, 10 inches in diameter using a CTS Tunnel Boring Machine, Model 490–013, with ground support provided by the installation of segmented 6-inch ring steel flush to the excavated circumference. The petitioner states that the tunnel boring process, a 24-inch elevated conveyor will run from the Tunnel Boring Machine trailing gear to the portal and mounted to the rib and narrow gauge, 36-inch rails will run down the center of the tunnel, pedestrian traffic within the tunnel will be limited to necessary personnel for periodic inspections and/or maintenance; Asarco's production area will not be a part of the tunnel; and all miners at Frontier-Kemper Constructors, Inc. will be transported to the face by rail-mounted conveyance. The petitioner asserts the proposed alternative method would allow for the use of Safety Platforms instead of shelter-holes and would provide at least the same measure of protection as the existing standard.

Request for Comments

Persons interested in these petitions are encouraged to submit comments via e-mail to ''comments@msha.gov,'' or on a computer disk along with an original hard copy to the Office of Standards, Regulations, and Variances, Mine Safety and Health Administration, 4015 Wilson Boulevard, Room 627,

Arlington, Virginia 22203. All comments must be postmarked or received in that office on or before July 31, 2000. Copies of these petitions are available for inspection at that address.

Dated: June 19, 2000.

Carol J. Jones,

Director, Office of Standards, Regulations, and Variances.

[FR Doc. 00–16486 Filed 6–28–00; 8:45 am]

BILLING CODE 4510–43–P

NATIONAL FOUNDATION ON THE ARTS AND HUMANITIES

Cooperative Agreement for Continued Management of ArtsLink

AGENCY: National Endowment for the Arts.

ACTION: Notification of availability.

SUMMARY: The National Endowment for the Arts is requesting proposals leading to one (1) award of a Cooperative Agreement to a nonprofit organization for continued management of ArtsLink. ArtsLink is a public-private partnership that offers opportunities for artistic exchange between the United States and the countries of Eastern and Central Europe and the former Soviet Union. The project awards grants to U.S. artists and arts organizations, and supports residencies. The work includes managing all phases of proposal review, artists and residency placements, and the financial award process, including the management of logistical arrangements for residencies, in regard to participants' arrival, lodging, and transfer to host organization locations. The successful recipient of the Cooperative Agreement will be expected to contribute matching funds of at least $75,000. Those interested in receiving the Solicitation package should reference Program Solicitation PS 00–07 in their written request and include two (2) self-addressed labels. Verbal requests for the Solicitation will not be honored. It is anticipated that the Program Solicitation will also be posted on the Endowment's Web site at http://www.arts.gov.

DATES: Program Solicitation PS 00–07 is scheduled for release approximately July 17, 2000 with proposals due on August 17, 2000.

ADDRESSES: Requests for the Solicitation should be addressed to the National Endowment for the Arts, Grants & Contracts Office, Room 618, 1100 Pennsylvania Ave., NW, Washington, D.C. 20506.

FOR FURTHER INFORMATION CONTACT: William Hummel, Grants & Contracts Office, National Endowment for the Arts, Room 618, 1100 Pennsylvania Ave., NW, Washington, D.C. 20506 (202/682–5482).

William I. Hummel,

Coordinator, Cooperative Agreements.

[FR Doc. 00–16487 Filed 6–28–00; 8:45 am]

BILLING CODE 7537–01–M

NATIONAL SCIENCE FOUNDATION

Agency Information Collection activities: Comment Request; Notice.

TITLE: Generic Survey Clearance of the Science Resources Studies Survey Improvement Projects and Quick Response Studies.

SUMMARY: Under the Paperwork Reduction Act of 1995, Pub. L. 104–13 (44 U.S.C. 3506(c)(2)(A)), and as part of its continuing effort to reduce paperwork and respondent burden, the National Science Foundation invites the general public and other Federal agencies to take this opportunity to comment on this new information collection.

COMMENT DUE DATE: Written comments should be received by August 28, 2000 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, the NSF Reports Clearance Officer, phone (703) 306–1125, or send e-mail to splimpto@nsf.gov. You may also obtain a copy of the data collection plans and instruments from Ms. Suzanne Plimpton, NSF Reports Clearance Officer, National Science Foundation, 4201 Wilson Blvd., Suite 295, Arlington, VA 22230, phone (703) 306–1125. 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:

Abstract

Generic Survey Clearance of the Science Resources Studies Survey Improvement Projects and Quick Response Studies. The National Science Foundation's (NSF) Division of Science Resources Studies (SRS) needs to collect timely data on constant changes in the science and technology sector and to provide the information to policy makers in Congress and throughout the Government. SRS will sponsor quick response surveys and workshops on science and technology subjects, perform cognitive testing to improve survey methodology and questionnaires, and pretest questions for future large-scale surveys.

Expected Respondents

The respondents will be from industry, academia, nonprofit organizations, members of the public, and Federal agencies. Data and information collection will be by mail, Internet, World Wide Web, telephone, visits, and/or workshops. As the table below shows, as many as 355 institutions will be contacted. No institution will be contacted more than twice in one year. Members of the public may be contacted for a survey of public attitudes toward science.

The information from the respondents is needed to provide policy makers with updates of the economic, financial, employment, and education situation in the science and technology sector of industry, academia, and nonprofit organizations. The information will also help NSF improve its current data collection instruments and processes.

To minimize burden on small entities and to make sure that a high proportion of the science and technology universe is captured, most respondent selection will be designed with probability proportional to size. It is possible that during the 3 years of the survey clearance, NSF will study an issue that focuses on small entities, such as start-up high-technology companies. In this case, every effort will be made to use technology to limit the burden on respondents from small entities.

Information being collected is not considered to be sensitive. In general, assurance of data confidentiality will not be provided to respondents to the Generic Survey Clearance of the Science Resources Studies Survey Improvement Projects and Quick Response Studies. Instead, respondents have the option of requesting that any and all data they submit be kept confidential.

Use of the Information

The purpose of these studies is to collect information on the science and technology sector to respond to questions from policy makers and to improve the current NSF science and technology surveys. NSF will publish a separate report on the findings and also

include them in other NSF compilations such as National Patterns of R&D Resources and Science and Engineering Indicators. In most cases the data and information will be made available on the World Wide Web. The results of surveys and studies will help policy makers in decisions on research and development funding, regulations, and reporting guidelines.

Burden on the Public

NSF estimates that a total reporting and recordkeeping burden of 5,860 hours will result from the collection of information. The calculation is:

Survey Name	Number of Respondents	Hours
Cognitive testing-Survey of Scientific & Engineering Research Facilities	50	100
Cognitive testing-Survey of R&D Funding & Performance by Nonprofit Organizations	30	60
Quick Response Survey for understanding change in R&D in the industrial sector	50	300
Workshops on surveys & economic issues	25	600
Additional surveys not specified	200	4,800
Total	355	5,860

Request for Comments

We invite comments specifically on:

(a) Whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility;

(b) The accuracy of the Agency's estimate of the burden of 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 collection of information on respondents, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of this information collection; they also will become a matter of public record.

Dated: June 26, 2000.

Suzanne Plimpton,

Reports Clearance Officer.

[FR Doc. 00–16512 Filed 6–28–00; 8:45 am]

BILLING CODE 7555–01–M

NUCLEAR REGULATORY COMMISSION

[Docket No. 40–8905]

Quivira Mining Company

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of receipt of Quivira Mining Company's Application for establishing Alternate Concentration Limits in Source Material License SUA–1473 for the Ambrosia Lake, New Mexico, facility and notice of opportunity for a hearing.

SUMMARY: Notice is hereby given that the U.S. Nuclear Regulatory Commission (NRC) has received, by letter dated February 17, 2000, an application from Quivira Mining Company (Quivira) to establish Alternate Concentration Limits and amend the Source Material License No. SUA–1473 for the Ambrosia Lake uranium mill facility.

FOR FURTHER INFORMATION CONTACT: Jill S. Caverly, Fuel Cycle Licensing Branch, Division of Fuel Cycle Safely and Safeguards U.S. Nuclear Regulatory Commission, Washington, DC 20555. Telephone (301) 415–6699.

SUPPLEMENTARY INFORMATION: The NRC hereby provides notice of an opportunity for a hearing on the license amendment under the provisions of 10 CFR Part 2, Subpart L, ''Informal Hearing Procedures for Adjudications in Materials and Operator Licensing Proceedings.'' Pursuant to § 2.1205(a), any person whose interest may be affected by this proceeding may file a request for a hearing. In accordance with § 2.1205(d), a request for hearing must be filed within 30 days of the publication of this notice in the **Federal Register**. The request for a hearing must be filed with the Office of the Secretary, either:

(1) By delivery to the Docketing and Service Branch of the Office of the Secretary at One White Flint North, 11555 Rockville Pike, Rockville, MD 20852; or

(2) By mail or telegram addressed to the Secretary, U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Docketing and Service Branch.

In accordance with 10 CFR 2.1205(f), each request for a hearing must also be served, by delivering it personally or by mail, to:

(1) The applicant, Quivira Mining Company, 6305 Waterford Blvd., Suite 325, Oklahoma City, Oklahoma 73118, Attention: William Paul Goranson; and

(2) The NRC staff, by delivery to the General Counsel, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852, or by mail addressed to the General Counsel, U.S. Nuclear Regulatory Commission, Washington, DC 20555.

In addition to meeting other applicable requirements of 10 CFR part 2 of the NRC's regulations, a request for a hearing filed by a person other than an applicant must describe in detail:

(1) The interest of the requestor in the proceeding;

(2) How that interest may be affected by the results of the proceeding, including the reasons why the requestor should be permitted a hearing, with particular reference to the factors set out in § 2.1205(h);

(3) The requestor's areas of concern about the licensing activity that is the subject matter of the proceeding; and

(4) The circumstances establishing that the request for a hearing is timely in accordance with § 2.1205(d).

The request must also set forth the specific aspect or aspects of the subject matter of the proceeding as to which petitioner wishes a hearing.

In addition, members of the public may provide comments on the subject application within 30 days of the publication of this notice in the **Federal Register**. The comments may be provided to David L. Meyer, Chief, Rules Review and Directives Branch, Division of Freedom of Information and Publications Services, Office of Administration, U.S. Nuclear Regulatory Commission, Washington DC 20555.

Dated at Rockville, Maryland, this 22nd day of June 2000.

For the U.S. Nuclear Regulatory Commission.

Philip Ting,

Chief, Fuel Cycle Licensing Branch, Division of Fuel Cycle Safety and Safeguards, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 00–16442 Filed 6–28–00; 8:45 am]

BILLING CODE 7590–01–P

POSTAL SERVICE

Sunshine Act Meeting

AGENCY: United States Postal Service Board of Governors

TIMES AND DATES: 10:00 a.m., Monday, July 10, 2000; 8:30 a.m., Tuesday, July 11, 2000.

PLACE: Washington, DC, at U.S. Postal Service Headquarters, 475 L'Enfant Plaza, SW., in the Benjamin Franklin Room.

STATUS: July 10 (Closed); July 11 (Open).

MATTERS TO BE CONSIDERED:

Monday, July 10—10:00 a.m. (Closed)

1. Financial Performance and Schedule for Fiscal Year 2001 Integrated Financial Plan.
2. Strategic Planning.
3. Rate Case Update.
4. International Funds Transfer.
5. Priority Mail Processing Centers (PMPCs).
6. Personnel Matters.
7. Compensation Issues.

Tuesday, July—8:30 a.m. (Open)

1. Minutes of the Previous Meeting, June 5–6, 2000.
2. Remarks of the Postmaster General/ Chief Executive Officer.
3. Board Resolution on Capital Funding.
4. Quarterly Report on Service Performance.
5. Quarterly Report on Financial Results.
6. Capital Investments.
   a. Surface-Air Management System (SAMS).
   b. Delivery Operations Information System (DOIS).
   c. 362 Automated Flat Sorting Machine (AFSM) 100s.
   d. Mail Evaluation Instrument (MERLIN).
7. Tentative Agenda for the August 7–8, 2000, meeting in Reno, Nevada.

CONTACT PERSON FOR MORE INFORMATION: David G. Hunter, Secretary of the Board, U.S. Postal Service, 475 L'Enfant Plaza, SW., Washington, DC 20260–1000. Telephone (202) 268–4800.

David G. Hunter,

Secretary.

[FR Doc. 00–16668 Filed 6–27–00; 3:33 pm]

BILLING CODE 7710–12–M

RAILROAD RETIREMENT BOARD

Proposed Collection; Comment Request

SUMMARY: In accordance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 which provides opportunity for public comment on new or revised data collections, the Railroad Retirement Board (RRB) will publish periodic summaries of proposed data collections.

Comments are invited on: (a) Whether the proposed information collection is necessary for the proper performance of the functions of the agency, including whether the information has practical utility; (b) the accuracy of the RRB's estimate of the burden of the collection of the information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden related to the collection of information on respondents, including the use of automated collection techniques or other forms of information technology.

Title and purpose of information collection:

Job Information Report, OMB 3220–0193.

In July of 1997, the Railroad Retirement Board (RRB) adopted standards for the adjudication of occupational disabilities under the Railroad Retirement Act (RRA). As part of these standards, the RRB requests job information to determine an applicants eligibility for an occupational disability. The job information received from the railroad employer and railroad employee is compared, reconciled (if needed), and then used in the occupational disability determination process. The process of obtaining information from railroad employers used to determine an applicant's eligibility for an occupational disability is outlined in 20 CFR 220.13.

To determine an occupational disability, the RRB determines if an employee is precluded from performing the full range of duties of his or her regular railroad occupation. This is accomplished by comparing the restrictions on impairment(s) causes against an employee's ability to perform his/her normal duties. To collect information needed to determine the effect of a disability on an applicant's ability to work, the RRB needs the applicant's work history. The RRB currently utilizes Form G–251, *Vocational Report* (OMB 3220–0141), to obtain this information from the employee applicant.

Note: Form G–251 is provided to *all* applicants for employee disability annuities and to those applicants for a widow(er)'s disability annuity who indicate that they have been employed at some time.

In accordance with the standards, the RRB also requests pertinent job information from employers. The employer is given thirty days from the date of the notice to respond. The responses are not required, but are voluntary. If the job information is received timely, it is compared to the job information provided by the employee. Any material differences are resolved by an RRB disability examiner. Once resolved, the information is compared to the restrictions caused by the medical impairment. If the restrictions prohibit the performance of the regular railroad occupation, the claimant is found occupationally disabled.

The RRB uses two forms to secure job information data from the railroad employer. RRB Form G–251a, Employer Job Information (job description), is released to an employer when an application for an occupational disability is filed by an employee whose regular railroad occupation is one of the more common types of railroad jobs (locomotive engineer, conductor, switchman, *etc.*) It is accompanied by a * generic job description * for that particular railroad job. The generic job descriptions describe how these select occupations are generally performed in the railroad industry. However, not all occupations are performed the same way from railroad to railroad. Thus, the employer is given an opportunity to comment on whether the job description matches the employee's actual duties. If the employer concludes that the generic job description accurately describes the work performed by the applicant, no further action will be necessary. If the employer determines that the tasks are different, it may provide the RRB with a description of the actual job tasks. The employer has thirty days from the date the form is released to reply.

Note: The generic job descriptions were prepared and approved by a joint committee consisting of representatives of railroad labor and railroad management.

Proposes Form G–251b, Employer Fob Information (general), is released to an employer when an application for an RRB occupational disability is filed by an employee whose regular railroad occupation does not have a generic job description. It notifies the employer that the employee has filed for a disability annuity and that, if the employer wishes, it may provide the RRB with job duty information. The type of information RRB is seeking is outlined on the form. the employer has thirty days from the date the form is released to reply.

The RRB proposes minor non-burden impacting changes to Form–251a and G–251b. The completion time for Form G–251a and G–251b is estimated at 20 minutes. Completion is voluntary. The RRB estimates that approximately 125

G–251a's and 305 G–251b's are completed annually.

FOR FURTHER INFORMATION CONTACT: To request more information or to obtain a copy of the information collection justification, forms, and/or supporting material, please call the RRB Clearance Officer at (312) 751–3363. Comments regarding the information collection should be addressed to Ronald J. Hodapp, Railroad Retirement Board, 844 N. Rush Street, Chicago, Illinois 60611–2092. Written comments should be received within 60 days of this notice.

Chuck Mierzwa,

Clearance Officer.

[FR Doc. 00–16488 Filed 6–28–00; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. IC–24544; File No. 812–12048]

Investment Company Act of 1940; Potomac Insurance Trust, et al.

June 22, 2000.

AGENCY: Securities and Exchange Commission (''SEC'').

ACTION: Notice of application for an order of exemption under section 6(c) of the Investment Company Act of 1940 (''1940 Act'') for exemption from sections 9(a), 13(a), 15(a) and 15(b) of the 1940 Act and Rules 6e–2(b)(15) and 6e–3(T)(b)(15) thereunder.

SUMMARY OF APPLICATION: Applicants seek an order pursuant to section 6(c) of the 1940 Act for exemptions from the provisions of sections 9(a), 13(a) and 15(b) of the 1940 Act and Rules 6e–2(b)(15) and 6e–3(T)(b)(15) thereunder to the extent necessary to permit shares of any current or future series of the Fund and shares of any other investment company that is designed to fund variable insurance products and for which Rafferty Asset Management, LLC (''Rafferty''), or any of its affiliates, may serve now or in the future, as investment adviser (the Fund and such other investment companies referred to collectively as the ''Insurance Products Funds'') to be offered and sold to, and held by variable annuity and variable life insurance separate accounts of both affiliated and unaffiliated insurance companies (''Participating insurance Companies''), qualified pension and retirement plans outside of the separate account context (''Qualified Plans''), and Rafferty or any of its affiliates (representing seed money investments in the insurance Products Funds)(''Order'').

APPLICANTS: Potomac Insurance Trust (''Fund'') and Rafferty Asset Management, LLC (''Rafferty'')

FILING DATE: This application was filed on March 24, 2000.

HEARING OF NOTIFICATION OF HEARING: An Order granting the application will be issued unless the Commission orders a hearing. Interested persons may request a hearing is the application or ask to be notified if a hearing is ordered. Any requests must be received by the Commission by 5:30 p.m. on July 17, 2000. You may request a hearing in writing, giving the nature of your interest, the reason for your request, and the issues you contest, and accompany such request with proof of service on the Applicants in the form of an affidavit or, for lawyers, a certificate of service. Persons who wish to be notified of a hearing may request notification by writing to the Commission's Secretary.

ADDRESSES: Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Applicants, Daniel D. O'Neill, Esq., Managing Director, Rafferty Asset Management, LLC, 1311 Mamaroneck Avenue, White Plains, New York 10605.

FOR FURTHER INFORMATION CONTACT: Lorna MacLeod, Senior Counsel, or Keith Carpenter, Branch Chief, Office of Insurance Products, Division of Investment Management, at (202) 942–0670.

SUPPLEMENTARY INFORMATION: The following is a summary of the application, the complete Application is available for a fee from the Commission's Public Reference Branch, 450 Fifth Street, NW., Washington, DC 20549–0102 (tel. (202) 942–8090).

Applicants' Representations

1. The Fund is a Massachusetts business trust registered under the 1940 Act as an open-end management company. The Fund currently is comprised of thirteen separately managed series, each of which has its own investment objective and policies.[1] Each series offers Class A and Class B shares, each of which have a different expense structure. Additional series could be added in the future.

2. Rafferty is registered under the Investment Advisers Act of 1940 and serves as the investment adviser for the Fund.

3. Shares of the Insurance Products Funds are or will be offered to separate accounts of Participating Insurance Companies to serve as investment vehicles for variable annuity and variable life insurance contracts (including single, premium, scheduled premium, modified single premium and flexible premium contracts) (collectively, ''Variable Contracts''). These separate accounts either will be registered as investment companies under the 1940 Act or will be exempt from such registration. Shares of the Insurance Product Funds also are or will be offered to Qualified Plans.

4. The Participating Insurance Companies establish their own separate accounts and design their own Variable Contracts. Each Participating Insurance Company will have the legal obligation of satisfying all applicable requirements under the federal securities laws. The role of the Insurance Products Funds will be limited to that of offering their shares to separate accounts of Participating Insurance Companies and to Qualified Plans and fulfilling the conditions set forth in the application and described later in this notice. Each Participating Insurance Company will enter into a fund participating agreement with the Insurance Products Fund in which the Participating Insurance Company invests.

Applicants' Legal Analysis

1. Applicants request that the Commission issue an order under section 6(c) of the 1940 Act granting exemptions from sections 9(a), 13(a), 15(a) and 15(b) thereof and Rules 6e–2(b)(15) and 6e–3(T)(b)(15) thereunder, to the extent necessary to permit shares of the Insurance Products Funds to be offered and sold to, and held by (a) variable annuity and variable life insurance separate accounts of the same life insurance company or of any affiliated life insurance company (''mixed funding''); (b) separate accounts of unaffiliated life insurance companies (including both variable annuity and variable life separate accounts) (''shared funding''); (c) qualified pension and retirement plans outside the separate account context; and (d) the Adviser or any of its affiliates (representing seed money investments in the Insurance Products Funds).

2. In connection with the funding of scheduled premium variable life insurance contracts issued through a separate account registered under the 1940 Act as a unit investment trust, Rule 6e–2(b)(15) provides partial exemptions from section 9(a), 13(a), 15(a) and 15(b) of the 1940 Act. These

[1] The Fund's series are: Potomac OTC Plus Fund, Potomac OTC/Short Fund, Potomac 30 Plus Fund, Potomac 30/Short Fund, Potomac Small Cap Plus Fund, Potomac Small Cap/Short Fund, Potomac Internet Plus Fund, Potomac Internet/Short Fund, Potomac U.S. Plus Fund, Potomac U.S./Short Fund, Potomac Japan Plus Fund, Potomac Japan/Short Fund and Potomac Money Market Fund.

exemptions are available only where all of the assets of the separate account consists of the shares of one or more registered management investment companies which offer their shares exclusively to variable life insurance separate accounts of the life insurer of any affiliated life insurance company. Therefore, the relief granted by Rule 6e–2(b)(15) is not available if the scheduled premium variable life insurance separate account owns shares of a management investment company that also offers its shares to a variable annuity separate account of the same insurance company or an affiliated insurance company. In addition, the relief granted by Rule 6e–2(b)(15) is not available if the scheduled premium variable life insurance separate account owns shares of an underlying management investment company that also offers its shares to separate accounts funding variable contracts of one or more unaffiliated life insurance companies. The relief granted by Rule 6e–2(b)(15) also is not available if the shares of the Insurance Products Funds also are sold to Qualified Plans.

3. In connection with the funding of flexible premium variable life insurance contracts issued through a separate account registered under the 1940 Act as a unit investment trust, Rule 6e–3(T)(b)(15) provides partial exemptions from sections 9(a), 13(a), 15(a) and 15(b) of the 1940 Act. These exemptions are available only where all of the assets of the separate account consists of the shares of one or more registered management investment companies which offer their shares exclusively to separate accounts of the life insurer, or any affiliated life insurance company, offering either scheduled premium variable life insurance contracts or flexible premium variable life insurance contracts, or both; or which also offer their shares to variable annuity separate accounts of the life insurer or of an affiliated life insurance company. Therefore, the exemptions provided by Rule 6e–3(T)(b)(15) are available if the underlying fund is engaged in mixed funding, but are not available if the fund is engaged in shared funding or if the fund sells its shares to Qualified Plans.

4. Applicants state that the current tax law permits the Insurance Products Funds to increase their assets base through the sale of shares to Qualified Plans. Section 817(h) of the Internal Revenue Code of 1986, as amended (the ''Code''), imposes certain diversification standards on the underlying assets of Variable Contracts. The Code provides that such contracts shall not be treated as an annuity contract or life insurance contract for any period (and any subsequent period) during which the investments are not adequately diversified in accordance with regulations prescribed by the Treasury Department. Treasury regulations provide that, to meet the diversification requirements, all of the beneficial interests in an investment company must be held by the segregated assets accounts of one or more insurance companies. The regulations do contain certain exceptions to this requirement, however, one of which permits shares of an investment company to be held by the trustee of a qualified pension or retirement plan without adversely affecting the ability of shares in the same investment company also to be held by the separate accounts of insurance companies in connection with their variable annuity and variable life contracts (Treas. Reg. 1.817.5(f)(3)(iii)).

5. Applicants state that the promulgation of Rules 6e–2 and 6e–3(T) preceded the issuance of these Treasury regulations. Applicants assert that, given the then current tax law, the sale of shares of the same underlying fund to separate accounts and to Plans could not have been envisioned at the time of the adoption of rules 6e–2(b)(15) and 6e–3(T)(b)(15).

6. Applicants request relief for a class or classes of persons and transactions consisting of Participating Insurance Companies and their scheduled premium variable life insurance separate accounts and flexible premium variable life insurance separate accounts (and, to the extent necessary, any investment adviser, principal underwriter and depositor of such separate accounts) investing in any of the Insurance Products Funds.

7. Section 6(c) authorizes the Commission to grant exemptions from the provisions of the 1940 Act, and rules thereunder, if and to the extent that an exemption is necessary or appropriate in the public interest and consistent with the protection of investors and the purposes fairly intended by the policy and provisions of the 1940 Act. Applicants assert that the requested exemptions are appropriate in the public interest and consistent with the protection of investors and the purposes fairly intended by the policy and provisions of the 1940 Act.

8. Section 9(a)(3) of the 1940 Act provides that it is unlawful for any company to act as investment adviser to or principal underwriter of any registered open-end investment company if an affiliated person of that company is subject to a disqualification enumerated in Sections 9(a)(1) or (2). Rules 6e–2(b)(15)(i) and (ii), and 6c–3(T)(b)(15)(i) and (ii) provide partial exemptions from section 9(a) under certain circumstances, subject to the limitations on mixed and shared funding. These exemptions limit the application of eligibility restrictions to affiliated individuals or companies that directly participate in the management or administration of the underlying investment company.

9. Applicants state that the relief from section 9(a) provided by Rules 6e–2(b)(15) and 6c–3(T)(b)(15), in effect, limits the amount of monitoring necessary to ensure compliance with section 9 to that which is appropriate in light of the policy and purposes of Section 9. Applicants assert that it is not necessary for the protection of investors or the purposes fairly intended by the policy and provisions of the 1940 Act to apply the provisions of section 9(a) to the many individuals who do not directly participate in the administration or management of the Insurance Products Funds, who are employed by the various unaffiliated insurance companies (or affiliated companies of Participating Insurance Companies) that may utilize the Insurance Products Funds as the funding medium for Variable Contracts. Applicants do not expect the Participating Insurance Companies to play any role in the management or administration of the Insurance Products Funds. Applicants assert, therefore, that applying the restrictions of section 9(a) to individuals employed by Participating Insurance Companies serves no regulatory purpose.

10. Applicants state that the relief requested should not be affected by the proposed sale of Insurance Products Funds to Qualified Plans because such plans are not investment companies and will not be deemed affiliates solely by virtue of their shareholdings.

11. Applicants submit that Rule 6e–2(b)(15)(iii) and 6e–3(T)(b)(15)(iii) assume the existence of a ''pass-through voting'' requirement with respect to management investment company shares held by a separate account. Applicants state that Rule 6e–2(b)(15)(iii) and 6e–3(T)(b)(15)(iii) provide exceptions from the pass-through voting requirements in limited situations, assuming the limitations on mixed and shared funding imposed by the 1940 Act and the rules thereunder are observed. More specifically, Rules 6e–2(b)(15)(iii)(A) and 6e–3(T)(b)(15)(iii)(A) provide that the insurance company may disregard the voting instructions of its contract owners in connection with the voting of shares of an underlying investment company if such instructions would

require such shares to be voted to cause an underlying investment company to make, or refrain from making, certain investments which would result in changes in the sub-classification or investment objectives of such company, or to approve or disapprove any contract between an investment company and its investment adviser, when required to do so by an insurance regulatory authority. In addition, Rules 6e–2(b)(15)(iii)(B) and 6e–3(T)(b)(15)(iii)(B) provide that an insurance company may disregard contract owners' voting instructions with regard to changes initiated by the contract owners in the investment company's investment policies, principal underwriter or investment adviser, provided that disregarding such voting instructions is based on specific good faith determinations.

12. Shares of the Insurances Products funds sold to Qualified Plans will be held by the trustees of such plans as required by section 403(a) of the Employee Retirement Income Security Act of 1974 (''ERISA''). Section 403(a) also provides that the trustees must have exclusive authority and discretion to manage and control the Qualified Plan with two exceptions: (a) when the Qualified Plan expressly provides that the trustees are subject to the direction of a named fiduciary who is not a trustee, in which case the trustees are subject to proper directions made in accordance with the terms of the Qualified Plan and not contrary to ERISA; and (b) when the authority to manage, acquire or dispose of assets of the Qualified Plan is delegated to one or more investment managers pursuant to section 402(c)(3) of ERISA. Unless one of the two exceptions stated in section 403(a) applies, the Qualified Plan trustees have exclusive authority and responsibility for voting proxies. Where a named fiduciary appoints an investment manager, the investment manager has the responsibility to vote the shares held unless the right to vote such shares is reserved to the trustees or the named fiduciary. The Qualified Plans may have their trustees or other fiduciaries exercise voting rights attributable to investment securities held by the Qualified Plans in their discretion. Where a Qualified Plan does not provide its participants with the right to give voting instructions, Applicants state that they do not see any potential for irreconcilable material conflicts of interest between or among Variable Contract holders and Plan participants with respect to voting of the respective Insurance Products Funds shares. Accordingly, Applicants note that, unlike the case with insurance company separate accounts, the issue of the resolution of material irreconcilable conflicts with respect to voting is not present with respect to Qualified Plans since such plans are not entitled to pass-through voting privileges. Even if a Qualified Plan were to hold a controlling interest in an insurance Products Fund, the Applicants do not believe that such control would disadvantage other investors in such Insurance Products Fund to any greater extent than is the case when any institutional shareholder holds a majority of the voting securities of any open-end management investment company. In this regard, the Applicants submit that investment in an Insurance Products Fund by a Qualified Plan will not create any of the voting complications occasioned by mixed funding or shared funding.

13. Applicants state that some of the Qualified Plans may provide for the trustee(s), an investment adviser(s) or another named fiduciary to exercise voting rights in accordance with instructions from Qualified Plan participants. Applicants state that, in such cases, the purchase of shares by such Qualified Plans does not present any complications not otherwise occasioned by mixed or shared funding.

14. Applicants state that no increased conflict of interest would be presented by the granting of the requested relief. Applicants submit that shared funding does not present any issues that do not already exist where a single insurance company is licensed to do business in several states. In this regard, Applicants note that when different Participating Insurance Companies are domiciled in different states, it is possible that the state insurance regulatory body in a state in which one Participating Insurance Company is domiciled could require action that is inconsistent with the requirements of other insurance regulators in one or more other states in which other Participating Insurance Companies are domiciled. The possibility however, is no different or greater than exists when a single insurer and its affiliates offer their insurance products in several states, as is currently permitted.

15. Applicants state that affiliation does not reduce the potential if any exists, for differences in state regulatory requirements. In any event, the conditions set forth in the application and later in this notice (which are adapted from the conditions included in Rule 6e–3(T)(b)(5)) are designed to safeguard against any adverse effects that differences among state regulatory requirements may produce. If a particular sate insurance regulator's decision conflicts with the majority of other state regulators, the affected insurer may be required to withdraw its separate account's investment in the relevant Insurance Products Funds.

16. Applicants also assert that affiliation does not eliminate the potential, if any exists, for divergent judgments as to when a Participating Insurance Company could disregard Variable Contract owner voting instructions. The potential for disagreement is limited by the requirements that disregarding voting instructions be reasonable and based on specified good faith determinations. However, if the Participating Insurance Company's decision to disregard Variable Contract owner voting instructions represents a minority position or would preclude a majority vote approving a particular change, such Participating Insurance Company may be required, at the election of the relevant Insurance Products Fund, to withdraw its separate account's investment in that Insurance Products Fund and no charge or penalty will be imposed upon the Variable Contract owners as a result of such withdrawal.

17. Applicants submit that there is no reason why the investment policies of an Insurance Products Fund with mixed funding would or should be materially different from what those policies would or should be if such Insurance Products Fund or series thereof funded only variable annuity or variable life insurance contracts. In this regard, Applicants note that a fund's adviser is legally obligated to manage the fund in accordance with the fund's investment objectives, policies and restrictions as well as any guidelines established by the fund's board. Applicants submit that no one investment strategy can be identified as appropriate to a particular insurance product or to a Plan. Each pool of variable annuity and variable life insurance contract owners is composed of individuals of diverse financial status, age, insurance and investment goals. A fund supporting even one type of insurance product must accommodate these diverse factors in order to attract and retain purchasers. Applicants submit that permitting mixed and shared funding will provide economic support for the continuation of the Insurance Products Funds. In addition, permitting mixed and shared funding also will facilitate the establishment of additional series of Insurance Product Funds serving diverse goals.

18. As noted above, section 817(h) of the Code imposes certain diversification standards on the underlying assets of variable annuity contracts and variable

life insurance contracts held in the portfolios of management investment companies. Treasury Regulation 1.817–5(f)(3)(iii), which established diversification requirements for such portfolios, specifically permits, among other things, ''qualified pension or retirement plans'' and insurance company separate accounts to share the same underlying investment company. Therefore, Applicants assert that neither the Code, nor the Treasury regulations, nor the revenue rulings thereunder present any inherent conflicts of interest if the Qualified Plans, variable annuity separate accounts, and variable life insurance separate accounts all invest in the same management investment company.

19. While there are differences in the manner in which distributions are taxed for variable annuity contracts, variable life insurance contracts and Qualified Plans, Applicants state that the tax consequences do not raise any conflict of interests. When distributions are to be made, and the separate account of the Participating Insurance Company or Qualified Plan cannot net purchase payments to make the distributions, the separate account or Qualified Plan will redeem shares of the Insurance Products Funds at their respective net asset values. The Qualified Plan will then make distributions in accordance with the terms of the Qualified Plan and the Participating Insurance Company will make distributions in accordance with the terms of the Variable Contract.

20. Applicants submit that the ability of the Insurance Products Funds to sell their respective shares directly to Qualified Plans does not create a ''senior security,'' as such term is defined under section 18(g) of the 1940 Act, with respect to any Variable Contract owner as opposed to a participant under a Qualified Plan. As noted above, regardless of the rights and benefits of participants under the Qualified Plans, or Variable Contract owners under their Variable Contracts, the Qualified Plans and the separate accounts of Participating Insurance Companies have rights only with respect to their respective shares of the Insurance Products Funds. They can redeem such shares at their net asset value. No shareholder of any of the Insurance Products Funds has any preference over any other shareholder with respect to distribution of assets or payments of dividends.

21. Applicants assert that there are no conflicts between the Variable Contract owners and the Plan participants with respect to state insurance commissioners' veto powers over investment objectives. The basic premise of shareholder voting is that not all shareholders may agree with a particular proposal. While time-consuming, complex transactions must be undertaken to accomplish redemptions and transfers by separate accounts, trustees of Qualified Plans can quickly redeem shares from Insurance Products Funds and reinvest in other funding vehicles without the same regulatory impediments or, as in the case with most Qualified Plans, even hold cash or other liquid assets pending suitable alternative investment. Applicants maintain that even if there should arise issues where the interest of Variable Contract owners and the interests of participants in Plans are in conflict, the issues can be almost immediately resolved because the trustees of the Plans can, on their own, redeem shares out of the Insurance Products Funds.

22. Applicants submit that mixed and shared funding should provide benefits to Variable Contract owners by eliminating a significant portion of the costs of establishing and administering separate funds. Participating Insurance Companies will benefit not only from the investment and administrative expertise of the Adviser and any sub-advisers, but also from the cost efficiencies and investment flexibility afforded by a larger pool of assets. Mixed and shared funding also would permit a greater amount of assets available for investment by the Insurance Products Funds, thereby promoting economics of scale, by permitting increased safety through greater diversification and by making the addition of new series more feasible. Therefore, making the Insurance Products Funds available for mixed and shared funding will encourage more insurance companies to offer Variable Contracts, and this should result in increased competition with respect to both Variable Contract design and pricing, which can be expected to result in more product variation and lower charges.

Applicants' Conditions

To the extent required by the Commission, Applicants consent to the following conditions.

1. A majority of each Insurance Products Fund's Board of Trustees or Directors (each, a ''Board'') shall consist of persons who are not ''interested persons'' thereof, as defined by Section 2(a)(19) of the 1940 Act and the Rules thereunder, and as modified by any applicable orders of the Commission, except that if this condition is not met by reason of the death, disqualification, or bona fide resignation of any Board member, then the operation of this condition shall be suspended: (a) For a period of 45 days, if the vacancy or vacancies may be filled by the Board; (b) for a period of 60 days, if a vote of shareholders is required to fill the vacancy or vacancies; or (c) for such longer period as the Commission may prescribe by order upon application.

2. Each Board will monitor its respective Insurance Products Funds for the existence of any material irreconcilable conflict between and among the interests of the Variable Contract owners of all Participating Separate Accounts and Qualified Plans participants investing in the Insurance Products Funds, and determine what action, if any, should be taken in response to such conflicts. A material irreconcilable conflict may arise for a variety of reasons, including: (a) An action by any state insurance regulatory authority; (b) a change in applicable federal or state insurance, tax, or securities laws or regulations, or a public ruling, private letter ruling, no-action or interpretive letter, or any similar action by insurance, tax, or securities regulatory authorities; (c) an administrative or judicial decision in any relevant proceeding; (d) the manner in which the investments of the Insurance Products Funds are being managed; (e) a difference in voting instructions given by variable annuity contract owners and variable life insurance contract owners and trustees of the Qualified Plans; (f) a decision by a Participating Insurance Company to disregard the voting instructions of contract owners; or (g) if applicable, a decision by a Qualified Plan to disregard the voting instructions of its participants.

3. Rafferty (or any other investment adviser of an Insurance Products Fund), any Participating Insurance Company and any Qualified Plan that executes a fund participating agreement upon becoming an owner of 10% or more of an Insurance Product Fund (''Participants'') will report any potential or existing conflicts to the Board of any relevant Insurance Products Fund. Participants will be obligated to assist the appropriate Board in carrying out its responsibilities under these conditions by providing the Board with all information reasonably necessary for the Board to consider any issues raised. This responsibility includes, but is not limited to, an obligation of each Participating Insurance Company to inform the Board whenever Variable Contract owner voting instructions are disregarded and, if pass-through voting is applicable, an obligation by each Qualified Plan to

inform the Board whenever it has determined to disregard Qualified Plan participant voting instructions. The responsibilities to report such information and conflicts and to assist the Boards will be contractual obligations of all Participating Insurance Companies and Qualified Plans investing in the Insurance Products Funds under their respective agreements governing participation in the Insurance Products Funds, and such agreements shall provide that these responsibilities will be carried out with a view only to the interests of Variable Contract owners and, if applicable, Qualified Plan participants.

4. If a majority of an Insurance Products Fund's Board members, or a majority of the disinterested Board members, determine that a material irreconcilable conflict exists, the relevant Participating Insurance Companies and Qualified Plans, at their expense and to the extent reasonably practicable (as determined by a majority of the disinterested Board members), shall take whatever steps are necessary to remedy or eliminate the material irreconcilable conflict, including: (a) Withdrawing the assets allocable to some or all of the Participating Separate Accounts from the Insurance Products Fund or any series thereof and reinvesting such assets in a different investment medium, which may include another series of an Insurance Products Fund; (b) in the case of Participating Insurance Companies, submitting the question of whether such segregation should be implemented to a vote of all affected Variable Contract owners and, as appropriate, segregating the assets of any appropriate group (*i.e.,* variable annuity or variable life insurance contract owners of one or more Participating Insurance Companies) that votes in favor of such segregation, or offering to the affected Variable Contract owners the option of making such a change, and (c) establishing a new registered management investment company or managed separate account. If a material irreconcilable conflict arises because of a decision by a Participating Insurance Company to disregard Variable Contract owner voting instructions, and that decision represents a minority position or would preclude a majority vote, the Participating Insurance Company may be required, at the election of the Insurance Products Fund, to withdraw its separate account's investment in such fund, and no charge or penalty will be imposed as a result of such withdrawal. If a material irreconcilable conflict arises because of a Qualified Plan's decision to disregard Qualified Plan participants' voting instructions, if applicable, and that decision represents a minority position or would preclude a majority vote, the Qualified Plan may be required, at the election of the Insurance Products Fund, to withdraw its investment in such fund and no charge or penalty will be imposed as a result of such withdrawal.

The responsibility to take remedial action in the event of a Board determination of a material irreconcilable conflict and to bear the cost of such remedial action shall be a contractual obligation of all Participating Insurance Companies and Qualified Plans under their agreements governing participation in the Insurance Products Funds and these responsibilities shall be carried out with a view only to the interests of the Variable Contract owners and, as applicable, Qualified Plan participants.

For purposes of this Condition 4, a majority of the disinterested members of the applicable Board shall determine whether or not any proposed action adequately remedies any material irreconcilable conflict, but in no event will the Insurance Products Fund or Rafferty (or any other investment adviser of the Insurance Products Funds) be required to establish a new funding medium for any Variable Contract. No Participating Insurance Company shall be required by this Condition 4 to establish a new funding medium for any Variable Contract if a majority of Variable Contract owners materially and adversely affected by the material irreconcilable conflict vote to decline such offer. No Qualified Plan shall be required by Condition 4 to establish a new funding medium for such Qualified Plan if (a) a majority of Qualified Plan participants materially and adversely affected by the material irreconcilable conflict vote to decline such offer or (b) pursuant to governing Qualified Plan documents and applicable law, the Qualified Plan makes such decision without Qualified Plan participant vote.

5. Participants will be informed promptly in writing of a Board's determination of existence of a material irreconcilable conflict and its implications.

6. Participating Insurance Companies will provide pass-through voting privileges to all Variable Contract owners so long as the Commission interprets the 1940 Act to require pass-through voting for Variable Contracts owners. Accordingly, such Participating Insurance Companies, where applicable, will vote shares of the Insurance Products Fund held in their Participating Separate Accounts in a manner consistent with voting instructions timely received from Variable Contract owners. In addition, each Participating Insurance Company will vote shares of the Insurance Products Fund held in its Participating Separate Account for which it has not received timely voting instructions from Variable Contract owners, as well as shares it owns, in the same proportion as those shares for which it has received voting instructions. Participating Insurance Companies will be responsible for assuring that each of their Participating Separate Accounts investing in an Insurance Products Fund calculates voting privileges in a manner consistent with all other Participating Insurance Companies. The obligation to vote an Insurance Products Fund's shares and calculate voting privileges in a manner consistent with all other separate accounts investing in the Insurance Products Fund will be a contractual obligation of all Participating Insurance Companies under the agreements governing participating in the Insurance Products Fund. Each Qualified Plan will vote as required by applicable law and governing Qualified Plan documents.

7. As long as the Commission continues to interpret the 1940 Act as requiring pass-through voting privileges for Variable Contract owners, Rafferty (or any of its affiliates) will vote its shares in any series of any Insurance Products Fund in the same proportion as all Variable Contract owners having voting rights with respect to that series; provided, however, that Rafferty (or any of its affiliates) shall vote its shares in such other manner as may be required by the Commission or its staff.

8. All reports of potential or existing conflicts received by a Board, and all Board action with regard to (a) Determining the existence of a conflict, (b) notifying Participants of a conflict and (c) determining whether any proposed action adequately remedies a conflict, will be properly recorded in the minutes of the meetings of the appropriate Board or other appropriate records. Such minutes or other records shall be made available to the Commission upon request.

9. Each Insurance Products Fund will notify all Participating Insurance Companies that separate account prospectus disclosure regarding the potential risks of mixed and shared funding may be appropriate. Each Insurance Products Fund shall disclose in its prospectus that: (a) Its shares may be offered to insurance company separate accounts that fund both variable annuity and variable life

insurance contracts, and to Qualified Plans; (b) differences in tax treatment or other considerations may cause the interests of various Variable Contract owners participating in an Insurance Products Fund and the interests of Qualified Plans investing in that Insurance Product Fund to conflict; and (c) the Board will monitor the Insurance Product Fund for any material conflicts and determine what action, if any, should be taken.

10. Each Insurance Products fund will comply with all provisions of the 1940 Act requiring voting by shareholders (for these purposes, the persons having a voting interest in shares of the Insurance Products Fund). In particular, each such Insurance Products Fund either will provide for annual shareholder meetings (except insofar as the Commission may interpret Section 16 of the 1940 Act not to require such meetings) or comply with section 16(c) of the 1940 Act (although none of the Insurance Products Fund shall be one of the trusts described in section 16(c) of the 1940 Act), as well as with sections 16(a) of the 1940 Act and, if and when applicable, section 16(b) of the 1940 Act. Further, each insurance Products Fund will act in accordance with the Commission's interpretation of the requirements of section 16(a) with respect to periodic elections of Board members and with whatever rules the Commission may promulgate with respect thereto.

11. If and to the extent that Rules 6e–2 and 6e–3(T) are amended, or Rule 6e–3 under the 1940 Act is adopted, to provide exemptive relief from any provision of the 1940 Act, or the rules promulgated thereunder, with respect to mixed or shared funding, on terms and conditions materially different from any exemptions granted in the Order requested in this Application, then the Insurance Products Funds and/or Participants, as appropriate, shall take such steps as may be necessary to comply with Rules 6e–2 and 6e–3(T), as amended, and Rule 6e–3, as adopted, to the extent such Rules are applicable.

12. The Participants, at least annually, shall submit to the Board such reports, materials, or data as the Board may reasonably request so that such Board may fully carry out the obligations imposed upon them by the conditions stated in this Application. Such reports, materials, and data shall be submitted more frequently if deemed appropriate by the applicable Board. The obligations of the Participants to provide these reports, materials, and data to the Boards shall be a contractual obligation of all Participants under the agreements governing their participation in the Insurance Products Funds.

13. If a Qualified Plan or Qualified Plan participant should become an owner of 10% or more of the assets of an Insurance Products Fund, such Qualified Plan will execute a fund participation agreement which includes the conditions set forth herein to the extent applicable. A Qualified Plan or Qualified Plan participant will execute an application containing an acknowledgment of this condition upon such plan's initial purchase of shares of any Insurance Products Fund.

Conclusion

For the reasons stated above, Applicants believe that the requested exemptions, in accordance with the standards of section 6(c) of the 1940 Act, are appropriate in the public interest and consistent with the protection of investors and the purposes fairly intended by the policy and provisions of the 1940 Act.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 00–16417 Filed 6–28–00; 8:45 am]

BILLING CODE 8010–01–M

SOCIAL SECURITY ADMINISTRATION

Agency Information Collection Activities: Proposed Request and Comment Request

In compliance with Public Law 104–13, the Paperwork Reduction Act of 1995, SSA is providing notice of its information collections that require submission to the Office of Management and Budget (OMB). SSA is soliciting comments on the accuracy of the agency's burden estimate; the need for the information; its practical utility; ways to enhance its quality, utility and clarity; and on ways to minimize burden on respondents, including the use of automated collection techniques or other forms of information technology.

I. The information collections listed below will be submitted to OMB within 60 days from the date of this notice. Therefore, comments and recommendations regarding the information collections would be most useful if received by the Agency within 60 days from the date of this publication. Comments should be directed to the SSA Reports Clearance Officer at the address listed at the end of this publication. You can obtain a copy of the collection instruments by calling the SSA Reports Clearance Officer on (410) 965–4145, or by writing to him at the address listed at the end of this publication.

1. Application for Lump Sum Death Payment—0960–0013. The information collected on form SSA–8 by the Social Security Administration is required to authorize payment of a lump-sum death benefit to a widow, widower, or children as defined in Section 202(i) of the Social Security Act. The respondents are widows, widowers or children who apply for a lump-sum death payment.

Number of respondents	43,850
Frequency of response	1
Average burden per response	10 mins.
Estimated annual burden	7308 hrs.

2. Application for Special Age 72-or-Over Monthly Payments—0960–0096. Form SSA–19–F6 is needed by the Social Security Administration (SSA) to determine whether an individual is entitled to Special Age-72 payments. Eligibility requirements will be evaluated by the data collected on this form. The respondents are individuals who attained age 72 before 1972.

Number of respondents	10
Frequency of response	1
Average burden per response	20 mins.
Estimated annual burden	3 hrs.

3. Request for Self-Employment Information, Request for Employee Information, Request for Employer Information—0960–0508. SSA needs the information collected on Forms SSA–L2765, SSA–L3365 and SSA–L4002 in order to credit the reported earnings to the proper earnings record. When W–2 wage data for an individual cannot be identified, the data are placed in the earnings suspense file, and SSA sends decentralized correspondence (DECOR) to the employee (in certain instances to the employer) in an attempt to obtain his/her correct name and SSN. The respondents are employees, employers or self-employed individuals being requested to furnish additional information for individuals for whom earnings were reported.

Number of respondents	3,000,000
Frequency of response	1
Average burden per response	10 mins.
Estimated annual burden	500,000 hrs.

4. State Agency Report of Obligations for SSA Disability Programs—0960–0421. The data collected on Form SSA–4513 are necessary for detailed analysis and evolution of costs incurred by Disability Determination Services (DDS) in making disability determinations for SSA. The data collected also help to

determine funding levels for each DDS. The respondents are DDSs, which are the State agencies that have the responsibility for making disability determinations for SSA.

Number of respondents	54
Frequency of response	4
Average burden per response	60 mins.
Estimated annual burden	216 hrs.

5. Statement For Determining Continuing Eligibility or Supplemental Security Income Payments—0960–0416. Form SSA–8203–BK (printed in both English and Spanish) is used by SSA for high-error-profile (HEP) redeterminations. It is completed in field offices by personal contact (face-to-face or telephone interview) and is not supposed to be mailed to recipients to be completed and returned. The form is used only when a systems limitation prevents the interview from being conducted using the automated Modernized SSI Claim System. A tear-off sheet (Pages 7 and 8 of the form) is given to recipients at the conclusion of a face-to-face interview or is mailed to recipients at the completion of the telephone interview. The tear-off includes information about how, what, when, where, and why Supplemental Security Income (SSI) recipients report when there is a change in income, resources, or living arrangements. The respondents are recipients of title XVI SSI benefits.

Number of respondents	920,000
Frequency of response	1
Average burden per response	17 mins.
Estimated annual burden	260,667 hrs.

II. The information collections listed below have been submitted to OMB for clearance. Written comments and recommendations on the information collections would be most useful if received within 30 days from the date of this publication. Comments should be directed to the SSA Reports Clearance Officer and the OMB Desk Officer at the addresses listed at the end of this publication. You can obtain a copy of the OMB clearance packages by calling the SSA Reports Clearance Officer on (410) 965–4145, or by writing to him.

1. Supplement to Claim of Person Outside the United States—0960–0051. The information collected on Form SSA–21 is used by the Social Security Administration (SSA) to determine continuing entitlement to Social Security benefits and the proper benefit amounts of alien beneficiaries living outside the United States (U.S.). It is also used to determine whether benefits are subject to withholding tax. The respondents are comprised of individuals entitled to Social Security benefits, who are, will be, or have been residing outside the U.S.

Number of respondents	35,000
Frequency of response	1
Average burden per response	5 mins.
Estimated annual burden	2,917 hrs.

2. Statement of Care and Responsibility for Beneficiary—0960–0109. SSA uses Form SSA–788 to select the most qualified representative payee who will apply the benefits in the beneficiary's best interests. The respondents are individuals who have custody of a beneficiary where someone else has filed to be the beneficiary's payee.

Number of respondents	130,000
Frequency of response	1
Average burden per response	10 mins.
Estimated annual burden	21,667 hrs.

(SSA Address)—Social Security Administration, DCFAM, Attn: Frederick W. Brickenkamp, 6401 Security Blvd., 1–A–21 Operations Bldg., Baltimore, MD 21235.

(OMB Address)—Office of Management and Budget, OIRA, Attn: Desk Officer for SSA, New Executive Office Building, Room 10230, 725 17th St., NW, Washington, DC 20503.

Dated: June 23, 2000.

Frederick W. Brickenkamp,

Reports Clearance Officer, Social Security Administration.

[FR Doc. 00–16407 Filed 6–28–00; 8:45 am]

BILLING CODE 4191–02–P

DEPARTMENT OF STATE

[Public Notice 3342]

Bureau of Educational and Cultural Affairs Request for Proposals: College and University Affiliations Program

SUMMARY: The Office of Global Educational Programs of the Bureau of Educational and Cultural Affairs in the Department of State announces an open competition for an assistance award program. Accredited, post-secondary educational institutions meeting the provisions described in IRS regulation 26 CFR 1.5019(C) may apply to pursue institutional or departmental objectives in partnership with foreign counterpart institutions with support from the College and University Affiliations Program. These objectives should support the overall goal of the Program: to strengthen mutual understanding and cooperation among U.S. and foreign educational institutions on specified themes of common interest to the United States and to the participating colleges and universities. The means for achieving the objectives of the applicant and its partner(s) may include teaching, scholarship, and outreach to professionals and other members of the communities served by the participating institutions.

Program Overview

Underlying the specific institutional objectives of projects funded by this program should be the goals of encouraging the growth of freedom and democracy, economic stability and prosperity, or environmental cooperation. Innovative strategies to address these underlying concerns in the pursuit of clearly defined institutional objectives are encouraged. Outreach from academic institutions to larger communities of citizens and practitioners to extend understanding about these issues is also encouraged.

The Bureau supports institutional linkages in higher education through the College and University Affiliations Program, for which this Request for Proposals invites applications for funding in FY2001. The College and University Affiliations Program operates in cooperation with the Fulbright Senior Scholar Program; the U.S. institutions of current and former participants in the Fulbright Program are encouraged to apply. Other college and university teachers and administrators with knowledge of educational institutions in other countries are also encouraged to build on this knowledge with support from the Bureau through the College and University Affiliations Program.

Separate Requests for Proposals for institutional linkages in higher education with the New Independent States of the former Soviet Union (N.I.S. College and University Partnerships Program and the N.I.S. Community College Partnerships Program) are being published this fiscal year. For further information about these N.I.S. programs, refer to the ''Foreign Country and Location Eligibility'' section of this solicitation.

Applicant Objectives

While the benefits of the project to each of the participating institutions may differ significantly in nature and scope, proposals should outline well-reasoned strategies leading to specific objectives for each participating U.S. and foreign department or institution as a whole.

For example, proposals may describe the parameters and possible content of new courses, new research or teaching capacities or methodologies, new or

revised curricula or programs, or other changes anticipated as a result of the project. Proposals to pursue a limited number of related thematic objectives at each institution are preferred to proposals addressing a large number of unrelated objectives at each institution.

Partner institutions may pursue their institutional objectives through exchanges of teachers, researchers, administrators or, in limited circumstances, students for any appropriate combination of teaching, consultation, research, and outreach. The length of time for each exchange may range from one week to an academic year. The strategy for achieving project objectives may include exchange visits in one or both directions, but no single formula is prescribed for the duration, sequence, or number of these visits. Visits of one semester or more for participants from at least one of the institutional partners are strongly encouraged. The number of visits of less than two weeks' duration should not exceed one visit in each direction over the course of the project. To provide adequate time to meet institutional project objectives, the Program awards grants for periods of approximately three years (36 months to 40 months).

Although strong budgetary and programmatic emphasis may be given to visits in one direction over another, the benefits of all these visits to the sending as well as the receiving sides should be clearly explained. Exchange visits for the purpose of attending conferences are not encouraged except in combination with other grant activities and in support of specific educational objectives at one or more of the participating institutions.

In addition to demonstrating how each participating institution can assist its partner(s) to meet institutional goals, proposals should also explain how this cooperation will enable each of the institutions to address its own needs. Accordingly, applicants are encouraged to describe the needs and deficiencies as well as the strengths and capabilities of each participating department and institution. Proposals that realistically assess institutional capacities will be better able to justify the request for support. Effective proposals will demonstrate that the proposed partnership institutions understand one another and are committed to support and cooperate with one another in project implementation. Accordingly, proposals should reflect substantial awareness of the foreign as well as the U.S. partner(s). Proposals that benefit only one institutional partner are not eligible for funding.

If the proposed partnership would occur within the context of a previous or ongoing project, the proposal should explain how the request for Bureau funding would build upon the pre-existing relationship or complement previous and concurrent projects, which must be listed and described with details about the amounts and sources of external support. Previous projects should be described in the proposal, and the results of the evaluation of previous cooperative efforts should be summarized.

Proposals should outline and budget for a methodology for project evaluation. The evaluation plan should include an updated assessment of the current status of each participating department's and institution's needs at the time of program inception; ongoing formative evaluation to allow for mid-course revisions in the implementation strategy; and, at the conclusion of the project, summative evaluation of the degree to which the project's objectives have been achieved together with observations about the project's influence within the participating institutions and their surrounding communities or societies. The final evaluation should also include recommendations about how to build upon project achievements, both with and without the Bureau's support. Evaluative observations by external consultants with appropriate subject or regional expertise are especially encouraged.

Costs

The commitment of all partner institutions to the proposed project should be reflected in the cost-sharing which they offer in the context of their respective institutional capacities. Although the contributions offered by U.S. and foreign institutions with relatively few resources may be less than those offered by applicants with greater resources at their disposal, all participating institutions are expected to identify costs that they will contribute. These costs may include the estimated costs of in-kind contributions. Consistent with the ''Review Criteria'' for this competition listed elsewhere in this document and with specific reference to ''Cost-Sharing'' and ''Institutional Commitment to Cooperation,'' proposed cost-sharing will be considered an important indicator of each participating institution's interest in the project and of the institution's potential to benefit from it.

Proposals must be submitted by the U.S. institutional partner and must include letters of commitment from all institutional partners. The letters should be signed by persons authorized to commit institutional resources to the project.

The Bureau's support may be used to defray the costs of the exchange visits as well as the costs (up to a maximum of 20 percent of the total grant) of the administration of the project at any partner institution, including administrative salaries and direct administrative costs but excluding indirect costs. Although the grants will be awarded to the lead U.S. institutional partner, adequate provision in the proposal for the administrative costs of the project at all partner institutions, including the foreign partner(s), is encouraged.

Administrative salaries may include salary support for project directors and administrative assistants for administrative activity within the 20 percent maximum that may be allocated to administrative costs, but the Bureau will not fund salaries, stipends, or honoraria for program participants. However, in proposals for Sub-Saharan Africa, faculty replacement costs are allowable once in a three-year grant period if they facilitate the work of a U.S. faculty member at an African partner institution for one quarter or one semester. (See sections of this document on ''U.S. Partner and Participant Eligibility'' and ''Foreign Partner and Participant Eligibility'' for additional details.) The fees of outside consultants reporting on the degree to which project objectives have been achieved are allowable as a program expense.

The proposal may include a request for funding to reinforce the activities of exchange participants through the establishment and maintenance of Internet and/or electronic mail communication facilities as well as through interactive technology or non-technology-based distance-learning programs. However, projects focusing primarily on technology or physical infrastructure development are not encouraged. Proposals that include Internet, electronic mail, and other interactive technologies should discuss how the foreign partner institution will support the costs of such technologies after the project ends. Applicants may propose other project activities not specifically mentioned in this solicitation if the activities reinforce the impact of the project.

With the exception of projects with Sub-Saharan Africa, the maximum award in the FY2001 competition will be $120,000; for projects with Sub-Saharan Africa, the maximum award will be $180,000. Requests for amounts smaller than the maximum are eligible.

Budgets and budget notes should carefully justify the amounts requested. Grants awarded to organizations with less than four years of experience in conducting international exchange programs will be limited to $60,000.

Grants are subject to the availability of funds for Fiscal Year 2001. The amount of funding available for proposals to the College and University Affiliations Program in FY2001 has not yet been determined. In Fiscal Year 1999, 66 eligible proposals were submitted to the College and University Affiliations Program, and 17 awards were made. The response to Requests for Proposals to the Bureau to support institutional linkages in higher education has been unusually strong in recent years and, except for Sub-Saharan Africa and the New Independent States of the former Soviet Union, the funds available have fallen significantly short of the demand for them.

However, additional funding may be available in Fiscal Year 2001 to award a limited number of grants under the College and University Affiliations Program to enable current and former Fulbright scholars to build on their experiences as individual Fulbright grantees through broadened institutional cooperation.

Eligible Fields

Eligible fields are the social, political, and economic sciences; environmental studies; law; business; public administration; and educational development or administration (excluding educational projects in the physical, technical, or health sciences, as well as the Teaching of English as a Foreign Language). Within the eligible fields, themes of special interest are described in additional detail in this document under the heading ''Foreign Country and Location Eligibility.''

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 community colleges, minority-serving institutions, undergraduate liberal arts colleges, research universities, and combinations of these types of institutions are eligible. Applications from consortia or other combinations of U.S. colleges and universities are eligible. Secondary U.S. partners may include non-governmental organizations as well as non-profit service and professional organizations. The lead U.S. organization 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.

With the exception of outside consultants reporting on the degree to which project objectives have been achieved, participants representing the U.S. institution who are traveling under the Bureau's grant funds must be teachers, graduate student teaching or research assistants, or administrators from the participating institution(s). Participants representing the U.S. institution must be U.S. citizens. Graduate student teaching or research assistants are eligible for Bureau-funded participation in this program only if they are working under the direction of an accompanying faculty participant or project director on the achievement of project objectives.

Foreign Institution and Participant Eligibility

In other countries, participation is open to recognized institutions of post-secondary education, which may include independent research institutes. Secondary foreign partners may include relevant governmental and non-governmental organizations, as well as non-profit service and professional organizations.

With the exception of outside consultants reporting on the degree to which project objectives have been achieved, participants representing the foreign institutions must be teachers, administrators, or student teaching or research assistants who are working under the supervision of an accompanying faculty participant or project director on the achievement of project objectives. Foreign participants must be citizens, nationals, or permanent residents of the country of the foreign partner and must be qualified to hold a valid passport and a U.S. J–1 visa.

Foreign Country and Location Eligibility

To increase the chances that competitive proposals can be funded, the number of eligible countries and locations is limited. However, country eligibility is expected to rotate within most of the following seven world regions according to a three-year cycle as outlined below. Countries may be added to the countries listed for FY2002 and FY2003; countries listed as anticipated for eligibility are expected to be eligible in the year(s) for which they are listed. Separate Requests for Proposals will be issued in the spring of 2001 for FY2002 and in the spring of 2002 for FY2003.

(1) New Independent States (former Soviet Union): Institutions interested in partnerships with institutions of higher education in the New Independent States should consult separate Requests for Proposals for the N.I.S. College and University Partnerships Program and for the N.I.S. Community College Partnerships Program. For information about these programs, contact the Humphrey Fellowships and Institutional Linkages Branch, Office of Global Educational Programs (ECA/A/S/U), Room 349, U.S. Department of State, State Annex 44, 301 4th Street, S.W., Washington, D.C. 20547, phone: (202) 619–5289, fax: (202) 401–1433.

(2) Sub-Saharan Africa: Proposals are encouraged that will strengthen the role of African institutions of higher education in their countries' national development and, more specifically, promote the increased interaction of African universities with other local and international institutions that contribute to African social, political or economic development.

Eligible for FY2001: Benin, Burkina Faso, Cameroon, Chad, Cote d'Ivoire, Ghana, Guinea, Madagascar, Mali, Mauritius, Niger, Nigeria, Senegal, South Africa, Togo, and Rwanda. In addition, multilateral proposals involving institutions in not more than four of the following countries are also eligible: Benin, Burkina Faso, Cameroon, Chad, Cote d'Ivoire, Guinea, Madagascar, Mali, Mauritius, Niger, Senegal, Togo, and Rwanda. These proposals should clearly outline a pattern of involvement and cooperation with all the participating African institutions and should indicate anticipated benefits to all the institutional partners.

Anticipated eligibility for FY2002: Kenya, Mozambique, Namibia, Nigeria, Tanzania, Uganda, and Zimbabwe. Subjects to be determined.

Anticipated eligibility for FY2003: Countries and subjects to be determined.

(3) Western Hemisphere: Proposals are especially encouraged which strengthen judicial, civic, economic, or educational reform in the eligible Latin American and Caribbean countries, or which address current issues in communications or the social or environmental sciences.

Eligible for FY2001: Argentina, Barbados, Brazil, Chile, Jamaica, Paraguay, Trinidad and Tobago, and Uruguay.

In addition to bilateral proposals with any one of these countries, proposals for projects involving educational institutions in two or more countries belonging to the South American

Common Market (MERCOSUR) are also eligible: Argentina, Brazil, Paraguay and Uruguay.

Anticipated Eligibility for FY2002: Costa Rica, El Salvador, Mexico, Guatemala, Honduras, Nicaragua, Panama, and trilateral projects including both Canada and Mexico. Subjects to be determined.

Anticipated Eligibility for FY2003: Bolivia, Colombia, Dominican Republic, Ecuador, Haiti, Peru, and Venezuela. Subjects to be determined.

(4) East Asia and the Pacific: Proposals for projects that will promote democracy, strengthen civil society, or help to create more transparent, market-oriented economies are encouraged.

Eligible for FY2001: China, Indonesia, Malaysia, Philippines, Thailand, and Vietnam.

Anticipated Eligibility for FY2002: China, Korea, Mongolia, and Taiwan. Subjects to be determined.

Anticipated Eligibility for FY2003: Cambodia, China, Indonesia, and Laos. Subjects to be determined.

(5) Europe: Proposals are encouraged that will equip universities to assist with the transitions to more market-oriented economies, to more democratic political life, and to more responsible and accountable administration in the public sector.

Eligible for FY2001: Albania, Bosnia and Herzegovina, Croatia, Hungary, Slovakia, Slovenia, and Turkey.

Anticipated Eligibility for FY 2002: Bulgaria, Czech Republic, Estonia, Latvia, and Lithuania. Subjects to be determined.

Anticipated Eligibility for FY2003: Former Yugoslav Republic of Macedonia, Poland, and Romania. Subjects to be determined.

(6) North Africa and the Middle East: Projects are encouraged which strengthen civil society, which support the development of programs in American Studies at universities in the region, or which assist the development of a more effective and more transparent public sector.

Eligible for FY2001: Egypt, Gaza, Israel, Jordan, Tunisia, West Bank, and Morocco.

Anticipated Eligibility for FY2002: Bahrain, Lebanon, Syria, and Tunisia. Subjects to be determined.

Anticipated Eligibility for FY2003: Algeria, Gaza, Qatar, Saudi Arabia, and West Bank. Subjects to be determined.

(7) South Asia: Proposals for projects that will help to develop good governance and strengthen educational and economic institutions in the region are encouraged.

Eligible for FY2001: India, Nepal, and Sri Lanka.

Anticipated Eligibility for FY2002: India, Pakistan, and Bangladesh. Subjects to be determined.

Anticipated Eligibility for FY2003: Countries and subjects to be determined.

Ineligibility

A proposal may be deemed technically ineligible if:

(1) It does not fully adhere to the guidelines established herein and in the Solicitation Package;

(2) It is not received by the deadline;

(3) It is not submitted by the U.S. partner;

(4) One of the partner institutions is ineligible;

(5) The foreign country or geographic location is ineligible;

(6) It involves a request to fund exchanges between the United States and more than one other country with the exceptions noted in the sections on country eligibility for the Western Hemisphere and for Sub-Saharan Africa.

(7) The amount requested from the Bureau exceeds $120,000 with the exception of proposals for Sub-Sahara Africa, where the maximum is $180,000.

Grant-Making 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 *Fulbright-Hays Act.*

Projects must conform with the Bureau's requirements and guidelines outlined in the solicitation package for this RFP, which can be obtained by following the instructions given in the section below entitled ''For Further Information.'' The ''Project Objectives, Goals, and Implementation'' (hereafter, POGI) and the ''Project Specific Instructions (hereafter, PSI), which contain additional guidelines, are included in the Solicitation Package. Proposals that do not follow RFP requirements and the guidelines appearing in the POGI and PSI may be excluded from consideration due to technical ineligibility.

Announcement Title and Number

All communications with the Bureau concerning this announcement should refer to the College and University Affiliations Program and reference number ECA/A/S/U–01–02.

Deadline for Proposals

All copies must be received at the Bureau of Educational and Cultural Affairs by 5 p.m. Washington, D.C. time on Monday, November 13, 2000. Faxed documents will not be accepted, nor will documents postmarked on Monday, November 13, 2000 but received on a later date.

Approximate program dates: Grant activities should begin on or about July 1, 2001.

Program Duration: July 1, 2001–June 30, 2004 (or until September 30, 2004).

For Further Information

Contact the Humphrey Fellowships and Institutional Linkages Branch (College and University Affiliations Program); Office of Global Educational Programs; Bureau of Educational and Cultural Affairs; ECA/A/S/U, Room 349; U.S. Department of State; SA–44, 301 Fourth Street, S.W.; Washington, D.C. 20547; phone: (202) 619–5289, fax: (202) 401–1433. Applicants may also send a message to affiliation@pd.state.gov to request a Solicitation Package. The Solicitation Package includes more detailed award criteria; all application forms; and guidelines for preparing proposals, including specific criteria for preparation of the proposal budget.

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/rfps.

Please read all information before downloading.

Please specify ''College and University Affiliations Program Officer'' on all inquiries and correspondence. Prospective applicants should read the complete **Federal Register** announcement before addressing inquiries to the College and University Affiliations Program staff or submitting their proposals. Once the RFP deadline has passed, Department staff may not discuss this competition in any way with applicants until the Bureau proposal review process has been completed.

Submissions

Applicants must follow all instructions given in the Solicitation Package. The original and 10 copies of the complete application should be sent to:

U.S. Department of State, Ref: ECA/A/S/U–01–02, Program Management, ECA/EX/PM, Room 336, Bureau of Educational and Cultural Affairs, SA–44, 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.

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 Sections at U.S. Embassies for review, with the goal of reducing the time needed to make the comments of overseas posts available in the Bureau's grant 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.'' Proposals should account for advancement of this goal, in their program contents, to the full extent deemed feasible.

Year 2000 Compliance Requirement (Y2K Requirement)

The Year 2000 (Y2K) issue is a broad operational and accounting problem that could potentially prohibit organizations from processing information in accordance with Federal management and program specific requirements including data exchange with the Department of State. The inability to process information in accordance with Federal requirements could result in grantees' being required to return funds that have not been accounted for properly.

The Department of State therefore requires all organizations use Y2K compliant systems including hardware, software, and firmware. Systems must accurately process data and dates (calculating, comparing and sequencing) both before and after the beginning of the year 2000 and correctly adjust for leap years.

Additional information addressing the Y2K issue may be found at the General Services Administration's Office of Information Technology website at http://www.itpolicy.gsa.gov.

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 evaluated by independent external reviewers. In addition, all eligible proposals will be reviewed by internal Bureau and U.S. Embassy or Fulbright Commission officers for non-binding advisory comment.

The independent external reviewers, who will be professional, scholarly, or educational experts with appropriate regional and thematic knowledge, will provide recommendations and assessments for consideration by the Bureau. The Bureau will consider for funding only those proposals which are recommended for further consideration by the independent external reviewers.

Proposals may also be reviewed by the Office of the Legal Advisor or by other offices of the U.S. Department of State. Funding decisions will be made at the discretion of the Under Secretary of State for Public Diplomacy and Public Affairs. Final technical authority for assistance awards (grants or cooperative agreements) will reside with a contracts officer with competency for Bureau programs.

Review Criteria

All reviewers will use the criteria below to reach funding recommendations and decisions. Technically eligible applications will be reviewed competitively according to these criteria, which are not rank-ordered or weighted.

(1) Broad Significance of Institutional Objectives: Project objectives should have significant but realistically anticipated ongoing consequences for the participating institutions and for their surrounding societies or communities through a deepened mutual understanding of one another and of issues pertaining to freedom and democracy, economic stability and prosperity, or environmental cooperation.

(2) Clarity and Relevance of Project Objectives to Institutional Needs: Proposed projects should outline clearly formulated objectives that relate specifically to the needs of the participating institutions.

(3) Creativity and Feasibility of Strategy to Achieve Project Objectives: Strategies to achieve project objectives should demonstrate the feasibility of doing so during a three-year period by utilizing and reinforcing exchange activities realistically and with creativity.

(4) Institutional Commitment to Cooperation: Proposals should demonstrate significant understanding at each institution of its own needs and capacities and of the needs and capacities of its proposed partner(s), together with a strong commitment, during and after the period of grant activity, to cooperate with one another in the mutual pursuit of institutional objectives.

(5) Project Evaluation: Proposals should outline a methodology for determining the degree to which a project meets its objectives, both while the project is underway and at its conclusion. The final project evaluation should include an external component and should provide observations about the project's influence within the participating institutions as well as their surrounding communities or societies.

(6) Cost-effectiveness: Administrative and program costs should be reasonable and appropriate with cost-sharing provided by all participating institutions within the context of their respective capacities and as a reflection of their commitment to cooperate with one another in pursuing project objectives. Although indirect costs are eligible for inclusion as cost-sharing by the applicant, contributions should not be limited to indirect costs.

(7) Support of Diversity: Proposals should demonstrate substantive support of the Bureau's policy on diversity by explaining how issues of diversity relate thematically to project objectives for all institutional partners 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.

Notice

The terms and conditions published in this RFP are binding and may not be modified by any State Department representative. Explanatory information provided by the Department of State that contradicts published language will not be binding. Issuance of the RFP 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: June 12, 2000.

Evelyn S. Lieberman,

Under Secretary for Public Diplomacy and Public Affairs, U.S. Department of State.

[FR Doc. 00–16506 Filed 6–28–00; 8:45 am]

BILLING CODE 4710–11–P

DEPARTMENT OF STATE

[Public Notice 3343]

Bureau of Educational and Cultural Affairs Request for Proposals: Curriculum Development in International Convention and Conference Management at Meio University, Okinawa, Japan; Notice

SUMMARY: The Office of Global Educational Programs of the Bureau of Educational and Cultural Affairs in the Department of State announces an open competition for an award program to assist Meio University, Okinawa, Japan, in strengthening its curriculum in convention and conference management in ways that will contribute to the prefecture's long-term international development goals and to building closer U.S.-Japanese people-to-people relations in Okinawa. Accredited, post-secondary educational institutions meeting the provisions described in IRS regulation 26 CFR 1.501(c) may submit proposals that address this objective. The means for achieving this objective may include teaching, distance learning, practicums and student internships of up to 12 months, and professional outreach from the U.S. and Okinawan institutions participating in this project.

Overview

The program is designed to assist Meio University to strengthen its curriculum in convention and conference management education to promote greater diversification and economic development in the prefecture of Okinawa, which is attempting to expand its economy internationally, including its international conference and convention capabilities. The prefecture is in the process of building the physical infrastructure to support tourism. New conference and convention facilities are being constructed, hotels are being upgraded, and telecommunications are being improved to accommodate tourists. However, there is a need to prepare qualified professionals in the fields of convention and conference management to utilize the prefecture's infrastructure resources more effectively.

Project Objective

The objective of this Department of State assistance program is to reinforce these efforts and to build closer U.S.-Japanese people-to-people relations in Okinawa by awarding one grant of up to $125,000 for a partnership in the fields of convention and conference management between a U.S. college or university and Meio University, Okinawa. Grants will not be awarded to organizations with less than four years of experience in conducting international exchange programs. The funds will be awarded for a period up to three years to defray the costs of either one-or two-way exchanges, to provide education materials, and to provide approximately 20 percent of the grand total to defray the costs of the project administration.

The project should pursue this objective through a strategy which coordinates the participation of faculty, administrators or, in limited circumstances, students for any appropriate combination of teaching, consultation, mentoring, student internships, and outreach, for exchange visits ranging from one week to an academic year. Two-way exchanges are encouraged, but no single formula is anticipated for the duration, sequence or number of these visits. One semester visits or more for participants from at least one of the institutional partners are strongly encouraged. Participants should make their training and personnel resources available to government, non-governmental organizations, and business practitioners.

Logistics

The U.S. grantee organization will be responsible for most arrangements associated with this project. These include providing international and domestic travel arrangements for all participants, making lodging and local transportation arrangements for visitors, orienting and debriefing participants, and preparing any necessary support material.

VISA/Insurance/Tax Requirements

Programs must comply with J–1 visa regulations including those pertaining to insurance. Please refer to Solicitation Package for further information. Administration of the program must be in compliance with reporting and withholding regulations for Federal, state, and local taxes as applicable. Recipient organizations should demonstrate tax regulation adherence in the proposal narrative and budget.

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 community colleges, minority-serving institutions, undergraduate liberal arts colleges, and combinations of these types of institutions are eligible. Applications from consortia or other combinations of U.S. colleges and universities are eligible. Secondary U.S. partners may include non-governmental organizations as well as non-profit service and professional organizations. The lead U.S. organization 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.

With the exception of outside consultants reporting on the degree to which project objectives have been achieved, participants representing the U.S. institution who are traveling under the Bureau's grant funds should be teachers, students, or administrators from the participating institution(s). Participants representing the U.S. institution must be U.S. citizens. Students are eligible for Bureau-funded participation in this program.

Japanese Institution and Participant Eligibility

In Japan, the partner is Meio University, Okinawa, which has a curriculum in management and a four-year tourism program under its Faculty of International Studies. Additional information is provided in the ''Project Objectives, Goals, and Implementation (POGI)'' guidelines for this solicitation.

Secondary foreign partners may include relevant governmental and non-governmental organizations, as well as non-profit service and professional organizations.

With the exception of outside consultants reporting on the degree to which project objectives have been achieved, participants representing the foreign institution must be teachers, administrators, or students from Meio University. Foreign participants must be citizens, nationals, or permanent residents of Japan and must be qualified to hold a valid passport and a U.S. J–1 visa.

Budget Guidelines

Applicants must submit a comprehensive budget for the entire project. The maximum award in this competition will be for one grant in the amount of $125,000. Requests for an amount 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 break-down reflecting the program and administrative budgets. Proposals with substantial private sector support will be rated as more highly competitive in this regard than those without such support. Cost-sharing will be considered an important indicator of institutional commitment. Proposals whose administrative request from the Bureau is less than 20 percent of the total amount of funds requested from the Bureau will receive more favorable consideration. Applicants may provide separate sub-budgets for each program component, phase, participants involved, or activity to provide clarification. 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 RFP should reference the program title ''Curriculum Development in Convention and Conference Management Project at Meio University, Okinawa, Japan'' and number ECA/A/S/U–01–07.

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: affiliation@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 ''Reference number ECA/A/S/U–01–07'' on all inquiries and correspondence.

Please read the complete RFP announcement before sending inquiries or submitting proposals. Once the RFP 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/rfps. Please read all information before downloading.

Deadline for Proposal

All proposal copies must be received at the State Department's Bureau of Educational and Cultural Affairs by 5 p.m. Washington DC time on Friday, September 29, 2000. 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 January 1, 2001.

Duration

January 1, 2001 to December 31, 2004 or before.

Submissions

Proposals must be submitted by the U.S. institutional partner and must include letters of commitment from all U.S. institutional partners. The letters should be signed by persons authorized to commit institutional resources to the project.

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–01–07, Program Management, ECA/EX/PM, Room 336, 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 RFP 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 Tokyo for its review, with the goal of reducing time it takes to get the post'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.'' Proposals should account for advancement of this goal, in their program contents, to the full extent deemed feasible.

Year 2000 Compliance Requirement (Y2K Requirement)

The Year 2000 (Y2K) issue is a broad operational and accounting problem that could potentially prohibit organizations from processing information in accordance with Federal management and program specific requirements including data exchange with the Department of State. The inability to process information in accordance with Federal requirements could result in grantees' being required to return funds that have not been accounted for properly.

The Department of State therefore requires all organizations use Y2K compliant systems including hardware, software, and firmware. Systems must accurately process data and dates (calculating, comparing and sequencing) both before and after the beginning of the year 2000 and correctly adjust for leap years.

Additional information addressing the Y2K issue may be found at the General Services Administration's Office of Information Technology website at http://www.itpolicy.gsa.gov.

Review Criteria

State Department officers in Washington, DC 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 have reasonable and feasible project objectives which are relevant to strengthening Meio University's curriculum in convention and conference management. Proposals should describe projected benefits to the institutions involved as well as for wider communities of educators and practitioners in Okinawa and the United States.

2. Program Planning

Proposals should include realistic and feasible program plans and a detailed schedule which should include a well-reasoned combination of useful and appropriate mentoring, teaching, faculty and/or staff development, curriculum development (including distance learning if conditions allows it), and workshops with business practitioners in Okinawa.

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 the 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 institutional needs and capacities of Meio University as well as the U.S. institution's capacities, and demonstrate a strong commitment, during and after the period of the grant activity, to achieve program goals. Relevant factors include: The match between partner departments and schools; and availability of sufficient number of faculty and/or administrators willing and able to participate in any combination of teaching, mentoring and outreach activities. Proposals should demonstrate promise of sustainability and long-term impact which will be reflected in a plan for continued, non-U.S. government support and follow-on activities.

5. Institutional Record/Ability

Proposals should demonstrate an institutional record of 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 Office of Contracts. The Bureau will consider the past performance of prior recipients and all reviewers will consider the demonstrated potential of new applicants. Reviewers will also consider the quality of exchange participants' academic credentials, skills, and experience relative to the goals and activities of the project plan.

6. Project Evaluation

The proposal should outline a methodology to assess progress made in supporting a program to strengthen a curriculum in conference and convention management at Meio University. The final evaluation should include an external component and should provide observations about the anticipated long-term impact on diversification and economic development in the prefecture of Okinawa.

7. Cost-Effectiveness

Administrative and program costs should be reasonable and appropriate with cost-sharing provided by all participating institutions within the context of their respective capacities and as a reflection of their commitment to cooperation with one another in pursuing project objectives. Although indirect costs are eligible for inclusion among other shared costs, a proposed contribution of indirect costs will not be considered a primary indicator of institutional interest or commitment. Proposals with substantial private sector support and those whose administrative request from the Bureau is less than 20 percent of the amount requested will be considered more highly competitive in this regard.

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 Fulbright-Hays Act.

Notice

The terms and conditions published in this RFP 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 RFP does not constitute an award commitment on the part of the Government. The Bureau reserves the right to reduce, revise, or increase proposals in accordance with the needs of the program and the availability of funds. Awards made will be subject to periodic reporting and evaluation requirements.

Projects must conform with Department of State requirements and guidelines outlined in the solicitation Package. The POGI, a document describing this project's objectives, goals, and implementation is included in the Solicitation Package.

Notification

Final awards cannot be made until funds have been appropriated by Congress, allocated and committed through internal Bureau procedures.

Dated: June 20, 2000.

Evelyn S. Lieberman,

Under Secretary for Public Diplomacy and Public Affairs, U.S. Department of State.

[FR Doc. 00–16505 Filed 6–28–00; 8:45 am]

BILLING CODE 4710–11–P

TENNESSEE VALLEY AUTHORITY

Paperwork Reduction Act of 1995, as amended by Pub. L. 104–13; Submission for Office of Management and Budget (OMB) Review; Comment Request

AGENCY: Tennessee Valley Authority

ACTION: Submission for Office of Management and Budget (OMB) Review; comment request.

SUMMARY: The proposed information collection described below will be submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35, as amended). The Tennessee Valley Authority is soliciting public comments on this proposed collection as provided by 5 CFR 1320.8(d)(1). Requests for information, including copies of the information collection proposed and supporting documentation, should be directed to the Agency Clearance Officer: Wilma H. McCauley, Tennessee Valley Authority, 1101 Market Street (EB 5B), Chattanooga, Tennessee 37402–2801; (423) 751–2523.

Comments should be sent to OMB Office of Information and Regulatory Affairs, Attention: Desk Officer for Tennessee Valley Authority no later than July 31, 2000.

SUPPLEMENTARY INFORMATION:

Type of Request: Regular submission, proposal to reinstate, with change, a previously approved collection for which approval has expired.

Title of Information Collection: Employment Applications.

Frequency of Use: On occasion.

Type of Affected Public: Individuals.

Small Businesses or Organizations Affected: No.

Federal Budget Functional Category Code: 999.

Estimated Number of Annual Responses: 17,583.

Estimated Total Annual Burden Hours: 15,913.

Estimated Average Burden Hours Per Response: 1.

Need For and Use of Information: Applications for employment are needed to collect information on qualifications, suitability for employment, and eligibility for veterans preference. The information is used to make comparative appraisals and to assist in selections. The affected public consists of individuals who voluntarily apply for TVA employment.

Jacklyn J. Stephenson,

Senior Manager, Enterprise Operations. Information Services

[FR Doc. 00–16489 Filed 6–28–00; 8:45 am]

BILLING CODE 8120–08–P

DEPARTMENT OF TRANSPORTATION

Coast Guard

[USCG–2000–7514]

National Preparedness for Response Exercise Program (PREP)

AGENCY: Coast Guard, DOT.

ACTION: Notice of public meeting and request for comments.

SUMMARY: The Coast Guard, the Environmental Protection Agency, the Research and Special Programs Administration and the Minerals Management Service, in concert with the states, the oil industry and concerned citizens, developed the Preparedness for Response Exercise Program (PREP). This notice announces the date, time, and location for the next PREP workshop. Federal, state, and local agencies and the public, are encouraged to participate and provide oral and written comments.

DATES: The meeting will be held on August 29, 2000, from 7:30 a.m. to 5 p.m. Written comments must reach the Docket Management Facility on or before September 15, 2000.

ADDRESSES: The workshop will be held at the U.S. Department of Transportation Nassif Building, Room 2230, 400 Seventh St. SW Washington, DC 20590. To make sure your comments and related materials do not enter the docket more than once, please submit them (labeled with the docket number, USCG 2000–7514) by only one of the following means:

(1) By mail to the Docket Management Facility, 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.*

The Docket Management Facility maintains the public docket for this notice. Comments and material received from the public 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 access the public docket on the Internet at *http://dms.dot.gov.*

FOR FURTHER INFORMATION CONTACT: For general information regarding the PREP program and the schedule, contact Mr. Bob Pond, Marine Safety and Environmental Protection Directorate, Office of Response, (G–MOR–2), (202) 267–6603.

The 1994 PREP Guidelines are available for downloading from the World Wide Web at *http://www.uscg.mil/hq/g-m/nmc/response/#PREP.* The PREP Guidelines are also available in hard-copy at no cost by writing or faxing the TASC Dept Warehouse, 3341Q 75th Avenue, Landover, MD 20785, fax: 301–386–5394, stock number—USCG–X0191. The schedule of PREP area exercises is also available at the above website along with an exercise design manual prepared by the Office of Pipeline Safety.

For questions on viewing or submitting material to the docket, call Dorothy Beard, Chief, Dockets, Department of Transportation, phone 202–366–9329.

SUPPLEMENTARY INFORMATION:

Request for Comments

We encourage you to participate in this program assessment by submitting comments and related material. If you do so, please include your name and address, identify the docket number for this notice (USCG–2000–7514), 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, 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 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 self-addressed, stamped postcard or envelope. We will consider all comments and material received during the comment period. We may change this program in view of the comments.

Background

The Coast Guard, the Environmental Protection Agency (EPA), the Research and Special Programs Administration (RSPA), and the Minerals Management Service (MMS), in concert with the states, the oil industry and concerned citizens, developed the Preparedness for Response Exercise Program (PREP). PREP was developed to establish a workable oil pollution response exercise program, which meets the intent of section 4204(a) of the Oil Pollution Act of 1990. PREP provides a mechanism for compliance with the exercise requirements, while being economically feasible for the government and oil industry to adopt and sustain. Since the inception of PREP, public meetings have been held periodically to assess the continuing vitality of the program. The last meeting, in August of 1997, concluded that no changes were necessary to the program at that time. Since then, several changes have been proposed or implemented which influence the way government and industry prepare for and respond to oil and hazardous substance incidents in the United States. As a result, some changes to the PREP program may be appropriate.

Therefore, the Coast Guard, EPA, RSPA, and MMS are holding a public workshop to conduct an assessment of the current PREP program. At the workshop, each agency will briefly outline its concerns with the current program and solicit participant input on resolution of those concerns, either through amendment of the PREP Guidelines or other means. Other participating stakeholders, including states and industry, will be invited to discuss their concerns as well. The workshop will reaffirm the vitality of the PREP program as it currently exists or identify outstanding concerns and gain commitment on the part of participants to a plan of action to resolve those concerns. It is anticipated that one or more additional workshops may be scheduled in order to resolve any outstanding concerns.

Workshop Agenda

The workshop will address current concerns with PREP, specifically: What should the PREP goals be for the next 5 years? Is the program sufficiently dynamic and robust to address the needs of plan holders, area committees and the response community in general? In order to discuss these issues, we will follow the agenda in Table 1.

BILLING CODE 4910–15–P

Table 1 Preparedness for Response Exercise Program Workshop Agenda

7:30 to 8:00	Registration	
8:00 to 9:00	Welcome to participants	
9:00 to 10:30	Overall Program - e.g., Internal and External Exercise types, number, frequency	Are exercises focused on the **right objectives?** Are they contributing to response community's preparedness to respond in a timely fashion using the **right tools?** Each agency will be invited to provide a five-minute comment on these questions. Registered speakers will also be allowed to make a five-minute comment. General discussion following should focus on satisfying any concerns raised by the speakers or in identifying those issues which can't be resolved during this workshop.
10:30 - 10:45	Break	
10:45 - 12:00	Participation - e.g., Government play in industry led; industry play in government-led; OSRO play in both	**Are industry plan holders participating** to the extent necessary and expected in government exercises? **Are government plan holders participating** to the extent necessary and expected in industry exercises? **Are OSROs playing** to the extent necessary and appropriate to demonstrate plan holder preparedness?
12:00 - 1:00	Lunch	
1:00 - 2:30	Evaluation and implementation of lessons learned	Are **lessons learned** being **captured and shared**? Are area committees and plan holders **effectively implementing them**? Should there be more emphasis on evaluating adequacy of response strategies in effectively mitigating the impacts of an incident? Each agency will be invited to provide a five-minute comment on these questions. Registered speakers will also be allowed to make a five-minute comment. General discussion following should focus on satisfying any concerns raised by the speakers or in identifying those issues which can't be resolved during this workshop.
2:30 - 2:45	Break	
2:45 - 4:30	General Discussion	Opportunity for sponsoring agencies and participants to raise **other issues**. Focus of this session will be on validating list of outstanding issues with the goal **confirming continuing vitality** of the PREP Guidelines **or identifying** consensus process to draft **appropriate amendments** to the Guidelines.
4:30 to 5:00	Wrap-up	

BILLING CODE 4910–15–C

Procedure

The meeting will be an informal workshop open to the public. It is intended to bring together people who are knowledgeable about the issues addressed in this notice to assist us in enhancing PREP.

Individuals or groups desiring to make presentations about their concerns during the workshop are asked to notify Mr. Bob Pond at the address or phone number under **FOR FURTHER INFORMATION CONTACT,** to ensure that all concerns are heard. The agenda for the workshop will be updated as appropriate to reflect concerns identified by other interested parties.

Information on Service for Individuals with Disabilities

For information on facilities or services for individuals with disabilities or to request special assistance at the meeting, contact Mr. Bob Pond at the address or phone number under **FOR FURTHER INFORMATION CONTACT** as soon as possible.

Dated: June 21 2000.

Joseph J. Angelo,

Acting Assistant Commandant for Marine Safety and Environmental Protection.

[FR Doc. 00–16448 Filed 6–28–00; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Advisory Circular 25.22, Certification of Transport Airplane Mechanical Systems

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice of issuance of advisory circular.

SUMMARY: This notice announces the issuance of Advisory Circular (AC) 25.22, Certification of Transport Airplane Mechanical Systems. This AC sets forth an acceptable means, but not the only means, of demonstrating compliance with the provisions of part 25 of the Federal Aviation Regulations (FAR) related to the mechanical systems and equipment installations for transport category airplanes. Like all ACs, it is not regulatory but is to provide guidance for applicants in demonstrating compliance with the objective safety standards set forth in the rule.

DATES: Advisory Circular 25.22 was issued by the Manager, Transport Airplane Directorate, Aircraft Certification Service, ANM–100, on March 14, 2000.

HOW TO OBTAIN COPIES: A copy may be obtained by writing to the U.S. Department of Transportation, Subsequent Distribution Office, DOT Warehouse, SVC–121.23, 3341Q 75th Ave., Landover, MD 20785, telephone 301–322–5377, or faxing your request to the warehouse at 301–386–5394. This AC can be found and downloaded from the Internet at http://www.faa.gov/avr/air/airhome.htm, at the link titled ''Advisory Circulars.''

Issued in Renton, Washington, on June 7, 2000.

Donald L. Riggin,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service, ANM–100.

[FR Doc. 00–16451 Filed 6–28–00; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF THE TREASURY

Submission for OMB Review; Comment Request

June 23, 2000.

The Department of Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments regarding this information collection should be addressed to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, Room 2110, 1425 New York Avenue, NW., Washington, DC 20220.

DATES: Written comments should be received on or before July 31, 2000 to be assured of consideration.

BUREAU OF ALCOHOL, TOBACCO AND FIREARMS (BATF)

OMB Number: 1512–0030.

Form Number: ATF F 5300.11.

Type of Review: Extension.

Title: Annual Firearms Manufacturing and Exportation Report.

Description: ATF collects this data for the purpose of: ATF law enforcement witness qualifications; Congressional investigations in aid of legislation; disclosure to interested members in accordance with a court order; furnishing info to other Federal agencies; ATF inspections of manufacturers ensuring that the requirements of the National Firearms Act (NFA) are met.

Respondents: Business of other for-profit, Federal Government, State, Local or Tribal Government.

Estimated Number of Respondents/Recordkeepers: 1,500.

Estimated Burden Hours Per Respondent/Recordkeeper: 45 minutes.

Frequency of Response: On occasion.

Estimated Total Reporting Burden: 1,125 hours.

OMB Number: 1512–0073.

Form Number: ATF F 5150.19.

Type of Review: Extension.

Title: Formula and/or Process for Articles Made with Specially Denatured Spirits.

Description: ATF F 5150.19 is completed by persons who use specially denatured spirits in the manufacture of certain articles. ATF uses the information provided on the form to insure the manufacturing formulas and processes conform to the requirements of 26 U.S.C. 5273.

Respondents: Business or other for-profit.

Estimated Number of Respondents: 2,683.

Estimated Burden Hours Per Respondent: 54 minutes.

Frequency of Response: On occasion.

Estimated Total Reporting Burden: 2,415 hours.

OMB Number: 1512–0075.

Form Number: ATF F 5150.18.

Type of Review: Extension.

Title: Users' Report of Denatured Spirits.

Description: The information on ATF F 5150.18 is used to pinpoint unusual activities in the use of specially denatured spirits. The form shows a summary of activities at permit premises. ATF examines and verifies certain entries on these reports to identify unusual activities, errors and omissions.

Respondents: Business or other for-profit.

Estimated Number of Respondents: 2,765.

Estimated Burden Hours Per Respondent: 18 minutes.

Frequency of Response: Annually.

Estimated Total Reporting Burden: 830 hours.

OMB Number: 1512–0204.

Form Number: ATF F 5110.38.

Type of Review: Extension.

Title: Formula for Distilled Spirits under the Federal Alcohol Administration Act (Supplemental).

Description: ATF F 5110.38 is used to determine the classification of distilled spirits for labeling and for consumer protection. The form describes the person filing, type of product to be made, and restrictions to the labeling

and manufacture. The form is used by ATF to ensure that a product is made and labeled properly and to audit distilled spirits operations.

Respondents: Business or other for-profit.

Estimated Number of Respondents: 200.

Estimated Burden Hours Per Respondent: 1 hour.

Frequency of Response: On occasion.

Estimated Total Reporting Burden: 4,000 hours.

Clearance Officer: Frank Bowers (202) 927–8930, Bureau of Alcohol, Tobacco and Firearms, Room 3200, 650 Massachusetts Avenue, NW., Washington, DC 20226.

OMB Reviewer: Alexander T. Hunt (202) 395–7860, Office of Management and Budget, Room 10202, New Executive Office Building, Washington, DC 20503.

Mary A. Able,

Departmental Reports Management Officer.

[FR Doc. 00–16412 Filed 6–28–00; 8:45 am]

BILLING CODE 4810–31–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Form 2220

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Form 2220, Underpayment of Estimated Tax by Corporations.

DATES: Written comments should be received on or before August 28, 2000 to be assured of consideration.

ADDRESSES: Direct all written comments to Garrick R. Shear, Internal Revenue Service, room 5244, 1111 Constitution Avenue NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the form and instructions should be directed to Larnice Mack, (202) 622–3179, Internal Revenue Service, room 5244, 1111 Constitution Avenue NW., Washington, DC 20224.

SUPPLEMENTARY INFORMATION:

Title: Underpayment of Estimated Tax by Corporations.

OMB Number: 1545–0142.

Form Number: 2220.

Abstract: Form 2220 is used by corporations to determine whether they are subject to the penalty for underpayment of estimated tax and, if so, the amount of the penalty. The IRS uses the information on Form 2220 to determine if the corporation had an underpayment of tax to which the estimated tax penalty applies and, if so, whether the amount of the penalty was computed correctly.

Current Actions: There are no changes being made to the form at this time.

Type of Review: Extension of a currently approved collection.

Affected Public: Business of other for-profit organizations.

Estimated Number of Respondents: 702,000.

Estimated Time Per Respondent: 29 hr., 34 min.

Estimated Total Annual Burden Hours: 20,761,187.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: June 21, 2000.

Garrick R. Shear,

IRS Reports Clearance Officer.

[FR Doc. 00–16413 Filed 6–28–00; 8:45 am]

BILLING CODE 4830–01–U

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Form 1099–PATR

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Form 1099–PATR, Taxable Distributions Received From Cooperatives.

DATES: Written comments should be received on or before August 28, 2000 to be assured of consideration.

ADDRESSES: Direct all written comments to Garrick R. Shear, Internal Revenue Service, room 5244, 1111 Constitution Avenue NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the form and instructions should be directed to Larnice Mack, (202) 622–3179, Internal Revenue Service, room 5244, 1111 Constitution Avenue NW., Washington, DC 20224.

SUPPLEMENTARY INFORMATION:

Title: Taxable Distributions Received From Cooperatives.

OMB Number: 1545–0118.

Form Number: 1099–PATR.

Abstract: Form 1099–PATR is used to report patronage dividends paid by cooperatives in accordance with Internal Revenue Code section 6044. The information is used by IRS to verify reporting compliance on the part of the recipient.

Current Actions: There are no changes being made to the form at this time.

Type of Review: Extension of a currently approved collection.

Affected Public: Business or other for profit organizations.

Estimated Number of Responses: 1,892,024.

Estimated Time Per Response: 11 min.

Estimated Total Annual Burden Hours: 359,485.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: June 20, 2000.

Garrick R. Shear,

IRS Reports Clearance Officer.

[FR Doc. 00–16414 Filed 6–28–00; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request For Form 8633

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Form 8633, Application to Participate in the IRS e-file Program.

DATES: Written comments should be received on or before August 28, 2000 to be assured of consideration.

ADDRESSES: Direct all written comments to Garrick R. Shear, Internal Revenue Service, room 5244, 1111 Constitution Avenue NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the form and instructions should be directed to Carol Savage, (202) 622–3945, Internal Revenue Service, room 5242, 1111 Constitution Avenue NW., Washington, DC 20224.

SUPPLEMENTARY INFORMATION:

Title: Application to Participate in the IRS e-file Program.

OMB Number: 1545–0991.

Form Number: 8633.

Abstract: Form 8633 is used by tax preparers, electronic return collectors, software firms, service bureaus and electronic transmitters as an application to participate in the electronic filing program covering individual income tax returns.

Current Actions: There are no changes being made to the form at this time.

Type of Review: Extension of a currently approved collection.

Affected Public: Businesses or other for-profit organizations, and not-for-profit institutions.

Estimated Number of Respondents: 50,000.

Estimated Time Per Respondent: 1 hour.

Estimated Total Annual Burden Hours: 50,000.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: June 19, 2000.

Garrick R. Shear,

IRS Reports Clearance Officer.

[FR Doc. 00–16415 Filed 6–28–00; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Request for Nominations for Members of Public Advisory Committee; Internal Revenue Service Advisory Council (IRSAC)

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice.

SUMMARY: The Internal Revenue Service (IRS) is requesting nominations for members to serve on the Internal Revenue Service Advisory Council (IRSAC). Nominations will be accepted for current vacancies and vacancies that will or may occur during the next 12 months. To ensure appropriate balance of membership, final selection from among qualified candidates will be determined based on experience, qualifications, and other expertise.

DUE DATE: July 31, 2000.

ADDRESSES: Send all applications to—Merci del Toro, Office of Public Liaison and Small Business Affairs, CL:PL, Room 7559 IR, 1111 Constitution Avenue, NW, Washington, DC 20224, Fax: 202–622–5886, E-mail: *public_liaison@irs.gov. The application package will be uploaded to the IRS web site with fill in the blank capabilities at the following addresses: Tax Professionals Corner—http://www.irs.ustreas.gov/prod/bus_info/tax_pro/index.html; and the Small Business Corner—http://www.irs.ustreas.gov/prod/bus_info/sm_bus/index.html.

FOR FURTHER INFORMATION CONTACT: Lorenza Wilds, Telephone: 202–622–6440, not a toll-free number.

SUPPLEMENTARY INFORMATION: IRS is requesting nominations for members to

serve on the advisory committee listed below.

Internal Revenue Service Advisory Council (IRSAC)

The IRSAC provides an organized public forum for discussion of relevant tax administration issues between IRS officials and representatives of the public. Through the years, IRSAC has focused on broad tax administration policy matters. Various groups have suggested operational improvements, offered constructive observations about IRS' current or proposed policies, programs, and procedures, and advised the Commissioner of Internal Revenue on particular issues having substantive effect on Federal Tax Administration. It is important that IRSAC membership continue to represent the range and make-up of broad and diverse taxpayer and stakeholder base.

Criteria for Members

Applicants shall be well-rounded, with a strong tax or business background and excellent communications skills, bring years of practical experience and knowledge to the group, and able to interact well in a diversified environment. Applicant's background should include several of the following experiences: applying tax law knowledge in the resolution of complex tax issues; developing and implementing customer service initiatives and tools, systems management and improvement, and change management; advising and/or as business owners and entrepreneurs; those who have established successful strategic partnerships; and, those who have the ability to examine situations from a ''macro'' viewpoint.

Nomination Procedures

Interested persons may nominate themselves and/or one or more qualified persons for membership on the IRSAC. Application packages are available on the IRS' Internet Site, on the Tax Professionals Corner—

http://www.irs.ustreas.gov/prod/bus_info/tax_pro/index.html

or

the Small Business Corner—

http://www.irs.ustreas.gov/prod/bus_info/sm_bus/index.html.

Applicants may also request an application package by calling Lorenza Wilds at 202–622–6440 (not a toll-free number). Federal income tax, FBI, and practitioner checks (if applicable), are required of all applicants. This notice is issued under the Federal Advisory Committee Act (5 U.S.C. app. 2) and 21 CFR part 14, relating to advisory committees.

Dated: June 6, 2000.

Susanne D. Sottile,

National Director, Public Liaison and Small Business Affairs, Designated Federal Official, IRS Advisory Council.

[FR Doc. 00–16416 Filed 6–28–00; 8:45 am]

BILLING CODE 4830–01–P

Corrections

Federal Register

Vol. 65, No. 126

Thursday, June 29, 2000

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 10, 13, 17, and 23

RIN 1018–AD87

Revision of Regulations for the Convention on International Trade in Endangered Species of Wild Fauna and Flora (CITES)

Correction

In proposed rule document 00–9980 beginning on page 26664 in the issue of Monday, May 8, 2000, make the following corrections:

1. On page 26664, in the first column, in the **ADDRESSES** section, in the 10th line, the E–mail address ''r9oma–cites@fws.gov'' should read ''r9oma__cites@fws.gov''.

2. On page 26684, in the first table, in the fifth column under the heading ''Totals'', ''863'' should be under the heading ''Total annual burden hours''.

§23.7 [Corrected]

3. On page 26689, in §23.7(a), in the table, in the second column, in the ninth line, the E–mail address ''r9IA OMA@fws.gov'' should read ''r9IA__OMA@fws.gov''.

§23.18 [Corrected]

4. On page 26695, in §23.18(c), in the table, in the second column, in the first entry, remove the second ''is''.

§23.22 [Corrected]

5. On page 26700, in §23.22(b)(1)(i), in the table, in the second column, in the first entry, remove the second ''Export''.

[FR Doc. C0–9980 Filed 6–28–00; 8:45 am]

BILLING CODE 1505–01–D

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[NV–930–1430–01; N–56474]

Notice of Realty Action; Nevada

Correction

In notice document 00–15610 beginning on page 38572 in the issue of Wednesday, June 21, 2000, make the following correction:

On page 38572, in the second column, in the **SUMMARY** section, in the second line from the end of the section, ''Section 2, Lots 1–2, S½, S½NE¼.'' should read ''Section 2, Lots 1–2, S½NE¼.''

[FR Doc. C0–15610 Filed 6–28–00; 8:45 am]

BILLING CODE 1505–01–D

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 2000-ASW-12]

Revision of Class E Airspace; Carrizo Springs, Glass Ranch TX

Correction

In rule document 00–9838 beginning on page 21301, in the issue of Friday, April 21, 2000, make the following correction:

§ 71.1 [Corrected]

On page 21302, in the first column, §71.1, under the heading **ASW TX E5 Carrizo Springs, Glass Ranch Airport, TX [Revised]**, in the second line, ''(Lat. 28° 15′46″ N.'' should read '' (Lat. 28° 27′ 01″ N. ''.

[FR Doc. C0–9838 Filed 6–28–00; 8:45 am]

BILLING CODE 1505–01–D

Federal Register

Thursday,
June 29, 2000

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 417 and 422
Medicare Program; Medicare+Choice Program; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 417 and 422

[HCFA–1030–FC]

RIN 0938–AI29

Medicare Program; Medicare+Choice Program

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period responds to comments on the June 26, 1998 interim final rule that implemented the Medicare+Choice (M+C) program and makes revisions to those regulations where warranted. We also are making revisions to the regulations that are necessary to reflect the changes to the M+C program resulting from the Balanced Budget Refinement Act of 1999 (BBRA). Revisions to the regulations reflecting changes in the law made by the BBRA are subject to public comment. Issues discussed in this rule include eligibility, election, and enrollment policies; marketing requirements; access requirements; service area and benefit policy; quality improvement standards; payment rates, risk adjustment methodology, and encounter data submission; provider participation rules; beneficiary appeals and grievances; contractual requirements; and preemption of State law by Federal law.

This final rule also addresses comments on the interim final rule published on December 2, 1997, which implemented user fees for section 1876 risk contractors for 1998, and formed the basis for the M+C user fee provisions in the June 26, 1998 interim final rule, and the provider-sponsored organization (PSO) interim final rule published April 14, 1998.

DATES: *Effective date:* This final rule is effective July 31, 2000.

Comment period: Comments on provisions reflecting provisions of the Balanced Budget Refinement Act of 1999 will be considered if received at the appropriate address, as provided below, no later than August 28, 2000. We will not consider comments concerning regulatory provisions that remain unchanged or that are revised in this final rule based on previous public comment.

ADDRESSES: Mail written comments (one original and three copies) to the following address ONLY: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1030-FC, P.O. Box 8013, Baltimore, MD 21244–8013.

Since comments must be received by the date specified above, please allow sufficient time for mailed comments to be received timely in the event of delivery delays.

If you prefer, you may deliver by courier, your written comments (one original and three copies) to one of the following addresses: Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201; or C5–14–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to the two above addresses may be delayed and received too late to be considered. Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1030–FC.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (Phone (202) 690–7890).

For comments that relate to information collection requirements, see section IV of the **SUPPLEMENTARY INFORMATION.**

FOR FURTHER INFORMATION CONTACT: Marty Abeln (410) 786–1032 (for issues related to user fees, service area, point-of-service option, PSOs, and intermediate sanctions).

Wendy Burger (410) 786–1566 and Lynn Orlosky (410) 786–5930 (for issues related to eligibility, elections, and enrollment).

Carol Barnes (410) 786–5496 (for issues related to continuation areas and marketing).

Anne Manley (410) 786–1096 (for issues related to emergency and urgently needed services, provider participation rules, and Federal preemption).

Eileen Zerhusen (410) 786–7803 (for issues related to post-stabilization care).

Tony Hausner (410) 786–1093 (for issues related to access, discrimination, and physician incentive rules).

Amy Chapper (410) 786–0367 (for issues related to information disclosure and confidentiality).

Brian Agnew (410) 786–5964 (for issues related to quality assurance and accreditation).

Al D'Alberto (410) 786–1100 (for issues related to payments, premiums, and ACRs).

James Hart (410) 786–4474 (for issues related to risk adjustment and encounter data).

Chris Eisenberg (410) 786–5509 (for issues related to contracts and contract appeals).

Michele Edmondson (410) 786–6478 (for issues related to beneficiary appeals).

Anita Heygster (410) 786–4486 (for issues related to M+C private fee-for-service plans).

Cindy Mason (410) 786–6680 (for issues related to M+C MSA plans).

SUPPLEMENTARY INFORMATION: For the convenience of the reader, we are providing a complete outline of this final rule, including a topical listing of the major areas raised by the comments, along with numerical regulatory citations.

I. Background
A. Balanced Budget Act of 1997
B. Overview of M+C Regulations
1. Interim Final Rule
2. Correction Notice
3. February 17, 1999 Final Rule
C. M+C Provisions of the Balanced Budget Refinement Act of 1999
II. Analysis of and Responses to Public Comments
A. Overview
1. Comments on June 26, 1998 Interim Final Rule
2. Issues in February 17, 1999 Final Rule
3. Organization of this Final Rule
4. General Comments and Subpart A Issues
a. Administrative Procedure Act Issues
b. Types of M+C Plans (§ 422.4)
c. Application Requirements and Procedures (§§ 422.6 and 422.8)
d. User Fees (§ 422.10)
B. Eligibility, Election and Enrollment (Subpart B)
1. Eligibility to Elect an M+C Plan (§ 422.50)
2. Continuation of Enrollment (§ 422.54)
3. Election Process (§ 422.60)
4. Enrollment Capacity (§ 422.60(b))
5. Election of Coverage Under an M+C Plan (§ 422.62)
6. Information about the M+C Program (§ 422.64)
7. Coordination of Enrollment and Disenrollment Through M+C Organizations (§ 422.66)
8. Effective Dates of Coverage and Change of Coverage (§ 422.68)
9. Disenrollment by the M+C Organization (§ 422.74)
10. Approval of Marketing Materials and Election Forms (§ 422.80)
C. Benefits and Beneficiary Protections (Subpart C)
1. Introduction
2. Emergency, Urgently Needed, and Post-Stabilization Care Services (§§ 422.2, 422.100, 422.112, and new § 422.113)
a. Definitions
b. Enforcement of Emergency Requirements

c. Access to Emergency and Urgently Needed Services
d. Post-Stabilization Care Services
3. Service Area Requirements (§§ 422.2, 422.100)
4. Benefits (§§ 422.2, 422.100, 422.101, 422.106)
5. Special Rules for Screening Mammography, Influenza Vaccine, and Pneumococcal Vaccine (§ 422.100(h))
6. Special Rules for Point-of-Service (POS) Option (§ 422.105)
7. Medicare Secondary Payer (MSP) Procedures (§ 422.108)
8. National Coverage Determinations (§ 422.109)
9. Discrimination Against Beneficiaries Prohibited (§ 422.110)
10. Disclosure Requirements (§ 422.111)
11. General Access Requirements (§ 422.112)
a. Introduction
b. Provider Network (§ 422.112(a)(1))
c. Primary Care Providers (PCP) Panels (§ 422.112(a)(2))
d. Specialty Care (§ 422.112(a)(3))
e. Serious Medical Conditions (§ 422.112(a)(4))
f. Written Standards (§ 422.112(a)(7))
g. Cultural Considerations (§ 422.112(a)(9))
12. Confidentiality and Accuracy of Enrollee Records (§ 422.118)
13. Information on Advance Directives (§ 422.128)
D. Quality Assurance (Subpart D)
1. Overview
2. Quality Assessment and Performance Improvement Requirements (§ 422.152)
3. External Review (§ 422.154)
4. Deemed Compliance Based on Accreditation (§ 422.156)
5. Accreditation Organizations (§ 422.157)
6. Procedures for Approval of Accreditation as a Basis for Deeming Compliance (§ 422.158)
E. Relationships With Providers (Subpart E)
1. Provider Participation Procedures (§§ 422.202(a), and 422.204(c))
2. Consultation Requirements (§ 422.202(b))
3. Treatment of Subcontracted Networks (§ 422.202(c))
4. Provider Antidiscrimination (§§ 422.100(j), 422.204(b), and new § 422.205)
5. Provider Credentialing (§ 422.204(a))
6. Prohibition on Interference with Health Care Professionals' Communication with Enrollees (§ 422.206)
7. Physician Incentive Plans (§§ 422.208 and 422.210)
8. Special Rules for Services Furnished by Noncontract Providers (§ 422.214)
9. Exclusion of Services Furnished Under a Private Contract (§ 422.220)
10. M+C Plans and the Physician Referral Prohibition
F. Payments to M+C Organizations (Subpart F)
1. General Provisions (§ 422.250)
2. Risk Adjustment and Encounter Data (§ 422.256 through § 422.258)
3. Special Rules for Hospice Care (§ 422.266)
G. Premiums and Cost-Sharing (Subpart G)
1. General Provisions (§ 422.300)
2. Rules Governing Premiums and Cost-Sharing (§ 422.304)
3. Submission Requirements of the Proposed Premiums and Related Information (§ 422.306)
4. Limits on Premiums and Cost-Sharing Amounts (§ 422.308)
5. Incorrect Collections of Premiums and Cost-Sharing Amounts (§ 422.309)
6. ACR Approval Process (§ 422.310)
7. Requirement for Additional Benefits (§ 422.312)
H. Provider-Sponsored Organizations (Subpart H)
I. Organization Compliance With State Law and Preemption by Federal Law (Subpart I)
1. State Licensure and Scope of Licensure (§ 422.400)
2. Federal Preemption of State Law (§ 422.402)
a. General Preemption (§ 422.402(a))
b. Specific Preemption (§ 422.402(b))
3. Prohibition on State Premium Taxes (§ 422.404)
4. Medigap
J. (Subpart J—Reserved)
K. Contracts with M+C Organizations (Subpart K)
1. Definitions (§ 422.500)
2. National Contracting (§ 422.501)
3. Compliance Plan (§ 422.501(b)(3)(vi))
4. Access to Facilities and Records (§ 422.502(e))
5. Disclosure of Information (§ 422.502(f)(2)(v))
6. Beneficiary Financial Protection (§ 422.502(g))
7. Requirements of Other Laws and Regulations (§ 422.502(h))
8. Contracting/Subcontracting Issues (§ 422.502(i))
9. Certification of Data that Determine Payment/Certification of Accuracy of ACR (§ 422.502(l))
10. Effective Date and Term of Contract (§ 422.504)
11. Nonrenewal of M+C Contracts (§ 422.506)
12. Provider Prior Notification and Disclosure (§§ 422.506(a), 422.508, 422.510(b), and 422.512)
13. Mutual Termination of a Contract (§ 422.508)
14. Termination of Contract by HCFA (§ 422.510)
15. Minimum Enrollment Requirements (§ 422.514)
16. Reporting Requirements (§ 422.516)
17. Prompt Payment by M+C Organization (§ 422.520)
L. Effect of Change of Ownership or Leasing of Facilities During Term of Contract (Subpart L)
M. Grievances, Organization Determinations, and Appeals (Subpart M)
1. Background and General Provisions (§§ 422.560, 422.561, and 422.562)
2. Grievance Procedures (§ 422.564)
3. Organization Determinations (§§ 422.566 through 422.576)
4. Reconsiderations by an M+C Organization or Independent Review Entity (§§ 422.578 through 422.616)
5. Effectuation of a Reconsidered Determination (§ 422.618)
6. Notification of Noncoverage in Inpatient Hospital Settings (§§ 422.620 and 422.622)
Subpart M—Comments and Responses
7. Definitions and General Provisions
8. Grievances
9. Organization Determinations
10. Written Notice
11. Time Frames
12. Expedited Organization/Reconsidered Determinations
13. Authorized Representatives
14. Other Appeal Rights
15. Inpatient Hospital Notice of Discharge
16. Other Comments
N. Medicare Contract Appeals (Subpart N)
O. Intermediate Sanctions (Subpart O)
P. Medicare+Choice MSA Plans
1. Background
2. General Provisions (Subpart A)
3. Eligibility, Election and Enrollment Rules (Subpart B)
a. Eligibility and Enrollment (§ 422.56)
b. Election (§ 422.62)
4. Benefits (Subpart C)
a. Basic Benefits Under an M+C MSA Plan (§ 422.102)
b. Supplemental Benefits (§§ 422.102 and 422.103)
5. Quality Assurance (Subpart D)
6. Relationships with Providers (Subpart E)
7. Payments Under MSA Plans (Subpart F)
8. Premiums (Subpart G)
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I. Background

A. Balanced Budget Act of 1997

Section 4001 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted August 5, 1997, added sections 1851 through 1859 to the Social Security Act (the Act) to establish a new Part C of the Medicare program, known as the ''Medicare+Choice (M+C) Program.'' (The previous Part C of the statute, which included provisions in section 1876 of the Act governing existing Medicare health maintenance

organization (HMO) contracts, was redesignated as Part D.) Under section 1851(a)(1) of the Act, every individual entitled to Medicare Part A and enrolled under Part B, except for individuals with end-stage renal disease, may elect to receive benefits through either the existing Medicare fee-for-service program (''Original Medicare'') or a Part C M+C plan, if one is offered where he or she lives.

As its name implies, the primary goal of the M+C program is to provide Medicare beneficiaries with a wider range of health plan choices through which to obtain their Medicare benefits. The M+C statute authorizes a variety of private health plan options for beneficiaries, including both the traditional managed care plans (such as those offered by HMOs) that traditionally have been offered under section 1876 of the Act, and new options that were not previously authorized. Specifically, section 1851(a)(2) of the Act describes three types of M+C plans authorized under Part C:

- M+C coordinated care plans, including HMO plans (with or without point of service options), provider-sponsored organization (PSO) plans, and preferred provider organization (PPO) plans.
- M+C medical savings account (MSA) plans (that is, combinations of a high-deductible M+C health insurance plan and a contribution to an M+C MSA).
- M+C private fee-for-service plans.

An entity contracting with us to offer any of the above plans to Medicare beneficiaries is called an ''M+C organization.''

In addition to expanding the types of health plans that can be offered to Medicare beneficiaries, the M+C program introduces several other fundamental changes to the managed care component of the Medicare program. These changes include:

- Establishment of an expanded array of quality assurance standards and other consumer protection requirements;
- Introduction of an annual coordinated enrollment period, in conjunction with the distribution by us of uniform, comprehensive information about M+C plans that is needed to promote informed choices by beneficiaries;
- Revisions in the way we calculate payment rates to M+C organizations that will narrow the range of payment variation across the country and increase incentives for organizations to offer M+C plans in diverse geographic areas; and
- Establishment of requirements concerning provider participation procedures.

B. Overview of M+C Regulations

1. Interim Final Rule

On June 26, 1998, we published in the **Federal Register** a comprehensive interim final rule (63 FR 34968) to implement the provisions of section 4001 of the BBA that established the M+C program. That interim final rule set forth the new M+C regulations in 42 CFR Part 422—Medicare+Choice Program. The major subjects covered in each subpart of part 422 are as follows:

- Subpart A—Definitions, including definitions of types of plans, application process, and user fees.
- Subpart B—Requirements concerning beneficiary eligibility, election, enrollment and disenrollment procedures, and plan information and marketing materials.
- Subpart C—Requirements concerning benefits, point of service options, access to services (including rules on enrollee assessments and notification upon termination of specialists), and others.
- Subpart D—Quality assurance standards, external review, and deeming of accredited organizations.
- Subpart E—Provider participation rules and the prohibition against interference with health care professionals' advice to enrollees.
- Subpart F—Payment methodology for M+C organizations, risk adjustment, and encounter data requirements.
- Subpart G—Requirements concerning premiums, cost-sharing, and determination of adjusted community rate.
- Subpart H—Requirements concerning PSOs.
- Subpart I—Organization compliance with State law and preemption by Federal law.
- Subpart K—Contract requirements.
- Subpart L—Change of ownership rules.
- Subpart M—Beneficiary grievances, organization determinations, and appeals.
- Subpart N—Contractor appeals of nonrenewals or terminations of contracts.
- Subpart O—Procedures for imposing intermediate sanctions.

2. Correction Notice

On October 1, 1998, we issued a correction notice in the **Federal Register** (63 FR 52610) to correct technical errors that appeared in the interim final rule. All references in this document to regulation text are to the corrected text unless otherwise noted.

3. February 17, 1999 Final Rule

Additionally, on February 17, 1999, we published a final rule in the **Federal Register** (64 FR 7968) that set forth limited changes to the M+C regulations published in the June 26, 1998 interim final rule. It specifically addressed only a limited number of issues raised by commenters on the June 26, 1998 interim final rule. We indicated in the preamble to the February 17, 1999 final rule that we intended to address all other issues raised by commenters on the M+C interim final rule in a comprehensive M+C final rule to be published at a later date. The types of comments we addressed in the February final rule are discussed in more detail in section II.A.2.

C. M+C Provisions of the Balanced Budget Refinement Act of 1999

On November 29, 1999, as we were completing the development of this final rule, the Balanced Budget Refinement Act of 1999 (Pub. L. 106–113) (BBRA) was enacted. The BBRA includes a number of provisions that affect the M+C program, and these provisions have necessitated a number of corresponding changes so that the changes in the law made by the BBRA are reflected in the text of the M+C regulations. For the most part, the statutory changes are self-explanatory, and have already taken effect. As noted above, we are accepting public comment on conforming changes to the M+C regulations made as a result of the BBRA provisions. We are revising the regulations to reflect the provisions of the BBRA as follows:

1. Changes in M+C Enrollment Rules (Section 501 of the BBRA)

a. Enrollment in Alternative M+C Plans and Medigap Coverage After Involuntary Terminations

Section 1851(e)(4) of the Act establishes special election periods during which M+C-eligible individuals may disenroll from an M+C plan or elect another M+C plan, including a special election period when an M+C organization or we have terminated a plan or the organization has otherwise discontinued providing the plan in the area in which the individual resides. Section 501(a)(1) of the BBRA revised section 1851(e)(4) to specify that this special election period now becomes available either upon termination or discontinuation or when the organization ''has notified the individual of an impending termination or discontinuation of such a plan.'' We have revised § 422.62(b)(1) to reflect this earlier opportunity for an affected

enrollee to elect an alternative M+C plan or return to original Medicare. We note that section 501(b) of the BBRA set forth conforming amendments to section 1882(s)(3) of the Act (concerning beneficiary rights to guaranteed issue of a Medicare supplemental policy, that is, a Medigap policy) to allow an individual guaranteed issue rights to a Medigap policy within 63 days of an organization's notification of an impending termination or service area reduction.

b. Open Enrollment for Institutionalized Individuals (Section 501(b))

Section 1851(e) of the Act establishes the time frames, or election periods, for making or changing elections. Section 501(b) of the BBRA amended section 1851(e)(2) of the Act by adding a new subparagraph (D), which provides for continuous open enrollment for institutionalized individuals after 2001. Thus, on or after January 1, 2002 (which represents the first day when limitations are placed on an M+C-eligible individual's enrollment and disenrollment opportunities), M+C-eligible individuals who are institutionalized, as defined by HCFA, may continue to change from original Medicare to an M+C plan, from an M+C plan to original Medicare, or from one M+C plan to another. We have added § 422.62(a)(6) to reflect this provision, with conforming changes at § 422.62(a)(4)(i) and § 422.62(a)(5)(i). We intend to provide guidance on the meaning of the term ''institutionalized'' in due time to permit orderly implementation of this change before it takes effect in 2002.

c. Continued Enrollment for Certain M+C Enrollees

Section 1851(b)(1) of the Act establishes the residence requirements for eligibility to elect an M+C plan. Section 501(c) of the BBRA amended section 1851(b)(1) of the Act by adding a new subparagraph (C) to allow an individual to choose to continue enrollment in an M+C plan offered by the organization if (1) the M+C organization eliminates the M+C plan in the service area in which the individual resides and, (2) no other M+C plan is offered in the service area at the time of the elimination of the M+C plan in the service area and, (3) the M+C organization chooses to allow the option to continue enrollment in an M+C plan offered by the organization. If the individual chooses to retain his or her enrollment in the M+C plan, the M+C organization may require that he or she agree to obtain the full range of basic benefits (excluding emergency and urgently needed care) through facilities designated by the organization within the plan's HCFA-approved service area. In the case of home health services, since this is a basic benefit that by its nature involves receipt of services in the home, while the provider of the home health services may be located in the service area, actual services would have to be offered in the beneficiary's home. We have reflected this provision in § 422.74(b)(3), with a conforming change made in § 422.66(e)(2).

2. Change in Effective Date of Elections (Section 502 of the BBRA)

Section 1851(f) of the Act establishes the effective dates for elections and changes to elections made during the various enrollment periods. Prior to enactment of the BBRA, section 1851(f)(2) stated that an election made during an open enrollment period was effective the first day of the following calendar month. Section of the 502 BBRA amended section 1851(f)(2) of the Act to state that an election made during an open enrollment period is effective the first day of the following calendar month, except that if the election or change in election is made after the 10th day of the calendar month, the election is effective the first day of the second calendar month following the date the election or change in election is made. We have revised § 422.68(c) to reflect this provision.

3. Extension of Reasonable Cost Contracts (Section 503 of the BBRA)

Section 503 of the BBRA amended section 1876(h)(5)(B) of the Act to permit the extension or renewal of Medicare cost contracts for an additional 2 years, that is, through December 31, 2004. We are revising § 417.402(b) to effect this change.

4. Phase-In of New Risk Adjustment Methodology (Section 511 of the BBRA)

Consistent with section 1853(a) of the Act, § 422.256 of the M+C regulations provides that M+C capitation payments are adjusted for age, gender, institutional status, and other appropriate factors, including health status, beginning January 1, 2000. In the January 15, 1999, Advance Notice of Methodological Changes for the CY 2000 M+C Payment Rates, we announced the risk adjustment methodology to implement this requirement. One element of the risk adjustment methodology we developed was a transition period during which M+C payments would be based on a blend of payment amounts under the previous system of demographic adjustments and payment amounts based on principal inpatient hospital diagnoses (the PIP–DCG risk adjustment methodology). Under a blend, payment amounts for each enrollee are separately determined using the demographic and risk methodologies, respectively. Those payment amounts are then blended according to the percentages for the transition year. On January 15, 1999, we announced the following transition schedule:

Year	Demographic method (percent)	Risk method (percent)
CY 2000	90	10
CY 2001	70	30
CY 2002	45	55
CY 2003	20	80
CY 2004	.....	100

(Using encounter data from multiple sites of care.)

Section 511(a) of the BBRA revised the original transition schedule for 2000 and 2001 to provide that the blend percentages will be:

Year	Demographic method (percent)	Risk method (percent)
CY 2000	90	10
CY 2001	90	10
CY 2002	at least 80	no more than 20

This provision does not require any changes in the existing M+C regulations, but we have described it here for the convenience of the reader.

5. Encouraging Offering of M+C Plans in Areas Without Plans (Section 512 of the BBRA)

Section 512 of the BBRA amended section 1853 of the Act by adding a new paragraph (i) to provide for ''new entry bonus'' payments to encourage M+C organizations to offer plans in payment areas (generally, counties) that currently do not have M+C plans serving the area. Under this provision, which we are incorporating into regulations under § 422.250(g), the amount of the monthly payment otherwise made to an M+C organization that offers the first M+C plan in a previously unserved county will be increased by 5 percent for the first 12 months that the plan is offered and by 3 percent for the second 12 months. These bonus payments will be available only for plans that are first offered during the 2-year period beginning January 1, 2000, and only in counties where no M+C plan has been offered, or where any plan offered was no longer offered as of January 1, 2000.

New section 1853(i)(3) specifies that if more than one M+C organization first

offers a plan in an uncovered area on the same date, the new entry bonus applies to the payments of both organizations. The BBRA does not expressly address situations in which an M+C organization or organizations begin offering more than one M+C plan simultaneously. Since the bonus is offered to the *organization* that first offers an M+C plan in an area, or to all *organizations* that do so on the same date, we interpret this to mean that the bonus would apply to all plans offered by a bonus-eligible organization on the same date. Thus, when an M+C organization offers two M+C plans simultaneously in a previously unserved county, the organization will receive the bonus payment for both plans. Similarly, if two or more M+C organizations first offer two M+C plans on the same date, each M+C organization will receive the bonus payments for each of its plans. Consistent with section 1853(i)(3) of the Act, the bonus payments are not available to M+C organizations offering a plan in a county that is already partially served by another plan, even if the new plan includes a portion of the payment area not previously covered by an existing plan. As we have stated in OPL 2000.117, a plan is considered to be offered when the sponsoring M+C organization has a contract in effect to serve beneficiaries in the previously unserved area and the plan is open for enrollment.

6. Modification of 5-Year Re-Entry Rule for Contract Terminations (Section 513 of the BBRA)

Section 513(a) of the BBRA amended section 1857(c)(4) of the Act to reduce from 5 to 2 years the period during which an M+C organization that has terminated its M+C contract at the organization's request is barred from re-entering into an M+C contract (absent our finding of special circumstances warranting an exception). Section 513(b)(1) further amended section 1857(c)(4) to provide for a new exception to this general exclusion period if, during the 6-month period after an M+C organization notified us of its intention to terminate an M+C contract, a legislative or regulatory change was adopted that resulted in increased Medicare payment amounts for the given payment area. In addition, section 513(b)(2) of the BBRA expressly states that the creation of the new exception does not affect our existing authority to grant an exception to this rule where ''circumstances which warrant special consideration,'' including in the circumstances identified in OPL #103 (OPL 99.103). OPL 99.103 states that we will grant an exception, for example, when an organization proposes to offer a different M+C plan type than it had previously offered, or an organization is proposing to introduce an M+C plan (1) in a geographic area currently served by two or fewer M+C plans, or (2) in an area other than that from which the organization had previously withdrawn when it ended its earlier contract with the Medicare program. We have incorporated the BBRA's revisions to section 1857(c)(4) of the Act into § 422.501(b)(5).

7. Flexibility to Tailor Benefits under M+C Plans (Section 515 of the BBRA)

Section 515 of the BBRA amended section 1854 of the Act to permit M+C organizations to elect to apply the premium and benefit provisions of section 1854 of the Act uniformly to separate segments of a service area, provided that the segments are composed of one or more M+C payment areas. This change, which is effective for contract years beginning on or after January 1, 2001, is largely consistent with our existing administrative policy, under which an M+C organization may offer multiple M+C plans, each with its own HCFA-approved service area, but must offer uniform benefits and premiums within each plan. For a full discussion of the implications of this change, and the conforming changes to the M+C regulations, we refer the reader to section II.C.3 of this preamble.

8. Delay in Deadline for Submission of Adjusted Community Rates (Section 516 of the BBRA)

Section 516 of the BBRA amended section 1854(a)(1) of the Act to delay the annual deadline for submission of adjusted community rate (ACR) proposals and information about enrollment capacity from May 1 to July 1. The statute provides that this change was effective for information submitted by M+C organizations in 1999 for benefits in calendar year 2000, and we are making changes to §§ 422.60(b)(1), 422.300(b)(2), and 422.306(a)(1) to reflect the new law.

9. Reduction in Adjustment in National Per Capita M+C Growth Percentage for 2002 (Section 517 of the BBRA)

An important element in the methodology used to calculate M+C payment rates involves the determination by the Secretary under section 1853(c)(6) of the Act of a ''national per capita M+C growth percentage.'' Each year, when determining M+C capitation rates, as explained in detail in the June 1998 interim final rule (63 FR 35004), this national growth percentage is applied to the area-specific component of the blended rate and to the minimum amount, also referred to as the ''floor''. The national per capita growth percentage is HCFA's estimate of the per capita rate of growth in expenditures. Section 1853(c)(6)(B) of the Act provided that in years from 1998 through 2002, the national per capita M+C growth percentage would be reduced, by 0.8 percentage points in 1998 and 0.5 percentage points in 1999 through 2002. Section 517 of the BBRA amended section 1853(c)(6)(B)(v) of the Act to change the adjustment for 2002 from 0.5 percentage point reduction to a reduction of 0.3 percentage points, and we are revising § 422.254(b)(2) to reflect this change.

10. Deeming of M+C Organizations to Meet Requirements (Section 518 of the BBRA)

Section 518 of the BBRA amended section 1852(e)(4) of the Act to set forth several changes related to (1) the process by which an M+C organization can be deemed, based on an accreditation organization's findings, to meet M+C requirements and (2) the standards for which such deeming is permissible. Revised section 1852(e)(4) now includes the following among requirements that must be deemed met if an accreditation body applies and enforces standards at least as stringent as those in this part: those requirements derived from section 1852(b) (concerning antidiscrimination), section 1852(d) (concerning access to services), section 1852(i) (concerning information on advance directives), and section 1852(j) (concerning provider participation rules), in addition to the requirements under section 1852(e)(1) and (2) concerning an M+C organization's quality assurance program and under 1852(h) concerning the confidentiality and accuracy of enrollee records. We are revising § 422.156(b) to add these requirements. In addition, new section 1852(e)(4) specifies that the Secretary must make a determination within 210 days on a private accrediting organization's application to act as an accrediting organization for M+C requirements. This provision in effect mandates the same approval time frame that applies to original Medicare accreditation under section 1865(b) of the Act, and we are incorporating this requirement into § 422.158(e).

11. Quality Assurance Requirements for PPO Plans (Section 520 of the BBRA)

Section 520 of the BBRA amended section 1852(e)(2) of the Act to change the quality assurance requirements for PPO plans, effective for contract years beginning on or after January 1, 2000. In the past, PPO plans had been treated under the M+C statute and regulations in the same manner as all other M+C coordinated care plans. New section 1852(e)(2)(D) establishes that, for purposes of the M+C quality assurance requirements, a PPO plan is an M+C plan that (1) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; (2) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and (3) is offered by an organization that is not licensed or organized under State law as a health maintenance organization. We are incorporating this definition into the M+C regulations at § 422.4. The quality assurance requirements that now will apply for PPO plans are identical to the existing requirements for non-network M+C MSA plans and M+C private fee-for-service plans. Thus, as set forth under revised § 422.152, M+C organizations are no longer required to conduct performance improvement projects relative to their PPO plans, or to have their PPO plans meet minimum performance levels. M+C organizations offering PPO plans must still report on standard measures, however, and continue to comply with the quality assessment and performance improvement requirements that apply to all plans, such as those relating to health information and program review. See section II.E of this preamble for further detail on the quality assurance requirements for various types of plans.

12. User Fee for M+C Organizations Based on Number of Enrolled Beneficiaries (Section 522 of the BBRA)

Under section 1857(e)(2) of the Act, the Secretary is directed to collect ''user fees'' from M+C organizations in order to pay for the costs associated with the enrollment and information distribution activities required for the M+C program under section 1851 of the Act and for the health insurance counseling and assistance programs under section 4360 of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 103–66). Before enactment of the BBRA, the aggregate amount to be collected from all M+C organizations was the lesser of (1) the estimated costs to be incurred by the Secretary in carrying out the applicable information dissemination activities or (2) an amount contingent upon the enactment of appropriations. An individual M+C organization's user fee was equal to its pro rata share of the aggregate amount of fees to be collected from all M+C organizations. Section 522 of the BBRA amended section 1857(e)(2) of the Act to provide that the aggregate amount of user fees to be collected from M+C organizations to carry out the required beneficiary education activities will be based on the lesser of the estimated costs of information dissemination or, for 2001 and thereafter, the ''M+C portion'' of $100 million, with the M+C portion representing the Secretary's estimate of the ratio of the average number of M+C enrollees for a fiscal year to the average total number of Medicare beneficiaries for the fiscal year. We are revising § 422.10 to reflect the new statutory provisions. Consistent with section 522(b) of the BBRA, these changes are effective for user fees charged on or after January 1, 2001, and the Secretary may not increase the user fees for the 3-month period beginning October 2000, above those in effect during the previous 9 months. While we will comply with this latter limitation, we are not including it in regulations text, just as Congress did not include it in the text of section 1857(e).

13. Clarification Regarding Operation of M+C Plans by Religious Fraternal Benefit Societies (Section 523 of the BBRA)

Section 523 of the BBRA amended section 1859(e)(2) of the Act to clarify that a religious fraternal benefit (RFB) society may offer any type of M+C plan, not just an M+C coordinated care plan. We are revising the definition of an RFB plan in § 422.2 to reflect this change.

14. Rules Regarding Physician Referrals for M+C Program (Section 524 of the BBRA)

Section 524 of the BBRA amended section 1877(b)(3) of the Act to specify that certain Medicare rules establishing prohibitions on physician referrals do not apply for purposes of M+C organizations offering M+C coordinated care plans, although they do apply for purposes of M+C MSA plans and private fee-for-service plans. As discussed in section II.E.10 of this preamble, this policy was incorporated into § 411.355(c)(5) of the Medicare regulations through our June 26, 1998 interim final rule.

II. Analysis of and Responses to Public Comments

A. Overview

1. Comments on June 26, 1998 Interim Final Rule

We received 87 items of correspondence containing hundreds of specific comments on the June 26, 1998 interim final rule. Commenters included managed care organizations and other industry representatives, representatives of physicians and other health care professionals, beneficiary advocacy groups, representatives of hospitals and other providers, insurance companies, States, accrediting and peer review organizations, members of the Congress, and others. Consistent with the scope of the June 26, 1998 rule, most of the comments addressed multiple issues, often in great detail. Listed below are the five areas of the regulation that generated the most concern:

- Access issues, including requirements concerning coordination of care, initial assessments of enrollees' health care needs, timely pre-approval of post-stabilization services, and notification responsibilities when an organization terminates its relationship with a specialist.
- Quality improvement standards.
- Payment rates and service area policy.
- Provider participation rules.
- Beneficiary appeals and grievances.

Among the other issues that generated substantial numbers of comments were:

- Eligibility, election, and enrollment policies.
- Marketing restrictions.
- Risk adjustment methodology and encounter data submission.
- Contractual requirements.
- Preemption of State law by Federal law.
- Deadline for ACR submissions and capacity waivers.

2. Issues in February 17, 1999 Final Rule

In the February 17, 1999 final rule, we attempted to address those issues raised by public commenters where we were convinced that changes were needed and could quickly develop policies necessary to implement the changes. We also included policy clarifications for certain areas in which the material in the interim final rule had been misinterpreted. Also, to the extent possible, we addressed time-sensitive issues, such as those that needed to be resolved before publication of this comprehensive M+C final rule or those that could affect plans or beneficiaries in areas where Medicare risk contractors

initially chose not to participate in the M+C program. Some of the specific issues we addressed related to provider participation procedures, beneficiary enrollment options, and several access-related issues, including initial care assessment requirements, notification requirements when specialists are terminated from an M+C plan, and coordination of care requirements.

3. Organization of Final Rule With Comment Period

In this comprehensive M+C final rule with comment period, we address all comments received on the interim final rule that were not addressed in the February 17, 1999 final rule. (As noted above, we are also incorporating changes necessitated by the BBRA, subject to public comment.) For the most part, we will address issues according to the numerical order of the related regulation sections. However, many of the comments raise interrelated issues that involve multiple sections of the regulations. In these cases, we generally address all comments on these issues together, whenever the first relevant section of the regulations arises. Also, we note that all comments on the definitions set forth in § 422.2 are addressed in the context of the requirements with which the applicable definitions are associated.

4. General Comments and Subpart A Issues

a. Administrative Procedure Act Issues

We received two comments on various aspects of the M+C rulemaking process, as discussed below.

Comment: A commenter contended that the June 26, 1998 interim final rule did not conform to requirements in the Administrative Procedure Act (APA). First, the commenter alleged that HCFA did not engage in ''reasoned decision making'' because in certain instances cited by the commenter, the preamble contained ''no discussion of * * * factual predicates, no discussion of alternatives that were evaluated and rejected, and no cost-benefit analysis.'' The commenter specifically cited requirements for a compliance plan and certifications by executives in connection with this contention. Second, the commenter contended that the regulations should have been subjected to prior notice and comment. The commenter argued that the authority in section 1856(b)(1) to issue interim final regulations only applied to existing standards under section 1876, and that failure to publish the rule by June 1 constituted ''a failure to satisfy a condition precedent for issuance of an interim final rule without notice and comment.'' Finally, the commenter argued that the rule impermissibly provided for compliance with our instructions, contending that this was an attempt to require compliance with instructions that should themselves be subjected to notice and comment.

Another commenter commended us on our success in issuing comprehensive regulations for a complex new program in a short period of time.

Response: The interim final rule includes an extensive preamble that explains the basis and purpose of the regulations, and meets the cited requirements of the APA. We believe that this preamble more than satisfies the requirements in the law for explaining the reasoning behind the decisions we made in the interim final rule. In some cases when we actively considered alternative approaches and rejected them, we included discussion of this in the interim final rule preamble. For example, in the discussion of grievance procedures (63 FR 35022–35023), we indicated that ''we considered'' including detailed requirements for M+C organization grievance procedures in the interim final rule, and ''we considered requiring certain time frames for addressing grievances.'' Our reasons for not doing so in that rule were also set out in detail.

We do not believe that the APA—or certain court decisions cited by the commenter—require us to discuss in the preamble every possible alternative that might have been considered to the approaches taken in the rule, but only to explain our reasons for the choices we made. To the extent we have received specific comments advocating alternative approaches, we explain in this final rule why we have not adopted these suggestions, where this is the case.

With respect to the specific requirement that M+C organizations have a plan in place for ensuring compliance with applicable State and Federal laws, we indicated in the preamble that we believe that such a plan was part of the administrative and managerial capabilities that should be in place to carry out the contract and *comply with* obligations under the contract. Many organizations agree with this conclusion, and had compliance plans in place before this requirement was adopted. We believe that this is an important component of proper management, like an accountable board of directors. We explained in the preamble that we were establishing this requirement as an M+C standard under our authority in section 1856(b)(1) to establish M+C standards by regulation.

As to the requirement for certifications as to the accuracy of data, we clearly explained in the preamble that we believed that since payments to M+C organizations are based on such data, the submission of the data is part of a ''claim'' for payment in the amount dictated by the data in question. We further explained that a certification of the accuracy of this information will help ensure accurate data submissions, and assist us and the DHHS Office of Inspector General in anti-fraud activities. We believe this is a clear and logical explanation of reasoned decision making in imposing this requirement.

We disagree with the commenter's contention that we were required to provide prior notice and comment before publishing final regulations. Section 1856(a)(1) gives the Secretary the authority to promulgate regulations establishing the standards that will apply under the M+C program, and that the Secretary is authorized to ''promulgate regulations that *take effect* on an interim basis, after notice and *pending opportunity for public comment*.'' (Emphasis added.) The commenter suggests that this authority only applies to requirements that are based on existing section 1876 standards. This is incorrect, and is contradicted by other BBA provisions citing this rulemaking authority. The reference to section 1876 merely provides that, ''consistent with the requirements of this part'' (meaning only to the extent that the BBA does not provide or authorize alternative approaches), ''standards established under this subsection shall be *based on* standards established under section 1876 *to carry out analogous provisions* of such section.'' section 1856(b)(2). This provision thus only applies to the extent we determine that doing so would be ''consistent with'' the new Part C provisions, and only with respect to those provisions in Part C that are ''analogous'' to a section 1876 standard. Even in this case, the new standards need only be ''based on'' the 1876 standards, not necessarily identical to such standards.

The commenter's interpretation that section 1856(b)(1) of the Act applies only to the repromulgation of existing 1876 standards is also contradicted by other references in the BBA to this rulemaking authority. For example, section 1876(k)(2), added by section 4002 of the BBA, provides for rules dealing with ''grandfathered'' Part B only enrollees. Since Part B only enrollees were permitted under section 1876, there were no section 1876 standards addressing the treatment of ''grandfathered'' enrollees. Yet, section

1876(k)(2) provides that such enrollees may ''continue [grandfathered] enrollment in * * * accordance with *regulations described in section 1856(b)(1).*'' Section 1876(k)(2). This makes clear that the rulemaking authority in section 1856(b)(1) is broader than the commenter contends.

The commenter's contention that we cannot avail ourselves of the interim final rule authority because the rule was not published by June 1, 1998, is illogical. If the Congress authorized interim final regulations because it wanted the rules to be in place by June 1, it would not wish regulations that have already missed this deadline to be delayed further by notice and comment rulemaking. Indeed, the fact that rules were not published by June 1 made the desirability and necessity of issuance in interim final form with an opportunity for public comment all the *more* urgent.

Finally, with respect to our instructions, we intend only to issue instructions that implement or interpret substantive provisions included in these regulations. To the extent the commenter believes that subsequent instructions are issued that should have been subjected to notice and comment, it can make this argument at that time. The fact that we require compliance with guidance we issue to implement these rules is fully consistent with the APA.

b. Types of M+C Plans (§ 422.4)

i. M+C Coordinated Care Plans (§ 422.4(a)(1))

A coordinated care plan is a plan that includes a network of providers that are under contract or arrangement with the M+C organization to deliver the benefit package approved by us. The network is approved by us to ensure that all applicable requirements are met, including access and availability, service area, and quality. Coordinated care plans may include mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care. Coordinated care plans include plans offered by HMOs, PSOs, and PPOs, as well as other types of network plans (except network MSA plans). We received no comments on our definition of coordinated care plan.

ii. Religious and Fraternal Benefit Society Plan

One specific type of M+C plan authorized by the BBA is a religious and fraternal benefit society plan (RFB plan), which is defined in section 1859(e) of the Act. An RFB plan is a new plan that may be offered under the M+C program. In § 422.2, an RFB society is defined as an organization that (1) is described in section 501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of that Act and (2) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches. As noted above, an RFB plan was defined in the BBA as a coordinated care plan that is offered by an RFB society. We received two comments regarding RFB plans.

Comment: Two commenters noted that the definition of religious and fraternal benefit (RFB) society found in § 422.2 of the regulations would be clearer if the word ''benefit'' were added to the beginning of this definition.

Response: We agree that the word ''benefit'' was inadvertently omitted and have added the word ''benefit'' after the words ''religious and fraternal'' in that section.

Comment: One commenter asked whether RFB society plans are limited to being a coordinated care plan, or whether an RFB society could also offer a private fee-for-service plan or an MSA plan. A related question asked by the commenter is whether RFB plans can include a point of service (POS) option.

Response: As noted above, under the BBA, a RFB society could only offer a coordinated care plan as a RFB plan. Section 523 of the BBRA, however, amended section 1859(e)(2) of the Act to provide that an RFB society may offer any type of M+C plan. An RFB plan that operates as an M+C coordinated care plan may include a POS option, as could any other M+C coordinated care plan.

iii. M+C MSA Plans (§ 422.4(a)(2))

The comments received regarding M+C MSA plans are discussed in section III of this preamble. iv. Multiple Plans (§ 422.4(b))

In the interim final rule, we specified that under its contract, an M+C organization may offer multiple plans, regardless of type, provided that the M+C organization is licensed or approved under State law to provide those types of plans (or, in the case of a PSO offering a coordinated care plan, has received from us a waiver of the State licensing requirement).

Comment: Noting that an M+C organization can offer multiple plans under a single contract with us, a commenter asked how multiple plans would work, and whether each would be required to have a separate health services delivery system. The commenter stated that in order to reduce the administrative cost of multiple plans, we should maximize assessment of compliance with Medicare requirements at the M+C organization level and minimize compliance assessment at the individual plan level.

Response: An M+C organization may offer multiple M+C plans under a single contract with us. Each M+C plan must have its own HCFA-approved service area, and a separate ACR submission that also must be approved by us. For coordinated care and network MSA plans, we will verify that each plan has a health care provider network under contract that meets M+C standards for access and availability to health care services for beneficiaries who enroll in the given plan. Although we will attempt to achieve all appropriate monitoring efficiencies when contractual elements are identical across plans, we have a responsibility to ensure compliance at the plan level when requirements are plan-specific, such as those noted above.

c. Application Requirements and Procedures (§§ 422.6 and 422.8)

These sections set forth application requirements for entities that seek a contract as an M+C organization offering an M+C plan. One of the new requirements we set forth in the interim final rule was that organizations wishing to contract with us must submit documentation of their appropriate State licensure, or submit documentation of State certification that the entity is, in fact, able to offer health insurance or health benefits coverage meeting State fiscal solvency standards and is authorized to accept prepaid capitation for providing, arranging, or paying for comprehensive health care services. We further specified that entities meeting the definition of a PSO can be exempted from this requirement if they meet conditions for a waiver, which can be granted by us in accordance with subpart H of part 422. Section 422.8 of the interim final rule describes the application requirements for entities seeking to contract with us to offer M+C plans, as well as our application evaluation procedures.

Comment: One commenter suggested that our use of terms referring to entities that qualify for M+C contracts (M+C organization) and applicants for such contracts are inconsistent and confusing. For instance, at §§ 422.8(a)(3), 422.8(e), and 422.8(g), we use the term ''entity'' to refer to an organization applying to become an M+C organization, while at §§ 422.8(d)

and (f) we use the term ''M+C organization.''

Response: Clearly, we should not refer to an organization that has not obtained approval from us to become a contractor under the M+C program as an ''M+C organization.'' Accordingly, we have revised § 422.8 to uniformly refer to organizations that apply to become M+C organizations as ''contract applicants.'' This is consistent with our use of this term elsewhere in this final rule.

We likewise agree with the comment that organizations that have received approval to operate as an M+C organization should uniformly be called an ''M+C organization.'' Accordingly, we have revised applicable subsections of § 422.8 to uniformly use the term ''M+C organization'' to refer to an existing contractor under the Medicare+Choice program.

d. User Fees (§ 422.10)

This section implements section 1857(e)(2) of the Act, as revised by section 522 of the BBRA. Section 1857(e)(2) requires that M+C organizations share in costs associated with beneficiary enrollment in M+C plans, including the costs of providing information and counseling on plan choices. It sets forth the maximum amount of the aggregate ''user fees'' that can be collected from M+C organizations as well as the procedures that we follow to assess and collect these amounts from M+C organizations.

In the June 26, 1998 interim final rule, we referred to interim final regulations published on December 2, 1997, which implemented section 1857(e)(2) for risk contractors under section 1876. (Under section 1876(k)(4)(D), the obligation under section 1857(e)(2) applied to section 1876 contractors in 1998.) These December 1997 interim final regulations set forth a methodology for determining an individual organization's ''pro rata share'' of the beneficiary costs to be assessed (62 FR 63669). We also explained in the June 26, 1998 interim final rule that we were simply adopting at § 422.10, for purposes of the M+C program, the user fee provisions previously set forth in § 417.472(h) of the December 1997 interim final rule. As we indicated in the June 26, 1998 interim final rule, we are addressing the comments received on the substance of the December 1997 interim final rule in this comprehensive M+C final rule. (Since there are no remaining section 1876 risk contractors, § 417.472(h) itself no longer has any applicability.)

As described above, section 522 of the BBRA subsequently amended the user fee provisions set forth in section 1857(e)(2) of the Act, effective for user fees charged on or after January 1, 2001. Revised section 1857(e)(2) now establishes that beginning in the year 2001 the maximum amount of aggregate user fees that we may collect during a fiscal year from M+C organizations will be determined by the percentage of Medicare enrollees in M+C plans. Specifically, we will calculate: the annual average number of Medicare beneficiaries enrolled in M+C plans during a fiscal year divided by the average number of individuals entitled to benefits under part A, and enrolled under part B, during the fiscal year. This ratio will be multiplied by $100,000,000 to determine the maximum aggregate user fees we may collect from all M+C organizations in a given fiscal year. (Under section 1857(e)(2), we collect the lesser of (1) the actual costs of carrying out the required information dissemination activities or (2) the maximum aggregate amount permitted under the Act.)

We received five letters of comment regarding the interim final rule of December 2, 1997, which established the assessment method under which all M+C organizations are assessed the same fixed percentage of their total monthly Medicare payments, in order to collect the M+C user fee. Two commenters supported the user fee assessment methodology selected by us and considered that it was equitable both to organizations and beneficiaries; three commenters opposed the methodology. We also received six letters commenting on the same methodology in response to the interim final M+C regulation of June 26, 1998. Again, three commenters argued that the user fee was unfair to M+C organizations since it resulted in these organizations funding an information campaign for all Medicare beneficiaries, not just those enrolled in M+C organizations. These latter concerns are now moot in light of the BBRA amendments limiting M+C user fees to the percentage of information dissemination costs representing the percentage of total Medicare beneficiaries that are M+C enrollees. Comments that remain relevant are discussed below.

Comment: A commenter expressed concern about the costs of the education campaign implemented by us and how the funds collected from M+C organizations would be spent. The commenter asked that we make available detailed information on the budget, resource allocation, and past and projected expenditures for the beneficiary information campaign, in order to justify the user fee funding levels. The commenter also expressed concern that we should not collect more in user fees than entitled by law. Specifically, the commenter noted that at § 422.10(d), we are only entitled to collect the lesser of the estimated costs necessary to implement educational activities in that fiscal year or the appropriated amount. The commenter also stated that the reduction in M+C payments due to the assessment of the user fee will deter new organizations from entering the M+C program.

Response: Although not required under the statute or the BBA, we provide an annual report to the Congress that includes an assessment of the implementation of the M+C program. This report also provides budgetary information on the expenditures of the fees we have collected to fund the M+C information campaign. As stated in revised § 422.10(d)(2), beginning in fiscal year 2001, we will collect in a fiscal year the lesser of either the amount needed to implement the required information dissemination and other activities, or the amount equal to the M+C portion of $100 million. The fees collected from any one organization would represent a very small percentage of the total annual Medicare payments to that organization, and we do not believe that they would deter an organization from entering the M+C program.

Comment: A commenter argued that the assessment method adopted by us, under which a percentage of the monthly payment to an M+C organization is assessed, is unfair because it results in organizations in high capitation payment areas paying more (in total dollars) than organizations in lower payment areas. The commenter expressed the view that it is unfair to charge an organization in New York more than an organization in Nebraska.

Response: In selecting an assessment methodology, we sought an approach that is as financially equitable as possible regardless of an M+C organization's size or geographical location. We also wanted a methodology that would not present a barrier to participation for smaller and new M+C organizations. We adopted the percentage of payment approach because it bases each organization's assessment on the total Medicare dollars flowing to that particular organization. Thus, the fee each organization pays is directly proportional to the total dollars the organization receives from the Medicare program. M+C organizations that receive larger payments (based on monthly enrollment and payment levels) will pay more in total dollars

than M+C organizations with less Medicare money coming in.

Comment: A commenter stated that the assessment of a user fee should be directly related to the costs of providing services. Since no evidence has been presented that the costs of a national mail campaign are higher in one county than another, the user fee should be even across all counties.

Response: While the fees collected from M+C organizations will be used primarily to fund a national information campaign designed to reach all Medicare beneficiaries, some funds will go to local efforts, where, as noted above, costs do vary. In any event, this assessment is not an organization-specific ''user fee'' such as those imposed under the user fee statute. The assessments are not based on specific costs associated with an individual M+C organization, but on a share of aggregate costs. Specifically, the statute provides for each M+C organization to pay its pro rata share ''as determined by the Secretary'' of the ''aggregate amount'' spent on the specified costs. Thus, data on actual costs associated with an individual organization are not relevant. Rather, we consider the fee as an assessment to be levied in a manner that, to the extent possible, equitably balances the financial impact on all organizations.

Comment: A commenter stated that we should not use the user fee assessment as a way to equalize Medicare managed care payments in different areas of the country. Noting that the Congress has provided for a minimum update in high payment areas, the commenter contended that we will be violating the spirit of the law by taking more from organizations offering M+C plans in these areas.

Response: No consideration was given to using the user fee assessment methodology as a tool to adjust the level of Medicare payment to M+C organizations in different parts of the country. In fact, since the percentage impact on all M+C Medicare payments is equal (a fixed percentage of total payment), this is the one approach that maintains the relative payment levels of all organizations.

Comment: Another commenter asserted that the user fee assessment method we selected—with fees based on percentage of an organization's M+C payment—has the effect of penalizing those M+C plan enrollees who reside in counties with higher payment rates. The commenter wrote that enrollees in high payment rate areas will pay much more for their existing benefits.

Response: In terms of total dollars, it is true that M+C organizations in high payment areas will pay more on a per member basis than organizations in lower payment areas. However, as previously noted, the assessment percentage is the same for all organizations. A method that does not take into account the total dollars flowing to each plan would be regressive and unfair, because it would have a disproportionately high financial impact on organizations (and their members) located in mid to lower payment areas and those with low enrollment.

Comment: One commenter recommended that all M+C organizations pay a minimum user fee amount and then, on top of that minimum amount, organizations should also pay a flat monthly amount for each member. The commenter stated that this approach would ensure that the user fee is reasonably related to the benefit that the organization will receive from the M+C program.

Response: We considered the approach suggested by the commenter but rejected it because, unless the flat fee were set at a very low level, it would present an entry barrier for organizations with relatively low enrollment levels. We also rejected a flat per member monthly assessment because it does not adjust for the geographic variation in our monthly capitation payments to M+C organizations.

B. Eligibility, Election, and Enrollment

1. Eligibility to Elect an M+C Plan (§ 422.50)

Section 1851(a) of the Act sets forth the criteria for an individual to be eligible to elect an M+C plan. Consistent with the statute, § 422.50 specifies that an individual is eligible to elect an M+C plan if he or she:

- Is entitled to Medicare under Part A and enrolled in Part B (except that an individual entitled only to Part B and who was enrolled in an HMO or Competitive Medical Plan (CMP) with a risk contract under part 417 on December 31, 1998 may continue to be enrolled in the M+C organization as an M+C plan enrollee);
- Has not been medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in an M+C plan or other health plan offered by an M+C organization may continue to be enrolled in the M+C plan, or if enrolled in another health plan, may enroll in an M+C plan offered by the organization, if the individual is otherwise eligible to enroll in the M+C plan;
- Resides in the service area of the plan, except that an individual who resides in a continuation area of an M+C plan while enrolled in a health plan offered by the M+C organization may continue to be enrolled with the M+C organization as an M+C plan enrollee under the terms that apply to enrollees in the continuation area;
- Completes and signs an election form and gives information required for enrollment; and
- Agrees to abide by the rules of the M+C organization after they are disclosed to him or her in connection with the election process.

We specified in the interim final rule that an M+C-eligible individual may not be enrolled in more than one M+C plan at any given time. Comments on the M+C eligibility rules are discussed below.

Comment: Several commenters objected to the omission from the regulations of any provision permitting individuals to remain enrolled with an organization upon becoming Medicare eligible if they were enrolled with the organization as a commercial enrollee, but live outside the Medicare service area. In particular, commenters recommended that beneficiaries residing outside of an M+C plan's service area be allowed to remain enrolled with the M+C organization offering the M+C plan as an M+C plan enrollee upon becoming eligible for Medicare, even if they live outside the M+C service area. Commenters noted that the previous regulations in Part 417 that applied to section 1876 risk contracts allowed an individual enrolled with an organization as a commercial enrollee to remain enrolled with the organization as a Medicare enrollee upon becoming eligible for Medicare even if the individual did not live in the Medicare service area. Several commenters asserted that the continuation area option provided for in the BBA (discussed in further detail below) was not an adequate replacement for the previous option; they believe that prohibiting out-of-area members from voluntarily remaining enrolled in M+C plans unduly restricts the options available to beneficiaries and causes unnecessary disruptions in care. One commenter noted that section 1851(b)(1)(A) of the Act gives us the discretion to make an exception to the requirement that the individual reside in the M+C plan's geographic area.

Response: The last commenter is correct that section 1851(b)(1)(A) states that, ''*Except as the Secretary may otherwise provide* (emphasis added), an individual is eligible to elect an M+C plan offered by the M+C organization

only if the plan serves the geographic area in which the individual resides.'' In accordance with the statute, existing § 422.250(a) generally limits eligibility to elect an M+C plan to individuals living in the plan's service area. The only discretion exercised by the Secretary in the M+C regulations was to permit individuals the option of continuing enrollment in the plan if they move out of the service area and into a plan's ''continuation area'' (which can be established pursuant to section 1851(b)(1)(B) of the statute and § 422.254 of the M+C regulations, as discussed in detail below.)

Based on the comments we received on the interim final rule, however, as well as the reluctance of M+C organizations to establish formal continuation areas, we have become convinced that the regulations should be amended to provide for additional choices for beneficiaries. Thus, we are amending § 422.50 (with conforming changes to §§ 422.66(d)(1) and 422.74(b)(2) and (b)(4)) to permit M+C organizations to offer a ''seamless conversion'' option to individuals who, upon becoming entitled to Medicare, live outside of an M+C plan's service area but are already enrolled in a commercial health plan offered by the same organization. If an M+C organization chooses to offer this option, it must offer the option to all individuals who were enrolled in a commercial health plan offered by the organization at the time they become Medicare-eligible. We do not believe it is appropriate to limit the availability of this option only to beneficiaries who had previously been enrolled in employer group health care plans, but instead are providing that both individual and employer group members of commercial health plans may elect to remain enrolled with their organization under an M+C plan under an expanded ''seamless conversion'' option. Similarly, we note that this expanded eligibility requirement is not limited to situations in which an enrollee becomes eligible for Medicare by virtue of age (referred to in the past as ''age in'' enrollees), but will apply to all newly eligible Medicare beneficiaries, including the ESRD and disabled population. (As noted above, we previously determined, in the interim final rule, that people with ESRD who are enrolled with an organization before becoming Medicare eligible may remain enrolled with the organization as an M+C plan enrollee.) We note that organizations that wish to offer this option must meet the M+C access standards under § 422.112, and must furnish the same benefits to these enrollees as to enrollees who reside in the plan service area. Such enrollees should be made aware by the M+C organization of the extent to which they will need to travel into the plan service area to obtain service.

Comment: One commenter pointed out that State-authorized managed long term care plans may identify a chronically ill target population to be served, while the M+C regulations at § 422.50 do not allow an M+C plan to discriminate within an approved service area among those who are eligible to enroll in M+C plans. The regulations also do not provide for plans to enroll special populations. The commenter asked whether these provisions are waivable to permit plans authorized as managed long-term care plans under State law to participate in the M+C program.

Response: There is no authority in the statute to ''waive'' the requirement that M+C organizations accept all M+C-eligible individuals in the service area who wish to enroll. However, we have approved demonstration projects under independent demonstration authority that involve managed care entities that restrict Medicare enrollment to long-term care populations. Long-term care plans may be able to participate in Medicare under such a demonstration.

Comment: One commenter asked for clarification regarding whether individuals who are enrolled only in Medicare Part B or who have ESRD, and were grandfathered into M+C plans as of January 1, 1999, can move from plan to plan in the same M+C organization or to another organization. The commenter supported allowing the individual to move between plans and organizations. Another commenter suggested that we allow an individual enrolled only in Medicare Part B who retained his or her enrollment in an M+C plan as of January 1, 1999, to enroll in another M+C organization for a period of time after disenrolling from an M+C plan. In addition, the commenter suggested that individuals enrolled only in Medicare Part B should be able to enroll in an M+C plan at any time until 2002.

Response: We agree that grandfathered Part B-only individuals and individuals with ESRD should be allowed to move between plans within an M+C organization, and have specified that this is permissible in OPL 99.084, issued on February 26, 1999. With respect to beneficiaries with ESRD, this policy is based on section 1851(a)(3)(B) of the Act, which we interpret as permitting an existing enrollee who develops ESRD while enrolled with an organization to remain enrolled with that organization. This is an exception to the general rule that an individual medically determined to have ESRD is not eligible to enroll in an M+C plan. However, we do not have statutory authority to permit a beneficiary with ESRD to enroll in a plan offered by a different M+C organization. Similarly, under section 1851(a)(3) of the Act, Part B-only enrollees generally are ineligible to enroll in an M+C plan. Section 1876(k)(2) of the Act, however, permitted a Part B-only beneficiary enrolled with an organization under a section 1876 risk contract on December 31, 1998, to continue enrollment in that organization if the organization has entered into an M+C contract effective January 1, 1999. Again, we have no statutory authority to expand upon this exception by permitting that individual to enroll with a different M+C organization from the one in which he or she was enrolled on December 31, 1998, under a section 1876 risk contract.

Comment: One commenter stated that individuals enrolled only in Medicare Part B who disenroll from M+C should be permitted to immediately enroll in Medicare Part A, and the surcharge for late enrollment should be eliminated.

Response: Provisions affording such beneficiaries these protections have been in place for some time. The Omnibus Reconciliation Act of 1990 established the Transfer Enrollment Period (TEP) during which individuals who have Part B only and whose coverage in a Medicare managed care plan is terminated for any reason may immediately enroll in Premium Part A. This provision is found at section 1818(c)(7) of the Social Security Act, and § 406.21(f) of our regulations, which also provide for relief from the premium surcharge for late enrollment. Under the TEP provisions, individuals may enroll in Premium Part A during any month in which they are still enrolled in the managed care plan or during the 8–month period following the last month of coverage under the plan. Under certain circumstances enrollment may occur up to 3 months in advance. If the individual enrolls in Premium Part A while still enrolled in the managed care plan or during the first full month when not so enrolled, Part A coverage is effective with the month of enrollment or, at the individual's option, the first day of any of the following 3 months. If enrollment occurs during the 7 remaining months of the TEP, Part A coverage is effective the month after the month of enrollment.

Comment: One commenter suggested that the regulation be revised to permit individuals with ESRD who have been

enrolled in a commercial plan or a Medicare Cost HMO offered by the M+C organization to enroll in an M+C plan of that organization.

Response: Existing § 422.50(a)(2) provides this protection, stating that an individual who develops ESRD while enrolled in an M+C plan, or in a health plan offered by the M+C organization offering an M+C plan in the area in which the individual resides, may continue to be enrolled in an M+C organization as an M+C plan enrollee. Also, consistent with section 1851(a)(3)(B) of the Act, we have specified in OPL99.084 that individuals with ESRD may move among plans within an M+C organization. (We note that under this final rule, the individual may remain enrolled even if he or she does not live in the service area if new § 422.50(a)(3)(ii) applies.) For purposes of § 422.50(a)(2), ''a health plan offered by the M+C organization'' includes any commercial health plan and any cost contract held by that organization. In the case of an individual who develops ESRD while enrolled in a commercial plan offered by a cost contractor, the section 1876 rules similarly allow such an individual to remain enrolled with that organization under its cost contract after becoming eligible for Medicare.

Comment: One commenter believes that we are interpreting the phrase ''entitled to benefits under Part A and enrolled in Part B'' incorrectly.

Response: Our interpretation of this phrase is explained in detail in the interim final rule (63 FR 34979), and we would refer the commenter to that detailed explanation. To briefly reiterate our reasoning, we believe that the Congress intended that a newly eligible individual be given the opportunity to be enrolled in an M+C plan only after he or she is actually entitled to receive benefits under Part A and Part B. This view is supported by language in section 1851(e)(1) of the Act, which refers to ''the time an individual first becomes entitled to benefits under Part A and enrolled under Part B,'' and provides for the Secretary to specify an initial coverage election period under which such an individual may elect coverage under an M+C plan ''effective as of the first date on which the individual may *receive* such [Part A and Part B] coverage'' (emphasis added). While an individual technically may have ''enrolled'' in Part B once an application has been completed, such an individual's right actually to ''receive'' coverage of services under Part B may not occur for a period of months. (See 63 FR 34979.) Since M+C organizations are paid in part from Part B trust funds, we do not believe it would be appropriate for an individual to be enrolled in an M+C plan before he or she is entitled to ''receive'' Part B trust fund payments. We therefore have interpreted ''enrolled in Part B'' to mean entitled to receive Part B coverage. Consistent with section 1856(b)(2) of the Act (which provides for use of section 1876 standards to carry out analogous M+C provisions), this interpretation follows our longstanding interpretation of identical language in section 1876(d) of the Act.

2. Continuation of Enrollment (§ 422.54)

Section 1851(b)(1)(B) of the Act permits M+C organizations to offer enrollees the option of continued enrollment in an M+C plan when enrollees leave the plan's service area to reside elsewhere (that is, in the ''continuation'' area) on a permanent basis. M+C organizations that choose to offer a continuation of enrollment option must explain the option in marketing materials, and make it available to all enrollees in the service area of the plan. Enrollees may choose to exercise the option of continued enrollment when they move out of the plan's service area, or they may choose to disenroll.

An M+C organization must obtain our approval of the continuation area and related marketing materials, and meet the access requirements under section 1851(b)(1)(B) of the Act, before it may offer a continuation of enrollment option to Medicare beneficiaries.

The payment rate for the M+C organization is based on the rate and adjustment factors that correspond to the beneficiary's permanent residence. Under section 1851(b)(1)(B) of the Act, the M+C organization must, at a minimum, provide or arrange for the provision of Medicare-covered benefits under section 1852(a)(1)(A) of the Act in the continuation area. This does not include any additional benefits the organization is required to provide to noncontinuation area members under section 1852(a)(1)(B) of the Act.

Section 1851(b)(1)(B) of the Act requires that ''reasonable access'' be provided in the continuation area, and that enrollees be subject to ''reasonable cost sharing.'' In the interim final rule, we required that M+C organizations satisfy the access requirements in § 422.112, and provide services either through written agreements with providers or by making payments that satisfy the requirements in § 422.100(b)(2).

We are defining ''reasonable cost sharing'' in the continuation area as limited to the cost-sharing amounts required in the M+C plan's service area (in which the enrollee no longer resides).

The interim final rule also provides that appeals and grievances of enrollees in the continuation area must be handled in the same timely fashion as for other enrollees. The ultimate responsibility for the handling of appeals and grievances is with the organization that is receiving payment from us.

We received 11 comments requesting further guidance regarding the continuation of enrollment option. Generally, commenters endorsed the continuation of enrollment concept and urged us to define continuation areas broadly in order to enhance coverage options for enrollees.

Comment: One commenter asked whether the beneficiary may choose the continuation area option verbally or in writing.

Response: Our current policy, as outlined in OPL 99.100 (which was published August 9, 1999), requires that the beneficiary choose the continuation area in writing, so that there is documentation of this choice. We further believe that in the absence of an affirmative choice to remain enrolled in an M+C plan under the different terms that apply to continuation enrollees, a move out of an M+C service area should be treated as a decision to disenroll from the M+C plan. We accordingly have amended § 422.54(c)(2) to provide that a beneficiary's choice to continue enrollment in a continuation area must be made in a manner specified by us, and that in the absence of such a choice, the beneficiary will be considered to have chosen to disenroll from the M+C plan if he or she moves out of its service area.

Comment: Commenters recommended that the benefits in the continuation area should reflect the level of reimbursement the M+C organization receives, and thus should include any additional benefits.

Response: As the commenters point out, the existing continuation of enrollment regulations at § 422.54(d) require, at a minimum, that M+C plans provide Medicare-covered services in the continuation area. We recognize that this permits M+C plans to offer less generous benefits in the continuation area while still receiving the full Medicare payment. Section 1851(b)(1)(B) of the Act provides that individuals exercising the continuation of enrollment option have access to the ''full range of basic benefits'' described in section 1852(a)(1)(A) of the Act. However, section 1852(a)(1)(A) of the Act refers only to those benefits available under Parts A and B, and not

to additional benefits, which are described in section 1852(a)(1)(B) of the Act. Thus, although we agree that it would be preferable that M+C organizations be required to provide additional benefits to continuation area enrollees, the statute does not support this requirement. Therefore, we are considering a legislative proposal that would correct this inequity.

Comment: Several commenters inquired about the process for applying to us for a continuation area.

Response: We are adding a continuation area chapter to the M+C application for new M+C organization applicants. A separate application form will be available for current M+C contractors who wish to apply for a continuation area. Further guidance regarding the application process will be available in a forthcoming OPL.

Comment: One commenter asked whether a member must use only Medicare-certified facilities in the continuation area.

Response: The pertinent requirements in § 422.204(a)(3) apply equally to services furnished in a continuation area. Under § 422.204(a)(3), benefits must be provided through, or payments must be made to, providers that meet applicable title XVIII requirements. Further, a hospital, nursing home, home health agency, or other ''provider of services'' as defined in section 1861(u) of the Act, must have a provider agreement with us in place. (See section II.E of this preamble for further details on this requirement.) We believe these requirements help to assure the quality of care that is provided to beneficiaries.

Comment: Another commenter suggested that we allow M+C organizations a 1-year transition period to establish continuation areas and implement any continuation area requirements.

Response: We believe the regulations provide organizations with sufficient opportunity to implement continuation area requirements. M+C organizations are not required to establish a continuation area for their enrollees. Thus, an M+C organization may choose not to offer a continuation area until it is ready to implement the requirements outlined in § 422.54.

Comment: One commenter questioned whether State licensing regulations may supersede the potential advantages or enrollment flexibility of the continuation area.

Response: We believe the commenter is questioning how State licensing requirements will affect an M+C organization's ability to establish or offer the continuation of enrollment option. Section 422.400(a) states that an M+C organization must be licensed under State law, or otherwise authorized to operate under State law, as a risk-bearing entity eligible to offer health insurance or health benefits coverage. Therefore, an M+C organization may establish a continuation area only in a State in which it is licensed under State law or otherwise authorized to operate. The individual States have the authority to determine whether they are going to require licensure or, for example, permit the M+C organization to use the licensure of an affiliate if it wishes to establish an out-of-State continuation area. Although we are not aware of State laws that unduly restrict the establishment of continuation areas, we would refer the reader to section II.I of this preamble for a detailed discussion of situations in which State laws are preempted by M+C laws and regulations.

Comment: Some commenters contended that we interpreted section 1851(b)(1)(B) of the Act too restrictively. For example, commenters objected to the requirement in § 422.54 that an M+C plan's service area must be geographically distinct from its continuation area. Commenters also questioned whether enrollees who move to continuation areas in counties adjacent to the M+C plan's service area may continue to receive services in the M+C plan's service area.

Response: A continuation area, as defined at § 422.54(a), is an additional area outside the service area in which the M+C organization furnishes or arranges for furnishing services to its enrollees. The regulation does not prohibit continuation areas adjacent to the M+C plan's service area, as the commenter appears to believe. Further, we agree that enrollees residing in a continuation area adjacent to the M+C plan's service area may receive services in the M+C plan's service area, as long as the access and service requirements of § 422.112 are met.

Comment: One commenter suggested that we allow enrollees to obtain services in the continuation area, even if they are not living in the continuation area permanently.

Response: The continuation area is intended for those enrollees who reside permanently outside of the service area (and permanently inside the continuation area) and want to remain enrolled in the plan. We do not have the authority to direct M+C plans to offer enrollees, temporarily residing in the continuation area, benefits in excess of the urgent/emergent care required by the statute and those benefits voluntarily offered by an M+C plan in its traveler/visitor policy.

Comment: One commenter requested clarification regarding whether the continuation of enrollment option is intended to replace current travel programs. The commenter also inquired whether an enrollee would remain enrolled for the first 12 months with coverage only for emergency and urgently needed care, and then convert to a continuation of enrollment option.

Response: The continuation of enrollment option is not designed to replace current travel programs. In general, the purpose of traveler/visitor programs is to allow enrollees the opportunity to continue obtaining health care services while traveling outside the service area of the M+C plan in which they are enrolled. In contrast, the continuation of enrollment option is intended to permit enrollees to remain enrolled with an M+C plan if they move permanently outside of the plan's service area. If the enrollee moves permanently into an area other than a continuation area, the member must be disenrolled as soon as the M+C organization is aware of the move and the enrollee has been notified. If an enrollee moves permanently into a geographic area designated as a continuation area, and chooses to remain a member of the M+C plan as a continuation of enrollment member, the enrollee must receive, at a minimum, Medicare-covered services. If an enrollee moves temporarily into the continuation area, or any area outside the service area, the M+C plan must provide coverage for emergency and urgently needed care. With respect to the question of whether an enrollee would remain enrolled for the ''first 12 months'' after a move, before converting to a continuation enrollment option, an individual can be a continuation enrollee as soon as he or she moves permanently to the continuation area. There is no waiting period.

3. Election Process (§ 422.60)

The general rule for acceptance of enrollees is that, except for the limitations on enrollment in an M+C MSA plan (§ 422.62(d)(1)), and for cases in which a plan has reached its enrollment capacity, each M+C organization must accept without restriction eligible individuals who elect an M+C plan during initial coverage election periods, annual election periods, and special election periods specified in §§ 422.62(a)(1), (a)(2), and (b).

Additionally, M+C organizations must accept elections during the open enrollment periods specified in

§§ 422.62(a)(3), (a)(4), (a)(5), and new (a)(6) if their M+C plans are open to new enrollees.

We stated in the interim final rule that the election form must comply with our instructions regarding content and format and have been approved by us as described in § 422.80. The form must be completed and signed by the M+C eligible individual (or the individual who will soon become entitled to Medicare benefits) and include authorization for disclosure and exchange of necessary information between the DHHS and its designees and the M+C organization. Persons who assist beneficiaries in completing forms must sign the form and indicate their relationship to the beneficiary.

We further stated that the M+C organization must file and retain election forms for the period specified in our instructions. An election in an M+C plan is considered to have been made on the date the election form is received by the M+C organization. Also, the M+C organization must have an effective system for receiving, controlling, and processing election forms that requires that each election form is dated as of the day it is received and election forms are processed in chronological order, by date of receipt. Additionally, the M+C organization must give the beneficiary prompt written notice of acceptance or denial in a format specified by us. We also provided that a notice of acceptance, in a format specified by us, informs the beneficiary of the date on which enrollment will be effective under § 422.68; and if the M+C plan is enrolled to capacity, explains the procedures that will be followed when vacancies occur. Also, a notice of denial explains the reasons for denial in a format specified by us. Within 30 days from receipt of the election form (or from the date a vacancy occurs for an individual who was accepted for future enrollment), the M+C organization transmits the information necessary for us to add the beneficiary to our records as an enrollee of the M+C organization.

Comment: Several commenters had concerns with allowing M+C organization representatives to assist individuals in completing any part of the election forms. One commenter believes that the common practice should be the beneficiary completing and signing his or her own form. Another commenter believes M+C organizations should be allowed to assist beneficiaries in completing the election forms only in limited circumstances, such as if the enrollee is disabled and needs assistance, and that organizations abusing this process should be subjected to meaningful penalties. One commenter suggested that when assistance is provided to a beneficiary in completing the election form, a reason for the assistance also be documented on the form, especially if an M+C organization agent completes the form. In contrast, two commenters supported a provision that permits individuals to assist a Medicare beneficiary in completing an election form.

Response: As discussed in the preamble of the interim final rule (63 FR 34984), section 1851(h)(4)(B) of the Act indicates that the ''fair marketing standards'' may include a prohibition against an M+C organization (or agent of such an organization) completing any portion of any election form used to carry out elections on behalf of any individual. However, we have decided at this time not to prohibit an M+C organization (or agent of such an organization) from assisting beneficiaries in completing the election form. We recognize that we must provide accommodations for persons with disabilities and for situations in which such a prohibition could represent a potential physical burden to beneficiaries. We believe requiring the signature of the individual who assisted the beneficiary in completing the form and an indication of his or her relationship to the beneficiary is a fair compromise.

We agree that the M+C organization should be allowed to assist beneficiaries in completing the election form only under limited circumstances. For this reason, representatives should be assisting the beneficiary in completing the election forms only when assistance is needed, such as for a person who is disabled, illiterate, or otherwise impaired by age or health. In fact, in some circumstances assistance may be required to comply with civil rights requirements, for example, to ensure that individuals with disabilities or limited English proficiency have an equal opportunity to participate. Any M+C organization that unduly influences beneficiaries through this assistance should be identified by our monitoring procedures and subject to sanctions as specified in § 422.750.

We believe requiring the signature and identifying their relationship to the individual who is enrolling in the M+C plan is a sufficient beneficiary protection. It provides adequate information to monitor a beneficiary's understanding that the form is for enrollment. The reason why an individual needs assistance should not be included on the enrollment form because it could undermine a Medicare beneficiary's right to privacy by disclosing health related information without his or her consent.

Comment: One commenter asked how enrollment and disenrollment requirements under Medicare compare to Medicaid rules, which the commenter erroneously believes allow the enrollee to enroll and disenroll at any time.

Response: Dually eligible individuals, that is, those individuals who are entitled to Medicare as well as Medicaid, have the same freedom of choice under Medicare as those who are entitled to Medicare only. M+C election provisions under section 1851(e) of the Act and § 422.62 of our regulations apply to all M+C-eligible individuals, and prior to 2002, permit Medicare enrollees to disenroll at any time. Under Medicaid rules, in contrast, managed care organizations (MCOs) are permitted to preclude Medicaid enrollees from disenrolling without cause for up to a year. MCOs are required only to permit disenrollment without cause in the first 90 days of enrollment, and annually thereafter. See section 1932(a)(4) of the Act.

Comment: One commenter requested clarification on when M+C organizations are required to be open for enrollment. In particular, the commenter expressed confusion over the meaning of the term ''open enrollment period.''

Response: We recognize the potential for confusion associated with the use of the term ''open enrollment period.'' In accordance with section 1851(e)(6)(A) of the statute, § 422.60(a)(1) specifies that M+C organizations must be ''open for enrollment'' (that is, must accept enrollments) during annual, initial coverage, or special election periods unless they have reached enrollment capacity. However, under section 1851(e)(6)(B) of the Act, an M+C organization may accept elections at *such other* times as the organization provides. These latter time periods, during which an M+C organization has the discretion to decide whether to be ''open'' for enrollment are frequently referred to as ''open enrollment'' periods. We note that, if an M+C organization chooses to be open to new enrollees during all or a portion of these discretionary ''open enrollment'' periods, it must be open for all M+C-eligible individuals.

Comment: One commenter found § 422.60(a)(2), which states that M+C organizations must accept elections during open enrollment periods if their plans are open to new enrollees, to be confusing and detrimental to newly eligible individuals. The commenter believes that new Medicare eligibles

should not be limited to these time frames.

Response: The new enrollees being referred to in § 422.60(a)(2) are individuals newly electing the M+C plan and not individuals newly eligible for Medicare. Individuals newly eligible to Medicare are given a different ''open enrollment'' period under which they may elect or change M+C plans. In particular, §§ 422.62(a)(4)(ii) and 422.62(a)(5)(ii) allow newly eligible individuals to make an election beginning the month the individual is entitled to Medicare Parts A and B and ending on the last day of the sixth month of entitlement (in 2002) or the third month of entitlement (in 2003 and thereafter) or on December 31, whichever is earlier. Therefore, we do not believe a regulatory change is necessary.

Comment: One commenter asked if we would be modifying our enrollment transmission schedule to account for the 30-day period in which the M+C organization must transmit the enrollment information as stated in § 422.60(e)(6).

Response: Based on this comment, we are amending § 422.60(e)(6) to state that ''upon receipt of the election form (or from the date a vacancy occurs for an individual who has been accepted for enrollment), the M+C organization transmits the information, within time frames specified by us, necessary for us to add the beneficiary to our records as an enrollee of the M+C organization.'' We are also revising § 422.60(f)(3) to state that ''upon receipt of the election form from the employer, the M+C organization must submit the enrollment within time frames specified by HCFA.'' These changes will allow us the flexibility to vary the time frames in the future, should technological or policy changes warrant it.

Comment: One commenter asked that we clarify and provide guidance as to when an election is considered to have been made.

Response: Section 1851(f)(2) of the Act, as revised by section 502 of the BBRA, states that the effective date of coverage during continuous open enrollment periods is the first day of the first calendar month following the date on which the ''election is made,'' except that if the election or change of election is made after the 10th day of a calendar month, the election or change of election takes effect on the first day of the second calendar month following the date on which the election or change is made. As noted in the preamble of the interim rule, it was necessary to define when an election is made in order to establish the effective date of coverage and to establish the date of our liability for payment. Therefore, the regulations at § 422.60(d) state that an election is considered to have been made on the date it is received by the M+C organization.

4. Enrollment Capacity (§ 422.60(b))

Sections 422.60(b) and 422.306(a) of the original M+C regulations required M+C organizations to submit information on the enrollment capacity of plans they offer by May 1 of each year. As noted in section I.C.8 of this preamble, section 516 of the BBRA amended section 1854(a)(1) of the Act to move the annual deadline for submission of ACR proposals and enrollment capacity data (if any) from May 1 to July 1, effective in 1999. If a plan reaches its HCFA-approved capacity limit, the M+C organization offering the plan generally is not obligated to accept new enrollees.

Comment: One commenter requested that we change the date that M+C organizations must notify us of the need for a capacity limit from May 1 to a date later in the year in order to allow the M+C organizations more time to analyze the previous year's capacity and better determine the need for a capacity waiver.

Response: While we had no discretion under the BBA to make the change in question, as just noted, Congress has done so. We have revised §§ 422.60(b)(1) and 422.306(a)(1) to reflect this BBRA change.

Comment: A commenter asked that we clarify our language on capacity limits within a service area. The commenter also asked what would happen if there are too many patients and too few providers.

Response: Section 422.60(b) allows an M+C organization to limit enrollment in the M+C plans it offers during any enrollment period, subject to our approval. If an M+C organization elects to establish a capacity limit for an M+C plan, the request normally must be submitted to us at the time the Adjusted Community Rate Proposal (ACRP) is submitted (except as provided in new § 422.60(b)(3)), as discussed below. This submission should take into account the number of providers, and how many patients they can serve. The situation described by the commenter, in which ''there are too many patients and too few providers'' generally should not occur if capacity is limited to the number submitted by the M+C organization on July 1.

As the commenter suggested, however, we recognize that under certain circumstances, there may be a legitimate need for an M+C organization to request a capacity limit or a revision of a capacity limit for an M+C plan during the contract year. The circumstances under which a capacity limit will be approved after the ACRP date would likely occur when a portion of a provider network that furnishes services under an M+C plan becomes unavailable during the course of a contract year. We have provided for HCFA to consider enrollment capacity requests outside of the ACR process under new § 422.60(b)(3), which permits consideration of such requests only if the health and safety of beneficiaries is at risk, such as if the provider network is no longer available to serve enrollees in all or a portion of the service area. The requirements for a midyear capacity limit request are also described in OPL99.095.

5. Election of Coverage Under an M+C Plan (§ 422.62)

All M+C plans must be open to M+C-eligible enrollees residing in the service area served by the plan during initial coverage election periods, annual election periods, and special election periods, unless such enrollment in the plan is limited based upon a limit on enrollment capacity.

The initial coverage election period is the period during which a newly M+C-eligible individual may make an initial election. This period begins 3 months prior to the month the individual is first entitled to both Part A and Part B and ends the last day of the month preceding the month of entitlement. An election made during this period is effective when entitlement to Part A and Part B coverage begins.

The month of November is the annual election period for the following calendar year. During the annual election period, an individual eligible to enroll in an M+C plan may change his or her election from an M+C plan to original Medicare or to a different M+C plan, or from original Medicare to an M+C plan. This election is effective on January 1.

Special election periods are periods during which enrollment must be made open to certain beneficiaries, for various reasons specified in the statute, or by us. We specify the effective date of elections made during special election periods.

M+C plans may be open to new enrollees at other times of the year (that is, during open enrollment periods) at the discretion of the M+C organization offering the plan.

From 1998 through 2001, the number of elections or changes that an M+C-eligible individual may make is not limited (except for M+C MSA plans).

Subject to the M+C plan being open to enrollees as provided under § 422.60(a)(2), an individual eligible to elect an M+C plan may change his or her election from an M+C plan to original Medicare or to a different M+C plan, or from original Medicare to an M+C plan any number of times. In 2002, an individual who is eligible to elect an M+C plan in 2002 generally may elect an M+C plan or change his or her election from an M+C plan to original Medicare or to a different M+C plan only once during the first 6 months of that year. For 2003 and subsequent years, an individual who is eligible to elect an M+C plan generally may elect or change his or her election from an M+C plan to original Medicare or to a different M+C plan, or from original Medicare to an M+C plan only once during the first 3 months of the year. (Note that consistent with section 501(b) of the BBRA, the restrictions that begin in 2002 do not apply to institutionalized individuals.) Even after the above limitations on changes in elections are in place, if certain circumstances exist, an individual may discontinue the election of an M+C plan offered by an M+C organization and change his or her election to original Medicare or to a different M+C plan. These circumstances include:

- When the individual is no longer eligible to be enrolled in a certain plan due to a change of residence,
- When HCFA terminates the organization's contract for the plan, or the organization terminates the plan or discontinues offering the plan in the service or continuation area in which the individual resides,
- When the M+C organization has violated a material provision of its contract or materially misrepresented the plan's provisions in marketing the plan to the individual, or
- When the individual meets such other exceptional conditions as we may provide.

Comment: Several commenters expressed concern because the new M+C election periods do not coincide with the time frames under which M+C eligible individuals elect health benefit options through their employer group health plans. The commenters believe these individuals should not be subject to the M+C election periods. One commenter pointed out that employer groups will experience considerable disruption in their yearly enrollment process, and, as a result, may have to stop offering their retirees wrap-around coverage to M+C plans, or they will have to modify their entire enrollment process.

Response: Section 422.62(b) states that we may grant special election periods for individuals who meet exceptional conditions. We have determined that the dilemma addressed by the commenters presents an ''exceptional condition'' that justifies the establishment of a special election period for M+C-eligible individuals who are members of an employer group plan that has open enrollment at a time other than the month of November. This is because such an individual could only change one part of his or her coverage at a time, which effectively would lock the beneficiary into his or her existing plan. As set forth in OPL 99.100, such M+C-eligible individuals may choose to elect an M+C plan offered by their employer during their employer group's open season, which constitutes a special election period for these individuals, as well as during the other election periods established under section 1851(e) of the Act.

Comment: Several commenters were opposed to the establishment of ''lock-in'' requirements beginning in 2002. They believe it will eliminate competition created in an environment where managed care plans compete continuously for enrollments. Several commenters also wanted to know who will be responsible for keeping track of the number of elections made by an individual once lock-in takes effect in 2002. They noted that beneficiaries and M+C organizations may not be aware of the number of elections an individual has made during a particular election period. One commenter recommended that we develop a mechanism that will allow exceptions to the limit of one change under §§ 422.62(a)(4) and (5).

Response: Sections 1851(e)(2)(B) and (C) of the Act limit an individual's election to one change during the open enrollment periods in the first 6 months of 2002 and the first 3 months of subsequent years. This ''lock-in'' requirement represents a gradual transition from the current system, under which a beneficiary may make any number of elections during the continuous open enrollment periods outlined in section 1851(e)(2)(A) of the Act to a restrictive system of annual ''lock-in.'' We do not have the authority to modify this requirement, or to provide for any exceptions to this limit. We are aware of the need for us to maintain a history of the number of times an individual has made an election during a specific election period. Such information will be necessary in order to determine whether an individual is eligible to elect an M+C plan at a given time.

Comment: One commenter believes that limiting the open enrollment and disenrollment opportunities defined in §§ 422.62(a)(4) and (5) to one election per period should not apply to plan changes within the same M+C organization.

Response: Section 1851(a)(1) of the Act requires that an M+C-eligible individual ''elect'' to receive benefits through the original Medicare fee-for-service program or through enrollment in an M+C ''plan.'' That is, enrollment in an M+C ''plan'' constitutes an election under Part C. Section 1851(e) of the Act further limits the ''election'' of an M+C ''plan'' or of original Medicare to one change during open enrollment periods in the first 6 months of 2002 and the first 3 months of subsequent years. Therefore the law does not permit us to allow M+C-eligible individuals to move from plan to plan without considering it an election, even if the change in plans occurs among plans offered by the same M+C organization.

Comment: One commenter requested further clarification of enrollment and disenrollment periods, while another asked whether a beneficiary who defaults to original Medicare has the option to elect an M+C plan.

Response: An individual who defaults to original Medicare may elect another M+C plan during any election period during which the plan is accepting new enrollments. As discussed in detail above, section 1851(e) of the Act and § 422.62 of the M+C regulations describe the election periods in which individuals can enroll in and disenroll from an M+C plan. M+C-eligible individuals may make or change an election during an initial coverage election period, an annual election period, a special election period, or an ''open enrollment'' period. The initial coverage election period is the 3-month period prior to the month an individual becomes entitled to Medicare Part A and Part B. The annual election period is November of every year. Special election periods are also allowed when M+C-eligible individuals experience certain circumstances that warrant the need to make a change in election. These include our termination of the M+C plan contract or M+C organization termination or discontinuance of the M+C plan in the service or continuation area in which the individual resides, a change in place of residence to a place outside of the M+C plan's service or continuation area, demonstration by the individual that the M+C organization substantially violated a material provision of its contract or materially misrepresented the M+C plan's provisions in marketing materials, or

other exceptional conditions as provided by us. In addition, § 422.62(c) also provides for a special election period for individuals age 65. Beginning in 2002 individuals age 65 who elect an M+C plan during the initial enrollment period may disenroll from the M+C plan and elect coverage under original Medicare within 12 months of their enrollment in an M+C plan.

Through 2001, open enrollment periods are continuous, that is, every month through 2001. Beginning in 2002, the open enrollment periods are the first 6 months of the year, or the first 6 months of Medicare Part A and Part B entitlement (or December 31, 2002, whichever is earlier). In 2003 and in subsequent years, the open enrollment periods are the first 3 months of the year, or the first 3 months of Medicare Part A and Part B entitlement (or December 31, 2003, whichever is earlier). Again, open enrollment periods remain continuous for institutionalized individuals during and after 2002.

The election rules for M+C MSA plans (see § 422.62(d)) include some exceptions to the election periods described above. M+C-eligible individuals may only enroll in an MSA plan during an initial coverage election period or an annual election period. They may not make an election of an MSA plan during open enrollment periods or special election periods. M+C-eligible individuals may only disenroll from an MSA plan during annual election periods and special election periods, excluding special election periods for individuals age 65. In addition, if an individual elects an M+C MSA plan for the first time during the annual November election period, he/she may revoke that election by December 15 of that same year.

Comment: One commenter supported the special election period for individuals age 65 as outlined at § 422.62(c), and requested that the provision also apply to newly eligible individuals with disabilities.

Response: Section 422.62(c) implements the last sentence in section 1851(e)(4) of the Act, which applies only to individuals who enroll in an M+C plan upon turning 65. Congress chose to provide this opportunity to individuals who become eligible based on age, but did not provide for such a benefit in the case of individuals who become eligible based on disability or ESRD status. We thus cannot apply section 1851(e)(4) of the Act to individuals who are not 65, since they do not meet an explicit condition set forth in the statute.

Comment: One commenter noted that § 422.62(b)(3) allows an individual a special election period if the M+C organization violates a material provision of its contract with the individual. However, it does not allow the M+C organization an opportunity to comment on the enrollee's assertion that the contract was violated. The commenter stated that we should be sensitive to the severity of this issue and should establish a timely and fair review process. Two other commenters stated that we should develop reasonable, consistent guidelines for establishing special election periods for exceptional conditions, as provided at § 422.62(b)(4).

Response: Section 1851(e)(4) of the Act gives us the authority to develop guidelines to establish special election periods for exceptional conditions and to establish the procedures for granting a special election period for contract violations that specify when individuals are entitled to disenroll from an M+C plan after disenrollment rights become limited in 2002. This authority provides us with the discretion and the time to develop beneficiary protection requirements that will be sensitive to the issues identified by the commenters. As we gradually transition from the current system of totally free movement to a restrictive system of annual ''lock-in,'' we have every intention of developing reasonable and consistent guidelines as the need for these guidelines in the year 2002 approaches.

Comment: One commenter requested that we clarify at § 422.62(a)(2)(ii) that eligible beneficiaries may elect to enroll in managed care demonstrations, section 1876 cost plans, and health care prepayment plans during the annual election period.

Response: The annual election period is an election period for M+C organizations operating under section 1851 of the Act. Health care prepayment plans, section 1876 cost plans, and some managed care demonstrations do not fall under section 1851 of the Act. Therefore, we do not have the authority to require these plans and demonstrations to be open for enrollment during an annual election period. Although such plans and demonstrations have the option of being open for enrollment to eligible individuals during that same time frame, this regulation only addresses requirements under section 1851 of the Act.

6. Information About the M+C Program (§ 422.64)

a. Overview

Section 422.64 contains requirements related to information about M+C plans. Paragraph (a) applies to M+C organizations, and requires that organizations annually provide to us, using a prescribed format and terminology, the information we need to carry out our annual information campaign for all Medicare beneficiaries. However, the remaining paragraphs of existing § 422.64 essentially reflect statutory provisions governing our information distribution activities.

Comment: Several commenters expressed confusion about whether we or M+C organizations were responsible for various information distribution requirements specified under § 422.64.

Response: We recognize the commenter's concerns and believe that the best means to avoid introducing confusion in this regard is to eliminate from the regulations the portions of § 422.64 that serve solely to delineate our responsibilities. Deleting these provisions from the Code of Federal Regulations in no way affects our information distribution responsibilities that had been reflected in these provisions, since these are set forth in the statute in sections 1851(d)(1) through (d)(4) of the Act. Also, we note that § 422.111 continues to list the information that M+C organizations are responsible for disseminating to their plan enrollees.

Comment: Two commenters were concerned that the many changes introduced by the M+C program to the plan enrollment and disenrollment process (for example, changes to the effective date, annual open enrollment, lock-in requirements) would lead to beneficiary confusion and disruption of the program, and stressed the need for improved communication with beneficiaries.

Response: We agree that the many changes necessary for the implementation of the M+C program will require that we carry out substantial educational efforts for beneficiaries and the health industry. We are strongly committed to keeping beneficiaries informed and educated about their choices, and have undertaken many efforts to accomplish this task. For example, we have created a toll-free line for M+C information (1–800–MEDICARE), developed the Medicare & You handbook, and have carried out special educational and publicity campaigns to inform M+C-eligible individuals about the availability of plans offered in different areas and about the election process. In 1999, we began conducting a nationally coordinated educational and publicity campaign about M+C plans and the election process that occurs every November. We also provide information

via our Internet website (www.Medicare.gov), which is a Medicare beneficiary-centered consumer website designed to provide a broad array of information on program benefits and health promotion. These are just a few of the many efforts we have begun to disseminate information to beneficiaries and prospective beneficiaries on their coverage options under the M+C program, and we believe that they should alleviate the potential confusion associated with the M+C program.

b. Access

Comment: A commenter recommended that § 422.64 specifically require notification and disclosure of Medicare's screening Pap smear benefit and of the ability of beneficiaries to directly access specialists to obtain this preventive service.

Response: The 2000 Medicare & You handbook includes a description of the new preventive benefits. With respect to direct access to a specialist who would perform a pap smear, § 422.112(a)(3) guarantees female M+C enrollees ''direct access to a women's health specialist within the network for women's routine and preventive health care services,'' which would include Pap smears (see section II.C of this preamble for further details on this issue.)

c. Performance Measures

Comment: Several commenters expressed concerns about the validity, reliability, and comparability of information to be provided by us to Medicare beneficiaries, particularly through Medicare Compare, our Internet-based database of comparative information on M+C plans. The commenters want us to ensure that the information presented to beneficiaries is objective, accurate, and complete. They also emphasize the importance of recognizing the audience for particular types of information.

Response: Medicare Compare is our electronic database of health plan comparison information. The database is designed to educate beneficiaries and others about their health care options so they can make informed health care choices. The information for this database is compiled by us with cooperation from M+C organizations. The Medicare Compare database is also updated regularly to reflect changes in cost and benefits. We are continuing to implement enhancements to ensure that the data submitted by M+C organizations are valid and reliable. Medicare also collects quality-of-care information known as Health Plan Employer Data and Information Set (HEDIS) from M+C organizations and we carefully check it for accuracy. This information should help beneficiaries compare the quality of health care that an M+C organization delivers by explaining how well the organization keeps enrollees healthy or treats them when they are sick. Medicare's Consumer Assessment of Health Plans Study (CAHPS), developed in collaboration with the Agency for Healthcare Research and Quality, is an initiative to collect and report information on beneficiaries' experience in receiving care through M+C organizations. We have also worked closely with the industry and researchers in order to provide the most accurate information for the Medicare & You 2000 handbook.

d. Continuation and Improvements

Comment: Commenters were concerned about the amount of information provided to Medicare beneficiaries by us. They recommend that the information specified in § 422.64 be included in the general information brochures and contain the customer service telephone numbers for each M+C organization. They also suggested that we need to differentiate between information provided to beneficiaries in written form, and that available to interested persons via the Internet. Written comparative information, which is to be available to all beneficiaries at specified intervals, should be easy to understand and focused in content.

Response: We provide access to information from a variety of sources. Beneficiaries, M+C organizations, providers, family members, and others can receive up-to-date information about the Medicare health plans available in their area, Medicare health benefits, fraud and abuse, nursing homes, appeals and grievances, patient rights, etc., at the following locations:

- Internet at www.Medicare.gov. Local libraries or senior centers may be able to help the person find the information on their computers.
- Medicare Choices Help line at 1–800–MEDICAR(E) and TTY for the speech and hearing impaired at 1–877–486–2048.
- State Health Insurance Assistance Program (SHIP) in the beneficiary's area.
- Local outreach events.

Comment: Several commenters encouraged us to evaluate all aspects of the information campaign in order to determine the most effective approach for reaching beneficiaries.

Response: We aim for timely distribution of all of our materials. We are legislatively mandated to mail specified information on the M+C program and individual M+C plans to beneficiaries at least 15 days prior to the annual election period. We are evaluating the impact of this timing on beneficiary decision making. Our ongoing evaluation of National Medicare Education Program (NMEP) includes assessment of telephone referrals, including toll-free line and State Health Insurance Assistance Programs (SHIPs), which are entities jointly funded by us and by the States to provide information and counseling to Medicare beneficiaries. The toll-free line has been operational nationally since March 15, 1999.

e. Beneficiary Input

Comment: Several commenters noted that in developing any educational materials or activities, it is important to ensure that the information is meaningful to beneficiaries. These commenters believe that we need to convey information to beneficiaries in an organized, straightforward manner to assure as complete an understanding as possible. For example, the commenters suggest that materials should be reviewed to determine whether they will provide needed information or simply raise more questions among beneficiaries, or whether beneficiaries will understand that they do not need to make any changes. The commenters specifically recommended that we conduct focus groups to gauge beneficiary responses to the Medicare & You handbook, and would like us to revisit our future plans and communications.

Response: We have performed extensive evaluation of the Medicare & You handbook, including focus-testing the Medicare & You 1999, and customer-testing of the Medicare & You 2000. We also used the results of the NMEP evaluation, survey of beneficiaries, expert review, plain language review, and comments submitted to us by mail and the Internet. The results received from all of these sources were used in the development of the Medicare & You 2000 handbook. We will continue evaluating our efforts to improve beneficiary communication.

Comment: Two commenters offered suggestions on the public input approach outlined in the preamble of our June 26, 1998 interim final rule. (In that preamble, we discussed in detail the process of obtaining public input about data collection and dissemination of selected data. We addressed only those data elements that would be disseminated as part of Medicare Compare or as part of any beneficiary

information campaign efforts.) One commenter suggested ensuring that physicians are involved in determining data specifications for M+C organizations, and the other looked forward to seeing our strategy for public input.

Response: As discussed in the interim final rule, we recognize the importance of obtaining public input on data needed by beneficiaries to make health plan choices. We also agree that we need to ensure physician input, particularly in areas such as quality of care. Our strategy for obtaining public input into the process, which is well under way and wide ranging, includes the following:

- Obtaining public input through currently established communication activities (for example, committees, consultation avenues, public meetings, training seminars). Limited resources and time demands do not permit the establishment of separate or overlapping processes with those already established and working (such as industry council meetings). It may not always be possible to hold public meetings to invite interested individuals to comment and provide input on the process of determining data specifications.

- Obtaining public input through normal data collection clearance channels when we are the lead for the data collection activity. The OMB clearance process is a very effective and efficient way to obtain broad public comment on the content and format specifications for data collection (for example, the Plan Benefit Package). However, it may not always be possible to publish a notice or a summary of public processes regarding data elements to be collected.

- Obtaining public input through collaborative efforts with private industry, health care providers, researchers, and other interested parties. This approach allows the Federal government to be a partner with other experts (private and public) in the field of managed care and thereby not duplicate already successful and useful collaborative efforts (such as HEDIS).

Thus, our strategy strongly supports the use of efficient and effective methods of public input into the determination of information and specifications for beneficiary information campaign material. We also recognize the need to collaborate with organizations and individuals involved in the development of quality and performance measurements that support beneficiaries' increased understanding of managed care.

7. Coordination of Enrollment and Disenrollment Through M+C Organizations (§ 422.66)

An individual who wishes to elect an M+C plan offered by an M+C organization may make or change his or her election during the election periods specified in § 422.62 by filing the appropriate election form with the organization or through other mechanisms as determined by us.

Additionally, an individual who wishes to disenroll from an M+C plan may change his or her election during the election periods specified in § 422.62 by either electing a different M+C plan by filing the appropriate election form with the M+C organization or through other mechanisms as determined by us. Individuals may also disenroll by submitting a signed and dated request for disenrollment to the M+C organization in the form and manner prescribed by us or by filing the appropriate disenrollment form through other mechanisms as determined by us.

Under existing § 422.66(d)(1), an M+C plan offered by an M+C organization must accept any individual (residing in the service area or continuation area of the M+C plan) who is enrolled in a health plan offered by the M+C organization (regardless of whether the individual has end-stage renal disease—see §§ 422.50(a)(2) and (a)(3)) during the month immediately preceding the month in which he or she is entitled to both Part A and Part B. This is generally known as a ''conversion'' of enrollment for the enrollee (from commercial status to M+C enrollee status).

Subject to our approval, under § 422.66(d)(2), an M+C organization may set aside a reasonable number of vacancies in order to accommodate conversions. Any set aside vacancies that are not filled within a reasonable time must be made available to other M+C-eligible individuals.

If the individual enrolled in a health plan offered by an M+C organization chooses to remain enrolled with the organization as an M+C enrollee, the individual must complete and sign an election form as described in § 422.60(c)(1). In that case, the individual's conversion to an M+C enrollee is effective the month in which he or she is entitled to both Part A and Part B. The M+C organization may disenroll an individual who is converting from its commercial plan to M+C status only under the conditions specified in § 422.74. The M+C organization must transmit the information necessary for us to add the individual to our records as specified in § 422.60(e)(6).

An individual who has made an election under this section is considered to have continued to have made that election until the individual changes the election under this section or the elected M+C plan is discontinued or no longer serves the service area in which the individual resides, and the organization does not offer, or the individual does not elect, the option of continuing enrollment, as provided in § 422.54, whichever occurs first.

Comment: Several commenters stated that they support procedures that would permit seamless continuation of coverage, under which an individual would be deemed to have elected an M+C plan at the time of the individual's initial coverage election period if they are enrolled in a commercial health plan that is offered by the same M+C organization. Several specific recommendations were made. One commenter recommended that we require M+C organizations to prospectively provide the necessary information that would allow us to default individuals into the M+C plan. One commenter recommended that M+C organizations notify individuals in their commercial plans who are about to become Medicare eligible that they are being enrolled in the M+C plan, and to transmit the necessary information to us. Another commenter suggested that we alert individuals through the mailing of the initial enrollment package. Two commenters were concerned about deeming an individual to have elected an M+C plan if the M+C organization offers more than one M+C plan from which he/she could receive benefits. One commenter suggested that if we decide to deem an individual to have elected an M+C plan, the organization should be required to provide the individual with a description of Medigap guaranteed issues and age rating policies. One commenter supported procedures that would permit seamless continuation of coverage, but expressed concerns about deeming an individual enrolled in an M+C plan if Medicare is a secondary payer.

Response: Although we have addressed an individual's right to choose to remain enrolled with an organization as an M+C enrollee upon becoming Medicare eligible (as discussed above), a default process through which an individual would be deemed by us to have elected a specific M+C plan would require that we identify M+C-eligible individuals, as well as their relevant health plan information before the individual's initial coverage election period. At

present we do not have access to information on the health plans in which specific individuals are enrolled, because such plans are private health plans, and do not have established linkages with our systems, nor is there a mechanism in our Medicare managed care data system to capture such information. While some M+C organizations may want to share this information with us, others may not. It should also be noted that enrollment in an M+C plan is contingent upon the individual's entitlement to Medicare Part A and Part B. Individuals that have not previously filed for Social Security and/or Medicare benefits will not have an entitlement record, nor will they receive an initial enrollment package from Medicare. Frequently, individuals in commercial plans who are about to ''age in'' to Medicare are still employed, and have not yet filed for Social Security or Medicare benefits. Individuals who have filed for benefits will receive general information on Medicare and comparative information on M+C plans available in their service area. They will have the opportunity to enroll in the M+C plan 3 months prior to their entitlement to Medicare Part A and Part B.

The expansion of the managed care provisions under the BBA has presented an extraordinary challenge to us and to the Medicare managed care data system that supports our information system business requirements. We anticipate that in the future, we will develop strategies to incorporate information collection activities in our managed care systems that will allow this kind of mechanism to be put in place. As we develop strategies that will incorporate additional information collection activities under our authority under section 1851(c)(2) of the Act, we will consider procedures necessary to identify in which plan a beneficiary wants to enroll if the M+C organization offers more than one M+C plan and also whether Medicare Secondary Payer rules apply. Until that time, and in accordance with § 422.66(d), an M+C plan offered by an M+C organization must accept enrollments from any eligible individual residing in the service area or continuation area of the M+C plan, who is enrolled in a commercial health plan offered by that same M+C organization during the month immediately preceding the month in which he/she is entitled to Medicare Part A and Part B.

Comment: Two commenters were opposed to the requirement in § 422.66(b)(3)(i) that disenrollment transactions be submitted within 15 days of receipt. Commenters pointed out that we do not process disenrollments every 15 days and suggested the requirement be modified to coincide with the 30-day requirement for enrollment transactions outlined at § 422.60(d)(6).

Response: Our intent when establishing this requirement was to ensure that a beneficiary's choice to disenroll would be handled as expeditiously as possible. We are in the process of implementing a system that will be capable of processing these transactions more than once a month. However, we recognize that until the systems are modified, the requirement may not allow a sufficient amount of time to process a disenrollment action. Therefore, we have modified the regulations at § 422.66(b)(3)(i) to state that the time frame to submit disenrollment transactions will be ''specified by HCFA,'' and have made a conforming change at § 422.66(f)(2). This will give us the flexibility to make changes as system enhancements are developed in the future. For the time being, we are specifying that disenrollment transactions be submitted within the same time frame as enrollment transactions.

Comment: Several commenters asked that we provide additional clarification in § 422.66(b)(5)(i) with respect to when an enrollment is not legally valid. Two of the commenters stated that we should clarify whether a lack of understanding would be included in the definition of a ''legally valid enrollment,'' and whether it would result in a retroactive disenrollment. One commenter stated that we should clarify that an enrollment is not legally valid if it is determined at a later date that the individual did not meet eligibility requirements at the time of enrollment.

Response: There are a number of circumstances that would result in an enrollment not being considered ''legally valid,'' and we agree that the lack of understanding of plan rules (such as the ''lock-in'') and ineligibility would be among these circumstances. However, a determination that an individual did not understand the terms of enrollment must be made on an individual basis. The criteria used in establishing evidence that an individual did not understand the terms of enrollment could include the following: continuing Medigap insurance coverage after receipt of the confirmation of enrollment letter from the M+C organization; an enrollment form signed by the member in situations where a legal representative should be signing for the member; enrolling in a supplemental insurance program immediately after enrolling in the M+C plan; or receiving nonemergency or nonurgent services out-of-plan immediately after the effective date of coverage under the plan. OPL 99.100 sets forth specific guidelines to assist M+C organizations when making determinations about lack of understanding and incorrect eligibility determinations.

Comment: One commenter asked for clarification of our process for approving retroactive disenrollments (either voluntary or involuntary) and the subsequent effective dates.

Response: Section 422.66(b)(5) describes retroactive disenrollments, which are disenrollments with a retroactive effective date in cases in which we determine that there was never a legally valid enrollment, or in which a valid request for disenrollment was properly made but not processed or acted upon. In cases of involuntary disenrollments, such as disenrollment for disruptive behavior or failure to pay premiums, the disenrollment actions are prospective and would not be retroactive. In cases in which we find that an enrollment was not legally valid, the disenrollment results in cancellation of the enrollment as of the effective date of the enrollment. Therefore, the effective dates for these retroactive disenrollments are based upon the effective dates for elections, as provided under § 422.68. If the election subsequently found to be invalid was made during the annual election period in November, the effective date would be the first day of the following calendar year. If the election was made during an open enrollment period, the election would be effective the first day of the first calendar month following the month in which the election is made (or for elections made after the 10th day of a month, the first day of the 2nd calendar month following the date of the election). Effective dates for elections made during a special election period vary, dependent on the situation, and guidelines concerning these effective dates are provided in instructions to the M+C organizations. Elections made during special election periods for individuals age 65 would be effective the first day of the first calendar month following the month in which the election is made.

Comment: Section 422.66(d) states that an M+C organization must accept any eligible individual who is enrolled in a health plan offered by ''an'' M+C organization. One commenter stated that this section needs to clearly state that the M+C organization must accept any individual who is enrolled in a health plan offered by ''the'' M+C organization

offering the other plan in which the individual is enrolled.

Response: We agree that the use of the term ''an'' could imply that the requirement applies to any organization, such that all M+C organizations must accept all eligible individuals enrolled in any commercial health plan offered by any M+C organization. In fact, our intent is for the requirement to apply to a specific M+C organization, namely the organization that offers both the commercial health plan in which the individual is enrolled and the M+C plan in which the individual will be enrolling. Therefore, we are revising § 422.66(d)(1) to specify that a plan offered by an M+C organization must accept any eligible individual who is enrolled in a health plan offered by ''the M+C organization.''

Comment: One commenter believes there is a conflict between paragraphs (3) and (5) in § 422.66(d). The commenter reads § 422.66(d)(3) to provide that the individual will convert to the M+C plan unless he disenrolls, while § 422.66(d)(5) provides that the individual must fill out an election form in order to convert.

Response: We do not agree that there is a conflict between the two sections of the regulation, but recognize that some clarification is desirable to prevent confusion. We are revising § 422.66(d)(3) of the regulation to refer to the individual affirmatively choosing to remain enrolled with the organization as an M+C enrollee, and to state that conversion is effective the month of entitlement to both Medicare Part A and Part B ''in accordance with the requirements in section § 422.66(d)(5).'' We also have deleted a reference in § 422.66(e)(2) to an individual being ''deemed'' to have made an election, since this reference is inconsistent with the requirement in § 422.66(d)(5) that an election form be completed and signed. These revisions will clarify that while we have established the effective date of coverage under § 422.66(d)(3), the coverage may begin only if the individual completes and signs an election form, as required at § 422.66(d)(5).

Comment: One commenter believes that § 422.66(e)(2) (which states that an individual is considered to have continued an election in an M+C plan until the M+C plan is discontinued or no longer services the area in which the individual resides, and the organization does not offer or the individual does not elect the option of continuing enrollment) may be interpreted to absolve the M+C organization of any obligations when the person leaves the service area and has not selected a new health plan or original Medicare. The commenter suggested that the regulations should make clear that an individual who leaves his or her M+C plan service area is entitled to a special election period, as is the case when the M+C plan ceases to serve the service area.

Response: If an M+C plan enrollee leaves the plan's service area, but has not informed the M+C organization offering the plan of a permanent move, the M+C organization does have continued obligations to cover emergency and urgent services that must be covered out of area. Once the M+C organization is made aware of such a permanent move, the organization is obligated under § 422.74(b)(2)(i) to disenroll the individual unless he or she has moved to a continuation area and requests to continue enrollment as a continuation area enrollee. With respect to the commenter's concern about a special election period being provided under these circumstances, § 422.62(b)(2) clearly provides an M+C plan enrollee who moves out of his or her M+C plan service area with the same right to a special election period that the enrollee gets under § 422.62(b)(1), cited by the commenter, in the case of an M+C plan termination.

Comment: One commenter was concerned about ensuring that all enrollees under a section 1876 risk contract—without regard to residence—be deemed to be enrollees of an M+C plan offered by the section 1876 contractor on January 1, 1999.

Response: We agree, and note that the interim final rule preamble states that we have interpreted the statute to allow an individual to transition from the section 1876 plan to an M+C plan ''without regard to location of residence'' (63 FR 34977). Our intent was to ensure that no individual enrolled in a section 1876 plan on December 31, 1998, would be adversely affected by the BBA changes, but instead would be able to maintain an established relationship with a Medicare contracting organization. Therefore, we clarified in the interim final rule that all individuals enrolled in a section 1876 plan on December 31, 1998 could convert to the corresponding M+C plan on January 1, 1999. We further clarified this ''grandfathering policy'' in OPL 99.084, dated February 26, 1999, which states that an individual who was enrolled in a section 1876 risk plan effective December 1, 1998 or earlier and remained with the risk plan on December 31, 1998, automatically continued to be enrolled in the M+C organization on January 1, 1999.

Comment: One commenter suggested that we include in the regulations text our operational policy recognizing State laws that govern who may sign election forms for beneficiaries. The commenter also believes we should clearly incorporate recognition of the State law, including health care consent laws.

Response: In general, and as previously discussed in the preamble of the June 26, 1998 interim final rule, we believe that the M+C-eligible individuals should personally complete and sign any election form or disenrollment request (referenced at § 422.66(b)) whenever possible. We also recognize that there may be times that an individual is unable to sign for himself or herself. Laws governing who may sign a health insurance application vary from State to State. Therefore, while the regulations provide for the beneficiary to sign an election form, we defer to State laws (for example, laws governing the exercise of a power of attorney) on who may sign on behalf of a beneficiary where a beneficiary signature is required. We do not believe it is necessary to make provision for this in the regulations text, because where State law permits another individual to sign for a beneficiary with respect to health care decisions, this authority would extend to cases in which the beneficiary's signature is required under Medicare regulations.

Comment: Section 422.66(d)(1) states that an M+C plan offered by an M+C organization must accept any eligible individual who is enrolled in a health plan offered by an M+C organization during the month immediately preceding the month in which the individual is entitled to Medicare Part A and Part B. One commenter asked us to clarify whether the use of the term ''health plan'' refers only to fully insured products, or whether the term would include self-funded members.

Response: The term ''health plan'' in § 422.66(d)(1) refers to any commercial health plan that the M+C organization offers. This may include fully insured products, self-funded products, and indemnity products.

8. Effective Dates of Coverage and Change of Coverage (§ 422.68)

An election made during an initial coverage election period as described in § 422.62(a)(1) is effective as of the first day of the month of entitlement to both Part A and Part B. Also, for an election or change of election made during an annual election period as described in § 422.62(a)(2), coverage is effective as of the first day of the following calendar year. For an election or change of election made during the open

enrollment periods described in § 422.62(a)(3) through (a)(6), coverage is effective as of the first day of the first calendar month following the month in which the election is made (except that if the election or change of election is made after the 10th day of a calendar month, the election takes effect on the first day of the second calendar month after the date of the election.)

For an election or change of election made during a special election period as described in § 422.62(b), we determine the effective date of coverage, to the extent practicable, in a manner consistent with protecting the continuity of health benefits coverage. For an election of coverage under original Medicare made during a special election period for an individual age 65 as described in § 422.62(c), coverage is effective as of the first day of the first calendar month following the month in which the election is made.

Comment: Several commenters objected to the effective date in the interim final rule for elections made during open enrollment periods, which was the first day of the month after the month the election is received. The commenters believe this effective date did not allow enough time to process the enrollment. They believed that this deadline would result in increased retroactive transactions and would be burdensome on M+C organizations. Commenters also expressed significant concerns over liability and access to services if Medicare entitlement is not verified expeditiously. Commenters also noted the need for us to make system changes to accommodate the new effective date requirements, and to clarify how we intend to implement the requirements with respect to M+C organization submission of data. The commenters recommended the effective dates be as they were under section 1876 of the Act which, under § 417.450(a)(2), may not be earlier than the first month after, nor later than the third month after, the month in which we receive the information necessary to include the beneficiary as a Medicare enrollee of the HMO or CMP in our records.

Response: Section 1851(f) of the Act supersedes all prior section 1876 requirements and specifically delineates the effective dates for elections made in the M+C program. Consistent with the changes to section 1851(f) of the Act made by section 502 of the BBRA, we are revising § 422.68(c) to provide that coverage is effective either on the first day of the calendar month after the date of an election or change of election or, for elections or changes of election made after the 10th day of a calendar month, on the first day of the second calendar month after the date of the election or change of election. In addition, based on our authority to establish requirements that can reduce the potential for retroactive transactions, we have developed guidelines for M+C organizations that include requirements for M+C organization verification of Medicare entitlement before submission of enrollment data (see OPL 99.100). The verification policy should minimize the potential for retroactive enrollment situations. Additionally, the new effective dates outlined in section 1851(f) of the Act have resulted in the need to clarify a number of operational issues. While the expansion of managed care provisions under the BBA has presented an extraordinary challenge to us, we have successfully implemented the necessary systems requirements to support this change in effective dates. Additionally, we have issued other guidelines to M+C organizations (OPL 98.074, our November 17, 1999 Systems Informational Letter, and OPL 2000.113) that outline how to identify the correct effective date and process the enrollments through our systems.

Comment: Several commenters were concerned that the new effective date requirements will not allow the M+C organization to receive our confirmation of the enrollment before the effective date, which could in turn increase beneficiary confusion.

Response: Section 1851(f) of the Act clearly outlines the effective dates of enrollment in M+C plans. If an eligible individual has elected an M+C plan, the M+C organization must cover the individual beginning on the effective date of coverage, even if the organization has not yet received final confirmation from us. An M+C organization can take several actions to reduce the chance of beneficiary confusion, including verifying Medicare entitlement before submission of enrollment data to us. This should increase the likelihood that we will confirm the individual's enrollment.

Comment: One commenter stated that original Medicare should pay M+C organizations for services furnished to individuals for whom retroactive disenrollments were processed.

Response: If a retroactive disenrollment is processed for a beneficiary, the M+C organization in which the beneficiary was enrolled can always bill for Medicare covered services rendered to the beneficiary.

Comment: One commenter stated that the effective date of coverage for individuals who enroll during an open enrollment period (the first day of the first calendar month following the month the election is made) is too rigid, and that delayed effective dates should be permitted.

Response: Again, section 501(b) of the BBRA provided for some relief in this regard by changing the effective dates for elections or changes in election made after the 10th day of a month. We also note that we have the authority under section 1851(f)(4) of the Act to establish effective dates for individuals who meet the condition for special election periods. We have provided for prospective effective dates for individuals electing benefits through their employer group health plans, and published this guidance on April 20, 1999 in OPL 99.087. We provided additional guidance on the effective dates of coverage for other special election periods authorized under § 422.62(b) in OPLs 99.098 and 99.100.

Comment: Two commenters questioned how M+C organizations will be expected to handle multiple transactions, given the new effective date requirements.

Response: As stated at § 422.50(b), an individual may not be enrolled in more than one M+C plan at any given time. Nevertheless, there are times when an individual will try to elect more than one plan for the same effective date, and it is not always clear with which plan the individual truly intends to be enrolled. On August 9, 1999, we issued OPL 99.100, which includes guidelines on what actions an M+C organization must take in the event of a multiple transaction in order to determine with which M+C plan the beneficiary should be enrolled.

Comment: One commenter stated that we should establish performance standards that take into account difficulties that we and M+C organizations will have in meeting effective date requirements.

Response: We recognize that section 1851 of the Act has resulted in significant changes to the Medicare program and that M+C organizations need time to prepare for the changes. We have provided additional guidance on implementation of M+C entitlement, eligibility, and elections to M+C organizations through various OPLs (98.072, 98.073, 99.083, 99.084, 99.087, 99.098, 99.100, 99.104, 99.105, 99.109, and 2000.113) and a November 17, 1998 Systems Informational Letter. These letters outline how to identify the correct effective date, how to process enrollments with the new effective dates, how to transition from section 1876 to M+C enrollment and disenrollment rules, and when grandfathered members must be disenrolled from M+C plans. As a result,

we believe we have given adequate time to modify operations and systems to implement the new M+C program. In addition, we continue to develop guidelines for M+C organizations on M+C entitlement, eligibility, and elections to M+C organizations. Any monitoring of performance will take into account the time M+C organizations have needed to implement the new program.

9. Disenrollment by the M+C Organization (§ 422.74)

The general rule for disenrollment by the M+C organization is that an M+C organization may not disenroll an individual from any M+C plan it offers; or request or encourage (orally or in writing, or by any action or inaction) an individual to disenroll. However, § 422.74(b) describes the conditions under which the M+C organization may either be permitted or required to disenroll an individual. Under § 422.74(b)(1), the M+C organization may choose to disenroll an individual based on that individual's (1) failure to pay premiums, (2) disruptive behavior, (3) provision of fraudulent information on his or her election form, or (4) having permitted his or her enrollment card to be abused. Section 422.74(b)(2) requires the M+C organization to disenroll the individual if the individual no longer resides in the M+C plan's service area, the individual loses entitlement to Medicare Part A or Part B benefits, or the individual dies. The M+C organization must follow the procedures specified at § 422.74(c) and (d) when disenrolling an individual. The procedures to be followed and the consequences of the disenrollment vary depending upon the cause of the disenrollment.

Comment: One commenter believes that the 90-day grace period that must be afforded to an enrollee before a disenrollment for nonpayment of premium could be financially burdensome in 1999 since ACRs that did not necessarily reflect these costs were filed before the M+C regulations were published.

Response: We recognize that 1999 was a transition year with many new requirements. With respect to 2000, however, M+C organizations were fully aware of all regulatory requirements before filing their ACRs.

Comment: Several commenters believed that the 90-day grace period for nonpayment of premiums is too long. Two commenters recommended a 30-day grace period rather than the 90-day grace period. They noted that if an organization has to wait 90 days before disenrolling an individual, this potentially results in 4 months without the organization receiving payment, since organizations do not send notice to beneficiaries until the beginning of the month after payment is due. One commenter recommended that grace period extend until the last day of the third month following the date payment is due.

Response: Section 1851(g)(3)(B)(i) of the Act requires us to provide for a ''grace period'' before enrollment can be terminated for nonpayment of premiums. In determining the grace period, we adopted the grace period that Congress provided for in section 1836(b)(2) of the Act with respect to a termination for nonpayment of premiums for Supplementary Medical Insurance Benefits for the Aged and Disabled (that is, Part B). This results in consistent standards between the M+C program and the original Medicare program.

Comment: Several commenters believe that M+C organizations should be permitted to allow an enrollee to remain enrolled and eliminate only optional benefits if a member fails to pay premiums charged for such optional benefits. Some commenters believe that the option to disenroll for nonpayment of premiums implied that an organization could only disenroll the beneficiary from the plan, and could not simply eliminate the optional benefits. One commenter questioned whether under our rules, it might be necessary to disenroll the individual and re-enroll them as a ''standard option'' enrollee to accomplish this.

Response: We agree that providing the M+C organizations the option to retain an enrollee while eliminating an optional benefit for which premiums are not paid is a desirable and appropriate means of promoting continuity of care for beneficiaries. We are adding a provision to § 422.74(d)(1)(iv) that expressly provides an M+C organization the option to discontinue an optional supplemental benefit for which premiums are not paid, while retaining the beneficiary as an M+C enrollee.

Such an action would not affect the beneficiary's status as a member of the M+C plan, and would not constitute a new election. Therefore, the M+C organization does not have to formally disenroll and re-enroll the individual when downgrading the member's enrollment to the standard benefit package because the beneficiary fails to pay the plan premiums.

Comment: One commenter recommended that the M+C organization should be required to send notice to enrollees that premium payment is overdue within 10 days, rather than 20 days. Another commenter supported the 20-day time frame.

Response: Section 1856(b)(2) of the Act provides for the use of standards established under section 1876 to implement analogous provisions of the M+C statute when those standards are consistent with standards established in the BBA for the M+C program. Section 417.460(c)(1)(iii) requires section 1876 contractors to send notices of disenrollment for nonpayment of premiums to the enrollee before it notifies us. In addition, § 417.460(c)(1)(i) requires that the contractor demonstrate to us that it made reasonable efforts to collect the unpaid amount. Section 422.74(d)(1) of the M+C regulations carries over both of these requirements and clarifies that ''reasonable efforts'' include sending a notice of nonpayment to the beneficiary within 20 days after the date the payment was due. The notice advises the beneficiary that he or she has 90 days from the date of the notice to provide payment. We continue to support this policy and believe that 20 days is a reasonable maximum time frame within which to make an effort to collect unpaid premiums. We note that an M+C organization may notify the individual as soon as the premium payments are past due (that is, send a notice before 20 days have passed), in which case the 90-day grace period would begin on the day the M+C organization sends the notice.

Comment: One commenter requested clarification of the effective date of disenrollments for nonpayment of premiums following the 90-day grace period. The commenter asked that we clarify for how long the organization is obligated to provide benefits and we will continue to pay capitation.

Response: The effective date of disenrollment for nonpayment of premiums is the first day of the month after the 90-day grace period ends.

The M+C organization must continue to provide benefits and we will continue to pay capitation until the disenrollment is effective. We clarified this policy in OPL 99.100, issued on August 9, 1999. We note that § 422.74(d)(1) erroneously refers to the possibility of disenrollment for an individual who fails to pay any ''basic *or* supplementary premiums.'' Section 1851(g)(3)(B)(i) of the Act refers to ''basic *and* supplementary premiums'' and we are revising the regulations accordingly.

Comment: Two commenters requested clarification regarding the standards for disenrollment for disruptive behavior under the Health Insurance Portability and Accountability Act (HIPAA) and

BBA, unsure if the two statutes were in conflict in this area.

Response: For any issues for which there is a perceived conflict in the disenrollment standards established under the BBA (or the BBRA) and those established under HIPAA, the BBA standards (that is, the standards in § 422.74 pursuant to section 1851(e) of the Act) would control for M+C purposes.

Comment: One commenter recommended that disenrollments for fraud and abuse should include other fraudulent activities related to the delivery of health services, such as visiting multiple doctors for the purpose of obtaining specific drugs and/or using another enrollee's membership card when benefits have been exhausted.

Response: As noted above, section 1856(b)(2) of the Act provides for the use of section 1876 standards to implement analogous provisions of the M+C statute when those standards are consistent with standards established in the BBA for the M+C program. The regulations in section 1876 of the Act addressing disenrollments for fraud and abuse at § 417.460(d) have been largely adopted in § 422.74(d)(3), which permits disenrollment of a beneficiary for providing fraudulent information that affects eligibility to enroll or for permitting others to use his or her enrollment card to obtain services. Manual instructions implementing § 417.460(d) further clarified that any abuse relating to a membership card was included as a ground for disenrollment. Thus, using another member's card would constitute grounds for disenrollment, just as would loaning someone else a card. With respect to the commenter's other example about multiple visits to physicians to obtain drugs, an M+C organization's utilization review system should be able to identify these abuses.

Comment: One commenter requested that we add clarification regarding when a disenrollment is effective in cases of fraudulent behavior.

Response: Disenrollment of an individual who has committed fraud or who permits the abuse of his/her enrollment card is effective the first day of the calendar month after the month in which the M+C organization gives the member the written notice of his/her termination.

Comment: One commenter is concerned that our process for making disenrollment decisions related to disruptive behavior would result in numerous retroactive disenrollment situations. The commenter suggested that we clarify or revise the regulation to assure that any effective dates for disenrollment be prospective in situations where an individual is being disenrolled for disruptive behavior.

Response: Section 422.74(d)(2)(v) establishes procedures for our review of an M+C organization's proposed disenrollment of an individual for disruptive behavior. Under these procedures, we review documentation submitted by the M+C organization within 20 working days, and notify the organization within 5 working days of whether it may disenroll the individual. Section 422.74(d)(2)(vi) then states that if we permit the disenrollment for disruptive behavior, the termination is effective the first day of the calendar month after the month in which the M+C organization gives the individual written notice of the disenrollment. Since these procedures do not allow an M+C organization to disenroll an individual for disruptive behavior until after we have approved the disenrollment, we believe the process provides only for prospective disenrollments.

Comment: Several commenters believe that 12 months is too long to wait before disenrolling an individual for being permanently out of the service area. Many commenters are concerned that the beneficiary will be able to receive only urgent and emergency care during this time, and that 12 months is too long without routine and coordinated care. They made several recommendations. One commenter recommended that 6 months would be reasonable to cover those individuals who live in different parts of the country during the year, while still maintaining contact with the primary care physician for preventive care. Two commenters recommended maintaining past policy of disenrollment of members that move outside of service area for more than 90 days, unless the plan has an affiliate. Another commenter also supported a return to a 3-month time frame. One commenter requested clarification regarding the requirements for disenrolling members from M+C organizations if they move permanently before the 12 months have expired. The commenter believes that if the request to disenroll was written or other acceptable evidence was presented, the M+C organization may disenroll the individual from the plan.

Response: We must first clarify that if an M+C organization determines that an individual has *permanently* left the service area of the M+C plan, it must disenroll the individual from that plan regardless of whether 12 months have passed, unless the individual chooses a continuation of enrollment option. This is outlined at §§ 422.74(b)(2)(i) and 422.74(d)(4). However, we believe that this point may not be entirely clear in the existing regulations and thus we are revising § 422.74(d) to specify that an individual who has ''permanently'' moved out of a plan's service area must be disenrolled. Note that this disenrollment requirement also applies to individuals who are enrolled in a plan under the expanded seamless conversion option for former commercial plan enrollees that is now set forth at §§ 422.50(a)(3)(ii) and (a)(4). That is, should the individual change his or her residence, he or she would be treated the same as any other enrollee who moves to a residence outside of the service area.

The 12-month rule set forth under existing § 422.74(d)(4) establishes the time limit for how long an individual who has left the service area on a temporary basis may remain a member of the M+C plan. That is, an M+C organization must disenroll an individual who has not permanently changed his or her address but has been out of the service area for over 12 months.

After considering the comments on this provision, we agree that 12 months is too long for a beneficiary to have access only to emergency and urgently needed care (based on our operational policy that when a member is out of the service area, the M+C organization is required to cover only emergency and urgently needed care). Therefore, we are further revising § 422.74(d)(4) to state that the M+C organization must disenroll an individual, unless he or she chooses the continuation option, if the individual leaves the plan's service area on a nonpermanent basis for over 6 months. This change is within the parameters of the previous requirement under section 1876 of the Act which, as provided in § 417.460(f)(2), allowed an uninterrupted absence from the geographic area for more than 90 days but less than 1 year. However, we believe it is appropriate to extend the time frame from 90 days to 6 months to accommodate the many beneficiaries who leave the service area for seasonal periods each year, which often last more than 90 days, but rarely more than 6 months.

We note that on August 9, 1999, we issued OPL 99.100, specifying that: (1) If an M+C organization receives notice of a permanent change of address from the member (or member's legal representative) at any time, then it must disenroll that individual from the plan if that change of address is outside the M+C plan's service area unless the member chooses the continuation of enrollment option; and (2) if a member

leaves the service area of the plan, then the M+C organization must disenroll the member if the absence extends beyond 12 months (now, 6 months).

Comment: One commenter asked whether an M+C plan can provide out-of-area coverage in excess of that required by Medicare for only part of the 12-month period when a member is out of the M+C plan's service area.

Response: We allow M+C organizations the flexibility to develop programs to continue benefits for those members who temporarily leave the service area. We have developed operational policies regarding visitor programs. Again, note that revised § 422.74(d)(4) requires an M+C organization to disenroll an individual, unless he or she chooses the continuation option, if the individual moves out of the plan's service area, for over 6 months.

Comment: One commenter asked for clarification of the effective date when an individual is disenrolled for being out of the area for over 12 months.

Response: Consistent with the change in § 422.74(d)(4), the effective date of disenrollment if a member is out of the area and has not informed the M+C organization that the move is permanent will be the first day of the calendar month after the 6 months has passed, and after appropriate written notice has been provided to the member. If the M+C organization is made aware of a permanent move out of the service area, disenrollment is effective the first day of the calendar month after the date the member begins residing outside of the M+C plan's service area, and after written notice has been provided to the member.

Comment: One commenter recommended that § 422.74(d)(7), which provides for disenrollment when a plan terminates services in the area in which the enrollee resides, explicitly states that disenrollment is automatic in this case.

Response: The effective date of a disenrollment based on an M+C plan termination or reduction in service area is the date that the M+C plan termination is effective, and disenrollment is automatic. Beneficiaries would have already received advance notice of such a termination as part of the nonrenewal requirements in § 422.506(a)(2). Accordingly, we have revised § 422.74(d)(7)(ii) to reference the time frames in § 422.506(a)(2).

Comment: One commenter recommended that notices for involuntary disenrollments should be mailed to individuals authorized to make elections on behalf of an enrollee as well as the enrollee.

Response: In general, and as indicated by our requirement that the beneficiary complete and sign the M+C enrollment form, we believe that an M+C-eligible individual should personally complete and sign any election form or disenrollment request whenever possible. If for some reason a beneficiary is unable to sign the election form and needs a surrogate, we defer to State law on who may sign for other persons. Legal representatives of such individuals who authorize the election of an individual must also sign the election form and specify their relationship with the enrollee. In instances of involuntary disenrollment, notifications of disenrollment occur before any action is taken, to ensure that the individual has adequate time to review his or her health care options. Since the legal representative has identified him/herself to the M+C organization, the M+C organization should ensure that both the legal representative and the enrollee subsequently receive, in a timely manner, any important information provided by the M+C organization related to the health care decisions of the beneficiary.

Comment: One commenter is concerned that the time frames for our review of an M+C organization's proposed disenrollment for disruptive behavior (20 working days for a determination and the subsequent 5 days to notify the M+C organization) are too long. The commenter believes that 5 days is reasonable for us to make our determination.

Response: Again, section 1856(b)(2) of the Act provides for the use of section 1876 standards to implement analogous provisions of the M+C statute when those standards are consistent with standards established in the BBA for the M+C program. Regulations at § 417.460(e)(5), which set forth the requirements for our review of an HMO's or CMP's proposed disenrollment for cause, addressed this issue. Under § 417.460(e)(5)(ii), we make this decision within 20 working days after receipt of the documentation material and notify the HMO or CMP within 5 working days after making our decision. We see no reason not to retain this standard under the M+C program, and have done so in § 422.74(d)(2)(v)(B). We believe that this period of time ensures that we can conduct a thorough review of all documentation submitted by the M+C organization and the beneficiary.

Comment: With respect to an M+C organization termination of an enrollee for disruptive behavior, one commenter asked for clarification of the process. For example, the commenter wanted to know who makes the determination, what appeal rights the beneficiary has, the time frame for a determination, and whether the beneficiary stays in the plan during the review of a determination. The commenter also asked if there is a possibility of coverage days lost while we are making the decision, and whether premiums would be refunded if the beneficiary is disenrolled.

Response: The M+C organization must make a serious effort to resolve the problems presented by the beneficiary, which includes the use of the M+C organization's grievance procedures. The M+C organization must notify the beneficiary of its intent to request such a disenrollment, as well as the beneficiary's rights under the M+C organization's grievance procedures. As described above, the final decision regarding the determination of disruptive behavior is made by us, as provided by § 422.74(d)(2)(v), which outlines our review authority of the M+C organization's proposed disenrollment. After reviewing the documentation submitted by the M+C organization and any information submitted by the beneficiary, we decide whether the M+C organization has met the disenrollment requirements. Until the disenrollment is effective, the beneficiary will continue to receive services from the M+C organization. Any premiums or other charges paid for coverage after the effective date would be refunded to the beneficiary; however, the beneficiary would be liable for the original Medicare cost-sharing and permitted balance billing in the case of any Medicare covered services provided by the M+C organization after the effective date of the disenrollment.

Comment: One commenter requested clarification regarding when to send out notices for disenrollments for cause.

Response: The basic requirement for notices is provided at § 422.74(c), which states that for any optional or required disenrollment (other than death or loss of entitlement), the organization must give the individual written notice of the disenrollment with an explanation of why the M+C organization is planning to disenroll. The notice must be mailed to the individual before submission of the disenrollment notice to us. Please note that we have amended §§ 422.74(c)(1) and (c)(2) to clarify that these notice provisions do not apply for disenrollments resulting from plan terminations or reduction of service or continuation areas, since there are no grievance rights provided in these

situations. The notice requirements for plan termination are outlined in §§ 422.74(d)(7) and 422.506(a)(2).

Comment: One commenter noted that § 422.74 only provides the opportunity for an individual to express a grievance to the M+C organization for an enrollment or disenrollment decision. The commenter believes that we should allow these decisions to be appealed because such decisions should not be left to the M+C organization.

Response: We agree with the commenter that decisions to disenroll for fraud or disruptive behavior should not be left solely to the M+C organization, which is why the regulations, at §§ 422.74(d)(2)(iv) and (3)(iii) provide for our role in these cases. However, in other cases, we believe that beneficiaries will be well-protected from a potentially wrongful disenrollment by the internal grievance procedures of the M+C organization. An M+C organization's decision to disenroll an individual does not meet the regulatory definition of an organization determination and thus, by definition, is not an issue that is eligible for the M+C reconsideration process.

10. Approval of Marketing Materials and Election Forms (§ 422.80)

Section 1851(h) of the Act outlines the requirements related to marketing by M+C organizations. These provisions are implemented in § 422.80 of the interim final rule. Section 422.80(a) implements the requirements in section 1851(h)(1) that all marketing material and application forms be submitted to us for approval 45 days before distribution, and that such materials may be used only if we do not disapprove such use by the end of the 45-day period. Section 422.80(b) defines the ''marketing materials'' that must be submitted for approval. We note that we have made a minor revision to this regulation to reflect the fact that HCFA does not review newsletters as marketing material. The reference to newsletters was included in the interim final rule because it appeared in the part 417 regulations governing marketing by section 1876 contractors. In fact, HCFA did not treat newsletters as marketing materials in the case of section 1876 contractors, and there was no intent in the interim final rule to change HCFA's practice on this point. The interim final rule thus should not have included the reference to newsletters, and we are correcting our error in doing so.

Section 1851(h)(2) of the Act requires that the M+C standards include guidelines for review of marketing materials and requires that the guidelines provide that the Secretary will not approve materials that are inaccurate or misleading. Section 422.80(c) establishes the guidelines for our review of marketing materials. Consistent with the provision in section 1856(b)(2) of the Act for use of existing section 1876 standards, the guidelines in § 422.80(c) include existing marketing guidelines for HMOs and CMPs (from § 417.428), which have been in effect since the inception of the Medicare risk contract program.

Section 1851(h)(3) of the Act provides that if we have not disapproved the dissemination of marketing materials or forms with respect to an M+C plan in an area, we are deemed not to have disapproved the distribution in all other areas covered by the M+C plan and M+C organization except with regard to any portion of the material or form that is specific to the particular area. This ''deemed approval'' or ''one-stop shopping'' provision is implemented in § 422.80(d).

Section 1851(h)(4) of the Act provides that M+C organizations shall conform to ''fair marketing standards'' and requires that the fair marketing standards prohibit organizations from providing cash or other monetary inducements for enrollment. Section 422.80(e) outlines the fair marketing standards provided for under section 1851(h)(4) of the Act, and includes existing section 1876 standards as provided for in section 1856(b)(2) of the Act.

Finally, § 422.80(f) specifies that we may permit M+C organizations to develop and distribute marketing materials specifically designed for members of an employer group who are eligible for employer-sponsored benefits through the M+C organization. Although these materials must be submitted for approval under § 422.80(a), we do not review portions of these materials that relate only to employer group benefits, rather than to M+C plan benefits.

The public comments that addressed marketing issues governed by § 422.80 are discussed below.

Comment: Two commenters suggested that we consider lengthening the review and approval processing time for marketing material from 45 days to either 60 or 90 days. The commenters believe that we need additional time to perform adequate review of marketing material submitted by M+C organizations. Another commenter suggested that the processing time be reduced to 14 days and the deemed approval time period be 30 days. The commenter asserted that M+C contractors must complete obligations within 14–30 days; therefore, we should be held to the same standard. The commenter also stated that 45 days for approval of marketing material is too long for effective marketing or to correct misinformation in the press.

Response: As noted above, section 1851(h)(1) of the Act establishes a 45-day limit for our review and approval of marketing materials. That is, absent our disapproval of such materials, the statute permits an M+C organization to distribute marketing materials 45 days after submitting the materials for review. Since any materials that are not affirmatively ''disapproved'' are effectively ''approved'' for distribution, we recognize the importance of completing our review of all marketing materials within 45 days. Accordingly, we are evaluating our marketing review procedures to identify ways we can promote greater efficiency in the marketing review process. We do not believe that reducing the marketing review and deemed approval periods would allow our staff adequate time to ensure that marketing material is accurate and not misleading to potential enrollees and beneficiaries.

Comment: Many commenters expressed concern regarding inconsistent review and treatment of marketing material by our different regional offices. A few commenters recommended that we consider centralized review of marketing material to promote greater consistency across the regions and central office. Several commenters also suggested that we require standard language and at a minimum, 12-point print, in all M+C marketing materials.

Response: We understand the concerns of M+C organizations regarding uniform application of marketing review and guidelines. To address these concerns, we have convened a team of representatives from our 10 regional offices and our central office that is responsible for addressing marketing issues which arise in policy and operationally. We recognize that centralized review may promote more consistent application of marketing review policy, and we are currently evaluating the feasibility of such review. Although we want to provide M+C organizations with the flexibility to develop marketing material that will distinguish their products and services from other organizations, we also believe that standardizing M+C marketing materials will facilitate beneficiary use and choice. Thus, we have taken steps to standardize beneficiary materials. Pursuant to our authority under § 422.80(c)(1) to require the use of ''a format * * * and * * * standard terminology * * * specified by HCFA,'' we required M+C

organizations to use a standardized Summary of Benefits format in describing their 2000 benefits, beginning in the fall of 1999. This Summary of Benefits provides beneficiaries with information on M+C plans that is standardized in terms of format, language, and content. We also plan to identify other beneficiary notification materials for which standardization will be required. The current marketing guide already directs M+C organizations to use 12-point print. M+C organizations can obtain the marketing guide from our website (www.hcfa.gov).

Comment: One commenter suggested that we clarify that documents developed by pharmacies to conduct pharmacy compliance programs are not marketing and promotional materials. Another commenter recommended that we clarify that marketing materials intended to promote the M+C organization (distinct from its Medicare contracting function) should not be subject to the marketing review process.

Response: To the extent that ''pharmacy compliance'' documents are directly related to health care or quality, we do not review them as marketing materials. On the other hand, if the ''pharmacy compliance'' materials are used to market the program in pre-enrollment marketing materials and advertisements, we treat them as marketing materials subject to our review and verification.

We do not review materials that are directed solely at an HMO's commercial population. However, we believe that any materials targeted at the Medicare population, and designed to inform beneficiaries about benefits, or encourage beneficiaries to enroll or remain enrolled, should be subject to our review on their behalf. Thus, we are retaining the provision under § 422.80(b)(1) that calls for review of materials that ''promote the M+C organization.''

Comment: A few commenters, particularly those providing services in rural areas, urged that we require M+C organizations to include a list of subcontracted providers in their pre-enrollment marketing material. Others suggested that we require organizations to include a list of participating providers in their marketing materials.

Response: We understand that provider directories are generally available at sales presentations or when a beneficiary visits the M+C organization. Thus, we do not think it is necessary or appropriate to mandate that an M+C organization identify subcontractors or furnish provider directories in general marketing materials or sales kits. We note that § 422.80(c)(1) directs M+C organizations to provide Medicare beneficiaries interested in enrolling in an M+C plan with a written description of plan rules (including any limitations on the providers from whom services can be obtained), procedures, basic benefits and services, and fees and other charges. M+C organizations also must meet the detailed disclosure requirements outlined in § 422.111, which include informing enrollees of the ''number, mix, and distribution (addresses)'' of available providers. We believe that these requirements adequately address beneficiary information needs.

Comment: Several commenters requested that we define ''significant non-English speaking population.'' One commenter recommended that 5 percent of the Medicare-eligible population be the standard, while another recommended a standard of 25 percent.

Response: Section 422.80(c)(5) of the interim final regulation requires, for markets with a significant non-English speaking population, that M+C organizations provide marketing materials in the language of these individuals. The term ''significant'' can refer to either the number or percentage of the affected population. We note that the Office for Civil Rights within the Department of Health and Human Services is responsible for implementing standards and providing guidance concerning the obligations of Federal fund recipients (such as M+C organizations) to provide language assistance to individuals who have limited English proficiency. As more information becomes available to HCFA, we will provide further guidance on M+C organizations' responsibility in this regard.

Comment: Some commenters asked that we clarify the role of physicians in the marketing of M+C products to their patients. The commenters also requested further guidance regarding whether physicians are allowed to counsel patients about their health insurance choices. Commenters both supported and opposed allowing physicians to advise potential enrollees and beneficiaries about M+C plan options.

Response: We agree that the role of physicians should be clarified. Accordingly, we are amending the standards for marketing to add a new § 422.80(e)(1)(vi) that permits provider groups and individual providers to distribute health plan brochures (exclusive of applications) at a health fair or in their own offices. Physicians may discuss, in response to an individual patient's inquiry, the various benefits in different health plans. While this discussion is entirely appropriate within the doctor-patient relationship, M+C organizations may not use providers/provider groups to distribute printed information comparing the benefits of different health plans, unless the materials have the concurrence of all organizations involved and have received prior approval from us. Physicians and other providers may not accept plan applications. We also are adding a new § 422.80(e)(1)(vii) that prohibits M+C organization representatives from accepting applications in provider offices or other places where health care is delivered.

Comment: One commenter recommended that we revise § 422.80(c)(4) to reflect a statutory reference in section 1851(h)(2) of the Act to marketing material that is ''materially inaccurate or misleading or * * * makes a material misrepresentation.'' The commenter believed that the omission of the term ''material'' creates a more stringent standard of review than that intended by Congress.

Response: We concur with this recommendation. As noted, section 1851(h)(2) states that ''the Secretary shall disapprove * * * such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.'' Therefore, we are modifying § 422.80(c)(4) to read as follows: ''In reviewing marketing material or election forms under paragraph (a) of this section, HCFA determines that the marketing materials: * * *. (4) are not materially inaccurate or misleading or otherwise make material misrepresentations.'' This language is more consistent with the standard outlined in the statute, and we believe it can help avoid delays in the review and approval of marketing materials for immaterial or irrelevant errors.

Comment: Commenters also requested further guidance regarding the permissibility of offering ''value-added services'' to beneficiaries.

Response: In general, ''value-added items and services'' (VAIS) are items or services offered to beneficiaries by an M+C organization that do not meet the definition of a benefit as stated in § 422.2; that is, benefits are health care services for which the M+C organization incurs a cost under the M+C plan that are submitted and approved through the ACR process. Examples of VAIS may include but are not limited to discounts in restaurants, stores, entertainment, or travel; they could also include discounts on health club memberships and on insurance policy premiums.

Because VAIS do not constitute a benefit under the M+C program, neither the actual costs of the VAIS nor associated administrative costs may appear in the ACR, nor are they subject to the Medicare appeals process. Nonetheless, VAIS may be of value to some enrollees, and we do not wish to deprive M+C enrollees of access to items and services commonly available to commercial enrollees. Therefore, M+C organizations may offer VAIS to Medicare enrollees, but materials describing VAIS must clearly distinguish between VAIS and M+C benefits, including clarifying that VAIS are not subject to the M+C appeal procedures. VAIS may not appear in the Beneficiary Information Form or the Plan Benefit Package. Further, VAIS may not be described in Medicare Compare, the Medicare and You handbook, or the Standardized Summary of Benefits. We will provide further guidance regarding VAIS in a forthcoming OPL.

Comment: One commenter inquired if the prohibition of monetary rebates to induce enrollment applies to the distribution of coupons.

Response: Cash or monetary rebates, including coupons that have more than a nominal cash value (if converted to cash) are prohibited under § 422.80(e)(1)(i). This prohibition does not apply to items of nominal value ($10 or less). The coupons, or the combined value of the coupons, must not exceed the nominal value standard. Coupons that offer discounts on premiums or copayments are not permitted, because they would violate the ''uniform premium'' provisions of the statute, as outlined in § 422.304. If coupons are for VAIS in excess of nominal value, they cannot be distributed or advertised pre-enrollment. However, these coupons may be used after enrollment.

Comment: Commenters objected to the fact that the regulations are silent regarding the consequences if an M+C organization violates the marketing standards. Two commenters recommended that we begin retrospective review of marketing materials, and pull the advertising campaign for those found to be egregiously inaccurate. Similarly, another commenter suggested that we nonrenew or terminate contracts with organizations that are substantially out of compliance with the marketing regulations.

Response: We recognize that marketing material distributed by M+C organizations must be accurate and not misleading to potential enrollees, and that M+C organizations should be subject to sanction for a substantial failure to comply with marketing rules. We accordingly are adding a new § 422.510(a)(12) to specify that a substantial failure to comply with marketing guidelines is a ground for termination, and thus also a ground for nonrenewal or intermediate sanction (consistent with §§ 422.506(b)(1)(iii) and 422.572(b)).

Comment: Several commenters requested that we provide additional guidance regarding the documentation necessary to demonstrate that marketing resources are allocated for marketing to both the disabled and beneficiaries age 65 and over.

Response: Section 422.80(e)(2)(i) requires M+C organizations to demonstrate to our satisfaction that marketing resources are allocated to marketing to the disabled Medicare population as well as beneficiaries age 65 and over. We plan to issue further guidance on this issue but, until then, we expect organizations to adopt their own procedures to implement these provisions. As a starting point, organizations may consider developing a formal marketing strategy that considers the needs of persons with disabilities and consulting with disability advocacy groups and outreach programs. We expect M+C organizations to avoid developing plans that could discourage the enrollment of persons with disabilities through the imposition of unusually large cost-sharing requirements for items and services frequently used by the disabled. M+C organizations are also expected to make their marketing materials accessible to persons with disabilities (including, for example, through use of alternative formats), and to establish mechanisms for making their marketing sessions accessible to the disabled Medicare population. Also, as discussed further in section II.C of this preamble, M+C organizations must comply with other applicable Federal statutes, including the Americans with Disabilities Act.

Comment: One commenter recommended that we revise or delete the heading ''Employer Group Retiree Marketing'' in § 422.80(f) to reflect marketing to Medicare-eligible employees of the employer.

Response: We believe that ''Employer Group Retiree Marketing'' is an appropriate heading. This provision addresses only marketing materials geared toward retirees of an employer group that reflect non-Medicare benefits offered to group members by that employer. These retirees generally would include individuals who have retired based on a disability rather than age. Thus, a reference to ''retirees'' is not necessarily limited to the over-65 Medicare market. Moreover, this provision in no way limits an M+C's obligation to market to both disabled and over-65 beneficiaries, both in a retiree group and otherwise.

Comment: Some commenters requested further clarification regarding the review of marketing material developed by employers for purposes of employer group marketing. One commenter inquired whether we will definitely permit M+C organizations to develop marketing materials for employer groups. Presently, § 422.80(f) states that we ''may'' permit M+C organizations to develop marketing materials for employer groups.

Response: Although we will not review all the specific benefits offered by the employer group, we will review those items that fall within the disclosure requirements of § 422.111. Further, we agree that the wording of § 422.80(f) may be unclear; thus we are revising the regulation to: (1) Specify that M+C organizations are permitted to develop marketing materials for employer groups; and (2) clarify that we will not review those portions of such marketing materials that relate solely to employer group benefits.

Comment: One commenter questioned whether it is appropriate to allow the term ''senior'' or the number ''65'' to appear in the name of an M+C plan. The commenter stated that including these terms could discourage some beneficiaries from enrolling in a particular M+C plan.

Response: We recognize that certain plan names may discourage enrollment by disabled beneficiaries. Accordingly, pursuant to our authority under section 1851(h)(4) of the Act to establish marketing standards, we have added a new § 422.80(e)(1)(viii) that will prohibit M+C plan names that suggest that a plan is available only to Medicare beneficiaries age 65 or over, rather than to all beneficiaries. This prohibition generally bars plan names involving terms such as ''seniors,'' ''65+,'' etc. In fairness to M+C organizations with an existing investment in a plan name, we are ''grandfathering'' existing M+C plan names, that is, plan names established before this final rule takes effect.

Comment: One commenter believes that tax dollars should not be spent on insurance counseling and assistance programs, such as State Health Insurance Assistance (SHIP) or Information Counseling and Assistance (ICA) programs. In the commenter's view, there are less expensive and better alternatives, such as licensed insurance agents. The commenter asserted that the licensure of these individuals assures public accountability, and that the

insurance professional is the best alternative for providing consumer information and expertise about the new M+C options. On the other hand, several commenters recommended that we not permit independent marketing agents to sell M+C products to potential enrollees.

Response: We believe that SHIPs and ICA programs are valuable, objective, and necessary resources for Medicare beneficiaries. These programs provide one-on-one counseling to beneficiaries on many complicated insurance issues and provide essential links to other important services and programs available to beneficiaries. SHIPs provide a service through a network of 10,000 trained volunteers. In addition, these programs effectively network with other key partners such as insurance carriers, departments of social services, and legal service agencies. SHIPs are able to provide assistance related to a broad spectrum of Medicare issues, and are required to conduct their programs with impartiality and confidentiality. While we strongly support these programs, which have been extremely valuable in educating beneficiaries on the new M+C provisions, we will continue to explore additional information mechanisms to ensure that beneficiaries receive information in the most efficient and effective manner.

We recognize that independent insurance agents may be able to provide a necessary service to Medicare beneficiaries who are considering enrolling in the M+C program. In the past, our position has been to strongly discourage, but not prohibit, Medicare managed care organizations from employing independent insurance agents to sell their products. Recently, we have engaged in extensive consultations on this issue with the DHHS Office of the Inspector General, and we intend to issue guidance to M+C organizations in the near future regarding the parameters for the participation of independent agents in marketing M+C plans.

C. Benefits and Beneficiary Protections

1. Introduction

Subpart C of these regulations details the scope of benefits a Medicare beneficiary is entitled to receive when electing coverage through an M+C plan, as well as establishing a number of beneficiary protections in areas related to access rules, enrollee notification requirements, confidentiality and others. The statutory authority for most of the provisions of subpart C is found in section 1852 of the Act, which outlines benefit requirements and provides authority for beneficiary protections under Medicare Part C. Many of the statutory provisions are the same as, or similar to, benefit provisions of section 1876 of the Act. Therefore, much of the regulatory language of part 417 is retained for purposes of establishing M+C standards, as provided for in section 1856(b)(2) of the Act (which provides for basing M+C standards on section 1876 standards implementing analogous provisions, where consistent with Part C).

All M+C organizations are required to cover the full range of Medicare benefits that are available under original Medicare to beneficiaries in the area who are not enrolled in an M+C plan, subject to certain rules regarding an accessible network of providers. M+C organizations are further required to cover Medicare preventive benefits with the same frequency that they are covered under original Medicare (for example, annual screening mammography examinations). Beneficiaries may be required to contribute to the cost of covered services in the form of cost sharing provided for under the M+C plan. Beneficiaries may have to cover all costs until a deductible is met (including the high deductible provided for under an MSA plan—see section III of this preamble), a percentage of costs in the form of coinsurance, or a fixed amount for services, in the form of a copayment. As discussed in section II.G below, there are limits that apply to the cost sharing that can be imposed on beneficiaries under M+C plans. For benefits that are covered under original Medicare, the benefits must be obtained through providers meeting the conditions of participation of the Medicare program.

This section of the preamble mainly discusses the requirements for network plans. Sections III and IV of the preamble provide more extensive information about benefit requirements applicable to non-network M+C MSA plans and to private fee-for-service plans, respectively. Organizations with network plans, which include coordinated care plans and network M+C MSA plans, are permitted to restrict enrollees to a specified network of providers in the case of non-emergency/urgent services if they have a network in place to provide these services directly or through arrangements (that is, written agreements with providers) that meet the availability and accessibility requirements of section 1852(d)(1) of the Act and § 422.112, discussed below.

2. Emergency, Urgently Needed, and Post-Stabilization Care Services (§§ 422.2, 422.100, 422.112, and new § 422.113)

In some situations, an M+C organization is required to assume liability for services provided to Medicare enrollees through noncontracting providers. In particular, under § 422.100(b), the organization is required to assume financial responsibility for the following items and services obtained from a provider that does not contract with the M+C organization:

- Emergency services;
- Urgently needed services;
- Renal dialysis services provided while the enrollee was temporarily outside the M+C plan's service area;
- Post-stabilization care services; and
- For both network and non-network plans, services denied by the M+C organization and found upon appeal (under subpart M of this part) to be services the enrollee was entitled to have furnished or paid for by the M+C organization.

The requirements that the M+C organization assume financial liability for renal dialysis services and post-stabilization care are new requirements introduced by the BBA that were not included in the requirements of section 1876 of the Act. The definitions of emergency services and urgently needed services in the M+C regulations are based on section 1852(d) of the Act, and thus differ from those used under the previous Medicare managed care program (see § 417.401). In accordance with section 1852(d)(3) of the statute, an ''emergency medical condition'' exists if a ''prudent layperson'' could reasonably expect the absence of immediate medical attention to result in serious jeopardy or harm to the individual. In addition, the new definition of ''emergency services'' includes emergency services provided both within and outside of the plan, while the definition of ''urgently needed services'' continues to encompass only services provided outside of the plan's service area (or continuation area, if applicable), except in extraordinary circumstances (as discussed below). Under section 1852(d)(1)(C)(i) of the Act, M+C organizations are required to pay for nonemergency services provided other than through the organization where the services are immediately required because of unforeseen illness, injury or condition, and it is not reasonable given the circumstances to obtain the services through the organization.

In the June 26, 1998 interim final rule, definitions of emergency services and

urgently needed services were provided at § 422.2; financial responsibility of the M+C organization for emergency, urgently needed, and post-stabilization care services provided outside of the organization was addressed at § 422.100; and special coverage rules for emergency services and urgently needed services were provided at § 422.112. In this final rule, general requirements for financial responsibility for services provided outside the M+C organization remain at § 422.100, while definitions and policies relating to all types of emergency episodes of care, including ambulance services, emergency services, urgently needed services, and post-stabilization care services, have been consolidated at § 422.113. Comments on these aspects of the subpart C regulations are discussed below.

a. Definitions (§ 422.2 and new § 422.113)

Comment: Two commenters requested that we specify in the definition of ''urgently needed services'' that these are not ''emergency services.''

Response: Section 1852(d)(1)(C)(i) of the Act specifies that urgently needed services are not emergency services. Thus, as the commenters suggested, we are revising the definition of urgently needed services to include the requested clarification.

Comment: One commenter expressed support for, while another commenter opposed, the inclusion of in-area unusual events in the definition of urgently needed services. The commenter opposing the inclusion of in-area urgently needed services suggested that if this provision is retained, M+C organizations should not be required to disclose it in member materials or that we give examples of circumstances in which this exception would apply. One commenter asked if this meant that beneficiaries could unilaterally obtain care out-of-plan if their M+C organization did not provide the care they requested. The commenter supporting our position provided the example of equipment failure as a case in which in-area services might not be available.

Response: As discussed in the preamble to the June 26, 1998 interim final rule (63 FR 34973), the inclusion of in-area unusual events in the definition of urgently needed services is based on the statutory language at section 1852(d)(1)(C)(i) of the Act, which does not specify that these services are covered only when the beneficiary is out-of-area. Rather, the statute provides for coverage of urgently needed services when ''it was not reasonable given the circumstances to obtain the services through the organization.'' As stated in the regulations, in-area coverage of urgently needed services applies only under unusual and extraordinary circumstances, for services provided when the enrollee is in the service or continuation area, but the organization's provider network is temporarily unavailable or inaccessible, and such services are medically necessary and immediately required. We believe that examples of when this could arise would include unusual events such as an earthquake or strike, if such events impede enrollee access to care through M+C plan providers. This regulatory definition of urgently needed services should be used in any materials that include a description of urgently needed services.

With regard to the request that the in-area exception in the definition of urgently needed services be interpreted to mean that beneficiaries could seek care out-of-plan if the particular services are not provided by an M+C organization, we believe that the commenter is asking about situations where an M+C organization has made a judgment that services are not necessary or not covered, rather than one in which the network is unavailable. There are other mechanisms in place to handle such situations. We may require a plan to take corrective action, where necessary, if a plan fails to provide services. In addition, services that the beneficiary believes he or she was entitled to receive from the M+C organization, but that the organization denied or otherwise did not provide, may be appealed under the regulations in subpart M of part 422. Whether situations involving equipment failures would be considered urgently needed services depends upon the clinical condition of the patient, and the M+C organization's ability to make services available notwithstanding the equipment failure.

We note that, inherent to the various requirements under § 422.112 relating to an M+C organization's responsibility to provide adequate access to covered services, is the obligation of an M+C organization to provide access to necessary care through out-of-network specialists when its network is inadequate or unavailable. That is, if in an individual case a plan's provider network is not adequate to meet an enrollee's health care needs (for example, the plan includes no specialist qualified to treat an enrollee's rare condition), the organization shall authorize the individual to go out of network to obtain the necessary care. We are revising § 422.112(a)(3) to make this requirement explicit. As discussed in detail in section II.M.9 of this preamble, failure to authorize such care constitutes an adverse organization determination, with concomitant appeal rights.

Comment: One commenter requested further elaboration on what is meant by ''prudent layperson'' within the definition of emergency services.

Response: Section 1852(d)(3) of the Act provides the definition of emergency services that includes the prudent layperson standard. Specifically, section 1852(d)(3)(B) of the Act states that an emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. This entire definition should be considered when making a determination of whether a beneficiary acted appropriately in seeking emergency care. This definition is what the independent review entity under contract with us will consider when making determinations on beneficiary appeals of emergency services that an M+C organization has denied. With respect to the term ''prudent layperson,'' we believe that the term ''prudent'' has a commonly understood meaning, and would refer the reader to the general dictionary definition of this term. A layperson refers to an individual with an average knowledge of health and medicine, as the definition of ''emergency medical condition'' states. We do not believe that further elaboration of the term prudent layperson is necessary.

b. Enforcement of Emergency Requirements (§§ 422.80, 422.100, 422.113)

Comment: Commenters requested clarification of what steps we were taking to ensure that M+C organizations provide access to emergency services intended by law.

Response: One mechanism we use to ensure appropriate provision of covered services by M+C organizations is a review process of all organization materials provided to beneficiaries, including both pre-enrollment marketing materials provided to prospective enrollees and post-

enrollment member materials for enrollees. For example, § 422.80(b)(5)(v) lists examples of membership communication materials we review, including membership rules, subscriber agreements (evidence of coverage), and member handbooks. In considering our response to this comment, we have determined that ''wallet-sized'' instruction cards that might be used in the case of an emergency should also be expressly included as materials to be reviewed, because these cards may contain instructions to enrollees on how to access care, including instructions on what to do in an emergency. We, therefore, are adding wallet card instructions to the list of examples of marketing materials to be reviewed under § 422.80(b)(5)(v) to ensure that wallet card instructions to enrollees are consistent with the statute and regulations, particularly requirements that apply to emergency and urgently needed services. We note that, as part of our monitoring of the ''prudent layperson'' standard, we have asked our independent review entity to report, on a quarterly basis, each instance in which it overturns a denial of a claim for emergency services.

Also in response to this comment, we have decided to specify at § 422.100(b)(1)(i) that M+C organizations are required to cover ambulance services provided other than through the organization that are dispatched through 911 or its local equivalent. Section 422.113 specifies that the M+C organization bears financial responsibility for ambulance services where other means of transportation would endanger the beneficiary's health. This policy is consistent with original Medicare's coverage of ambulance services where other means of transportation would endanger the health of the beneficiary as provided by section 1861(s)(7) of the Act, as well as with the emergency coverage provisions of section 1852(c)(1)(E) of part C of the Act. In particular, we believe that the law's reference to use of the 911 telephone system indicates statutory intent for coverage of ambulance services whether provided through the organization or other than through the organization. Ambulance services provided through the organization would also be considered part of basic benefits under §§ 422.100(a) and 422.101. We note that nonemergency ambulance services generally would be covered only when provided through the organization, to the same extent the services are covered under the general Medicare principles set forth in section 1861(s)(7) of the Act (that is, when use of other forms of transportation would endanger the health of the beneficiary.) Regulations on original Medicare coverage of ambulance services may be found at § 410.40.

c. Access to Emergency and Urgently Needed Services (§§ 422.112(c) and 422.113)

Comment: Commenters generally supported emergency services policies, such as the prudent layperson definition, the prohibition of prior authorizations, the requirement for out-of-plan coverage, and the requirement that the treating physician determine when the patient is stable. Commenters requested clarification of the prohibition on prior authorization.

Response: In considering our policy prohibiting prior authorization for emergency services as required under section 1852(d)(1)(E) of the Act, we have determined that the regulations should expressly reflect the fact that two parties are protected from prior authorization requirements, that is, the beneficiary and the emergency provider treating the beneficiary. We are clarifying at § 422.113(b)(2)(ii)(A) that prior authorization may not be required from the beneficiary in any materials furnished to enrollees (including wallet card instructions) and that, consistent with section 1852(c)(1)(E) of the Act, disclosure of an enrollee's right to coverage of services must include disclosure of the enrollee's right to use the 911 telephone system. Also, § 422.113(b)(2)(ii)(B) specifies that materials furnished to providers (including contracts with providers) may not include instructions to seek prior authorization before an enrollee has been stabilized.

We believe that these clarifications will promote compliance with the prohibition in section 1852(d)(1)(E) of the Act on prior authorization requirements for emergency services.

Comment: A commenter requested that we specify that retroactive denials should not be allowed based solely on a final diagnosis, and that the presenting condition from the perspective of the prudent layperson should determine coverage.

Response: As noted in our preamble discussion of the provisions of § 422.112 in the June 26, 1998 interim final rule, long-standing Medicare managed care manual policy (§ 2104) prohibited retrospective denial for services that appeared to be emergencies, but turned out not to be emergency in nature. This policy is consistent with the ''prudent layperson'' element of the definition of an emergency medical condition, in that the perspective of the enrollee is a significant factor in determining whether an enrollee acted appropriately in seeking emergency care. As explained in the preamble to the interim final rule, we believe that the current regulations already require such coverage. However, in light of the commenter's concern, we are including in new § 422.113(b)(2)(iii) the explicit requirement that M+C organizations assume financial responsibility for services meeting the prudent layperson standard in the definition of emergency medical condition, regardless of final diagnosis.

Comment: We received a number of comments regarding the limit in § 422.112(c) on copayments for emergency services obtained outside the M+C plan's provider network (the lower of $50 or whatever the plan would charge for in-plan emergency care). Some commenters argued that significant copayments were necessary to deter unnecessary visits to the emergency room, and noted that commercial fee-for-service insurance plans have copayments for emergency care that may be higher than the $50 limit. Other commenters thought the $50 limit was a reasonable standard. Some commenters suggested that the copayment for an emergency room visit should be higher than that for a physician office visit. One commenter requested that a requirement for advance disclosure of the emergency room copayment amount be substituted for a dollar limit. One commenter requested clarification that the $50 limit be for the ''sum total'' for all care received for the emergency episode. Another commenter argued for a rule prohibiting copayments altogether, or at least for a reduced limit for low-income beneficiaries.

Response: We appreciate the commenters' responses to our request for public comment on the policy of limiting the amount that can be imposed as a copayment for emergency services. As we stated in the preamble to the June 26, 1998 interim final rule, our data showed that only 7 percent of Medicare managed care plans were charging more than $50 for emergency services. We believe that all of the above comments have some merit, but that, on balance, retaining the current policy (the lower of $50 or whatever the plan would charge for in-plan emergency care) is the best course of action. Although we agree that copayments can effectively deter unnecessary use of services, we believe that a $50 copayment accomplishes this objective, since 93 percent of M+C organizations do not exceed this amount. We also believe, however, that a copayment higher than this amount

could potentially deter an enrollee from receiving necessary emergency services. M+C organizations retain flexibility to set copayment amounts up to $50, including possible consideration for low-income beneficiaries, and organizations may provide for a substantial differential between copayments for physician office visits and emergency room visits. We believe that the difference between a $50 copayment for an emergency room visit and the typical $5 to $10 copayment for a physician's office visit is sufficient incentive to receive nonemergency services at a physician's office. With respect to the commenter who advocated disclosure of emergency room copayments, such copayments are already disclosed in the MedicareCompare database on the Internet at HCFA's website, www.hcfa.gov, and M+C organizations are required to disclose these amounts in membership materials provided to beneficiaries. Finally, we believe that the current language already conveys that $50 is the sum total limit for copayment for services defined as emergency services, and that further clarification beyond this response is not necessary.

Comment: One commenter suggested that beneficiaries be issued a single Medicare identification card that could be presented to their treating physicians and staffs, rather than one card issued by the M+C organization and one issued by Medicare. The commenter stated that beneficiaries frequently do not present the correct card denoting M+C plan coverage to their treating physicians. The commenters believe that the use of a single card would allow physicians and staffs to easily identify exact Medicare coverage and the appropriate administrative and billing procedures to be applied.

Response: The purpose of the Medicare card issued to the beneficiary is to serve as proof of entitlement to the Medicare program. We believe that the Medicare card and the M+C plan membership card serve two different purposes—to identify the individual as entitled to Medicare and to subsequently identify how the individual receives the services. Combining these elements into a single identification card would require the issuance of a new card each time the beneficiary chose a new plan or returned to original Medicare. Thus, although we welcome suggestions to improve the efficiency of our operations, we do not believe that a single card should be issued to the beneficiary.

d. Post-Stabilization Care Services (§§ 422.100 and 422.113)

Section 1852 (d)(2) of the Act gives the Secretary express authority to establish requirements needed to promote the ''efficient and timely coordination of appropriate maintenance and post-stabilization care'' (hereafter together referred to as ''post-stabilization care''). Section 1852(d)(1)(C)(iii) of the Act establishes an M+C organization's responsibility to provide reimbursement for these services. Implementing regulations at §§ 422.100(b)(1)(iii) and 422.113(c) specify that an M+C organization is financially responsible for post-stabilization care services obtained within or outside of the M+C organization. This requirement applies both to services pre-approved by the organization and services that were not pre-approved, under certain circumstances, including situations where an M+C organization fails to respond within 1 hour to a request for pre-approval from a provider of post-stabilization care services (as discussed in detail below). We received a number of comments regarding this section.

In this final rule, the special rules for post-stabilization care services are included under new § 422.113. The requirement for financial responsibility for post-stabilization care services provided outside the organization remains at § 422.100.

Comment: One commenter stated that after stabilization of the emergent medical condition, no immediate health risks should exist. This commenter asked why there is a need to change the time frame for obtaining approval of post-stabilization care, which the commenter apparently believed was 48 hours. Several commenters responded favorably to the 1-hour window for responding to a request for authorization of post-stabilization services, with one commenter suggesting that 30 minutes would be a better time frame.

Response: If no immediate health risks exist following an emergency episode, the patient would most likely be discharged. Post-stabilization care services are administered to ensure that the patient remains stabilized following an emergency episode. We agree with the majority of commenters who supported the 1-hour time frame. We believe that an untimely response to a request for post-stabilization care services would delay the delivery of these services, thereby compromising their effectiveness. We are not aware of the 48-hour time frame referenced by one commenter, as no such time frame exists under Medicare law.

Comment: Several commenters recommended that we require that the request for approval not be made until after the enrollee is stabilized, so that the organization will have the necessary information at its disposal. Commenters requested clarification as to what constitutes a response by the M+C organization to a call from the hospital. For instance, one commenter asked if an organization would be in compliance with the 1-hour rule if it calls back within the hour and states it needs more time to make a decision on post-stabilization care services. One of these commenters also stated that we should require that the emergency department treating the member contact the M+C organization within an hour of the point at which the member is stabilized. Another asked how the emergency provider would be held accountable for notification to the M+C organization once the patient is stable.

Response: Section 1852(d)(1)(E) of the Act states that the M+C organization must provide coverage for emergency services without regard to prior authorization or the emergency care provider's contractual relationship with the organization. Implicit in this requirement is the fact that the organization may not require the provider to call for approval of services prior to the point of stabilization. If the hospital chooses to notify the organization while the patient is still being stabilized, the organization will still need an update on the status of the patient at the point of stabilization, in order to make an informed decision. If the provider calls when the enrollee is stabilized, an organization which calls back within the hour should not need more time to make a decision. Therefore, we consider a response by the M+C organization to be when the M+C organization submits a decision to the provider about its request for post-stabilization care. While we believe it is reasonable to expect the emergency provider to contact the M+C organization within an hour of the point at which the member is stabilized, we do not believe that this final rule, which establishes and clarifies the requirements that M+C organizations must meet, is an appropriate vehicle to impose such a requirement on hospitals. (We are considering including such a requirement in future hospital provider agreements with Medicare, however.) It is clearly in the hospital's best interest to contact the organization as soon as a patient is stabilized in order to ensure plan coverage of post-stabilization services furnished by the hospital. In

addition, in order to be able to bill the beneficiary in circumstances where the plan is not liable for payment, the treating provider is expected to provide the stabilized patient with a notice of non-coverage, such as an Advance Beneficiary Notice.

Comment: A number of commenters asked for clarification of the definition of post-stabilization care services. The majority of these commenters requested that post-stabilization care services be linked to the emergency episode. Two commenters inquired if the term post-stabilization care replaces the pre-BBA term ''follow-up'' care, which includes only routine care following an out-of-area emergency medical episode.

Response: We agree that the concept of post-stabilization care services could be clarified further, and we have expanded on the definition, including the addition of language addressing services furnished while waiting for a response to a request for authorization from an M+C organization. We also agree with the commenter that post-stabilization services should be limited to services related to the emergency medical condition.

By post-stabilization care services, we generally mean covered services, related to an emergency episode, provided after the enrollee is considered to be stable (see new § 422.113(c)). Under the post-stabilization provisions set forth in the interim final rule, ''post-stabilization'' services were limited to services authorized by the M+C organization or services furnished when the organization cannot be reached, or fails to respond to a request for authorization within an hour. This definition did not address services that may be required during that hour to keep the patient stabilized. We believe that it is necessary to ensure that the patient continues to receive necessary treatment during the 1-hour time frame when the provider waits for the organization to respond. These services consist of those necessary to maintain the stable condition achieved through previously administered emergency services. Any period of instability that rises to the level of an emergency medical condition that occurs during this time would be covered under § 422.113(b).

Section 422.113(c) also establishes that if the M+C organization does not respond within the 1-hour time frame, the M+C organization cannot be reached, the treating physician can proceed with post-stabilization services that are administered not only to ensure stability, but also to improve or resolve the patient's condition. When an M+C organization representative who is a non-physician and the treating physician cannot reach agreement on a course of treatment, the M+C organization must allow the treating physician to speak with a plan physician. By allowing the treating physician to proceed with care of the patient in these cases, we are ensuring that M+C enrollees receive the same standard of timely care as beneficiaries under original Medicare.

Accordingly, the revised definition of post-stabilization care services at § 422.113(c)(1) reads as follows:

''(c) Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after the enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (2)(iii) below, to improve or resolve the enrollee's condition.''

Section 422.113(c)(2) then describes the M+C organization's financial responsibility for post-stabilization care services. Specifically, ''the M+C organization is financially responsible (consistent with § 422.214) for post-stabilization care services obtained within or outside of the M+C organization that are— (i) Pre-approved by a plan provider or other M+C organization representative; (ii) Not pre-approved by a plan provider or other M+C organization representative, but administered to maintain the stabilized condition, within 1 hour of a request to the M+C organization for pre-approval of further post-stabilization services; or (iii) Not pre-approved by a plan provider or other M+C organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if—

(A) The M+C organization does not respond to a request for pre-approval within 1 hour;

(B) The M+C organization cannot be contacted; or

(C) The M+C organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the treating physician may continue with the care of the patient until a M+C organization physician is reached or one of the criteria in § 422.113 (c)(3) is met.''

To further clarify the above requirements, consider the following example: A patient is brought to the emergency department with the preliminary diagnosis of a seizure. The patient is screened and receives services to stabilize his condition. Thus far, the services that the patient has received are emergency services under § 422.113(b). Once the emergency room physician considers the patient stabilized, the M+C organization is notified of the need to consult a neurologist in order to proceed with relevant diagnostic tests to determine the cause of the seizure, and to treat the cause of the seizure definitively. While the emergency provider waits 1 hour for a response from the organization, post-stabilization services necessary to maintain the stable condition achieved through previously administered emergency services are administered.

If the M+C organization responds within 1 hour, it can approve the request for additional post-stabilization services under § 422.113(c)(2)(i) or make other arrangements for additional services. If the organization did not respond within the 1-hour time frame, if the organization could not be contacted, or if the organization representative and the treating physician could not reach an agreement and a plan physician was not available for consultation during the hour, the treating physician can proceed with post-stabilization services administered not only to maintain the stabilized condition, but to improve or resolve the patient's condition. Again, if the organization representative and the treating physician cannot reach an agreement, the M+C organization must give the treating physician the opportunity to speak with a plan physician concerning the care of the patient. If a plan physician responds to a request for consultation outside the one hour time frame, the plan physician and the treating physician are expected to execute a plan for safe transfer of responsibility of the patient.

Comment: One commenter sought clarification as to when the M+C organization's liability to pay ends. This commenter does not believe that the M+C organization physician should have to ''arrive,'' as stated in the preamble of the June 26, 1998 interim final rule, in order to terminate the organization's responsibility to pay. This commenter also recommended that we explicitly state that even if the M+C organization does not respond within the hour, once it does respond, it should have the absolute right to control the care that is given to the member.

Response: We agree that the issue of when the M+C organization's financial responsibility ends needs further clarification. We also agree that the physician should not have to arrive in person at the hospital in order to assume responsibility for his or her patient. Therefore, we are incorporating the following language into § 422.113(c)(3): ''The M+C organization's financial responsibility

for post-stabilization care services it has not pre-approved ends when—(i) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care; (ii) A plan physician assumes responsibility for the enrollee through transfer; (iii) An M+C organization representative and the treating physician reach an agreement concerning the enrollee's care; or,(iv) The enrollee is discharged.''

We do not agree that the M+C organization should have the absolute right to control the care that is given to the member when it does eventually respond and the one hour time period has elapsed. For example, a late response could result in a scenario where post-stabilization care services may have already started, and in such a situation, we believe that interruption of a procedure in progress in order to transfer the enrollee to another facility could be harmful to the member. The M+C organization is financially responsible for post-stabilization services until the M+C organization and the treating physician execute a plan for safe transfer of responsibility. Safe transfer of responsibility should occur with the needs and the condition of the patient as the primary concern, so that the quality of care the patient receives is not compromised.

Comment: Several commenters asked that HCFA clarify that only an M+C plan physician with privileges at the treating hospital may assume responsibility for the M+C plan enrollee's care.

Response: Generally, only an M+C plan physician may assume long-term responsibility for care furnished to an enrollee of that M+C plan. However, if there are no M+C plan physicians with privileges at the treating hospital, we would expect the treating physician and the M+C organization to make arrangements for appropriate care to be provided. Thus, we do not agree that an M+C plan physician with privileges at the treating hospital must necessarily assume responsibility for a plan enrollee's care.

Comment: Several commenters asked that we address how disputes between M+C organizations and providers would be resolved. One commenter asked that we develop guidelines for notification of organizations. Another commenter wanted to know how we will determine if a call was made, or responded to within 1 hour, if the provider's and M+C organization's records do not agree. Still another commenter suggested a provision holding the patient harmless for disputes between M+C organizations and the emergency provider regarding post-stabilization benefits and coverage.

Response: We believe that providers and M+C organizations will develop methods of documentation to ensure that calls are made and received in a timely manner, so that the 1-hour response requirement can be met and the possibility of disputes can be minimized. We do not believe the development of guidelines by HCFA to be necessary or appropriate. Complaints and disputes are addressed in the HCFA monitoring process, and resolution would depend on the circumstances encountered. Ultimately, if agreement cannot be reached, a dispute over whether the conditions for M+C coverage for post-stabilization care services under § 422.100 and § 422.113 have been met could be resolved in an enrollee's appeal of the M+C organization's denial of payment for post-stabilization services, or an appeal by a provider if the provider agrees not to charge the enrollee. (We note that the rules governing payment for services furnished by noncontracting providers would apply in post-stabilization cases, as set forth in § 422.214 and discussed in detail in section II.E of this preamble. We have made this explicit at § 422.113(c)(2).) Based on this comment, we agree that M+C enrollees should be protected from excessive charges for post-stabilization care services. Therefore, new § 422.113(c)(2)(iv) provides that cost-sharing for post-stabilization care services must not exceed cost-sharing amounts for services obtained through the organization.

Comment: One commenter stated that if an enrollee is admitted to a hospital for services that are later determined not to be emergency services, the M+C organization has no obligation to pay for services that a provider asserts are for post-stabilization care. In addition, a commenter asked whether, if there is a denial of post-stabilization care services, the treating physician can be given the right to speak with an M+C plan physician regarding the patient. Another commenter recommended we add protections against denials of post-stabilization care services.

Response: Section 1852(d)(3) of the statute states that the M+C organization is responsible for services required to treat an emergency medical condition under the prudent layperson standard. Organizations are not responsible for care sought by the enrollee when this standard is not met. Post-stabilization services are similarly covered only following treatment for an emergency (as noted above, we have revised the definition, at § 422.113(c)(1), to make this explicit.) If the patient did meet the prudent layperson standard, but the condition did not turn out to be an actual threat to the health of the patient, the M+C organization would not be responsible for any services beyond those services provided as part of the medical screening to determine whether an emergency medical condition existed. In such a nonemergency situation, the treating physician is expected to provide the patient with an Advanced Beneficiary Notice (ABN) to inform the patient that further services will not be covered.

With respect to the comment concerning denials, if the organization representative and the treating physician cannot reach an agreement concerning the enrollee's care, the M+C organization must give the emergency physician an opportunity to consult with an M+C organization physician.

With respect to the request for further patient protections, as noted above, the enrollee (or, the provider, if the provider agrees not to charge the enrollee) has the right to appeal any decision by an M+C organization to deny payment for post-stabilization services.

Comment: One commenter asked that post-stabilization care services be limited to services that can be furnished at the facility at which the emergency treatment was provided. Another commenter recommended that we require M+C organization staff, including plan providers, to defer to an emergency provider's preference to keep an enrollee in an emergency facility after stabilization to prevent any needless disruption in the patient's care.

Response: We disagree that treatment decisions should be limited by what services a facility can provide. If a treating physician or facility is prepared to provide additional needed treatment to a patient, and the M+C organization cannot be reached, or has not responded within an hour, we do not believe that the patient should have to wait for this treatment until the organization responds, simply because it would not be provided in the same physical location as the emergency services. Section 422.113(b)(3) specifies that the physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge and that decision is binding on the M+C organization. We would expect the M+C organization to allow the treating physician to speak with a plan physician if he or she is concerned about the care (for example, a transfer) planned for the patient.

Comment: One commenter asked which provider, the emergency provider

or the M+C plan provider, has the authority to establish a plan of care.

Response: In providing emergency services, the emergency provider has the authority to establish the plan of care. Once the enrollee has been stabilized, post-stabilization care services are provided in accordance with § 422.113(c). Thus, once the M+C provider assumes responsibility, then he or she has the authority to revise the plan of care or establish a new plan of care as long as the new plan of care is consistent with a safe transfer of responsibility.

Comment: One commenter recommended that the language in § 422.100(b)(iv)(A) be changed from ''Pre-approved by the organization'' to ''Pre-approved by a plan provider or other M+C organization representative.''

Response: In response to this comment, we have changed the language in question to read, ''Pre-approved by a plan provider or other organization representative.'' (See § 422.113(c)(2)(i).)

3. Service Area Requirements (§§ 422.2, 422.100, 422.304(b)(2))

In the June 26, 1998 interim final rule, we defined the term ''service area'' as a geographic area approved by us within which an M+C eligible individual may enroll in a particular M+C plan offered by an M+C organization. We specified that for coordinated care plans and network medical savings account (MSA) plans only, the service area also is the area within which a network of providers exists that meets the access standards in § 422.112. Existing regulations also require that an M+C plan's uniform benefit package must be available throughout a plan's service area (see the discussion below of modifications to this policy made by the BBRA). In deciding whether to approve a service area proposed by an M+C organization for an M+C plan, we consider the M+C organization's commercial service area for the type of plan in question (if applicable), community practices generally, whether the boundaries of the service area are discriminatory in effect, and, in the case of coordinated care and network MSA plans, the adequacy of the provider network in the proposed service area. As discussed in the interim final rule preamble, because of unique rules pertaining to the amount deposited in MSA plan accounts, we may approve single county M+C non-network MSA plans even if the M+C organization has a different commercial service area (63 FR 34971).

We note that since the publication of the interim final rule, we have issued further guidance implementing the definition of service area set forth in § 422.2, including an affirmation of our longstanding policy of not approving less than full county service areas unless circumstances justify an exception to this rule. This policy, which we refer to as the ''county integrity policy,'' is explained in detail in OPL 99.090 released April 23, 1999. The county integrity rule, which implements the reference in the service area definition to consideration of whether boundaries are discriminatory in effect, prevents the establishment of boundaries that could ''game'' the county-wide M+C payment system by excluding high cost areas of a county. (Note that M+C organizations are paid based on Medicare expenditures at the county level.) Under limited circumstances, as described in OPL 99.090, we will allow an M+C organization to establish a service area that includes a partial county. However, it is never acceptable for an M+C organization to devise an M+C plan service area that excludes portions of a county because it anticipates enrollees with higher health care needs.

Under § 422.100(f), an M+C organization may offer more than one M+C plan in the same service area subject to the conditions and limitations for each M+C plan set forth in subpart C of the M+C regulations. For example, § 422.100(g) provides that we review and approve each M+C plan to ensure that the service area boundaries do not promote discrimination (for example, that they do not include partial counties unless justified), discourage enrollment, steer specific subsets of Medicare beneficiaries to particular M+C plans, or inhibit access to services.

We received about 20 letters commenting on various aspects of M+C service area policy and an M+C organization's ability to offer multiple M+C plans.

Comment: Several commenters objected to the requirement that each M+C plan offered by an M+C organization must be offered to beneficiaries with a uniform benefit package and cost-sharing structure that cannot vary throughout each M+C plan's service area. Some of these commenters expressed concern that this requirement will make it difficult for M+C organizations to serve multi-county areas due to the differences in Medicare payment rates across counties, and that this could result in beneficiaries in low-payment or rural counties having decreased access to M+C plans.

Response: As noted by the commenters, existing M+C regulations provide that each M+C plan offered by an M+C organization must be offered to all beneficiaries in an M+C plan's service area with a uniform benefit package and uniform cost-sharing arrangements. This requirement implemented the requirement of section 1854(c) of the Act for uniform premiums for all individuals enrolled in an M+C plan. Thus, under § 422.2, an M+C plan was defined as health benefits coverage offered under a policy or contract by an M+C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M+C plan. The BBA requirement that an M+C plan consist of a uniform benefit package that cannot vary in terms of benefits or price throughout the plan's HCFA-approved service area contrasted with our previous ''flexible benefits'' policy, which permitted HMOs and CMPs under section 1876 to vary premium and benefit offerings by county within a service area. As discussed in the preamble to the interim final rule, however, an M+C organization was able to achieve the same result as the flexible benefits policy by offering multiple M+C plans, either in the same or in different service areas. This administrative policy allowed an M+C organization great flexibility to offer M+C plans that take into account varying county payment rates and preferences of the Medicare population. (Each M+C plan offered by an M+C organization must have a HCFA-approved service area and meet access standards for health care services as described in our regulations at § 422.112.)

As noted in section I.C of this preamble, section 515 of the BBRA amended section 1854 of the Act by adding a new paragraph (h) to permit, effective for contract years beginning on or after January 1, 2001, the application of the uniformity rule to individual ''segments'' of an M+C plan service area, provided that each segment is composed of one or more M+C payment areas (that is, one or more counties), and a separate complete ACR is submitted for each such segment. The practical implications of this option are similar to our existing administrative policy, under which M+C organizations have the flexibility, by offering multiple plans in a given area or areas, to tailor the benefits offered under their M+C plans to the areas where the plans are offered. In practice, we anticipate that organizations will likely continue to offer multiple M+C plans, since they have already established such separate

plans, and they would have to submit the ACR information required under section 1854(a)(2) of the Act for each segment under the BBRA option, just as they do for each M+C plan now. However, the statute gives M+C organizations the alternative of choosing instead to establish a single M+C plan consisting of segmented service areas, with a separate ACR submission for each segment of the service area. In this final rule, we are adding a new § 422.304(b)(2) which reflects section 515 of the BBRA. We also are making needed conforming changes to the definitions of ''service area'' and ''M+C plan'' in § 422.2, and to § 422.100(d) concerning the structure of M+C plans.

Comment: A commenter asked that we clarify our requirements for approving the service area of M+C plans. The commenter stated that the discussion of service area in the preamble and the definition at § 422.2 did not provide specific guidance on what constitutes an acceptable service area for an M+C plan offered by an M+C organization.

Response: Although we believe that the service area definition in § 422.2 is fairly detailed and specific, we agree that some additional guidance and reorganization of the definition could be of value. Specifically, while our county integrity policy discussed above implements language in the current definition with regard to discriminatory boundaries, the current regulation text does not expressly reflect our longstanding county integrity policy. In response to this comment, and under our authority in section 1856(b)(1) of the Act to establish M+C standards, we are revising the service area definition to specify that in deciding whether to approve an M+C plan's proposed service area, we consider the following criteria:

(1) Whether the area meets the ''county integrity rule'' that a service area generally consists of a full county or counties. However, we may approve a service area that includes a portion of a county if we determine that the ''partial county'' area is necessary, nondiscriminatory, and in the best interests of the beneficiaries.

(2) The extent to which the proposed service area mirrors service areas of existing commercial health care plans or M+C plans offered by the organization.

(3) For M+C coordinated care plans and network M+C MSA plans, whether the contracting provider network meets the access and availability standards set forth in § 422.112. Although not all contracting providers must be located within the plan's service area, HCFA must determine that all services covered under the plan are accessible from the service area.

(4) For non-network M+C MSA plans, we may approve single county non-network M+C MSA plans even if the M+C organization's commercial plans have multiple county service areas.

We believe that these revisions to the service area definition, although they do not constitute policy changes, should help to clarify for M+C organizations our method for determining whether a service area is acceptable.

Comment: A commenter supported the M+C standard that the delineation of an M+C plan's service area should not discriminate against beneficiaries through ''gerrymandering'' or ''red-lining'' to deliberately avoid particular areas (for example, to prevent the enrollment of poorer Medicare beneficiaries, or those known to be in poor health). The commenter asked that we also include cultural accommodations (for example, language access) as part of the requirements for service area designation.

Response: We are very concerned that the service areas for M+C plans be drawn in a manner that avoids discriminating against certain groups of beneficiaries who may be perceived as having higher than average health care needs. The general requirement that M+C plan service areas be made up of whole counties, as discussed in OPL 99.090, is intended in part to preclude any incentive to create M+C service areas that serve only the lowest cost population of a particular county. We believe that the revised service area definition, which continues to provide for our consideration of discriminatory effects, already provides sufficient authority to disapprove a service area if there is evidence that an M+C organization attempted to establish boundaries based upon cultural discrimination, or discrimination against non-English speaking beneficiaries.

Comment: A commenter pointed out that the definition of service area states that the service area also is ''the area within which a network of providers exists that meets the access standards in § 422.112.'' The commenter believes that this wording implies that all services must be provided in the service area itself, and that this requirement conflicts with § 422.101(a), which states that services obtained outside the geographic area are acceptable if it is common practice to refer patients to sources outside the geographic area. The commenter asked that we allow some services to be furnished outside of an M+C plan's service area if patients traditionally go outside the service area to receive such services. Another commenter stated that the M+C organizations should be permitted the flexibility of structuring plan benefits and provider networks in accordance with local patterns of care regardless of political boundaries. The commenter believes this would afford a broader choice of health care options to beneficiaries.

Response: The intent of the cited language from the service area definition is to require that services are available to a plan's enrollees through an M+C plan provider network that is accessible from the service area. We have not interpreted this language to prohibit the inclusion in a plan's network of providers physically located outside the area. In fact, as noted above, we allow M+C coordinated care and network MSA plans to establish a provider network with contracting providers located outside of the M+C plan service area, provided that we determine that the M+C organization's contracted provider network meets Medicare access and availability standards at § 422.112. We believe that the revised service area definition described above should eliminate any implication that all network providers must be located within the service area.

Under both the former risk contracting program and the M+C program, we generally have required that M+C organizations make health care services available through a network of contracting providers located within the boundaries of the M+C plan service area. Under certain circumstances, however, we have always allowed exceptions to this policy, such as in rural areas when providers were not available in a plan's service area, when traveling outside the service area to obtain health care is not uncommon, and also when the services are still reasonably accessible and available. We have also allowed plans to provide certain specialist services outside of a plan's service area if the specialist services were not available in the plan's service area and if the specialist was reasonably accessible.

Another reason that we do not require an M+C plan's provider network to be located entirely within the plan's service area is to allow for multiple M+C plans in the same or close geographic areas that share the same provider network, as discussed in the next comment and response. However, we will continue to employ the same criteria in evaluating whether beneficiaries enrolling in an M+C plan are provided with the required access and availability to health care services. Generally, we will evaluate the provider

network supporting an M+C plan by considering the prevailing community patterns of care in obtaining health care services (for example, where people obtain care, the types of providers available in the community, reasonable travel times to obtain care) and the access standards at § 422.112.

Comment: A commenter notes that an M+C organization can offer multiple M+C plans under a single M+C contract with us. The commenter asks how multiple plans would work, and whether each would be required to have a separate health services delivery system.

Response: In order to respond to the commenter's question, we will briefly review the principal requirements that each M+C plan offered by an M+C organization must independently meet. We note that these M+C plan requirements also are discussed in greater detail in other parts of this preamble. Each M+C plan must be approved by us through the adjusted community rate (ACR) process, and each M+C plan must be offered to all beneficiaries in the given M+C plan's service area. An M+C organization can offer multiple M+C plans. Each M+C plan offered by an M+C organization must have a HCFA-approved service area that is generally made up of whole counties consistent with our county integrity policy discussed above, and reflected in OPL 99.090. The M+C plans offered by an M+C organization can have the same or different service areas. For example, an M+C organization may choose to offer more than one M+C plan in the same service area in order to provide beneficiaries with a choice of plan benefit packages and cost-sharing structures, including differing basic premium amounts. Also, each M+C coordinated care plan must provide enrolled beneficiaries access to health care service through a network of contracting providers. M+C plans may share the same provider network and portions of the provider network may be located outside of the plan's service area. However, the provider network supporting an M+C plan must meet M+C access standards with respect to all enrollees in that plan's service area (see § 422.112) as determined by HCFA. We note that under § 422.501(e), when an M+C organization includes several M+C plans under a single contract, the contract must provide for an amendment upon our request to remove an individual M+C plan from the contract, so that we have the flexibility to nonrenew or terminate only a single M+C plan if a problem is confined to one such plan.

4. Benefits (§§ 422.2, 422.100, 422.101, 422.106)

The regulations contained in subpart C describe the requirements for M+C organizations' benefit offerings. The statutory basis for these provisions generally can be found in section 1852 of the Act. The basic categories of benefits parallel those that applied under the section 1876 risk contracting program with the exception of the use of the term ''basic benefits,'' which we now define as both original Medicare benefits and additional benefits. Despite the limited changes, we believe it is important to carefully define the different benefit categories, because, historically, organizations participating in the risk-contracting program often used different terminology in describing their benefit packages to beneficiaries and in structuring benefits under Medicare risk contracts.

Thus, in order to promote consistency, M+C organizations must use the benefit terminology specified in the M+C regulations and in instructions and operational policy letters. We intend to provide further instructions over the next several years to assist organizations in standardizing the structure and terminology used in describing their benefit offerings. In addition to issuing instructions, we will be reviewing benefit design closely to provide feedback to M+C organizations on ways they can improve their benefit descriptions and ensure that the benefits comply with our requirements. The use of consistent terminology in describing benefit categories will result in better information for Medicare beneficiaries to compare their Medicare options as well as help us to review both benefits paid for with Medicare capitation payments and benefits for which Medicare beneficiaries are charged a premium.

Comment: Several commenters asked for additional clarification regarding the new definitions of the benefit categories under the M+C program.

Response: We have been aware of confusion about the benefit terminology used in the Medicare risk contracting program, and have attempted to clarify the terminology in the M+C regulations. As noted above, a significant change under the M+C program involves the definition of the term ''basic benefits.'' Under the M+C program, basic benefits means both benefits covered under original Medicare and additional benefits, not otherwise covered under original Medicare, that are paid for with Medicare payments. Additional benefits are grouped with original Medicare benefits because they are part of the package of basic benefits for which beneficiaries are not charged a premium, beyond any premium the M+C organization is permitted to charge for original Medicare benefits. As discussed more fully below in section II. D, the costs of additional benefits are funded by the difference between an organization's ACR for the original Medicare benefit package, and the M+C payment plus any approved enrollee cost sharing.

Mandatory supplemental benefits are M+C plan benefits not otherwise covered under original Medicare for which anyone who enrolls in an M+C plan is charged a premium. Thus, additional benefits (included in the basic benefit package) and mandatory supplemental benefits are similar in that they are not covered by original Medicare, and *all* M+C enrollees receive them as part of their M+C plan. The difference is in the way these benefits are funded: additional benefits are funded with Medicare payments through the M+C payment rate, and mandatory supplemental benefits are fully paid for by M+C enrollees through a separate premium or cost sharing.

Like additional benefits and mandatory supplemental benefits, optional supplemental benefits are not covered by original Medicare. However, plan enrollees may choose whether to elect and pay for optional supplemental benefits. M+C organizations may offer M+C plans that have individual items or groups of items and services as optional supplemental benefits.

We are making several minor technical changes to improve the accuracy and consistency of the benefit-related definitions set forth in § 422.2. For example, we are clarifying under the definitions of ''mandatory supplemental benefits'' and ''optional supplemental benefits'' that these categories of benefits consist of ''health care services'' that may be paid through premiums ''and/or'' cost sharing. Also, we are clarifying in the definition of ''benefits'' that the costs an M+C organization incurs in providing benefits may not be solely an administrative processing cost and that benefits must be ''submitted and approved through the ACR process.''

Comment: Commenters suggested that we consider developing standardized definitions or descriptions for the individual items and services that make up a benefit package.

Response: The intent of the regulations is to clarify the meaning of the terms used in the statute, which reflect the funding source for various groups of benefits. We recognize the value of standardizing the definitions of

individual items and services that might be included as additional or supplemental benefits, such as a drug benefit. Both the annual Summary of Benefits and the Plan Benefit Package are important parts of our standardization efforts. As noted above, we intend to provide further instructions over the next several years to assist organizations in standardizing the terminology used in describing their benefit offerings. Work on defining individual items and services so that beneficiaries may compare benefit offerings is taking place predominantly within the context of our information campaign. We are not including standardized definitions in this final rule.

Comment: Several commenters asked for further clarification of the meaning of the requirement in § 422.101(a) that an M+C organization provide all Medicare-covered services that are available to beneficiaries residing in a plan's geographic area, including services obtained outside of the area if it is common practice to refer patients to sources outside the area. Two commenters noted that the term ''common practice'' might be misleading, and recommended that we revise the regulations to state that services may need to be provided outside the area, provided that the services are reasonably accessible to enrollees and such use is consistent with community practice patterns. One commenter recommended that we confirm in the final rule the basic premise that M+C organizations must provide all their enrollees with all services covered under original Medicare, including any needed out-of-area care. Another commenter questioned whether the requirement that an M+C organization provide all Medicare-covered services that are available to beneficiaries residing in the service area implies that the M+C organization's health care delivery patterns must mirror care delivery patterns in original Medicare.

Response: Consistent with section 1852(a)(1)(A) of the Act, § 422.101(a) establishes the principle that an M+C organization must provide its plan enrollees with all the Medicare-covered services available to other Medicare beneficiaries in the area served by the plan. We recognize that the existing regulatory language in this section creates some potential for confusion and are making several changes along the lines suggested by commenters in order to clarify the regulations. Revised § 422.101(a) continues to specify that an M+C organization must provide coverage of all Medicare-covered services available to beneficiaries residing in a plan's service area. We are adding a provision to state explicitly that services may be provided outside of the service area of the plan if the services ''are accessible and available to enrollees in the same area.''

When we assess the capability of any proposed plan to serve an M+C service area, we consider the numbers, types, and locations of all providers needed to provide all Medicare-covered services or, in regulation terms, the access and availability of Medicare-covered services. We continue to believe that it is in the best interest of the Medicare program and Medicare beneficiaries to evaluate proposed M+C plan networks on a case-by-case basis taking into account the patterns of care and access to care in particular geographic areas. It is not unusual for services such as a dialysis center or transplant center not to be available in a county. If, for example, a Medicare beneficiary would normally have to travel to a different county for renal dialysis or a transplant, we believe it would not be unreasonable for an M+C plan enrollee to be required similarly to travel outside of a service area for access to such services. Such exceptions to in-area care access should, however, be limited in order to have a viable M+C plan.

The fundamental requirement under § 422.101(a) that an M+C organization provide coverage for all Medicare-covered services is not intended to dictate care delivery approaches for a particular service. For example, M+C organizations may furnish a given service using a defined network of providers, some of whom may not see patients in original Medicare. M+C organizations may also encourage patients to see more cost-effective provider types than would be the typical pattern in original Medicare (as long as those providers are working within the scope of care they are licensed to provide, and the M+C organization complies with the provider antidiscrimination rules now set forth under new § 422.205).

M+C organizations' flexibility to deliver care using cost-effective approaches should not be construed to mean that Medicare coverage policies do not apply to the M+C program. If original Medicare covers a service only when certain conditions are met, these conditions must be met in order for the service to be considered part of the Medicare benefits component of an M+C plan. M+C plans may cover the same service when the conditions are not met, but these benefits would then be defined as additional or supplemental.

In summary, each M+C plan must include all Medicare-covered services available in the service area served by the M+C plan, with the exception of hospice services. Our longstanding policy of allowing organizations flexibility in the provision of services (for example, in terms of who provides the service, what equipment is used, where the service is provided, and what procedure is used) has not been affected by the BBA. Organizations are required to provide services within the guidelines of Medicare national coverage policy and other Medicare rules and requirements that apply to the traditional Medicare fee-for-service system. When a health care service can be Medicare-covered and delivered in more than one way, or by more than one type of practitioner, we continue to recognize a managed care organization's right to choose how services will be provided. These decisions have been left to managed care organizations to allow them to maximize their value purchasing power, and use resulting savings to provide services not covered by the Medicare program.

Comment: Several commenters raised questions about the requirements in § 422.101(b) that M+C organizations comply with our national coverage decisions and with the coverage decisions of local carriers and intermediaries with jurisdiction for claims in an M+C plan's geographic area. Among the issues raised were the following.

- The national requirements which must be followed, and the meaning of ''HCFA's national coverage decisions''.
- General confusion about the relationship between national coverage decisions and local medical review policy.
- Need for additional guidance in situations when plan service areas extend over a geographic area involving multiple carriers or intermediaries, and thus potentially conflicting medical review policies.
- Difficulties in obtaining coverage decisions by local carriers and intermediaries, and the unwillingness of some carriers to permit M+C organizations to be represented on carrier advisory boards.

Response: As discussed in detail above, M+C organizations must provide their plan enrollees access to all Medicare covered services. However, there is a distinction between the general rule that a health care service is covered under Medicare and the decision that an individual patient fits the clinical criteria necessary for receipt of the service. National coverage determinations and local medical

review policies establish what could be a covered benefit under Medicare and the clinical criteria under which the benefit must be provided. The M+C organization must determine whether or not an individual patient fits this clinical criteria. This process at the plan level constitutes an organization determination. In making organization determinations, M+C organizations are required to follow all national coverage determinations and relevant local medical review policies.

It is important to note, that all M+C organization determinations must be made based on the individual circumstances of a given case, using the best and most relevant information available. All organization determinations are subject to enrollee appeals to the M+C organization and subsequently to an independent review entity. The fact that an M+C organization determination was applying a local medical review policy does not in itself ensure that an appeal to the independent review entity might not result in a determination that the service in question was medically necessary for the individual enrollee and therefore should be covered.

In this final rule, we are revising § 422.101(b)(1) to clarify that the requirement that M+C organizations comply with national coverage decisions includes following the general coverage guidelines included in original Medicare's manuals and instructions to contractors, unless superseded by the M+C regulations or operational policy letters. The Coverage Issues Manual is the primary resource for national coverage decisions. Additional guidance on coverage of hospital and skilled nursing services, home health services, physician services, and other Medicare services can be found in the instructions in the Carriers, Intermediaries, and other HCFA manuals. In the absence of a national standard, M+C organizations should follow local medical review policies in making medical necessity decisions.

We recognize the potential for conflicting local medical review policies when an M+C plan's service area extends across the jurisdictions of more than one carrier, for example. Our general rule under OPL 46 continues to be that the M+C organization should apply the medical review policy of the Medicare carrier in the area where the services are furnished, since that is the policy that would apply to those services under original Medicare. However, as one commenter pointed out, an M+C organization is not precluded from covering services that a local carrier may have determined are not covered, if the organization's own utilization and quality management standards support the medical necessity of the service. Similarly, an organization may occasionally need to make a coverage determination in a situation when there is neither national coverage policy or relevant local review guidelines. In all such cases, an M+C organization's fundamental responsibility is to use the best information available to make an informed decision on the medical necessity of a given service, and then to provide the medically necessary service, even if doing so may conflict with local medical review policies.

One way for an M+C organization to attempt to pursue consistency in medical review policies is to participate on the review boards of local carriers or intermediaries. We are aware of the difficulties M+C organizations are encountering in some areas of the country in participating on these boards, and are actively working to address this issue. We remain committed to establishing more standardized procedures for developing medical review policies, and for increasing M+C representation in formulating these policies.

Comment: Several commenters requested clarification of our policy regarding employer groups and the coordination of benefits with employer group health plans (EGHPs). They asked for clarification as to whether members of an EGHP had to be offered the same benefits as other Medicare enrollees, and whether it would be acceptable to offer an actuarial equivalent package. Another commenter asked that § 422.106 be amended to address coordination of Medicaid benefits, as well as EGHP benefits.

Response: EGHPs that are offered by an M+C organization must provide Medicare-eligible EGHP members the same benefits provided to all other Medicare enrollees under the M+C plan in which the beneficiary is enrolled. The benefits in the M+C plan may not be reduced or otherwise changed, and actuarially equivalent benefits may not be substituted in place of the M+C plan benefits. As noted below in the next response, EGHP benefits beyond those benefits offered under the M+C plan are considered outside the purview of our regulatory authority under the M+C program. However, we retain the authority and responsibility to assure that all Medicare beneficiaries enrolled in organizations that have a contract with Medicare (even if they are dually entitled to coverage under another plan) receive the same benefits and protections as other Medicare beneficiaries enrolled in the plan.

We recognize that the existing regulations describing these situations are somewhat unclear. Therefore, we are revising the language at § 422.106 by reorganizing its requirements for clarity. Revised § 422.106(a)(1) clarifies that if an M+C organization contracts with an EGHP that covers enrollees in an M+C plan, or contracts with a State Medicaid agency to provide Medicaid benefits to individuals who are eligible for both Medicare and Medicaid, and who are enrolled in an M+C plan, the enrollees must be provided the same benefits as all other enrollees in the M+C plan, with the EGHP or Medicaid benefits supplementing the M+C plan benefits. Section 422.106(a)(1) states that all M+C program requirements apply to the M+C plan coverage provided to enrollees eligible for benefits under an EGHP or Medicaid contract. We also are revising § 422.106 to delineate clearly that our review authority extends only to the M+C plan benefits provided to members of the EGHP, and the associated marketing materials, rather than to any other complementary benefits provided only under the EGHP. The rules contained in this regulation and the corresponding instructions and operational policy letters take precedence for benefits included in the M+C plan.

We are also adopting the commenter's suggestion that § 422.106 incorporate our requirements concerning the coordination of M+C and Medicaid benefits. These rules are conceptually identical to those governing EGHPs. Thus, for individuals dually eligible under Medicare and Medicaid who are enrolled in an M+C plan, the enrollees must be provided the same benefits as all other enrollees in the M+C plan, with the Medicaid benefits supplementing the M+C plan benefits.

Comment: One commenter questioned whether group health benefits offered by employers were considered to be supplemental benefits under the M+C program.

Response: Employer group health plan benefits paid by an employer on behalf of an employee or retiree, as well as Medicaid benefits furnished under a Medicaid State plan, are neither basic nor supplemental benefits. They are therefore outside the scope of M+C plan benefits regulated by the Medicare program. Other laws and regulations may apply to these benefits (such as ERISA requirements for EGHPs). We recognize in § 422.106 that M+C organizations may contract with employers to furnish benefits that complement those that an employee or

retiree receives under an M+C plan. Such benefits may include M+C plan premiums, cost sharing, and additional services. M+C organizations may design an M+C plan with the expectation that an employer group will offer a particular set of complementary benefits. In such a case, however, the M+C plan must be offered to all Medicare beneficiaries in the service area, regardless of whether they are eligible for the employer group benefits, and meet all other M+C plan requirements.

Comment: Several commenters expressed confusion regarding the benefit-related implications of the ''conscience protection'' provision contained in section 1852(j)(3) of the Act, which is a new provision giving enrollees rights to unrestricted physician counseling and advice. Under the conscience protection provision in section 1852(j)(3)(B) of the Act, implemented in § 422.206(b), the prohibition on interference with provider advice to enrollees in section 1852(j)(3)(A) of the Act (reflected in § 422.206(a)) may not be construed to require an M+C organization to provide or pay for counseling or referrals if the organization objects on moral or religious grounds and notifies enrollees of its policies in this regard. Some commenters asked whether the conscience clause in section 1852(j)(3)(B) of the Act and § 422.206(b) would permit an M+C organization to refuse to include a Medicare-covered service in its M+C plan, as otherwise required under § 422.101.

Response: The conscience protection in section 1852(j)(3)(B) of the Act affects only obligations under section 1852(j)(3)(A) of the Act, not obligations that arise elsewhere in the statute, such as the obligation under section 1852(a)(1) of the Act to cover all Medicare-covered services available in the area served by the M+C plan. To the extent the operation of the right to advice and counseling under section 1852(j)(3)(A) of the Act would obligate an M+C organization to cover counseling or referral services that it would not otherwise be obligated to cover, section 1852(j)(3)(B) of the Act allows the organization to decline to provide such service on conscience grounds if appropriate notice is provided to beneficiaries. However, if the service is one that the organization is obligated to provide independent of section 1852(j)(3)(A) of the Act, it could not be affected by a provision that by its own terms affects only the way that ''[s]ubparagraph (A) [of section 1852(j)(3)] shall * * * be construed.'' It in no way affects obligations that arise elsewhere in the statute. Therefore, an M+C organization could not rely upon section 1852(j)(3)(B) of the Act or § 422.206(b) in an attempt to avoid coverage of services that it is obligated under section 1852(a)(1) to cover.

We note, however, that in the case of abortion-related services, Congress has provided M+C organizations with conscience protections independent of that in section 1852(j)(3)(B) of the Act. Specifically, under section 211 of the fiscal year 2000 Department of Health and Human Services Appropriations Act, Pub. L. 106–113, we are prohibited from denying a M+C contract to an entity on the grounds that it refuses on conscience grounds to cover abortions. We are required, however, to make appropriate adjustments to such an entity's M+C capitation payments to cover our costs in providing Medicare-covered abortion services outside the M+C contract.

Comment: Commenters requested that copayments for outpatient psychiatric services be limited to the same percentages of copayments allowed for other services.

Response: With the sole exception of out-of-area emergency services, we have not prescribed limitations on copayments for individual Medicare services in the M+C regulations. In this case, the commenter's suggestion would impose a requirement on M+C organizations that is inconsistent with the cost-sharing structure of original Medicare. We do not believe this would be appropriate.

5. Special Rules for Screening Mammography, Influenza Vaccine, and Pneumococcal Vaccine (§ 422.100(h))

Section 422.100(h) establishes special rules for screening mammography, influenza vaccine, and pneumococcal vaccine. Enrollees of M+C organizations may directly access, through self-referral, screening mammography and influenza vaccine. In addition, M+C organizations may not impose cost sharing for influenza vaccine and pneumococcal vaccine.

Comment: Several commenters expressed concern that enrollees may directly access out-of-network providers through self-referral. They believe that self-referrals should be limited to in-network providers. Furthermore, they feared that an enrollee may self-refer to noncertified facilities or noncredentialed providers.

Response: The right to directly access screening mammography services and flu vaccines does not include accessing these services out of network. Section 422.112(a) specifies that an M+C organization ''may specify the networks of providers from whom enrollees may obtain services'' if the organization meets a number of specified conditions. M+C organizations thus have the discretion under § 422.100(h)(1) to require that self-referrals be made to a provider within the M+C plan's network, as long as sufficient access is provided in that network. We note that if an M+C organization offers a point-of-service (POS) option under its M+C plan, an enrollee selecting this option could self-refer to an out-of-network provider, consistent with the payment rules established by the M+C organization.

Comment: One commenter stated that we should prohibit cost sharing for mammography as well as vaccines, noting that both health care services are preventive in nature and would be cost-effective measures for the Medicare program in the long term. The commenter pointed out that women constitute a substantial portion of the Medicare population, and asserted that allowing cost sharing for screening mammographies could be perceived as both gender-specific and discriminatory in nature.

Response: Various provisions of Title XVIII of the Social Security Act specify the coverage of mammography, influenza vaccine, and pneumococcal vaccine. The Act provides that there should be no deductible for any of these services. Further, while the Act indicates that there be no copayment for influenza and pneumococcal vaccine, it provides for a 20 percent coinsurance for mammography. (See, for example, section 1834(c) of Title XVIII and 42 CFR 410.152(h).) These are policies established by statute for the original Medicare program, and we see no basis for requiring M+C organizations to provide more favorable treatment to M+C enrollees than that provided to original Medicare beneficiaries.

Comment: A commenter requested that we clarify in the regulations that the prohibition on cost-sharing for influenza and pneumococcal vaccine applies to the imposition of cost-sharing on M+C plan enrollees.

Response: As requested by the commenter, we have added language to the regulation text to clarify that M+C organizations are prohibited from imposing cost sharing ''on their M+C plan enrollees'' for influenza and pneumococcal vaccines.

6. Special Rules for Point-of-Service (POS) Option (§ 422.105)

A POS benefit is an option that an M+C organization may offer under an M+C coordinated care plan, or network M+C MSA plan, to provide enrollees in

such plans with additional choice in obtaining specified health care services. A coordinated care plan may include a POS option as an additional benefit, a mandatory supplemental benefit, or an optional supplemental benefit. A network MSA plan may include a POS option only as a supplemental benefit.

Under a POS option, the M+C organization generally permits enrollees to obtain specified items and services outside of the M+C plan's normal prior authorization rules, but provides that enrollees will incur higher financial liability for such services. The enrollee may be required to pay a premium for the benefit unless the benefit is offered as an additional benefit. M+C organizations can establish what services are available under a POS benefit and the amount of member cost sharing subject to ACR limits. M+C organizations may also place other limits on the benefit; for example, a plan could offer a POS benefit as a travel benefit allowing members to access specified services when the member is traveling outside of the plan's service area.

Comment: Several commenters objected to the restriction in the interim final regulation at § 422.105(a) stating that a POS benefit can be used only to obtain services from providers that do not have a contract with the M+C organization. The commenters maintained that an important aspect of a POS benefit is that it allows beneficiaries who have reservations about joining a managed care plan the opportunity to enroll without following strict prior authorization requirements to access services, and that this consideration applies without regard to whether the provider is part of the M+C plan network. Some commenters also noted that the restriction against in-network use of a POS benefit was particularly unfair to M+C plans with large provider networks, since the likelihood of an in-network referral was much greater. Several commenters stated that if we are concerned about in-plan use of a POS benefit, the solution is monitoring rather than prohibiting beneficiary choice.

Response: In the interim final M+C regulations, we specified that an M+C POS benefit could be used by plan members only to obtain health care services from providers outside of the plan's contracted provider network (non-network providers). The intent of this restriction was to ensure that plan enrollees were not inappropriately induced to use a POS benefit to obtain services at higher cost from plan contracting providers that they could otherwise receive at lower cost by following the plan authorization rules for obtaining health care services. However, we have reconsidered this position in response to the above comments, and in recognition of the fact that a number of organizations withdrew their POS benefit due to this restriction. We recognize that for some beneficiaries the ability to obtain health care services directly from providers without obtaining advance authorization is an important choice. Accordingly, in order to ensure that beneficiaries have the widest possible array of choices, we have decided to allow plans the option of offering a POS benefit that can be used by plan members to receive services from plan contracting providers.

We remain concerned about the potential for inappropriate cost-shifting to beneficiaries. To help guard against this possibility, we have revised § 422.105 to require that M+C organizations offering a POS benefit must track, and report to us upon request, POS utilization at the M+C plan level by both contracting providers and noncontracting providers. In monitoring use of the POS benefit, we will pay particular attention to potential over-utilization of the POS benefit by plan enrollees in obtaining services from the plan contracting provider network. We will attempt to verify that it is a matter of choice when a plan member uses a POS benefit to obtain services, rather than due to the member being inappropriately denied prompt access to the service by the plan. We note that an M+C organization still has the option of offering a POS benefit through an M+C plan that can be used by plan members only to obtain health care services from providers who do not contract with the plan.

Comment: A commenter asked if the POS regulations apply to POS benefits that are offered only for employer group members. The commenter noted that under § 422.106, employer group benefits that are designed to complement the Medicare benefits are exempted from our review.

Response: An employer may through negotiation with an M+C organization provide a POS benefit for members of an employer group who elect to join an M+C plan. As described in the regulations at § 422.106, such enhancements to the Medicare-approved benefit package are not subject to our review or approval.

Comment: A commenter expressed concern about the requirement at § 422.105(d)(2)(iv) that a POS benefit must have a maximum annual out-of-pocket cap on enrollee liability. The commenter questioned whether capping enrollee out-of-pocket expenses would leave the plan at risk for all out-of-network care received by the enrollee once the cap was exceeded.

Response: As the commenter stated, M+C plans offering a POS benefit must place an annual maximum cap on an enrollee's financial liability in using a POS benefit. The reason for requiring a cap on beneficiary financial liability is to ensure that beneficiaries understand in advance what their maximum financial risk is in using a POS benefit. However, once the annual maximum for a POS benefit is reached (including the beneficiary cap), the plan does not have to continue paying for health care service under a POS benefit. For example, consider a plan that offers a POS benefit with a $5,000 annual maximum, and requires 20 percent coinsurance from the beneficiary using the POS benefit. In this example, the member's annual maximum financial liability under POS is $1,000 (20 percent of $5,000). Once the $5,000 overall POS annual maximum is reached, the beneficiary has paid the out-of-pocket maximum of $1,000 and the plan has contributed $4,000 of the $5,000 annual maximum for the POS benefit. At this point, the plan has no further obligation to cover services for the beneficiary under the POS benefit. Thus, any use of the POS benefit beyond this maximum would be at the enrollee's financial liability. We note that § 422.105(d)(2)(iii) specifies that an M+C organization must explain in the Evidence of Coverage the enrollee's financial responsibility for services that are not covered under the POS benefit or services beyond the maximum POS limit.

In general, we expect that organizations offering a POS benefit will be able to provide enrollees with timely information on the POS financial limits, coverage rules, and enrollee cost-sharing for a given service, including the capacity to provide enrollees with advance coverage information over the phone. For example, if the POS benefit has an annual dollar cap, enrollees should be able to phone the organization offering the POS benefit and be informed of how close they are to reaching the financial cap on the benefit. In addition, the plan should be able to advise an enrollee whether a particular service will be paid for under a POS benefit, how much the member will pay out-of-pocket, and how much the plan will contribute under the POS benefit.

7. Medicare Secondary Payer (MSP) Procedures (§ 422.108)

As stated in the June 26, 1998 interim final rule, Medicare does not pay for services to the extent that there is a third party that is to be the primary payer under the provisions in section 1862(b) of the Act and 42 CFR Part 411. The M+C organization must, for each M+C plan, identify payers that are primary to Medicare under section 1862(b) of the Act and part 411; determine the amounts payable by those payers; and coordinate its benefits to Medicare enrollees with the benefits of the primary payers.

The M+C organization may charge, or authorize a provider to charge, other individuals or entities for covered Medicare services for which Medicare is not the primary payer. If an enrollee receives from an M+C organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the M+C organization may charge, or authorize a provider to charge the insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and part 411 of this chapter, or the M+C enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

Where Medicare is a secondary payer to employer coverage in the case of certain working Medicare beneficiaries, an M+C organization may charge a group health plan (GHP) or large group health plan (LGHP) for services it furnishes to a Medicare enrollee who is also covered under the GHP/LGHP, and may charge the Medicare enrollee to the extent that he or she has been paid by the GHP/LGHP.

Comment: Two commenters requested that the M+C regulations provide that Medicare secondary payer regulations apply generally to M+C organizations. One of these commenters also favored a cross reference to the Medicare overpayment regulations.

Response: M+C organizations are to apply only the Medicare secondary payer (MSP) rules as found in section 1852(a)(4) of the Act and in § 422.108. Other MSP provisions do not apply to M+C organizations, and they do not have recourse to them. However, M+C organizations are expected, as provided under § 422.108(a), to look to section 1862(b) of the Act and 42 CFR Part 411 to determine whether Medicare or some other party is the primary payer.

Since section 1852(a)(4) of the Act and § 422.108 are the only MSP provisions that apply in the M+C context, M+C organizations would pursue their Federally authorized claims under State law. Federal preemption of State laws in the MSP context would occur only to the extent a State law would prohibit an M+C organization from complying with what the Federal rules authorize (that is, from billing and recovering from specified third parties, and from beneficiaries to the extent they have received third party payments that are primary to Medicare under MSP rules). These recoveries are not made on behalf of the United States and, therefore, the Federal overpayment rules cited by the commenter do not apply.

Comment: One commenter requested that enrollees be given written notice of their right to appeal an M+C organization decision to withhold payment under MSP rules, or file a request for a waiver of recovery of the overpayment.

Response: Section 422.568 requires an M+C organization to give an enrollee written notice of any denial, in whole or in part, which includes a description of the enrollee's appeal rights. It is not necessary to create a separate requirement in the MSP context. With respect to a request for waiver of recovery of the overpayment, since any recoveries are not obtained on behalf of the United States, State laws rather than Federal overpayment rules would apply.

Comment: One commenter believes that if an M+C plan enrollee with coverage primary to Medicare obtained services from providers not participating in the M+C plan, the M+C organization should pay for the services. By paying nonplan providers first, and then seeking recovery from the primary payer, the beneficiary would not be held responsible for the bill.

Response: There is no statutory authority to require M+C organizations to make payments to nonplan providers, except in the circumstances set forth in § 422.100(b)(1) (for example, emergency or urgently needed services, out-of-area dialysis) and § 422.114(b) (for example, access to services under an M+C private fee-for-service plan).

Comment: Three commenters recommended that since some States have laws that do not allow HMOs and health insurers to seek payment from primary payers, the regulations should be clarified to indicate that MSP rules preempt any State laws that would prevent an M+C organization from complying with the Federal law and regulations.

Response: We are adding a new paragraph ''f'' to § 422.108 to clarify that a State cannot take away an M+C organization's Federal rights to bill or authorize providers to bill for services for which Medicare is not the primary payer. However, nothing in section 1852(a)(4) of the Act would prohibit a State from limiting the amount of the recovery; therefore, State law could modify an M+C organization's rights in this regard, but could not deny them entirely.

Comment: One commenter believes that the use of the term ''charge'' in this section is not appropriate. The commenter pointed out that ''charge'' has a specific meaning in the Medicare context (as in ''reasonable charge''), and the use of ''charge'' in this section is not consistent with the commenter's understanding of the common meaning of this term. The commenter recommended revising the regulations to use the term ''bill'' or ''collect from.'' The same commenter also suggested that there was ambiguity in the use of the word ''determine'' in § 422.108(b)(2), because ''determine'' and ''determinations'' also have different specific meanings under Medicare. ''Calculate'' or ''identify'' was suggested as a replacement.

Response: The intended meaning of ''charge'' as used in this section is ''the imposing of a pecuniary obligation on another entity.'' Although this usage is technically correct and consistent with statutory language, in the interest of clarity, we are adopting the commenter's request, and changing ''charge'' to ''collect from'' in the regulation headings, and to ''bill'' in the body of the regulation text. We also have changed ''determining'' to ''identify'' in subsection (b)(2).

8. National Coverage Determinations (§ 422.109)

Section 422.109 addresses how M+C organizations are paid when a new Medicare benefit is required under a national coverage determination, but payment for this benefit is not yet included in the organization's capitation rate. Frequently, we develop coverage policy on new procedures or technology during the year. M+C organizations must provide these benefits as soon as they are covered by Medicare, even if this occurs during the middle of a contract year. If the cost of such new benefits exceeds a specified threshold, we pay the M+C organization on a fee-for-service basis under original Medicare payment rules to cover the services in question.

Comment: Commenters requested that we include a definition of ''national coverage determination'' in the M+C regulations, and objected to the fact that beneficiaries would be liable for paying

the Part A deductible, when the beneficiary in most cases has already been charged premium or cost-sharing amounts based on the actuarial value of this deductible.

Response: The definition of ''national coverage determination'' was not included in the M+C regulations because it is already set forth in § 400.202 of title 42 of the CFR; however, for the convenience of users of the M+C regulations, we have now repeated this definition in § 422.2. With respect to the issue of the Part A deductible, section 1852(a)(5)(A) of the Act provides that services covered by a national coverage determination involving significant costs not included in M+C capitation payments are not covered as a service that must be provided under the M+C contract in exchange for capitation payments. Section 1852(a)(5)(B) of the Act provides that the normal rule that capitation payments are made in lieu of regular Medicare payments (section 1851(i)(1) of the Act) does not apply in the case of additional services covered under a national coverage determination. Thus, the services would be covered under original Medicare's coverage rules. Congress did not provide for a similar exception, however, to the rule in section 1851(i)(2) of the Act providing that ''only the M+C organization shall be entitled to receive payments from the Secretary under this title for services furnished to [an M+C enrollee of that organization].'' Read together, these provisions mean that the M+C organization will receive Medicare payment under original Medicare's payment rules for services covered by a national coverage determination that triggers the procedures in § 422.109.

Under these payment rules, a beneficiary is liable for deductible and cost-sharing amounts, which is why § 422.109(b)(5) provides that enrollees would pay these amounts. Although the enrollee has in most cases paid a premium and other cost sharing based on the actuarial value of Part A and Part B deductibles and cost sharing, this amount is for services covered under the contract. These services are covered outside the contract under original Medicare payment rules. However, since the general Part A deductible arguably would already have been satisfied for the beneficiary through M+C plan premiums and cost sharing, we are revising § 422.109(b)(5) in response to this comment to provide that M+C enrollees are responsible only for coinsurance amounts. Medicare payments will thus be made without regard to satisfaction of the Part A deductible.

9. Discrimination Against Beneficiaries Prohibited (§ 422.110)

Consistent with section 1852(b)(1) of the Act, § 422.110 establishes that an M+C organization may not discriminate among Medicare beneficiaries based on any factor that is related to health status, including, but not limited to the following factors: medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability. The only exception to this rule is that an M+C organization may not enroll an individual who has been medically determined to have end-stage renal disease (unless the individual is already enrolled with the organization under a different plan). M+C organizations are required to observe the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, and Americans with Disabilities Act.

Comment: One commenter suggested that we require M+C organizations to provide handicapped-accessible facilities for marketing presentations, full access to plan information and plan providers, as well as access to the M+C organization itself.

Response: This comment speaks to the practice of health screening and the allocation of marketing resources with respect to disabled populations. Section 422.110(c) requires M+C organizations to meet the requirements of the Americans with Disabilities Act (ADA). Consistent with ADA, an M+C organization must ensure that its providers and marketing presentations accommodate persons with disabilities, both in terms of physical accessibility and communication of information. Thus, the organization and providers must afford the same freedom of choice with respect to providers to all enrollees. Further, access to information must be provided in appropriate alternative formats upon request, such as Braille, enlarged font (at least 14 point), audio cassette, closed or open captioning, or formats that accommodate low-literacy beneficiaries. In providing information access to hearing-impaired individuals, M+C organizations must not rely on relay services but must make available TTY/TDD service as well. Again, these requirements are consistent both with the Americans with Disabilities Act and with the M+C provisions in § 422.80(e)(2) regarding marketing to the disabled population.

10. Disclosure Requirements (§ 422.111)

Section 1852(c) of the Act lists several areas where an M+C organization must disclose specific information to each M+C plan enrollee. These disclosure requirements are set forth in § 422.111 of the regulation. M+C organizations are required to provide to each M+C plan enrollee, at the time of enrollment and at least annually thereafter, in a clear, accurate, and standardized form (that is, through the Evidence of Coverage), the following information regarding the enrollee's M+C plan: Service area, benefits offered under the plan and under original Medicare, access to providers, out-of-area coverage, emergency coverage, supplemental benefits, prior authorization rules, grievance and appeals rights and procedures, quality assurance programs, and disenrollment rights and responsibilities.

M+C organizations are also required to provide additional information upon request of a beneficiary, including: General coverage and comparative plan information, information on the number and disposition of grievances and appeals, information on the financial condition of the M+C organization, the procedures the organization uses to control utilization of services and expenditures, and a summary of physician compensation arrangements. Section 422.111 also includes procedures for an M+C organization to follow when it intends to change its rules for an M+C plan, and describes the enrollee notification requirements when there are changes in a plan's provider network.

Finally, as discussed in section II.B of this preamble, § 422.64 no longer lists the information that we must provide to beneficiaries. However, because § 422.111 referred to this material in several places, we are revising § 422.111 to incorporate the necessary specifications into a new paragraph (f).

Comment: Several commenters acknowledged the importance of providing beneficiaries with information on their range of health care choices, so that they can make informed decisions about their Medicare coverage. However, they were concerned that duplication of efforts will result from our responsibilities to provide beneficiaries with the information formerly specified in § 422.64(c) (now set forth in § 422.111(f)) combined with the requirements in § 422.111 concerning information that an M+C organization must disclose to its enrollees. The commenters viewed these requirements

as an unnecessary overlap of information.

Response: We have no intention of burdening M+C organizations with unnecessary disclosure requirements that duplicate our efforts. However, just as section 1851(d) of the Act mandates our responsibilities for distributing information to all beneficiaries (including the requirement at section 1851(d)(7) of the Act that M+C organizations provide us with the information needed to carry out these responsibilities), section 1852(c) of the Act establishes several specific requirements for M+C organizations to disclose plan information to their enrollees, and to individuals eligible to enroll in their plans. The M+C regulations do not expand upon the disclosure requirements set forth in the M+C statute. In general, the plan-specific information that we collect from M+C organizations for Medicare Compare (our database of comparative plan information) can also be used by M+C organizations to meet their statutory information disclosure responsibilities. Thus, although the statute does mandate that M+C organizations report similar information both to us and to their plan enrollees, we do not believe that the M+C disclosure requirements should result in significant additional burdens for M+C organizations.

Comment: Commenters discussed the importance of conveying required information to beneficiaries in a culturally competent manner. They suggested that criteria be developed by us for use by M+C organizations.

Response: We agree that plan information needs to be provided to beneficiaries in a culturally competent manner, so that beneficiaries are provided with the opportunity to make fully informed health care choices. We note that § 422.80(c)(5) addresses this concern by specifying that, for markets with a significant non-English speaking population, marketing materials and election forms must be provided in the language of those individuals. In order for M+C organizations to provide beneficiaries with plan information in a culturally competent manner, we provide guidance for both developing and reviewing marketing materials through our managed care manual, marketing guidelines, and operational policy letters. M+C organizations are required to submit their marketing materials and election forms to us for review prior to distribution to Medicare beneficiaries. The Regional Offices (RO), with direction from Central Office, are involved in reviewing and approving plans' marketing materials. In carrying out these efforts, the ROs balance the M+C organizations' needs for flexibility in developing beneficiary information with our responsibility to assure that materials are compliant with the regulation and are consistent nationwide. The ROs require that information be changed if it is inaccurate, misleading, or unclear.

Our plans for standardizing beneficiary enrollment and appeals notices, including the Evidence of Coverage (EOC), involve consulting with interested parties, including beneficiary advocacy groups. We are now in the process of consumer testing the enrollment and appeals notices to ensure that the message of each notice is clearly understood by beneficiaries. (For a further discussion of cultural competency issues as they pertain to the delivery of services, see section II.C.11 below.)

Comment: Commenters suggested that information should be disclosed in a standard format or model notice, including information that must be provided upon request of the beneficiary.

Response: We agree that standardized formats for M+C beneficiary notification materials are needed. Health care information that is provided in a well-designed standardized format, using consistent, descriptive terminology, assists beneficiaries in making important decisions about their health care.

We have initiated a two-phase Marketing Material Standardization Project that includes input from the managed care industry and beneficiary advocacy groups. In Phase I, we have implemented, beginning October 15, 1999, a standardized Summary of Benefits (SB), the key pre-enrollment marketing document provided to beneficiaries, so that they can compare the same benefits and costs across several M+C plans and original Medicare. Phase II will involve standardizing beneficiary enrollment and appeals notices. We are conducting consumer testing of these notices in preparation for the final phase of the standardization initiative.

Phase II of our standardization project includes the EOC, also known as the Subscriber Agreement and Member Contract. The EOC contains an explanation of plan benefits (covered services), member rights, and member/M+C plan contractual responsibilities and obligations. The EOC is provided to beneficiaries when they join the M+C plan and annually thereafter. As part of the standardization process for the EOC, we released a model EOC on December 1, 1999, for use in contract year 2000, that M+C organizations are required to distribute to all enrolled members by May 15, 2000. In developing the model EOC, we consulted with managed care industry representatives and beneficiary advocacy groups, and we intend to use this model as a baseline for developing the standardized EOC. The process for standardizing a document as important and comprehensive as the EOC requires adequate time for input from the industry and beneficiary advocacy groups, for public review and comment, and for implementation of the standardized document. We plan to begin standardization of the EOC in the Spring of 2000 and to complete the process in time for the November 2001 annual election period for contract year 2002.

We also have provided guidance to M+C organizations on the manner and form for disclosing the information required under § 422.111(c) upon a beneficiary's request. For example, OPL 099.081, issued on February 10, 1999, addresses appeal and grievance data disclosure requirements, and further clarifying instructions were issued in OPL 2000.114. These disclosure requirements are consistent with the reporting units for the Health Plan Employer Data and Information Set (HEDIS), the Medicare Consumer Assessment of Health Plans Study (CAHPS), and the Medicare Health Outcomes Survey (HOS). We have also issued guidance on how M+C organizations can best provide information relating to compensation for physicians, specifically incentive arrangements. The guidance includes suggested language for marketing materials as well as suggested responses for requests from beneficiaries. Again, our ROs will review these materials as part of their usual responsibilities for pre-approving beneficiary materials.

Comment: Commenters expressed concern that information concerning the number and disposition of appeals and grievances from M+C plans with low enrollment may not be statistically valid, and suggested that reporting such data could be misleading to beneficiaries. They recommended that, if an M+C organization offers a number of different M+C plans in a single service area, the organization should report appeals and grievance data on an aggregate basis, rather than on a plan-specific basis.

Response: We assessed alternative ways to report this information and decided that the most meaningful way to report this information would be to make it consistent with the reporting unit for HEDIS, CAHPS, and the Medicare HOS. The reporting unit for

these instruments is the ''contract market,'' which implies either reporting by contract or by a market area within a contract. M+C organizations must report for each contract unless we divide the contract service area into ''market areas.'' We will assess all contract service areas to determine whether M+C organizations must report by market area, and will notify plans as soon as possible whether they must report by market area. Further details on subdividing the contract service area into market areas can be found in OPL 099–081. The OPL also describes the data collection periods and reporting periods that have been established in order for M+C organizations to report data consistently. We and our contractors are working with M+C organizations and consumer groups to determine additional information needed to develop a national managed care appeal and grievance data collection and reporting system, with data disclosure requirements to be built into this system.

Comment: Several commenters expressed concerns over the requirement for public reporting of quality improvement results. They feared that this reporting could result in: (1) M+C organizations altering their decision making to produce competitively attractive numbers'' at the expense of good patient care, or (2) the dissemination of data that could easily be misinterpreted by Medicare beneficiaries, rather than of value in facilitating informed beneficiary choice.

Response: The reporting of plan-specific quality and performance indicators is based directly on the requirements of section 1851(d)(4)(D) of the Act. Moreover, we believe that it is essential for plan comparison purposes that M+C organizations report on standardized quality measures. The standardized measures that we are requiring, as discussed in detail in section II.D of this preamble, are largely those of HEDIS. These measures are predictive of health care outcomes, well-defined, and well-established in the private sector. Thus, we do not believe that the commenters' concerns that the reporting of these measures will negatively affect M+C organizations' decision making and lead to widespread public misinterpretation are justified.

Comment: We received several comments regarding notification of beneficiaries of changes in an M+C plan's provider network. Three commenters suggested that the requirement that written notification to the enrollee occur within 15 working days of the receipt or issuance of a notice of provider termination would be confusing for enrollees and an administrative burden for M+C organizations. Another commenter suggested that the 15 working days be converted to calendar days to be consistent with the appeals requirements under Subpart M.

Response: We recognize that the requirement that written notice be provided ''within 15 working days of receipt or issuance of a notice of termination'' has the potential in some situations to cause confusion for beneficiaries and impose an unnecessary administrative burden on M+C organizations. For example, because contract negotiations with providers often extend beyond a 15-day period after initial notice of termination, an M+C organization may be unable to furnish definitive network information to its enrollees within the 15-day time frame. Therefore, we are revising § 422.111(e) to decouple the enrollee notice time frame from the ''issuance or receipt'' of a notice of termination and instead require that an M+C organization make a good faith effort to provide written notice at least 30 calendar days before the termination effective date. (As the commenter suggested, we agree that measuring this time frame by using calendar days, rather than working days, would improve the internal consistency of the M+C regulations, as well as eliminating any possible confusion over what constitutes a ''working day.'')

Comment: Two commenters suggested defining ''regular basis'' for purposes of § 422.111(e). Under this requirement, a M+C organization must notify ''all enrollees who are patients seen on a regular basis by the provider whose contract is terminating.'' One commenter suggested that ''regular basis'' be defined as seeing a provider within the last 180 days or 6 months.

Response: Section 422.111(e) is clear that all enrollees who are patients of a primary care professional (PCP) must be notified by the M+C organization when a PCP's contract is terminated. We are not making any change in this regard. For other providers, the regulations establish the ''regular basis'' standard. Generally, we would interpret this standard to require the notification of all enrollees who have a referral to a specialist for an ongoing course of treatment, or of all regular patients of an OB/GYN, for example. In combination with the explicit requirement for notification of all patients of a PCP, we believe that the ''regular basis'' standard is sufficient for accomplishing the objective of notifying all enrollees who are likely to be affected by a provider termination. We note that this requirement does not preclude the providers themselves from notifying M+C enrollees of the termination of their participation in an M+C plan's provider network.

11. General Access Requirements (§ 422.112)

a. Introduction

Section 422.112 establishes a series of requirements aimed at ensuring that enrollees in M+C plans have adequate access to services. As discussed in our June 26, 1998 interim final rule (63 FR 34989), these requirements stem from section 1852(d) of the Act and existing regulations and policies under part 417, as well as addressing recommendations from the Consumer Bill of Rights and Responsibilities, and reflecting standards from the Quality Improvement System for Managed Care (QISMC).

On February 17, 1999, we published a final rule (64 FR 7968) that set forth limited changes to the M+C regulations published in the June 26, 1998 interim final rule. In the February 17, 1999 final rule, we made changes to several of the access provisions of this section. These changes involved the coordination of care requirements, provisions related to complex or serious medical conditions, notification requirements when specialists are terminated from an M+C plan, and initial care assessment requirements.

More specifically, for serious and complex conditions, the treatment plan may be updated by a health care professional other than the primary care provider. Furthermore, this section now requires that the M+C organization ensure adequate coordination of providers for persons with serious or complex medical conditions. Under the general coordination of care requirements, the responsibility for ensuring coordination of care is not limited to an individual provider. Instead, the organization must: (1) Establish policies to ensure coordination; and (2) offer each enrollee a primary source of care. Further, as to the initial assessment, each organization will be expected only to demonstrate a ''best effort'' attempt to complete the assessment of health care needs within 90 days of enrollment. Finally, we no longer require, when a specialist is involuntarily terminated from an M+C plan, that the M+C organization offer to provide enrollees with the names of other plans in the area that contract with the specialist. However, as discussed above, the general requirements regarding notification of affected patients upon provider

termination remain in effect. Comments on aspects of the access requirements that were not addressed in our February 17, 1999 final rule are discussed below.

b. Provider Network (§ 422.112(a)(1))

Section 422.112(a)(1) requires M+C organizations that wish to limit an enrollee's choice of providers to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. We received several comments regarding access standards and one comment regarding contracting with community pharmacies.

Comment: Several commenters asked us to elaborate on access standards by including time and distance travel standards, such as specifying a 30-mile standard except where travel is difficult.

Response: Both the Medicare managed care manual and the QISMC guidelines issued on September 28, 1998 specify that a 30-mile standard must be satisfied in order to meet access requirements, except where a different standard is justified by geographic factors. We believe the inclusion of this requirement in these documents provides sufficient guidance on this subject. Furthermore, because the community pattern of care in some rural areas is to travel further than 30 miles for care, we do not believe it would be appropriate to establish an absolute 30-mile standard in the regulations.

Comment: One commenter requested that we require M+C organizations to contract with community pharmacies that are easily accessible.

Response: Community pharmacies have a number of advantages, and thus, M+C organizations should consider this as an option in providing pharmacy services. However, other options, such as pharmacy benefit management companies or mail order pharmacies, may have other advantages that are appropriate for M+C organizations to consider, such as lower cost. In choosing among these options, the M+C organizations must ensure that the providers of pharmacy services meet the various access and quality standards required by these regulations, implementing manuals and guidelines. Given these criteria, we do not believe it appropriate to require that community pharmacies be mandated as the source of pharmacy services.

c. Primary Care Provider Panel (§ 422.112(a)(2))

Section 422.112(a)(2) requires an M+C organization that wishes to limit an enrollee's choice of providers to establish a panel of PCPs from which an enrollee may choose. We received two comments regarding the PCP panel.

Comment: One commenter specified that all PCPs should be licensed physicians or Doctors of Osteopathy.

Response: QISMC Standard 3.2.1.2 provides additional guidance with respect to our policies regarding PCPs. The guideline states:

> An organization may permit licensed practitioners other than physicians to serve as primary care providers, consistent with requirements of applicable State laws. (Qualifications of such practitioners, and the degree of supervision required, are generally established under State law). If an organization designates nonphysician practitioners as primary care providers, it must still ensure that each enrollee has a right to direct access to a physician for primary medical care. This right may be ensured in either of two ways: (a) the enrollee may choose between a physician and nonphysician primary care provider, and may change this choice at any time; or (b) when the enrollee is not allowed such a choice, an enrollee with a nonphysician primary care provider may have timely access to a physician upon request.

The guideline further states: ''An organization may allow an enrollee to select a physician group, clinic, federally qualified health center, or other facility with multiple practitioners as his or her primary source of care. To the extent feasible, the enrollee must be allowed to choose an individual primary care provider within the group or facility.''

Thus, the QISMC guidelines do not limit enrollees to the use of physicians or Doctors of Osteopathy as PCPs. However, as indicated, an M+C organization must provide enrollees with access to physicians or Doctors of Osteopathy upon request. Furthermore, § 422.112(a)(1) requires that the M+C organization have an adequate network of providers and § 422.112(b)(2) requires the organization to offer each enrollee a source of primary care. In addition, consistent with the BBA provisions regarding antidiscrimination, and the Consumer Bill of Rights and Responsibilities, we intend to provide enrollees with freedom of choice in the selection of providers subject to the above constraints. Therefore, we are not adopting the commenter's suggestion. We note that an M+C organization's use of nonphysicians to deliver Medicare benefits must be consistent with Medicare coverage requirements, such as ''incident to'' supervision requirements. To the extent nonphysicians are providing non-Medicare covered services as an additional or supplemental benefit, these requirements do not apply.

d. Specialty Care (§ 422.112(a)(3))

This section requires an M+C organization to provide or arrange for necessary specialty care, and gives women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services, notwithstanding that the M+C organization maintains a PCP or some other means for continuity of care.

Comment: One commenter expressed concern that an M+C organization may prohibit enrollee access to a specialist without a referral from a PCP, even when not all enrollees will choose to select, or be provided, a PCP. This would effectively deny access to specialist care to such individuals.

Response: Again, all M+C organizations must provide an adequate network of providers (§ 422.112(a)(1)), offer to provide each enrollee with an ongoing source of primary care (§ 422.112(b)(2)), and provide a primary source of care to each enrollee who requests one. In addition, § 422.112(a)(3) requires an M+C organization to provide or arrange for necessary specialty care. (As discussed above in section II.C.1, we are revising § 422.112(a)(3) to clarify that an M+C organization shall authorize out-of-network specialty care when its plan network is unavailable or inadequate to meet an enrollee's medical needs.) If an M+C organization requires its enrollees to obtain a referral in most situations before receiving services from a specialist, specialty care is medically necessary, and the enrollee has not selected a PCP, the M+C organization must either assign a PCP for purposes of making the needed referral or make other arrangements to provide the necessary care. Accordingly, we have revised § 422.112(a)(2) to specify that the M+C organization must make specialty care available even if a plan enrollee has not selected a PCP.

Comments: Several commenters asked for clarification of the terms ''routine'' and ''preventive'' as they apply to women's health services. They asserted that routine services should include more than just preventive services, while the examples offered in the preamble to the June 26, 1998 interim final rule only were limited to preventive services. One commenter noted that there are many services that OB/GYNs are most appropriately qualified to provide that should not require a referral from another physician, such as hormonal replacement therapy, and treatment of osteoporosis, genital relaxation disorders, incontinence, abnormal uterine bleeding, urinary tract infections

(UTI), and sexual dysfunction. Another commenter suggested that we clarify that even though women have direct access to women's health specialists, it was not intended that the PCP be bypassed.

Response: We consider routine and preventive women's health care services to mean: an exam that is provided on a regular, periodic basis, in the absence of presenting symptoms, diagnosis or complaints, for disease prevention and health maintenance. The examples from the commenter, therefore, are not routine and preventive.

In the setting of such an exam, abnormalities may be found, such as incidental vaginitis or UTI, or abnormal Pap smear. We would consider routine services to follow up on such gynecologic abnormalities to be included under this definition.

We agree that the provision is unclear about the role of PCPs, and have deleted from § 422.112(a)(3) the reference to ''while the plan maintains a PCP or some other means for continuity of care.''

Although the regulations require that M+C organizations allow women direct access (that is, without referrals or preauthorization) to a women's health care specialist within the network for women's routine and preventive services, if there is a PCP, he or she needs to be kept informed of the health care provided by such specialists. It is up to the M+C organization to develop appropriate strategies for assuring such an outcome.

We note that an M+C organization may place restrictions on enrollees as to the eligible universe of providers to whom they may ''self-refer'' for women's health services. Thus, QISMC guideline 2.2.3.2 provides for M+C organizations to create formal subnetworks. In these cases, an organization can require an enrollee at the time of initial selection of a PCP, to choose an entire subnetwork that may also include specialists, hospitals, or other providers. The enrollee may be required to obtain covered services, including routine and preventive women's health services through providers affiliated with the system. Under the QISMC guideline, an enrollee could change his or her choice of subnetwork at any time. (See the guidelines for further details, including an M+C organization's responsibilities to ensure that enrollees are aware of the implications of their choice of a PCP in terms of the available subnetworks associated with a given PCP.)

Comment: One commenter suggested that we allow OB/GYN specialists to serve as PCPs.

Response: Although such a practice is permissible under the M+C regulations, we believe that this is a decision that should be made by the M+C organizations, based upon the needs of their enrollees and available resources. This position is consistent with that adopted regarding use of specialists with respect to ''serious and complex'' medical conditions, as stated in the February 17, 1999 final rule.

e. Serious Medical Conditions (§ 422.112(a)(4))

Under § 422.112(a)(4), M+C organizations must have procedures that enable the organization to identify individuals with serious or complex medical conditions, assess and monitor those conditions, and establish and implement treatment plans.

Comment: Several commenters asked for clarification of what is meant by ''serious or complex medical conditions.''

Response: On August 31, 1999, the Institute of Medicine (IOM) submitted a final report to us, entitled ''Definition of Serious and Complex Medical Conditions.'' This report is available through the Internet at ''www.nas.edu''.

A key recommendation made in the report is: ''The committee recommends that the Health Care Financing Administration should provide guidance [emphasis added] to health plans to assist their efforts to identify patients with serious and complex medical conditions. Specifically, the committee recommends the following language be used to facilitate efforts of plans to identify their enrollees with ''serious and complex conditions'': A serious and complex condition is one that is persistent and substantially disabling or life-threatening that requires treatments and services across a variety of domains of care to ensure the best possible outcomes for each unique patient or member.''

In view of the committee's recommendation that it is premature to establish an administrative definition of these terms, we have decided not to make any changes at this time to the regulations regarding serious medical conditions. We will provide further policy guidance on the meaning of this definition through a future OPL. For now, M+C organizations have the option of adopting the IOM definition or developing an alternative definition.

The committee also recommended that rather than focus on access to specialists, the treatment plans that M+C organizations develop should address access to specialty care. Furthermore, the committee recommended that M+C organizations develop a care management strategy that integrates the participation of all those involved in the care of the patient, including primary care physicians; medical and surgical specialists; nurses and nurse specialists; behavioral and mental health specialists; physical, occupational, and speech therapists; social workers; allied health professionals; and community-based service providers. The forthcoming OPL will address these strategies, as well as provide guidance on implementation and monitoring procedures.

f. Written Standards (§ 422.112(a)(7))

Section 422.112(a)(7) (as recodified in the February 17, 1999 final rule) requires the establishment of written standards for specified areas of policy and procedures (coverage rules, practice guidelines, payment policies, and utilization management). This section is based on existing regulations and policies under part 417. We received two comments regarding this requirement.

Comment: In a comment cosigned by one hundred and fifty advocacy organizations, it was suggested that we amend the regulations regarding use of practice guidelines to specifically encourage or require contracting managed care plans to use Federally-developed practice guidelines, where appropriate.

Response: In general, we concur with the commenters that the use of Federally-developed practice guidelines, such as those produced by the Department of Health and Human Services, in the provision of services is a desirable objective. However, we believe that the commenter's suggestion that use of these guidelines be mandated by regulation would be inconsistent with section 1801 of the Act, which provides that the Medicare statute ''shall [not] be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided. * * *'' While we thus do not believe that mandating use of Federal guidelines is appropriate, we do encourage M+C organization health provider committees to explicitly consider such recommendations, particularly as they relate to care of enrollees with high-risk, complex care needs (such as those with HIV disease, cancer, *etc.*).

Comment: One commenter requested that we specify that the ''responsible health professionals'' be included in the development of practice guidelines and medical review criteria.

Response: We encourage M+C organizations to include the responsible health professionals in the development of such written standards. In some cases, however, a physician may be qualified to develop standards that apply to other health professionals, and it could impose an undue burden on M+C organizations to require that all responsible health care professionals always be consulted about standards. We therefore do not believe it would be appropriate to impose an absolute requirement that all health professionals always be included in developing written practice guidelines. We believe, however, that as a general matter, it is important that health care professionals such as physician assistants, advanced practice nurses, clinical psychologists and others integrally involved and knowledgeable regarding treatment planning and delivery, contribute to the process of standard development. We would thus expect that M+C organizations generally will consult with such professionals in developing guidelines in their areas, even though we are not imposing an absolute requirement for such consultation in all cases. For a further discussion of this issue, see the portion of the February 17, 1999 final rule dealing with provider participation rules.

g. Cultural Considerations (§ 422.112(a)(9))

Section 422.112(a)(9) (as recodified in the February 17, 1999 final rule) requires that services be provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities. We received many comments regarding this section.

Comment: Many commenters asked for clarification regarding the term ''culturally competent'' and our expectations with respect to the implementation and monitoring of this requirement. While some commenters asserted that the cultural competence requirement would be too burdensome and should be deleted, most supported the requirement, but requested additional detail and guidance regarding its interpretation.

Response: In reviewing the comments received, there were several recurrent themes: (1) Widespread support of the general requirement that all health care services be provided in a culturally competent fashion; and (2) a need for us to clarify our expectations with respect to acceptable activities undertaken to achieve that goal.

We do not believe that changes to the regulation text regarding the definition of cultural competence are needed, other than to delete the reference in the regulations to mental and physical disabilities (as discussed below). However, in this preamble, we will attempt to provide further guidance on this issue. We also intend to incorporate the principles discussed here into the QISMC guidelines as we revise the QISMC cultural competence standards.

We believe that the delivery of culturally competent health care and services requires health care providers and administrative staff to possess a set of attitudes, skills, behaviors, and policies that enables the organization to function effectively in cross-cultural situations. Appropriate care delivery should reflect an understanding of the importance of acquiring and using knowledge of the unique health-related beliefs, attitudes, practices and communication patterns of beneficiaries and their families to improve services, strengthen programs, increase community participation and eliminate disparities in health status among diverse population groups.

Activities to promote achievement of this objective fall under a variety of categories, including but not limited what we refer to as ''Organizational Readiness,'' ''Community Assessment,'' ''Program Development,'' and ''Performance Improvement,'' for example. Under Organizational Readiness, M+C organizations would conduct educational programs to increase the knowledge of their staff about the unique health care beliefs, attitudes, practices, and communication patterns of the populations served by their plan. Title VI of the Civil Rights Act (see 28 CFR § 42.405(d)(1)) specifically requires that M+C organizations provide assistance to persons with limited English proficiency, where a significant number or percentage of the eligible population is likely to be affected. These requirements may require the organization to take some of the following steps: assess the language needs of beneficiaries in their service area, provide sufficient access to proficient interpreters, and disseminate written policies on the use of interpreters. In addition, the M+C organization provider network should be capable of meeting the cultural, linguistic, and informational needs of the beneficiaries residing in the service area. Ideally, the racial and ethnic diversity of the service area would be reflected in the provider network and staff of the M+C organization. The literature has demonstrated that enrollees are more likely to seek and accept health care services when delivered by one of their own racial or ethnic group. The M+C organization must ensure that all employees have received education regarding the importance of providing clinically competent and culturally appropriate services.

Community Assessment entails conduct of a market assessment to identify the specific health care needs of the beneficiary population as they relate to enrollee groups' health problems (for example, some diseases are ethnically and genetically linked). Using existing and secondary data resources, organizations would collect data to the extent necessary to identify any special culturally-based health care needs among their beneficiaries. Program Development would entail implementation of formal programs and culturally sensitive patient education projects that reduce and eventually eliminate cultural, linguistic, and informational barriers known to deter or discourage health-seeking behavior.

Finally, Performance Improvement would entail addressing an identified need or opportunity for improvement, either through a quality improvement project or other formal program that seeks to resolve undesirable differences in utilization of services and outcomes of care across all relevant racial, ethnic and cultural groups served by the managed care organization.

The goal is to promote quality health care services, ensure effective dissemination of information, and enhance consumer rights and protections by fostering a demonstrated commitment to and establishing a coordinated and integrated system for, cultural competence. This approach is consistent with other Federal initiatives and recommendations from the President's Race Initiative and from the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

As achieving this objective is a M+C program requirement, M+C organizations will be monitored for compliance in this regard. We have developed additional implementation tools to assist M+C organizations in meeting the cultural competency requirement, such as operational specifications for five initial test measures and further steps which could be taken to improve, test, and expand on enrollee, disparity and standard-based inventories. The specifications for the five initial measures were developed based upon the recommendations of an expert panel and would require no new data collection on the part of the M+C

organization. We will soon be offering these measures to M+C organizations for use in their QAPI projects.

Finally, ensuring culturally competent care is congruent with our commitment to being a prudent purchaser of health care services. A growing body of knowledge demonstrates that when care is provided in a clinically competent and culturally appropriate fashion, it is more readily understood and accepted by the patient. As a result, patient compliance with treatment is enhanced, outcomes are improved, and health care costs and expenses are reduced as a result of diminished morbidity and mortality.

Comment: One commenter pointed out that physical and mental disabilities are unrelated to cultural competence issues. The commenter stated that including a reference in § 422.112(a)(9) to individuals with physical and mental disabilities was insensitive and inappropriate, noting that such disabilities are not a ''culture''.

Response: We believe that the principle objective underlying the requirement to provide services in a culturally competent manner is to address unique racial and ethnically-related health care concerns. Thus, we agree with this commenter, and are deleting the relevant language. We note that the special concerns and rights of individuals with physical or mental disabilities are addressed elsewhere in the M+C regulations (for example, under §§ 422.110(c) and 422.502(h)(1)(iii)).

Comment: One commenter believes that Federal law prohibits providing material below high school reading level.

Response: We were unable to locate any statutory citation in support of the commenter's view, and none was provided by the commenter. We believe that the commenter is mistaken that materials at a reading level below high school cannot be provided. Market research has shown that the majority of Medicare enrollees are able to most effectively comprehend the complex issues addressed in our literature when the information is targeted for those at a 4th–6th grade reading level. The Medicare Handbook accordingly is geared for individuals at precisely that level. Therefore, we believe that our current approach is both appropriate and well-justified.

12. Confidentiality and Accuracy of Enrollee Records (§ 422.118)

Consistent with section 1852(h) of the Act, § 422.118 requires M+C organizations to establish procedures that safeguard the confidentiality and accuracy of enrollee records that identify a particular enrollee, including medical documents, administrative documents, and enrollment information. The regulations specify that information from these records may be released only to authorized individuals. Each M+C organization must establish procedures for complying with the confidentiality standards, including policies governing access to information within the organization as well as when and how information may be disclosed outside the organization without enrollee authorization. Additionally, the M+C organization must maintain accurate records and ensure timely access for enrollees who wish to examine their own records.

The M+C organization must abide by all applicable State and Federal laws regarding confidentiality and disclosure of health information and any other information about enrollees. In the existing regulations, ''mental health records'' are mentioned separately as subject to this requirement. However, because mental health records clearly constitute a subset of the other health records specified at § 422.118 (that is, ''medical records, health information, and any other enrollee information''), we are revising the regulations via this final rule to eliminate the redundant separate reference. This has no effect on the substance of the requirement.

Comment: Several commenters have suggested that the industry needs one Federal standard for confidentiality, especially in light of the fact that State confidentiality laws would not be preempted unless they conflict with Federal requirements. One commenter stated that there thus could be 50 different sets of patient confidentiality standards.

Response: The M+C regulations are not the appropriate vehicle for establishing the balance between State and Federal confidentiality laws. This issue is under discussion in Congress, which is a more appropriate venue for making this determination. Further, because Federal standards for confidentiality and privacy of individually identifiable health information have recently been proposed by the Secretary (as discussed in some detail below), and because M+C organizations will be required to comply with those regulations once they are finalized, we have chosen not to make substantive changes in the existing M+C confidentiality regulations at this time. In the interests of clarification, however, we have made some technical changes in the existing requirements, including reorganizing them to (1) promote consistency with the confidentiality requirements under other Federal health care programs (such as Medicaid) and (2) emphasize the importance of applicable Federal and State laws, while still ensuring that the privacy of M+C enrollees' health information is safeguarded in the absence of other applicable laws.

Pursuant to Section 264 of the Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. 104–191), the Secretary of Health and Human Services was directed to promulgate regulations on the confidentiality and privacy of individually identifiable health information if confidentiality legislation governing electronic health information was not enacted by August 20, 1999. Such legislation was not enacted, and the Secretary published a notice of proposed rulemaking, Standards for Privacy of Individually Identifiable Health Information, in the **Federal Register** at 45 FR 160, *et seq.*, on November 3, 1999. (This proposed rule is available at the Administrative Simplification web site, http://aspe.hhs.gov/admnsimp/). As proposed, these regulations would apply to health information that has been maintained or transmitted electronically, or held by health plans, health care providers who engage in certain electronic transactions, and health care clearinghouses. M+C organizations would be considered health plans for the purposes of the proposed privacy regulation. The proposed rule would establish detailed standards for the use and disclosure of electronic health information.

Comment: Several commenters suggested that we develop procedures regarding the maintenance of confidentiality of patient records, and have said that these procedures should be provided to the beneficiary.

Response: As noted above, in light of the pending privacy regulations, we are not imposing any additional requirements here. The Secretary's proposal would require health plans (including M+C organizations) and other covered entities to develop procedures for maintaining the privacy of health information and to inform patients and enrollees of their confi dentiality practices.

Comment: Several commenters asked for clarification of preamble language at 63 FR 34991, which they read to preclude M+C organizations from sharing patient information with outside contractor claims administrators without individual patient consent.

Response: The M+C regulations are not intended to prohibit the sharing of patient identifiable information within an M+C organization or between the

organization and its contractors for the purposes of payment, treatment or coverage decisions. Thus, an M+C organization may circulate such information within the organization, and externally, to the extent that such information is needed to coordinate or bill for the care of an M+C enrollee. However, M+C organizations generally are prohibited from selling or circulating patient identifiable data to outside organizations or entities that are not involved in payment, treatment, or coverage decisions, without specific authorization from the enrollee or an enrollee's authorized representative.

Comment: Several commenters asked us to specify that patient data may be shared for bona fide medical research, and to limit the extent to which patient identifiable information could be released for research purposes. One commenter asked for clarification as to whether information can be shared in the event of a court order or subpoena.

Response: As discussed above, we are not expanding on the existing M+C confidentiality requirements to address specific issues here, such as to whom and under what conditions release of patient identifiable information is authorized. To the extent that M+C organizations have proper safeguards in place and to the extent that State law authorizes the release of such information, this section of this regulation does not bar the use and disclosure of records for medical research. Section 422.118(a) expressly states that medical records may be released in accordance with ''court orders or subpoenas.'' The Department's proposed privacy regulation would set forth specific standards for disclosing information in both of these situations, and when that regulation is finalized, M+C organizations will be permitted to disclose information only in accord with those standards. In the interim, M+C organizations could voluntarily use those proposed privacy standards as a guide in formulating their policies and making disclosure decisions.

13. Information on Advance Directives (§ 422.128)

Advance directives are documents recognized under State law, signed by a patient or his/her authorized representative that explain the patient's wishes concerning a given course of medical care should a situation arise when he or she is unable to make these wishes known. The M+C organization is legally responsible for providing enrollees with information on their rights under State law to establish advance directives, and ensuring that advance directives are documented in a prominent part of the beneficiary's medical record. The M+C organization is permitted to contract with other entities to furnish information concerning advance directives requirements. The M+C regulations retain for M+C organizations the requirements that applied to HMOs and CMPs under part 417, which state an HMO must maintain written policies and procedures concerning advance directives as defined in § 489.100 with respect to all adult individuals receiving medical services by or through HMOs.

Comment: Commenters asserted that M+C organizations should not be responsible for obtaining or documenting the existence of an advance directive, and that organizations should ensure that ''responsible health care entities educate patients and document the existence of advanced directives.'' The commenters stated that an M+C organization cannot reasonably be held responsible for documenting whether an individual has elected an advance directive because the chart is in the control of the primary care physician.

Response: Our position that an M+C organization should be responsible for obtaining and documenting the existence of advance directives is consistent with the requirements of both State law and the Patient Determination Act of 1991, which we expanded upon in our final rule on June 27, 1995 (42 CFR § 489.100). Both the Act and the regulations include managed care organizations among the entities responsible for obtaining and documenting advance directives information. The BBA made these same standards applicable to M+C organizations.

Comment: A commenter asked for clarification as to what we will accept as evidence of best efforts and reasonable plan oversight. Another commenter suggested we should require M+C organizations to submit and receive approval on all advance directive documents. This commenter feared (and alleged that there is proof) that an M+C organization might lead beneficiaries down a path of less care in times of greatest need, and that advance directives could be used by an organization to coerce a beneficiary to forego care.

Response: The M+C advance directive requirements, which fee-for-service providers have been following for some years, are guidelines which refer to State law. Therefore, M+C organizations must comply with the advance directive requirements of the States which they serve, and we cannot give detailed guidelines as to what constitutes best efforts in each State. We believe the Medicare regulations give provider entities and States a great deal of flexibility, and we are prepared to work with them on specific entities.

Regarding the commenter's concerns about possible encouragement of inappropriate underutilization as the result of advance directives, we believe that the monitoring process will prevent and/or identify abuses of advance directives. For example, the M+C contractor interim monitoring guide states that an organization's policies must promote enrollee understanding of their conditions and facilitate the development of mutually agreed upon treatment goals. We have stated in QISMC and OPL 98–72, that with respect to advance directives, the M+C organization must meet several criteria, including that it may not make treatment conditional or otherwise discriminate on the basis of whether an individual has executed an advance directive. Underutilization patterns should be revealed by other aspects of the monitoring process, and, with regard to advance directives specifically, we are exploring the possibility of developing further monitoring criteria.

D. Quality Assurance

1. Overview

The quality assurance requirements for M+C organizations were addressed in subpart D of the June 26, 1998 interim final rule. These requirements implement and are based on the provisions of section 1852(e) of the Act. Further, they incorporate the requirements of section 1851(d)(4)(D) of the Act, which provides that the information made available to Medicare beneficiaries for plan comparison purposes must include plan quality and performance indicators, to the extent available. Section 1852(e)(1) of the Act sets forth the general rule that each M+C organization must establish an ongoing quality assurance program, consistent with implementing regulations, for the health care services it provides to enrollees in the organization's M+C plan or plans. The remaining portions of section 1852(e) of the Act contain the required elements of the quality assurance program, requirements for external review, and provisions concerning the use of accreditation organizations to determine compliance with the quality assurance requirements.

2. Quality Assessment and Performance Improvement Requirements (§ 422.152)

Section 422.152 incorporates each of the explicit statutory requirements of

sections 1852(e)(1) and (2) and section 1851(d)(4)(D) of the Act. Section 422.152 also includes additional detail to clarify what an M+C organization must do to meet the statutory requirements. Sections 422.152(b) through (d) of the interim final rule set forth requirements that M+C organizations must meet with respect to M+C coordinated care plans and network MSA plans.

Section 422.152(c) requires that the organization: (1) measure and report its performance to HCFA using measures required by HCFA; and (2) for M+C coordinated care plans, achieve any minimum performance levels that may be established locally, regionally, or nationally by HCFA.

Section 422.152(d) establishes the requirements for performance improvement projects, beginning with the requirement that performance improvement projects focus on specified areas of clinical and nonclinical services. It also explains that we will set M+C organizational and plan-specific requirements for the number and distribution of these projects among the required areas. In addition, it authorizes us to direct an M+C organization to undertake specific performance improvement projects and participate in national and state-wide performance improvement projects. Section 422.152(d) reflects many of the provisions of section 1852(e)(2) of the Act.

In enacting the quality assurance provisions of the BBA, Congress recognized that not all of the quality assessment and performance improvement activities that are appropriate for a plan with a defined provider network would be appropriate for an M+C non-network MSA plan or an M+C PFFS plan. The requirements specific to these types of plans are addressed in § 422.152(e). (Note that, as discussed below and in section I.C of the preamble, section 520 of the BBRA amended section 1852(e) of the Act to apply the non-network plan requirements to PPO plans as well.)

In order to support the measurement of performance levels and the conduct of performance improvement projects, if applicable, M+C organizations offering all types of M+C plans must maintain a health information system that collects, analyzes, integrates, and reports data. This requirement is covered at § 422.152(f)(1). Section 422.152(f)(2) requires that for each M+C plan an M+C organization offers, it has a process for formal evaluation, at a minimum annually, of the impact and effectiveness of the quality assessment and performance improvement program strategy with respect to services under that plan.

Comment: A number of commenters asserted that the quality assessment and performance improvement (QAPI) requirements will be difficult for M+C organizations offering M+C plans with loosely organized provider networks to meet, and will discourage such organizations from participating in the M+C program. In particular, commenters were concerned that the QAPI requirements will deter organizations from offering MSA plans, PFFS plans, and PPO-type coordinated care plans. One commenter explained that organizations offering non-HMO plans cannot require physicians to track outcomes for these plans because the organizations do not have contracts with the physicians, making data collection and reporting infeasible. Four commenters specifically addressed the challenges facing PPOs in producing performance data and influencing provider practice patterns as required to demonstrate performance improvement. Two commenters complained that it is not appropriate to require reporting of all clinical performance indicators from the ''Healthplan and Employer Data and Information Set'' (HEDIS) in the case of a broad access PPO-type coordinated care plan. These and other commenters suggested that we instead establish quality standards that account for variation in organization capabilities.

Response: The BBA recognized that the structure of health plans has a direct impact on the degree to which the organizations that offer them can reasonably be expected to directly affect the health care services provided to their enrollees. As a result, the M+C statute and interim final regulations, as well as guidance implementing these provisions, have been tailored to the varying structural differences and associated capabilities of M+C organizations. As discussed in section I.C of this preamble, section 520 of the BBRA amended section 1852(e) of the Act to revise the quality assurance requirements for PPO plans. Consistent with the commenters' concerns, the quality assurance requirements for PPO plans are now the same requirements that apply to non-network M+C MSA plans and M+C PFFS plans. Thus, while PPO plans are still considered coordinated care plans, they are treated differently than other coordinated care plans for the purposes of the M+C quality assurance requirements of § 422.152, in recognition of the fact that their provider networks are subject to a lesser degree of control and accountability. The result is that M+C organizations are no longer required to conduct performance improvement projects relative to their PPO plans, or to have their PPO plans meet minimum performance levels. M+C organizations offering PPO plans must still report on standard measures, however, and continue to comply with the QAPI requirements that apply to all plans, such as those relating to health information and program review. We are revising § 422.152 to implement these changes.

Section 520(a)(3) of the BBRA defined a PPO plan as an M+C plan that (1) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; (2) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and (3) is offered by an organization that is not licensed or organized under State law as a health maintenance organization. This definition is being added to the regulation at § 422.4.

Comment: A few commenters addressed the costs associated with collecting and reporting QAPI data. They argued that the data required will add significant administrative costs to M+C organization operations, with two commenters contending that most of the patient encounter data required for quality improvement projects go beyond the claims data currently collected and processed by organizations and Medicare fiscal intermediaries. Another commenter suggested that because the data collection and reporting costs will be so significant, we should make decisions as to what information to require only after much deliberation. One commenter expressed concern that M+C organizations will pass along the costs of data collection and reporting to hospitals.

Response: While not all M+C organizations are accredited, the majority are either seeking or have already been granted accreditation by national bodies such as the National Committee for Quality Assurance (NCQA). For those organizations in particular, the collection and reporting of standard measures does not constitute a new activity as it is a condition of the accreditation process. In addition, many managed care organizations have been voluntarily conducting a variety of quality improvement projects over the years, although they may not have routinely reported on standard measures. Again, for these organizations, the process of identifying quality of care concerns, selecting a patient population for study, implementing an intervention and

collecting data on the outcomes of that intervention are not at all new. The quality improvement process under the M+C program is essentially comparable to current industry practice, with the slight addition of the requirement to report on specific types of indicators relevant to the condition in question. For these reasons, we do not believe that the data collection and reporting requirements established under the M+C regulations will impose unreasonable costs, and we believe that a great deal of deliberation has already gone into the establishment of these requirements (for example, the collection and reporting of HEDIS measures) at this time.

With respect to the issue of whether hospitals will be asked to bear costs associated with data collection, we do not expect these costs to be unreasonable, and we note that they are voluntarily assumed when the hospital decides to participate in the M+C organization's network.

Comment: A few commenters contended that the costs of implementing their QAPI programs would be excessive.

Response: We have given M+C organizations significant latitude in terms of designing their performance improvement projects, so that they can choose efforts that are relevant to their enrollees and that involve cost effective interventions To further reduce administrative and financial burden, M+C organizations may collaborate with entities such as the Peer Review Organizations (PROs) on their performance improvement projects.

Comment: Two commenters addressed the collection and reporting of HEDIS measures. These commenters were concerned that the HEDIS measures do not, in their view, adequately address the health issues of older adults in Medicare, and they do not track the experiences of people with chronic and disabling conditions.

Response: M+C organizations are required to report HEDIS measures for the purposes of §§ 422.152(c)(1) and (e)(1). Currently, the HEDIS measures offer the most comprehensive view of managed care performance available. We have been working with the Geriatric Measurement Advisory Panel to develop additional measures for people with chronic and disabling conditions. It is important to recognize that HEDIS is an evolving instrument, and as valid measures of other aspects of care are developed, they will be incorporated. For example, HEDIS 1999 added measures for cholesterol management after acute cardiovascular events, and HEDIS 2000 has added a measure to assess whether blood pressure was controlled among people with diagnosed hypertension. Additionally, Medicare will be requiring six measures for people with diabetes. Additions such as these, plus others that will be added as valid measures are developed, should address the commenters' concerns.

Comment: Two commenters suggested that we add other areas for standard measures in § 422.152(e)(1) for M+C PFFS and non-network MSA plans. These commenters believe that the information collected for these types of plans should be as consistent as possible with that collected for other types of M+C plans to allow for comparison among them. The commenters recommended that if certain types of data are unavailable for non-network M+C MSAs and M+C PFFS plans, a statement should be made available to beneficiaries explaining the lack of information.

Response: We agree with commenters that for purposes of plan comparison, reporting on standard measures should be as consistent across plan types as possible. Therefore, we are revising § 422.152(e) to specify that the standard measures on which reporting will be required for M+C PFFS plans, non-network MSA plans and now PPO plans will relate to the same areas to which the measures required for M+C coordinated care plans (other than the PPO plans) and network M+C MSA plans relate. As stated in the preamble to the interim final rule, no M+C organization will be required to report information to which it does not reasonably have access under a plan. Where data on particular measures are not reasonably available with respect to a given plan, organizations will be allowed to report ''not available.''

Comment: A number of commenters addressed the form and content of the required standard measures. One commenter asked that we develop core measures not just at the M+C plan level, but also at the provider and facility level. Another commenter asked that we develop core measures for high-risk, low-incidence conditions. Another commenter asked that we develop measures for all persons with disabilities under age 65 that are comparable to the senior health status data that are being collected for a sample of Medicare beneficiaries over 65 in Medicare managed care plans as part of HEDIS 3.0.

Response: Each of these suggestions has merit; however, we are taking an incremental approach to implementation with respect to the QAPI activities under the M+C program that includes working with private purchasers to expand the set of measures. We believe it is important to give M+C organizations time to adjust to the current standard measures before imposing further requirements. Our experience with the standard measures in place now will also be helpful in deciding whether additional measures are appropriate, and if so, which measures would be most effective.

Comment: Certain commenters asked that the standard measures we require be predictive of outcomes, and be established utilizing evidence-based medical research. One commenter asked that we establish a ''data dictionary'' that will give M+C organizations detailed and clear definitions of the required measures. Another commenter cautioned that the development of another set of core measures for M+C organizations will result in unnecessary duplication and lead to confusion if the measures are defined differently by accreditation organizations and by HCFA.

Response: As mentioned earlier, M+C organizations are required to report HEDIS data. The HEDIS measures are predictive of outcomes, are well defined, and are well established in the private sector. Our requirements may change in future years as the HEDIS instrument evolves and as other measurement instruments are developed.

Comment: One commenter asked what role, if any, JCAHO's ORYX performance indicators will have in meeting our data reporting requirements, and whether there would be duplication. One commenter asked that we consider the OASIS data set and OBQI system for home care (and eventually PACE) to be reasonable alternatives to HEDIS for managed long-term care plans.

Response: Again, our goals with respect to data management are to minimize burden and maximize effectiveness. We are working collaboratively with accrediting organizations like the JCAHO, with these goals in mind. The ORYX indicators are still in the developmental stage and, furthermore, since they focus specifically on hospitals, they cannot be used to measure much of the performance of managed care organizations. All home health agencies serving Medicare beneficiaries, whether in managed care or traditional Medicare, are required to provide information through OASIS. In general, we are not requiring managed long-term care plans to provide HEDIS information, with the exception of several demonstration sites. However, reporting requirements

for long-term care entities may change in the future.

Comment: A few commenters addressed our intention to consider historical plan and original Medicare performance data and trends when establishing minimum performance levels. One asked for clarification as to the standards we will use. Two objected to basing minimum performance levels on historical performance data and trends, explaining that many Medicare program requirements, including those related to access to services, emergency services and due process, are not ideal targets, but rather legal requirements under Federal law. The commenters were concerned that looking to historical performance might result in establishing a minimum performance level that is less than what the law requires.

Response: We agree with commenters that it would not be appropriate to establish minimum performance levels for aspects of care or service for which required levels of performance have already been dictated by regulation or statute. However, there are many measures of care, such as mammography or immunization rates, for which no mandated minimum exists. In these areas, it is useful to know what historical performance has been, because while we are interested in establishing minimum performance levels that motivate improvement, we want those levels to be achievable. At this time, the process for establishing minimum performance levels has not been finalized, but we expect that we will set the minimum at a percentile of previous performance, and revise the minimum year by year as overall performance rises.

Comment: A number of commenters objected to our intention to establish minimum performance levels. One commenter said that it would be inconsistent with our statement in the preamble to the interim final rule that we would not adopt a ''one size fits all'' approach to performance measurement. Another commenter, although not opposed to minimum performance levels, asked that we take into consideration variation in the model of delivery, such as network-model or group-model, when establishing the levels.

Response: We believe that it is feasible and in the best interest of Medicare beneficiaries to require that the quality of care provided by M+C organizations offering network plans meet minimum standards. This is an additional protection above making performance information available to beneficiaries for the purpose of plan selection. We believe that there would be a de facto requirement that organizations achieve minimum performance levels, even if there were no explicit requirement in the regulation. That is, even if the regulation required only that organizations report their performance on standard measures, we would still judge their performance by comparing it with some benchmark for the purpose of determining whether to take remedial action or continue contracting with the organization, which would have the same effect as applying a minimum performance level. We see no reason not to recognize this implicit requirement in the regulation.

As we stated in the preamble to the interim final rule, we are sensitive to the different structures of plans. We will consider the impact plan structure has upon the ability of an M+C organization to affect provider behavior. We will consider these issues when making our decisions regarding the standard measures for which it is appropriate to establish minimum levels of performance.

Comment: Two commenters addressed the possibility that some of the minimum performance levels HCFA establishes will be regional instead of national. One commenter objected to establishing non-national performance levels. The other supported the idea of establishing minimum performance levels with consideration for regional area variation.

Response: Because it is our intention to establish minimum performance levels that are meaningful as well as achievable, we must consider regional variation where it exists. It is our ultimate goal to have national minimum performance levels, but it may be necessary to move towards this goal incrementally by first establishing regional performance levels.

Comment: One commenter asked how we can require that M+C organizations meet minimum performance levels 1 year after the levels are established, if we recognize a 3-year cycle as the standard for performance improvement.

Response: The purpose of performance improvement projects is not to bring plan performance up to minimum performance levels, but rather to move it closer to national benchmarks. In most cases, we believe that plan performance would already surpass the ''minimum performance levels'' that we are now in the process of developing. An immediate intervention and not a lengthy performance improvement project would probably be called for if a plan offered by an M+C organization failed to meet a minimum performance level.

Comment: One commenter asked that we establish some minimum performance levels related to the care of persons with disabilities.

Response: As noted above, we are still in the early stages of identifying the measures for which minimum performance levels will be established. When we do, we will consider the commenter's suggestion.

Comment: A number of commenters objected to the possibility that we will nonrenew an organization's contract on the basis of its failure to meet minimum performance levels. Two of these commenters complained that any organization might fall short of a specific numerical standard because of random events beyond its control. As an alternative to nonrenewal, one commenter asked that we impose intermediate sanctions. Another asked that we not impose sanctions at all if an organization is making a good faith effort to meet the requirements. Some commenters suggested that we work with organizations to improve their performance in lieu of nonrenewal. In particular, one commenter recommended that we require organizations to participate in PRO-sponsored improvement projects when minimum performance levels are not met.

Response: As a value-based purchaser, HCFA has a responsibility to implement requirements that promote accountability on the part of M+C organizations. Although we have the authority to nonrenew an organization's contract for failure to meet quality assurance requirements, we have stated that in most instances we will first offer technical assistance and/or require corrective action plans. Intermediate sanctions are also within HCFA's prerogative.

Comment: One commenter asked that we reward an organization that shows demonstrable improvement in the health status of beneficiaries by giving it a bonus payment such as a percentage of its capitation rate. The commenter contended that a bonus payment is necessary to ensure that organizations are equitably reimbursed, since under a risk-adjusted ACR, organizations will receive lower payments for healthy enrollees.

Response: It is appropriate that an M+C organization receive lower payments for healthy enrollees because the cost of caring for them is proportionately lower. Because an organization that successfully completes a performance improvement project will have reduced the incidence of negative

outcomes and the expenses associated with them, any reduction in Medicare payment as the result of risk adjustment should not adversely affect the organization's profitability. Indeed, the successful completion of performance improvement projects should bolster an organization's business. The information that an organization has successfully completed performance improvement projects will be shared with potential enrollees, and should help its market position.

Comment: One commenter asked that we establish public recognition awards at the state and national level for innovative and successful organization performance improvement projects.

Response: Although there has been much discussion around the issue of establishing performance incentives, we currently have no plans to develop an awards program for M+C organizations. However, they may wish to consider promoting their excellent performance themselves through the media and their marketing materials.

Comment: One commenter requested that we specify the nature and form of the documentation and data that organizations must make available to demonstrate compliance.

Response: With respect to monitoring compliance, we have completed the design of a revised M+C interim monitoring tool that follows the structure of both the M+C regulations and the Quality Improvement System for Managed Care (QISMC) Interim Standards and Guidelines (which provide interpretive guidance for both subpart D standards as well as standards relating to the delivery of health care and enrollee services). The monitoring tool specifies the documentation and data that we will look for in our compliance monitoring.

Comment: Many commenters emphasized the importance of collaboration between the managed care industry and HCFA as implementation of the regulation proceeds. One commenter recommended that we establish a formal advisory counsel composed of representatives of industry associations. Other commenters urged that we consult with physicians and accreditation organizations in selecting standard measures and setting minimum performance levels.

Response: Since we began developing QISMC 4 years ago, we have been engaged in an ongoing dialogue with representatives of the managed care industry, advocacy groups, various health care providers, and state regulatory bodies to ensure broad involvement in the document development process. We recognize the value of this type of collaborative exchange and intend to continue this activity.

Comment: A number of commenters asked that we coordinate our quality improvement efforts with those of the private sector, particularly NCQA. One commenter was concerned that we are establishing an independent system of quality improvement requirements rather than building upon the collaborative public-private efforts that we have participated in, such as HEDIS.

Response: The QAPI requirements established in the regulation build upon a number of the public-private efforts mentioned by commenters. For instance, as noted above, the standard measures on which M+C organizations now are required to report to comply with § 422.152 (c)(1) and (e)(1) are the HEDIS measures; we have been collaborating with private sector group purchasers since 1994 to develop these measures, and we recognized the value of incorporating them into our QAPI strategy.

Comment: One commenter questioned HCFA's authority to require that performance improvement projects achieve ''significant'' improvement, pointing out that the statute requires only that M+C organizations ''take action'' to improve quality. Another commenter questioned our authority to impose as much structure on performance improvement projects as we have, asserting that by requiring that projects focus on specified areas of clinical and nonclinical services, and directing M+C organizations to undertake specific projects among the required areas, we have exceeded our statutory mandate.

Response: We believe that our responsibility as a value-based purchaser and duty as a trustee of Medicare funds includes requiring that M+C organizations provide high quality services, and the statute recognizes this responsibility. For instance, section 1852(e)(2)(A)(vi) of the Act requires that M+C organizations ''provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part'' (emphasis added). Requiring that M+C organizations conduct projects that achieve improvement that is significant and sustained over time is one way for us to meet our obligation under the statute. We also believe that the language quoted by the commenter, requiring that M+C organizations ''take action'' to improve quality can be reasonably interpreted to require that improvement actually occur. A requirement to ''take action'' to improve quality clearly suggests that the M+C organization have an objective in mind in doing so. We believe that a significant improvement is a reasonable and logical objective for ''action'' to improve quality. While the structure imposed in the interim final rule is flexible, and grants M+C organizations broad discretion in many areas in designing their QAPI programs, we believe that some structure is necessary in order to ensure that the projects will be meaningful for Medicare enrollees. We believe that the M+C quality assurance requirements represent a reasonable interpretation of requirements in section 1852(e), and a reasonable exercise of our broad authority under section 1856(b)(1) to establish M+C standards by regulation.

Comment: Two commenters addressed the issue of the number of performance improvement projects M+C organizations are required to perform. One commenter explained that it is difficult to conduct valid and reliable performance improvement projects with a small number of participants, and asked that the number of required performance improvement projects be proportionate to the size of the plan. The second commenter asked that we limit the number of required performance improvement projects to one new project per year, and limit the number of projects required to be underway at any one time to four.

Response: QISMC requires that M+C organizations initiate two performance improvement projects a year. Given that projects are allowed 3 years in which to achieve significant improvement, once QISMC is fully implemented an organization will not need to have more than six projects underway at any one time: two in the initiation stage, two in the intervention stage, and two in the completion stage. We believe this is a reasonable burden for both large and small plans. Smaller plans are not at a disadvantage because organizations are not required to show statistically significant improvement on every topic affecting a small population. Statistical significance is only required in instances when an organization chooses to sample its population. For small populations, an organization has a strong incentive to measure the results of its project on the entire affected population, because, when the organization's project targets the entire affected population, only a 10 percent reduction in the ''performance gap'' is required, not statistical significance. For example, if an organization chose to study a condition that affected only 100 enrollees, and its current performance was 50 percent, to achieve a 10 percent

reduction in the performance gap it would have to demonstrate that it improved the care to five enrollees. If the organization measured the results of its project on a sample of the population, it would have to show improvement for many more enrollees to achieve statistical significance.

We are aware that a number of technical issues relating to improvement project design remain to be resolved. For instance, we must decide what to do when a project population is so small that measurement of the results of the project is not meaningful or what to do if the baseline performance is so high that the sample size required for statistical significance is very large. We intend to resolve these issues in an updated version of QISMC.

Comment: One commenter pointed out that a significant period of time will be required following the intervention before improvements are observed at the population level, and the commenter was concerned that there appears to be no allowance for this time period.

Response: QISMC allows for such a time period. As mentioned earlier, QISMC does not require a performance improvement project to achieve significant improvement until the end of its third year. Experience has shown that there are many opportunities for an intervention to yield results within three years. QISMC makes an even more generous allowance for more complicated projects.

Comment: Many commenters addressed the requirement that performance improvement projects achieve significant improvement. The majority of these commenters opposed the 10 percent standard for reduction in the performance gap. As discussed above, this standard (which is specified in QISMC) requires that the organization reduce by at least 10 percent the percentage of cases in which the quality indicator that measures its performance in the project's focus area is failed. Several of these commenters complained that the standard is not realistic. One commenter explained that in many data situations, administrative claims may not be complete or be reliable to allow for a meaningful evaluation. Other commenters offered other examples of impediments to achieving significant improvement, including regional variation of utilization and imperfect provider and enrollee compliance. One commenter asked us to recognize that enrollee lifestyle choices, diet, and compliance with medical treatment will impact upon an organization's ability to achieve significant improvement in health status. Another commenter asked that we recognize that it is the provider who actually has control of the care process. For these reasons, these commenters asked that we not hold organizations responsible for achieving significant improvement, but for initiating activities that, if followed by enrollees and providers, are likely to improve the health status of enrollees.

Two other commenters suggested that we take a different approach. They recommended that in lieu of requiring a 10 percent reduction in the performance gap, we follow NCQA's approach and require that managed care organizations provide meaningful evidence that they are making improvements in clinical care and service. One of these commenters suggested that to define ''meaningful,'' we consider whether the improvement resulted in a better outcome for the enrolled population, whether it is attributable to the organization's actions, and whether it affects high-volume, high-risk, and/or high-cost conditions or services. The commenter added that this would be more effective in encouraging complex or innovative projects that have a high risk of failure but that offer significant potential, a comment that was echoed by other commenters who were concerned that a rigid numerical significant improvement standard would encourage organizations to pursue performance goals that are easily attainable.

A third alternative to the 10 percent standard was submitted by a commenter concerned that certain characteristics of the Medicare population will complicate the achievement of significant improvement. This commenter pointed out that the elderly population is at a higher risk of illness and disease, and that a greater percentage of Medicare beneficiaries have multiple disabilities and comorbidities, which results in greater instability in their health status. This commenter recommended that we require only that organizations establish measurable goals for their interventions, and that we evaluate organizations on their ability to demonstrate the strength of their interventions and performance gains over time. Further support of this approach was offered by an additional commenter who was concerned that the 10 percent standard would encourage risk selection and discourage the enrollment of sicker beneficiaries with more complex health issues.

Response: We chose to make a 10 percent reduction in the performance gap the standard because we believe it is necessary to have an objective standard to assess whether an organization has achieved significant improvement in health care quality, and because we have observed much higher percentage increases in performance than 10 percent. Therefore, 10 percent is a reasonable benchmark to use based on our observation of past organizational performance in improving health care quality. Nationally recognized standards that do not incorporate objective standards for determining if quality improvement has occurred have been criticized as being subjective and lacking in reliability and validity. We have learned from the lessons of such standards, and based on the strong evidence from the Medicare and Medicaid programs, have elected to implement a standard that is consistent with our knowledge of quality improvement in both the Medicare and Medicaid programs.

The 10 percent improvement standard is the best way we have at present to ensure that projects are meaningful, and that they translate into positive changes in enrollees' lives. In the long run, in order to mitigate the incentive to choose trivial projects, we will attempt to devise a way to measure and report the relative contribution of each performance improvement project, taking into account such factors as the number of enrollees affected by the improvement and the impact the improvement actually has upon enrollee health and satisfaction. Such a system is years away, but we have taken a first step towards it by starting to develop a common vocabulary for performance improvement projects.

As for the comment that requiring a 10 percent reduction in the performance gap will encourage risk selection, we believe that there exist numerous opportunities for M+C organizations to improve performance on measures relating to the care of sicker enrollees with complex health care needs. In fact, we believe the improvement potential associated with the care of sicker enrollees exceeds that associated with the care of healthier enrollees. In addition, the introduction of risk-adjusted payments to M+C organizations should further discourage risk selection.

Comment: One commenter was concerned that allowing an organization to set its own performance goals would be a disincentive to undertaking any project that might ''lower its status'' with us or with enrollees.

Response: We believe the commenter is referencing the QISMC standard that addresses projects in which data are collected on the entire population to be studied (that is, in which a census is involved). QISMC specifies that, in the case of a project developed by the

organization itself, significant improvement is demonstrated by achieving a benchmark level of performance that is defined in advance by the organization. However, the standard goes on to say that the organization's benchmark must reduce the opportunity for improvement by at least 10 percent, which is the same standard for HCFA specified projects. So, the commenter's concern is unfounded because the objective nature of the benchmark ensures an acceptable level of effort on the part of the organization.

Comment: One commenter noted that when multiple interventions are employed, they all would have the potential to bring about improvements in outcomes. The commenter asked how we will determine which intervention was responsible for the observed change.

Response: It is only necessary that an M+C organization show that its improvement was the result of its own actions and not chance. It is not necessary to determine to which of its interventions the improvement should be attributed, although we expect that the M+C organization will want to do so for its own management purposes.

Comment: A number of commenters addressed the issue of required participation in national or statewide performance improvement projects. Half of the commenters supported the idea of such projects. One commenter asked that we consider the identification and diagnosis of persons with Alzheimer's as a possible national performance improvement project, and another asked that we require organizations to participate in national improvement projects pertaining to persons with disabilities.

One of the commenters opposed to national or statewide performance improvement projects complained that mandated projects will detract from the flexibility organizations need to best care for their enrollees. This commenter pointed out that many organizations have already conducted projects addressing flu and pneumonia; consequently, it would be a poor use of resources for them to be required to conduct another such project. Another opponent argued that national or statewide performance improvement projects may prove to be inconsistent with local market considerations.

Response: In response to these concerns, we included in OPL 98–72 a statement that an M+C organization is not required to participate in the HCFA-sponsored national diabetes project but may, at its discretion, conduct another diabetes-focused project that utilizes the Diabetes Quality Improvement Program (DQIP) indicators, and meets the project requirements as outlined in QISMC Domain 1. For their second performance improvement project, M+C organizations were free to select a topic and focus area of their choice.

With respect to the concern that organizations may have already conducted projects addressing influenza and pneumonia, which have been selected as the national project topics for 2000, there are many aspects to the care and prevention of these diseases that organizations may not have fully addressed in previous projects that would lend themselves very well to further projects.

At this point, we have not selected national project topics beyond year 2000, but we will consider the care of enrollees with Alzheimer's and with disabilities when making future selections.

Comment: One commenter asked us how we will decide who must participate in national or statewide performance improvement projects.

Response: It is a contracting requirement for all M+C organizations offering coordinated care plans that they conduct a project addressing a topic that we have determined represents a national health care priority. At this time, although we have the authority to specify State-specific topics, we have not done so.

Comment: One commenter advocated that we explicitly include requirements in the regulation for organization participation in PRO-sponsored activities.

Response: There is no requirement that organizations participate in PRO-sponsored activities: there is only the requirement, as stated in QISMC, that one of the two performance improvement projects that an organization initiates per year relate to a topic and involve quality indicators chosen by us. The PRO is required to provide technical assistance on the national project (and on all other projects) if an organization requests it, but organizations are not required to work with the PROs on their projects. However, we expect that many organizations will choose to work with the PROs, because the PROs can provide clinical and biostatistical expertise; assistance in the design and conduct of projects; advice on sampling, data collection and analysis; and, review and analysis of project findings and interventions.

Comment: A few commenters opposed allowing organizations to select the topics of their performance improvement projects from within the specified clinical and nonclinical areas. One commenter was concerned that organizations will choose the disease with which they are most familiar, thereby neglecting low-incidence diseases. Two other commenters were concerned that organizations will avoid undertaking projects in areas that highlight poor performance or that relate to discrete, but vulnerable, cohorts of patients, such as those with disabilities or rare conditions. These commenters recommended that as alternatives to allowing organizations to select their own performance improvement project topics, we standardize the topics across all organizations; we standardize the topics across all organizations within a given service area, selecting the topics on the basis of the morbidity and mortality measures for seniors in the service area; or, we select the topics for each individual organization on the basis of needs identified through an annual onsite audit.

Response: We believe it is essential that M+C organizations be allowed to target at least some of their performance improvement activities to those areas they determine would be of most benefit to their enrollees. Balanced against this opportunity is the obligation to address areas that we consider to be of universal importance to the Medicare population. Between organization-specific projects and national projects, we expect that all significant improvement opportunities can be addressed. If upon review we find that an organization's performance in a particular aspect of care or service is poor and the organization has repeatedly failed to initiate action to improve it, we have the authority to direct that the organization do so.

Comment: Two commenters asked that we expand the required clinical focus areas. One asked that we include high-risk, low-incidence conditions and populations, and the other asked that we include laboratory and other diagnostic services.

Response: High-risk, low-incidence conditions are subsumed within the high-risk focus area. Although issues selected for study generally should affect a significant portion of the organization's Medicare enrollees (or a specified subpopulation of enrollees), organizations should target infrequent conditions or services if data indicate they warrant study. As for laboratory and other diagnostic services, they could fall under a number of the current focus areas. Therefore, we do not find it necessary to add to the current list of focus areas.

Comment: One commenter asked how ''high-volume services'' and ''high-risk services'' are defined.

Response: We did not provide a definition of ''high-volume'' or ''high-risk'' services for several reasons. First, it was our intention to allow organizations discretion in developing their own definitions and criteria, consistent with the needs of their organizations. For the most part, both terms have commonly understood meanings, and therefore, we did not think they required explanations.

Since M+C organizations will be monitored on whether they conduct QAPI projects addressing these focus areas, and to respond to the request for further information, we suggest that organizations consult the QISMC Interim Standards and Guidelines (specifically, Standards 1.3.4.5 and 1.3.4.6) for further guidance as to our expectations. In selecting a quality improvement project focusing on high-risk or high-volume services, we note that the focus does not necessarily have to be on a clinical condition per se, but on a service and how it may be improved. In HEDIS 99, Volume 2, Technical Specifications, there are several clinical conditions for which suggested indicators are provided in assessing ''High-Occurrence/High-Cost'' DRGs. Congestive heart failure, angina pectoris, chronic obstructive pulmonary disease and other conditions which place the enrollee at risk of increased morbidity or mortality would certainly constitute appropriate conditions under the ''high-risk'' category. An organization may assess experiences of care received from specialized centers inside or outside of its network, such as burn centers, transplant centers, or cardiac surgery centers. With respect to ''high-volume'' services, an M+C organization may target quality improvement in a frequently performed surgical procedure, or across different surgical or invasive procedures.

Comment: One commenter asked how ''clinical area'' is defined. The commenter asked whether it is a clinical condition, such as diabetes, or, an opportunity within a clinical condition, such as the number of glycohemoglobin blood tests performed for diabetic enrollees.

Response: The answer is that it can be either. Standard 1.3.4 of the QISMC Interim Standards and Guidelines provides additional detail regarding the specific focus areas. It should be noted that in choosing the areas, we avoided a disease-specific focus, opting instead to define them in a broad sense and therefore allow M+C organizations maximum discretion in determining where their specific project might best fit. For example, performance of dilated eye exams in the diagnosis and treatment of diabetic retinopathy might best be placed under the clinical focus area of Secondary Prevention of a chronic condition (Standard 1.3.4.2), as it serves to identify and potentially control a diabetes-related condition.

Comment: One commenter recommended that the clinical area of ''continuity and coordination of care'' include an evaluation of whether the appropriate mix of services is being furnished, and of whether there is adequate access to specialty care.

Response: These are aspects of continuity and coordination of care that organizations may choose to select as project topics. However, we will not require these as topics because such specificity might serve to unduly restrict an organization in its efforts to identify those aspects of care and service most in need of a formal performance improvement project. General requirements and concepts relating to continuity of care and access to services are found at § 422.112.

Comment: Two commenters addressed the need to coordinate performance improvement projects. The first commenter asked that in areas where there are multiple M+C organizations, we require that organizations coordinate their selection of project topics so as to minimize the data gathering and reporting burden that will be imposed on hospitals. The second commenter asked that we allow M+C organizations serving in more than one region to partner in collaborative projects, perhaps under the aegis of a national organization such as the Blue Cross Blue Shield Association. This commenter also asked that we permit collaborative projects through the Agency for Health Care Policy and Research (now known as the Agency for Healthcare Research and Quality) or professional organizations/societies.

Response: We agree with these commenters. We have consistently stated that we encourage M+C organizations to collaborate across plans, with other organizations, and within their States and regions to promote reduction of administrative burden and to enhance the general applicability of study findings. Certainly, the PROs may serve in a convener/collaborator role with respect to promoting such activity. To further this effort, we co-sponsored a National Diabetes Conference in conjunction with the American Association of Health Plans and the American Diabetes Association to provide additional guidance and materials which may be used uniformly by M+C organizations in the conduct of their diabetes performance improvement projects. We expect other ad hoc collaborations to occur in the future.

Comment: One commenter asked that we encourage M+C organizations to work with their contracted providers, as well as other health care professionals and associations, in developing their performance improvement projects.

Response: As indicated in the previous response, we recognize the importance of collaboration. To that end, QISMC requires that an organization allow its providers (and enrollees) an adequate opportunity to provide input regarding the selection and prioritization of performance improvement projects.

Comment: Two commenters addressed the requirements relating to health information. One commenter claimed that without uniform collection methods, it is unreasonable to require organizations to ensure that the information they receive from providers of services is reliable and complete. This commenter believes that some organizations, especially those offering non-network M+C MSA plans and M+C PFFS plans, will be unable to meet this requirement. The other commenter asked that we clarify what level of organization oversight will be necessary for an organization to meet the requirement that it ensure the reliability and completeness of the information it receives from providers of services.

Response: To promote continuous quality improvement, it is essential that collection and management of meaningful statistical information be seen as means to that end. Statistically valid data that assist in explaining patterns of care and in justifying variations in care are as valuable as data that identify problems in the provision of care. Without good data, we cannot make scientifically defensible or financially meaningful health care decisions. Therefore, collection of appropriate and accurate data is both good science and good business. To the extent that a particular M+C organization currently is unable to meet these requirements, we believe that the answer is not to change the requirements, but for the organization to make the changes necessary to be able to meet these requirements.

As for oversight of the health information system, the organization is ultimately responsible for determining at what level within its structure there will be oversight which ensures the reliability and completeness of information received from providers.

Comment: One commenter suggested that we require that organizations, in processing requests for initial or continued authorization of services, follow written policies and procedures that reflect scientifically sound and evidence-based medical guidelines, rather than reflect current standards of medical practice. The commenter contended that not all current standards reflect the best medical practices.

Response: Historically, current standards of medical practice have been the benchmark for care provided by managed care organizations. The purpose of using these standards has been to ensure that the quality of care delivered through managed care organizations was comparable to, or better than, that provided by fee-for-service entities. During the last decade, advances in quality measurement and the development of practice guidelines and improved mechanisms for assessing utilization management have been adopted as standard practice in many organizations.

We agree with the commenter that in processing requests for authorization of services, the organization should follow policies and procedures that are based on scientifically sound and evidence-based guidelines. Nevertheless, we recognize that in instances where such guidelines do not exist, individuals making authorization determinations may need to refer to current standards of medical practice. In those cases, an M+C organization must have in place written policies and procedures to ensure that all coverage decisions are designed to provide care in the safest, most beneficial and cost-effective fashion.

Comment: One commenter asked that we require organizations offering M+C PFFS and non-network MSA plans to use written protocols for utilization review, and to provide their utilization review findings to enrollees and providers at least annually.

Response: Section 1852(e)(2) of the Act does not require that M+C PFFS and non-network MSA plans (and under the BBRA, PPO plans) establish written protocols for utilization review. To the contrary, section 1852(e)(2)(B)(ii) imposes requirements ''insofar as'' an organization provides for such protocols, clearly contemplating that some M+C organizations may choose to do so, and some may not. Thus, we do not believe that such a requirement would be consistent with statutory intent.

Comment: Four commenters were concerned about the lack of an explicit requirement that organizations take immediate remedial action when individual quality problems are found. Two commenters explained that performance measurement and performance improvement projects result in the collection of data that can be used to establish baselines and track performance over time, but neither serves as a mechanism for ensuring that real problems experienced by current enrollees are systematically identified and corrected. These commenters recommended that we require that organizations ''take appropriate remedial action whenever inappropriate or substandard services have been provided or services that ought to have been furnished have not been provided.''

Response: Clearly, an essential component of any effective ''ongoing quality assurance program'' as required under section 1852(e) of the Act is the correction of identified problems. QISMC already requires that an organization correct significant systemic problems that come to its attention through internal surveillance, complaints or other mechanisms. As the commenters suggested, we are adding a modified version of this requirement under new § 422.152(f)(3) to require correction of all identified problems, because it is our intention that an organization take appropriate remedial action whenever a problem comes to its attention. Although § 422.152 generally focuses on systemic improvement, we believe it is appropriate to make our intention explicit. In monitoring this requirement, HCFA reviewers will operate by a ''rule of reasonableness,'' taking into consideration factors including but not limited to the severity and prevalence of the complaints and the level of effort demonstrated by the organization in seeking to resolve the matter.

Comment: Many commenters addressed the relationship between QISMC and the M+C regulations. Two commenters asserted that it was premature to model the regulation on the QISMC requirements, arguing that the QISMC requirements should be tested and evaluated before being applied to M+C organizations. These commenters asked that we scale back the quality assurance requirements until after they have been tested and evaluated, and if appropriate, restore them to the regulation using the normal notice and comment process. Two other commenters also recommended deleting the QAPI requirements of QISMC from the final rule, explaining that there are areas within QISMC that should be refined before they are implemented, such as the number and kinds of performance improvement projects that will be required.

Response: As we mentioned earlier, we have developed a cross-walk between the QISMC requirements and the NCQA accreditation requirements, which are currently considered the industry standard. For the most part, QISMC requirements are either identical to or consistent with NCQA requirements. Therefore, we are confident that our expectations have not outpaced the state of the art. Also, the HEDIS measures on which M+C organizations must report have already been fully tested and adopted by the managed care industry.

Finally, in response to concerns raised by managed care organizations regarding the potential burden imposed by the QISMC performance improvement project requirements, we significantly scaled back the number of required projects per year from nine required projects to only two per year. To assist M+C organizations further in this effort, we are currently developing model performance improvement projects and other implementation tools.

Comment: Two commenters addressed the time frame for QAPI program implementation. The first commenter recommended that the regulation reflect the transition policy found in the QISMC document, which allows organizations a period of time in which to build and refine their quality assessment infrastructure before their quality improvement projects will be expected to achieve significant improvement. The second commenter echoed the need for a long implementation time frame.

Response: Implementation policy is more appropriately handled through the issuance of operational policy letters and program manuals than through regulation. In addition, we have stated publicly that we will ''phase-in'' both implementation and enforcement of these requirements, in recognition of the fact that many organizations are still navigating the performance improvement learning curve.

Comment: A few commenters objected to the statement in the preamble to the interim final rule that we would not make public the results of an organization's performance improvement projects. One commenter complained that such a policy would be contradictory to our commitment to informed consumer choice. Another commenter challenged our rationale for withholding results, which was that releasing them might compromise enrollee confidentiality as they might involve enrollee-specific information. This commenter suggested that we

redact enrollee-specific information, or direct organizations to report information in ways that protect enrollee identities. Another commenter also supported the notion of releasing pertinent, non-confidential information about organization quality gleaned from performance improvement projects.

One commenter praised the policy we put forth in the preamble, explaining that providing the results of performance improvement projects to Medicare beneficiaries could undermine the legal confidentiality of peer review activities and could make such information reported outside the organization discoverable in legal proceedings. Another commenter also expressed support for our disclosure policy, noting that performance improvement requirements are new and that a non-punitive atmosphere is most conducive to improvement. However, this commenter recommended that we reexamine our disclosure policy in the future, and make it our goal to provide public access to performance information that will not violate patient confidentiality.

Response: To promote collaboration, we believe that it is important where possible to share development of best practices and interventions that work. In addition, to provide the necessary information to assist enrollee decision-making as they choose among various health plans, it is essential that we inform the public generally as to whether an M+C organization has met its responsibility to achieve demonstrable improvement. M+C organizations are free to release the specific results of their performance improvement projects, and we encourage this, but we do not believe such release should be mandatory. We are concerned that M+C organizations might be reluctant to undertake projects addressing their areas of poorest performance, if that means that their poor performance will be highlighted. The natural progression of performance improvement projects will be to generate additional measures for inclusion in the HEDIS data set. At that point all organizations will be required to submit this information for public disclosure.

We note that we do make a substantial amount of information available to the public for research purposes, such as the HEDIS public use file on our website; moreover, there is nothing to preclude researchers from attempting to obtain information directly from the M+C organizations themselves as long as enrollee confidentiality is protected.

Comment: Certain commenters asked that we require M+C organizations to report their performance on standard measures and the results of their performance improvement projects to entities other than HCFA. One commenter asked that we require that organizations report their performance on standard measures to their designated external review entity. The commenter explained that this information would help optimize the effectiveness and timeliness of interventions by the PROs, which as the external review entities will be assisting organizations in meeting their QAPI requirements. Another commenter recommended that organizations be required to make information available to their State, in that the organization is licensed under State law. A third commenter asked that organizations be required to share the results of their performance improvement projects with the Agency for Health Care Policy and Research (now known as the Agency for Healthcare Research and Quality).

Response: We agree that it is essential that the PRO, in its role as independent quality review and improvement organization, have access to performance data, but it is preferable that the data not go directly from the M+C organization to the review organization (or State) for two reasons. First, the M+C organization's reporting burden would be doubled. Also, raw performance data are not useful to the review organization, State, or HCFA, which is why we have contracted with NCQA to analyze the data for us. M+C organizations will report the HEDIS measures to NCQA, and after its analysis, NCQA will report the measures to us. At this point, we will share summary data with the review organizations and States.

The same is true for the results of performance improvement projects. We again believe it preferable that performance improvement project data not go directly to the PRO. The data will be reported either to HCFA or to the specialized quality review organizations with which we have contracted to evaluate the success of performance improvement projects (the M+C/QROs). HCFA or the M+C/QROs will then present and interpret the results for the PROs.

3. External Review (§ 422.154)

Section 422.154 implements section 1852(e)(3) of the Act. Section 1852(e)(3) requires, subject to certain exceptions, that each M+C organization, for each M+C plan it operates, have an agreement with an independent quality review and improvement organization approved by us to perform functions of the type described in part 466 of chapter 42, which establishes review responsibilities for utilization and quality control Peer Review Organizations (PROs). This general requirement appears in § 422.154(a) of the interim final rule. The terms of the agreement are described in § 422.154(b), and the exceptions to the general requirement are stated in § 422.154(c).

Comment: One commenter expressed concern that organizations contracting with both Medicare and Medicaid would be burdened by dual external reviews.

Response: Sections 1932(c)(2)(B) and (C) of the Act specifically address this scenario. The first provision authorizes a State to exempt a Medicaid-contracting managed care organization (MCO) that is accredited by a private independent entity, or that has a Medicare review conducted under section 1852(e)(3) of the Act, from Medicaid review activities conducted under section 1932(c)(2)(A) of the Act that would be duplicative of the accreditation process or the Medicare review activities. The second provision provides a State with the option to exempt entirely from the external review requirements under section 1932(c)(2)(A) a Medicaid MCO that is also an M+C organization, as long as that organization has had a Medicaid contract under section 1903(m) for at least 2 years during which the new BBA external quality review procedures are in effect. On December 1, 1999, we published a separate notice of proposed rulemaking setting forth our proposed interpretation of these provisions of section 1932(c)(2) of the Act (64 FR 31101).

Comment: A number of commenters asked that the regulation identify distinct review organization functions. One commenter recommended the following functions: population-based surveillance monitoring of access, quality and outcomes of care in M+C plans; auditing and validating the results of performance improvement projects; sponsoring national and statewide performance improvement projects; investigating quality complaints; conducting reconsiderations of hospital notices of non-coverage and conducting expedited appeals; and collaborating with consumer assistance organizations to better understand and use national and statewide performance improvement information when counseling beneficiaries on plan selection. Another commenter asked that we define external review requirements in the regulation that align with the PRO contractual requirements delineated in the Sixth Scope of Work.

Response: As we explained in the preamble to the interim final rule, we have approved the PROs to serve as independent quality review and improvement organizations (review organizations) for the purpose of this section of the regulation. We believe that the functional specifics of review organization responsibility are more appropriately detailed in the PRO scope of work than in the regulation. As M+C organizations implement their QAPI programs, needs may become apparent that will suggest that the review approach of the PRO be refined. The scope of work process permits a more rapid response to changing circumstances than does the regulatory process, which we believe should be used only for purposes of making changes in substantive standards for review.

Comment: One commenter asked that we require review organizations to involve broad community interests, particularly representatives of the Medicare beneficiary and consumer communities, in policy making and review activities.

Response: Such a requirement already exists. As stated in the PRO manual, each PRO is obligated to have at least one consumer representative on its governing board, and that representative must be a Medicare beneficiary. In addition, the Sixth Scope of Work requires each PRO to conduct beneficiary outreach and to maintain a Medicare hotline to facilitate communication with beneficiaries within its State.

Comment: One commenter addressed the external review waiver, supporting our decision to delay rulemaking on the waiver until we have experience with the implementation of the QAPI program.

Response: We appreciate the commenter's support of our decision.

Comment: A few commenters addressed our intention to exempt M+C organizations from external review activities that duplicate our monitoring activities. Two commenters argued that such a policy has no statutory basis and advocated its elimination. These commenters believe that this policy is inconsistent with the fact that HCFA, as Medicare purchaser and regulator, is ultimately responsible for monitoring and overseeing all quality assurance functions including the work of both review organizations and accreditation organizations. The commenters stated that our work, by definition, necessarily duplicates the work of review organizations, and therefore they were concerned that we would use the duplication as a pretense to design a PRO scope of work that is meaningless and insignificant. One commenter, although not opposed to exemption in principle, asked that any exemption of external review activities be subject to the notice and comment process.

Response: Section 1852(e)(3)(B) of the Act mandates that the Secretary ensure that the external review activities under section 1852(e)(3)(A) of the Act ''are not duplicative of review activities conducted as part of the accreditation process.'' The commenter is correct that HCFA has overall responsibility for monitoring and overseeing quality assurance functions. We believe that this extends to our review of areas addressed in the accreditation process. In this sense, we believe that our quality monitoring activities constitute a part of an overall ''accreditation process'' in that they are relevant to the continuing accreditation of M+C organizations. We also believe that Congress intended in section 1852(e)(3)(B) of the Act to require that we ensure that external review activities are not duplicative generally. Because there is little value and much additional burden in having the review organization repeat monitoring activity already conducted by HCFA, we are interpreting section 1852(e)(3)(B) of the Act broadly to extend to review activities that would be duplicative of our own monitoring activities. We believe that this interpretation of the intent of section 1852(e)(3)(B) of the Act, combined with our broad authority under section 1856(b)(1) of the Act to establish M+C standards by regulation, supports our decision to ensure that external review activities are not duplicative of our own review.

With respect to the comment that our application of the ''anti-duplication'' policy in section 1852(e)(3)(B) of the Act be subjected to notice and comment, we believe that the process of determining whether review activities are duplicative in a given case represents ''operational'' implementation of the substantive standard set forth in the regulations. We believe it would be neither workable nor appropriate to subject such operational judgments to notice and comment rulemaking.

Comment: Two commenters complained that the regulation does not indicate how we will determine what constitute duplicative review activities. One commenter recommended that we place the burden on the M+C organization to demonstrate how the accrediting process duplicates a specific external review activity. The commenter advocated that such demonstration include full disclosure of the standards and protocols used by the accrediting organization to reach accreditation decisions, a comparison of the actual survey data and reports, and information about the composition of the review teams. The commenter recommended that the M+C organization's enrollees be informed when the organization seeks exemption from external review activities, and that they be given an opportunity to comment upon the application for exemption. Finally, the commenter asked that the exemption not be granted for more than one year at a time, and not be granted if the accreditation results in nonpublic reports.

Response: We intend to make the decision as to which external review activities an M+C organization accredited by an approved accreditation organization is exempt from as part of the process of approving the accreditation organization. The accreditation organization will supply us with all the information necessary to determine where its activities overlap with those of the review organization. The exemption will be reviewed as the accreditation process or scope of work changes. We are revising § 422.154(b)(2) to make it clear that an exemption based on duplicative review under the accreditation process will be made only with respect to approved accreditation activities because these are the only activities we will be in a position to evaluate when determining whether there is duplication.

With respect to the commenter's advocating that we require ''disclosure'' by accreditation bodies of their protocols, and disclosure to beneficiaries of decisions on duplication (with an opportunity to comment), we do not believe these steps are warranted. The quality standards that apply to M+C organizations apply without regard to whether duplication has been found. A beneficiary has access to detailed information on these standards, which are all public. We believe that it should not make a difference to the beneficiary whether our judgment that these standards are being satisfied is based on the findings of an accreditation body, HCFA, or an external review entity, as long as HCFA is responsible for ensuring that they are met.

We do not see the point in limiting exemptions to a year, if there is no reason to believe that the factors we will consider in making a decision on duplication will be changing.

On the issue of ''nonpublic reports,'' we expect that the public will have access to the same quality information for all M+C organizations, without regard to whether specific review activities were found to be duplicative.

Comment: One commenter asked that we designate the PROs as review organizations in the regulation text, and not simply in the preamble.

Response: We currently have the authority to contract with non-PRO entities to perform functions of the type described in part 466, and although we have not chosen to exercise this authority at this time, we believe that it is important to maintain it. There may come a time when we decide that it is desirable to allow other entities to serve as review organizations; thus, we are not designating the PRO as the review organization in the regulation text.

Comment: One commenter expressed concern that the regulation does not explicitly obligate M+C organizations to cooperate with review organizations' investigation of quality of care complaints. This commenter suggested that § 422.154(b)(1)(ii) be revised to require that the M+C organization provide to the review organization all pertinent data it needs to carry out its reviews and make its determinations, including assessments of beneficiary quality of care complaints.

Response: Because assessments of beneficiary quality of care complaints are among the determinations that the review organization makes, we believe the existing requirement as written is sufficient to compel M+C organizations to cooperate with any complaint investigations conducted by the review organization.

Comment: One commenter asked that M+C organizations not be responsible for the cost of the external review.

Response: HCFA pays the cost of the external review, not the M+C organization. The M+C organization might initially bear the cost of duplicating medical records requested by the review organization, but the organization will be reimbursed for that cost.

Comment: Two commenters stressed the importance of public access to external review results. One of the commenters specifically asked that we require review organizations to release an annual report to the public summarizing their activities and the results of M+C organization performance improvement projects.

Response: In the PRO manual, there are detailed requirements relating to an annual report, which the PRO is required to send to the State and local offices of aging, and to senior citizen groups. In addition, the PRO is obligated to make the report available to beneficiaries upon request. Because specialized quality review organizations (the M+C/QROs), rather than PROs, will be evaluating the results of M+C organization performance improvement projects, the PRO annual report will not include this information. However, we will ensure that there is a vehicle to inform the public of whether M+C organizations have met the requirement for achieving significant improvement.

Comment: One commenter asked that the regulation require that the external review address each component of the health delivery system, including laboratory services.

Response: Our own monitoring will assess the adequacy of an organization's health delivery system, of which we acknowledge laboratory services are a part.

Comment: One commenter asked that we define the adequate space and data requirements in paragraph (b)(1).

Response: We are not defining ''adequate space'' because the PRO's need for room in which to work could vary with each review. As for data requirements, they are generally stated in § 476.102(c). This paragraph requires health care practitioners and providers to maintain evidence of the medical necessity and quality of health care services provided to Medicare patients as required by the PROs.

4. Deemed Compliance Based on Accreditation (§ 422.156)

Section 1852(e)(4) of the Act gives the Secretary the authority to deem that an M+C organization meets certain requirements if the M+C organization is accredited and periodically reaccredited by a private organization under a process that we have determined ensures that the M+C organization, as a condition of accreditation, meets standards that are no less stringent than the applicable HCFA requirements.

Section 422.156(a) of the M+C regulations specifies the conditions under which an M+C organization may be deemed to meet the HCFA requirements permitted to be deemed under section 1852(e)(4) of the Act.

The current version of § 422.156(b) specifies the requirements that could be deemed under the original BBA deeming provisions. In accordance with those BBA provisions, these included only the quality assessment and performance improvement requirements of § 422.152, and the requirements of § 422.118 related to confidentiality and accuracy of enrollee records. As discussed in section I.C. of this preamble, the BBRA amended section 1852(e)(4) of the Act to provide for deeming of additional requirements. An M+C organization accredited by an approved accreditation organization could be deemed to meet any or all of the requirements specified in section 1852(e)(4) of the Act, depending on the specific requirements for which its accreditation organization's request for approval was granted.

Section 422.156(c) establishes when deemed status is effective. Deemed status is effective on the later of the following dates: The date on which the accreditation organization is approved by us, or the date that the M+C organization is accredited by the accreditation organization.

Section 422.156(d) establishes the obligations of deemed M+C organizations. An M+C organization deemed to meet Medicare requirements must submit to surveys to validate its accreditation organization's accreditation process, and authorize its accreditation organization to release to us a copy of its most current accreditation survey, together with any information related to the survey that we may require (including corrective action plans and summaries of unmet HCFA requirements.)

Section 422.156(e) addresses removal of deemed status. We will remove part or all of an M+C organization's deemed status if: (1) We determine, on the basis of our own survey or the results of the accreditation survey, that the M+C organization does not meet the Medicare requirements for which deemed status was granted; (2) we withdraw our approval of the accreditation organization that accredited the M+C organization; or (3) the M+C fails to meet the requirements of paragraph (d) of this section.

Finally, § 422.156(f) explains that we retain the authority to initiate enforcement action against any M+C organization that we determine, on the basis of our own survey or the results of the accreditation survey, no longer meets the Medicare requirements for which deemed status was granted.

In addition to expanding the types of requirements that are deemable, section 518 of the BBRA also specified procedural changes to the accreditation process which are also discussed in section I.C above and in several responses below. As noted above, these changes have been reflected in a revised version of § 422.156.

The comments and responses regarding § 422.156 are discussed below.

Comment: Several commenters expressed general support for the deeming provisions as stated in the regulation.

Response: The M+C deeming provisions are modeled on those that have been used successfully in original Medicare, and commenters have validated our belief that these

provisions will work equally well in Medicare managed care.

Comment: One commenter was concerned that if we allow deeming, we will not be able to ensure access for disabled enrollees. This commenter recommended that we ensure that accreditation organizations include in their review an assessment of an organization's ability to treat members with disabilities and complex care needs.

Response: We appreciate this comment, and agree that it is important that the needs of disabled enrollees not be overlooked. In evaluating whether standards imposed by an accreditation organization are at least as stringent as HCFA's, specifically QISMC Standard 3.1, we will take into account whether these standards account for the needs of disabled enrollees.

Comment: Two commenters recommended that we expedite the implementation of the deeming program.

Response: We recognize the value of deeming to M+C organizations and intend to proceed with deeming at the earliest opportunity. As a first step in this process, we will require that accreditation organizations develop crosswalks between their standards and the QISMC standards relating to the M+C requirements for which the organizations are seeking deeming approval. Only after we have revised the interim QISMC standards to reflect the changes made in this final rule and the final rule published February 17, 1999, will we have an accurate set of standards for use by the accreditation organizations in completing their crosswalks. We expect to release a revised set of QISMC standards shortly after publication of this final rule. Thirty days after publication we will begin accepting applications from accreditation organizations. A **Federal Register** notice formally announcing this timetable is being published concurrently with this final rule.

Comment: Three commenters addressed the requirement that, as a condition of deemed compliance, an M+C organization be ''fully accredited.'' The commenters believe this condition would be problematic, given that many accreditation organizations have multiple accreditation categories. One of the commenters, an accreditation organization, stated that this policy is '' * * * a significant and substantive change from the current process under Medicare. At this time there exists a variety of accreditation levels * * *,'' not only within accreditation organizations but among them. A second accreditation organization complained that restricting deeming to only M+C organizations that have been ''fully accredited'' contradicts the stated policy of deeming on a standard-by-standard basis. It explained that requiring an M+C organization to meet all of an accreditation organization's standards decreases the potential savings and efficiencies associated with deeming.

Response: Because accreditation categories differ among accreditation organizations, we expect that ''fully accredited'' will have to be defined on an organization by organization basis. Fully accredited will generally mean that all elements within all the accreditation standards for which the accreditation organization has been approved by HCFA have been surveyed and fully met or otherwise determined as acceptable without significant findings, recommendations, required actions or corrective actions. The commenter who complained that the requirement that an M+C organization be fully accredited is inconsistent with our intent to approve accreditation organizations on a standard-by-standard basis has misunderstood the requirement. The M+C organization must be fully accredited for only those standards for which the accreditation organization has been approved, not all of the accreditation organization's standards. We understand how the commenter misinterpreted the existing regulations, and we are revising § 422.156(a)(1) to clarify this requirement.

Comment: One commenter pointed out that if an M+C organization chooses not to be accredited, we will perform a complete audit of its functions. Because there is no cost to the M+C organization for our audit, the commenter believes it would be to an M+C organization's advantage not to be accredited, because it would avoid the cost of accreditation as well as duplicate reviews (for example, an accredited M+C organization's grievance and appeal program would be reviewed both by the accreditation organization and by HCFA because the grievance and appeal requirements are not deemable). The commenter asked whether this interpretation is correct.

Response: The commenter's interpretation is correct, although there are benefits associated with accreditation, such as improved marketability, that we believe make accreditation attractive.

Comment: Many commenters addressed the scope of deeming. The majority of commenters supported the limited deeming reflected in the interim final regulation. One of these commenters cited as support for limited deeming a recent report regarding the problems associated with deeming based on private accreditation of hospitals. One commenter advocated the continued development and implementation of the ''enhanced review'' process begun several years ago. One commenter opposed limited deeming. This commenter, an accreditation organization, asserted that the regulation does a disservice to its clients as they are still subject to a our survey. Further, this accreditation organization complained that the regulation fosters ''the very duplication of effort and stifling of innovation that the BBA sought to avoid by requiring deemed status.''

Response: In recognition of the efficiencies associated with deeming, section 518 of the BBRA amended section 1852(e)(4) of the Act to provide for the deeming of additional requirements. Specifically, the additional deemable requirements are those related to the following sections of the Act: section 1852(b) (which relates to antidiscrimination); section 1852(d) (which relates to access to services), section 1852(i) (which relates to information on advance directives), and section 1852(j) (which relates to provider participation rules). We are revising § 422.156(b) to add these requirements.

We note that HCFA's oversight of managed care accreditors will be different from that of hospital accreditors, *i.e.*, the JCAHO. Deeming based on JCAHO accreditation is explicitly required by statute, whereas potential M+C accreditors must demonstrate their ability to apply and enforce standards at least as stringent as our own as a condition of approval. In the event that a managed care accreditor fails to perform as promised, we retain the authority to withdraw its approval. Therefore, there are safeguards in place to prevent the situation that has arisen in hospital deeming from repeating itself in managed care.

Comment: Four commenters addressed the topic of approving accreditation organizations on a standard by standard basis as outlined in the regulation. Three commenters were in favor. One commenter asked if approving on a standard by standard basis means that we will ''* * * approve an accreditation organization for some standards but not for others.'' One commenter contended that our decision to approve accreditation organizations on a standard by standard basis is ''inconsistent with the need to reduce the duplication of effort.'' This commenter, an accreditation

organization, recommended that accreditation organization standards be assessed to determine if overall they equal or exceed HCFA's requirements. This commenter continued to state that ''* * * approving individual standards will lead to a stifling of innovations and improvements over time.''

Response: Section 518 of the BBRA has caused us to revise our approach to approving accreditation organizations. Originally, section 1852(e)(4) of the Act stipulated that ''the Secretary shall provide that a Medicare+Choice organization is deemed to meet requirements'' of certain subsections of the Act if the organization were accredited by an approved organization. The BBRA changed the provision to read that ''the Secretary shall provide that a Medicare+Choice organization is deemed to meet *all the* requirements'' (emphasis added) of certain cites within the Act. The result of the change is this: it is still possible for us to approve an accreditation organization for a subset of the deemable requirements alone; for instance, we may approve an accreditation organization for the quality assurance subset (which includes the quality assessment and performance improvement program requirements of § 422.152) without approving it for any others. However, the accreditation organization must now have a comparable standard to every one of the M+C requirements within the quality assurance subset. Prior to enactment of the BBRA, an accreditation organization with only some quality assurance standards equivalent to the M+C requirements would have been permitted to participate in deeming; HCFA would have monitored for compliance with the M+C requirements for which no equivalent accreditation organization standards existed. Now, because the BBRA requires, in essence, that HCFA deem an accredited M+C organization by subset, rather than by requirement, we can approve an accreditation organization only if it has a standard that meets or exceeds each of the M+C requirements of the subset. While this policy could limit the extent to which an accreditation organization may be involved in deeming, it could be viewed as simplifying the oversight process, since there is no longer the potential for HCFA and an accreditation organization to divide responsibility for monitoring an M+C organization's compliance with the requirements of the same subset. We have revised the introductory clause in § 422.157(a) (discussed below) to reflect this BBRA change.

Comment: One commenter requested that public notice be given if an M+C organization's deemed status is removed or an accreditation organization's approval is withdrawn.

Response: We agree that when we withdraw an accreditation organization's approval, HCFA should give public notice because the information may influence the choice of accreditation organization made by M+C organizations seeking accreditation. We expect to give this notice by posting it on our website.

When we withdraw an accreditation organization's approval, we also remove the deemed status of all M+C organizations accredited by the organization. Upon removal of an M+C organization's deemed status, HCFA immediately assumes responsibility for ensuring that the organization meets our standards. Because beneficiaries are not at risk, and because notifying them of the loss of their M+C organization's deemed status could cause them to be concerned that they are at risk, we do not believe it is necessary or appropriate to so notify beneficiaries.

Comment: A few commenters addressed our authority under § 422.156(e)(1) to remove deemed status on the basis of a review of accreditation survey results. One of the commenters, an accreditation organization, strongly disagreed with the provision, complaining that it ''* * * would allow us to take the results of an accreditation survey and essentially ignore the decision of the accreditation organization without any independent data gathering.'' The commenter contended that the provision presumes that HCFA staff understand the accreditation requirements, and are better able to judge the performance of the M+C organization against those requirements than the accreditation organization's own surveyors. This commenter encouraged HCFA to conduct its own survey if we believe an M+C organization is not in compliance. If we reach a different conclusion than the accreditation organization after its own survey, then the commenter believes that we would be justified in removing deemed status. Another accreditation organization expressed similar concern with § 422.156(e)(1), stating that the regulation language could be used by us to ''second guess the compliance determination using only the results of the accreditation survey.'' This commenter recommended limiting the removal authority to reflect this concern.

Response: We do not intend to overrule an accreditation organization's survey decision without doing our own investigation. If our own investigation reveals, however, that a condition is not met, we reserve the right to remove deemed status even when the accreditation organization has not removed accreditation with respect to that condition. In order to clarify the distinction between—(1) a removal of deemed status by HCFA, based on HCFA's own survey, and (2) a removal based on a determination of noncompliance by an accreditation organization as a result of its accreditation survey, we have revised § 422.156(a) to separate these two situations. This should make it clear that we will not ''second guess'' the accreditation organization's conclusions based on its review without doing our own independent investigation.

5. Accreditation Organizations (§ 422.157)

In § 422.157(a), we discuss three conditions for our approval of an accreditation organization. We may approve an accreditation organization if the organization applies and enforces standards for M+C organizations that are at least as stringent as Medicare requirements (as discussed above); the organization complies with the application and reapplication procedures set forth in § 422.158, ''Procedures for approval of accreditation as a basis for deeming compliance;'' and, the organization is not controlled by the managed care organizations it accredits, as defined at § 413.17.

Section 422.157(b) of the interim final rule describes notice and comment procedures. Because the approval of an accreditation organization could have broad impact upon large numbers of organizations, providers, and consumers, we are providing notice and comment opportunities similar to those provided in the fee-for-service arena.

Section 422.157(c) establishes ongoing accreditation organization responsibilities. These responsibilities largely parallel those currently imposed upon accreditors under original Medicare. One exception is the requirement at § 422.157(c)(4) that an accreditation organization notify us in writing within 3 days of identifying, with respect to an accredited M+C organization, a deficiency that poses immediate jeopardy to the M+C organization's enrollees or to the general public.

Section 422.157(d) establishes specific criteria and procedures for continuing oversight and for withdrawing approval of an accreditation organization. Oversight consists of equivalency review, validation review, and onsite observation.

Section 422.157(d) states that an accreditation organization dissatisfied with a determination to withdraw our approval may request a reconsideration of that determination in accordance with subpart D of part 488 of this chapter. The comments and responses regarding § 422.157 are discussed below.

Comment: One commenter recommended that HCFA, when making a determination based on its own survey or the results of an accreditation survey that an M+C organization does not meet Medicare requirements, ''define the requirements, data collection tools, and scoring (including relative weights) guidelines'' used to make the determination. The commenter explained that disclosure of such information is consistent with assuring beneficiaries and providers that HCFA determinations and surveys are objective and based on criteria that are public, relevant and valid.

Response: We agree with the need to make our process for making determinations available to the public. That is why materials such as our monitoring protocol are available to the public on HCFA's website, www.hcfa.gov/medicare/mgdcar1.htm.

Comment: We received six comments requesting public disclosure of accreditation survey results. One commenter requested that we require in the regulation that enrollees be able to obtain from us their organization's accreditation survey results. An accreditation organization itself agreed with the need for public disclosure and stated that ''If the accreditation is to be used for a public purpose, participation in Medicare, then we are accountable for the decision and the information upon which it was based.''

Response: We agree that public disclosure of accreditation survey results is appropriate. If an accreditation organization does not have a policy for publicly disclosing accreditation survey results, it will be required to develop one as a condition of our approval.

Comment: An accreditation organization recommended that we provide accreditation organizations with quality-related information, for example, performance measurement data, quality improvement projects, etc.

Response: We concur with the importance of ''two way communication,'' which is why we routinely publish or otherwise make available to interested parties the types of information referred to by the commenter, such as HEDIS results.

Comment: One accreditation organization contended that the monthly reporting requirements exceed our needs, and it recommended that the regulation reflect our right to receive the information but not specify a reporting frequency until after information use and need is determined.

Response: We believe the reporting requirements of § 422.157(c)(1) accurately reflect our need for information. The information that accreditation organizations are required to report and the time frames in which they are required to report it are based on requirements that have proven their usefulness and necessity in deeming under original Medicare. We have no reason to believe that the organizations that accredit M+C organizations should be held to a different standard.

Comment: Two commenters addressed the conflict-of-interest provision at § 422.157(a)(3). One commenter stated that the provision is ''so broadly drawn as to preclude managed care organizations from serving on the boards of accreditation organizations, or otherwise participating in the accreditation development process.'' This commenter requested that we clarify that such activities are permissible. The second commenter also objected to the conflict-of-interest provision as written, recommending that we focus instead on whether the accreditation organization has policies in place that separate individuals affiliated with an M+C organization from an accreditation decision impacting that organization. This commenter asked for a definition of ''controlled'' that allows M+C organizations to participate in appropriate accreditation organization governance and policy making activities, but prohibits M+C organizations from having inappropriate influence on accreditation decisions affecting themselves.

Response: We believe it is important that no single or group of managed care organizations be allowed to exert undue influence over a private accreditation organization in any decision making process that would allow that single or group of organizations to benefit at the expense of others. However, we recognize the valuable role that representatives of managed care organizations may play in private accreditation organizations, and we agree that the regulation as written appears to prohibit a number of acceptable activities. Therefore, we are revising § 422.157(a)(3) to require that an accreditation organization ensures that: (1) Any individual associated with it who is also associated with an entity it accredits does not influence the accreditation decision concerning that entity; (2) the majority of the membership of its governing body is not comprised of managed care organizations or their representatives; and (3) its governing body has a broad and balanced representation of interests and acts without bias.

Comment: One commenter asked whether we must act on an accreditation organization's application for approval within 210 days, as is the case with respect to fee-for-service accreditation.

Response: The 210-day time frame that applies to accreditation under original Medicare is set forth in section 1865(b)(3) of the Act, and was not originally included by the Congress in section 1852(e)(4) of the Act. However, section 518 of the BBRA amended section 1852(e)(4) of the Act to add this requirement, and we are incorporating it into § 422.158(e).

In addition, because we are now required to make our decision on an accreditation organization's application within 210 days, we are revising § 422.157(b)(1) to restructure the provisions concerning timing and content of the **Federal Register** notice that solicits public comments on accreditation organization applications to allow for a comment period that is concurrent with HCFA's review. This process, also used by original Medicare, will give the public a meaningful opportunity to comment on the applications.

In the interim final rule, we modeled § 422.157(b)(1) on the original Medicare deeming regulation at § 488.8(b)(1). However, § 488.8(b)(1) was written before section 1865(b)(3)(A) of the Act was amended to require 210-day turnaround on accreditation organization applications, and we are now in the process of revising § 488.8 to conform with the Act. If we do not revise § 422.157(b)(1) to follow original Medicare's model, we are concerned that our review of the accreditation organization's standards will be so time consuming, there will be little time left within the 210 days for the public comment period. Therefore, revised § 422.157(b)(1) specifies that the **Federal Register** notice will announce our receipt of the accreditation organization's application for approval, describe the criteria we will use in evaluating the application, and provide at least a 30-day public comment period. Again, the timing and content of this notice are consistent with the way in which we solicit comments on accreditation organization applications in original Medicare deeming, pursuant to section 1865(b)(3)(A) of the Act.

Comment: One commenter argued that it is not appropriate for us to take action against an accreditation

organization ''irrespective of the rate of disparity'' between certification by the accreditation organization and certification by us or our agent. The commenter agreed that accreditation organizations are ''accountable to us and the public for the decisions they make and failure to properly assess the performance of the organizations they accredit should be grounds for action.'' However, the commenter complained that open-ended authority to withdraw an accreditation organization's approval regardless of the rate of disparity is inappropriate.

Response: It is an approved accreditation organization's responsibility to ensure that accredited M+C organizations meet or exceed our standards. As per the regulation, if widespread or systematic problems are identified that indicate that an accreditation organization can no longer make that assurance, we reserve the right to take appropriate action, regardless of the disparity rate. However, we can assure the commenter that in Federal oversight of accreditation organizations, a variety of factors and measures are considered and utilized, only one of which is the disparity rate.

In response to the commenter's concern, we are requiring that accreditation organizations provide us annually with summary data relating to their accreditation activities and observed trends. These data will assist us in making a comprehensive assessment of accreditation organization performance, and will help ensure that our oversight decisions are well-informed and appropriate. This change appears at § 422.157(c)(6).

Comment: One commenter requested that we clarify the term ''enforces'' as it is used in §§ 422.157(a)(1) and 422.158(a)(3)(iii)(C).

Response: An approved accreditation organization must apply and enforce standards that are at least as stringent as HCFA's requirements. By that, we mean that we expect the accreditation organization to assess compliance with the approved standards, and where it finds that an M+C organization is not in compliance, to ensure that corrective action is taken.

6. Procedures for Approval of Accreditation as a Basis for Deeming Compliance (§ 422.158)

The requirements of § 422.158, which pertain to required application materials, the mechanics of the approval process, and the reconsideration of an adverse determination, are essentially restatements of the original Medicare requirements under § 488.4.

Comment: One commenter disagreed with the provision that prohibits an accreditation organization that has requested reconsideration of a denial from filing a new application while the reconsideration is pending. The commenter believes that this provision will discourage accreditation organizations from challenging a denial and result in a denial of due process.

Response: An accreditation organization may request a reconsideration if it receives a denial of its application. This may be done by submitting a request for reconsideration, the requisite supplemental information, and any necessary supporting documentation. In lieu of the reconsideration, an accreditation organization may select the option of submitting a new application that has been revised to address the deficient areas that led to the initial denial. Therefore, the prohibition against simultaneously submitting a request for reconsideration and a new application does not deprive an M+C organization of the right to submit a new application.

E. Relationships With Providers

Part 422, subpart E of the M+C regulations focuses on requirements for relationships between M+C organizations and health care professionals with whom they contract to provide services to beneficiaries enrolled in an M+C plan. Many of these requirements stem from the rules regarding provider participation that are set forth in section 1852(j) of the Act. In our February 17, 1999 final rule, we addressed comments and made changes concerning several aspects of the provider participation requirements contained in subpart E, including the scope and applicability of the provider participation procedures. This final rule addresses comments on all other requirements in subpart E.

1. Provider Participation Procedures (§§ 422.202(a) and 422.204(c))

For the most part, we responded to comments on issues related to §§ 422.202(a) and 422.204(c) of the regulations in our February 17, 1999 final rule (64 FR 7975). In reviewing the comments on the interim final rule, however, we believe that additional clarification may be necessary on the applicability of the provider appeals procedures now set forth under § 422.204(c).

Comment: Several commenters objected to language in the preamble to the June 26, 1998 interim final rule that implied that health care professionals should have access to a formal appeals process when they viewed changes in an M+C organization's provider participation policies as having an adverse effect. The commenters pointed out that these policies should be subject to the consultation rules set forth under § 422.204(b), but did not believe that changes in these policies warranted a formal appeals process.

Response: As discussed in the February 1999 rule, the appeals procedures set forth under existing § 422.204(c) apply only in cases of adverse participation decisions, that is, when an M+C organization suspends or terminates a physician's contract with the organization. We believe this policy is consistent with the intent of section 1852(j)(1) of the Act, which provides for a process for appealing ''adverse decisions'' relating to the ''participation of physicians'' under a plan. We did not intend to imply that a physician has a right to a formal hearing to appeal a participation policy adopted by the M+C organization, although we would expect physicians to have input on those polices through the consultation process required under § 422.202(b). Clearly, however, an M+C organization ultimately is legally entitled to adopt the policies necessary to govern its operations, as approved by its board of directors, provided they are consistent with applicable Federal requirements. Please note that as part of a minor restructuring of the M+C provider participation provisions, and to help clarify that the appeals procedures apply only for adverse participation decisions, we are redesignating the provider appeals procedures from § 422.204(c) to new § 422.202(d).

Comment: Two commenters objected to the requirement in existing § 422.204(c)(3) that an M+C organization must notify the appropriate licensure or disciplinary bodies when it suspends or terminates a contract because of deficiencies in the quality of care. These commenters suggested that we leave State reporting requirements to the States. Another commenter recommended that the appeals hearing panels (under § 422.202(c)(2)) be required to include physicians that did not contract with the M+C organization as a means of ensuring the ''independence'' of the panel's review.

Response: Existing statutes and regulations consistently establish the need for cooperation between Federal and State authorities in their administration of the Medicare program. A primary example is the requirement under section 1855(a)(1) of the Act that an M+C organization generally must be licensed under State law in order to qualify for participation in the M+C program. Thus, we believe it is wholly

appropriate to require in Federal regulations that the suspension or termination of a physician's contract with an M+C organization be reported to State licensing and disciplinary bodies.

With regard to the membership of appeals panels, an M+C organization is free to enlist non-contracting physicians on these panels if it chooses to do so. However, section 1852(j)(1)(C) of the Act refers to an appeals process ''within the organization,'' and we do not believe it would be reasonable to require the participation of non-contracting physicians.

Comment: A commenter pointed out that at least one State has laws exempting an organization from the State's requirements for provider notification and review procedures in cases of imminent harm to a patient, determination of fraud, or final disciplinary action by a State licensing board. The commenter asked whether the notification and appeals provisions of subpart E would preclude exemption in these situations.

Response: As discussed in further detail below, section 1856(b)(3)(B) of the Act specifies that State ''requirements relating to inclusion or treatment of providers'' are superseded by the analogous Federal standards. Thus, State reporting exceptions to the M+C notification and appeals procedures are precluded under the existing M+C regulations. However, we do not believe that the general notice requirement under existing § 422.204(c)(1) and (3), which do not include specific time frames for notification, should present a conflict with the State law mentioned by the commenter. We note that 60-day time frame for termination notifications under § 422.204(c)(4) applies only for terminations ''without cause,'' rather than in situations addressed by the law in question.

2. Consultation Requirements (§ 422.202(b))

In accordance with section 1852(j)(2) of the Act, § 422.202(b) specifies that an M+C organization must consult with physicians participating in its M+C plans regarding the organization's medical policies, quality assurance programs, and medical management procedures. Under the regulations set forth in our June 26, 1998 interim final rule, these provisions were applied to other health care professionals as well as physicians. However, in response to comments on the interim rule, we revised this section in our February 1999 final rule to limit the applicability of these requirements to physicians. We also received a number of comments on other aspects of the consultation provisions, which are discussed below.

Comment: Commenters generally supported the objectives of the consultation requirements contained in § 422.202(b). However, several commenters representing physician groups suggested that the regulations should be expanded to establish a specific methodology for obtaining consultative input. For example, one commenter advocated requiring the establishment of a medical committee structure broken down into separate subcommittees focusing on various aspects of medical management policy (for example, professional relations, credentialing, quality improvement, *etc.*).

Other commenters representing M+C organizations asked for confirmation that the use of physician committees to obtain consultation was an acceptable means of satisfying the consultation requirements. Two M+C organizations suggested that we define ''consultation'' as ''soliciting and considering advice from participating professionals through committees established by the M+C organization.'' Another commenter noted that local medical review procedures (LMRP) should be part of the consultation process, and could in some instances substitute for the consultative process. One commenter indicated that the consultative requirements could be read to require consultation with hundreds of individual physicians and expressed concern that the consultative requirements would interfere with an individual physician's judgement in treating patients.

Response: We agree that the most appropriate method for an M+C organization to consult with its contracting physicians is likely to be through the establishment of a committee structure. Rather than limit organizational flexibility by establishing a single model for consultation, however, we are revising § 422.202(b) to state that an M+C organization must ''establish a formal mechanism'' for consulting with the physicians who provide services under plans offered by the organization. As we monitor the types of consultative arrangements implemented by M+C organizations, we will consider whether more specific regulatory guidance is necessary.

Similarly, although we agree with the definition of consultation offered by the commenters, we believe that the term is sufficiently self-explanatory and that inserting a formal definition of the term into the regulations is unnecessary. We also agree that M+C organizations should take local medical review policies into consideration in establishing and updating their medical review policies. However, we believe that the regulations need not include that degree of specificity concerning the evidence-based guidelines an M+C organization must consider in adopting practice guidelines. We will consider adding such policies to the list of guidelines now described in the QISMC standards on this subject (QISMC Guideline 3.4.1.1).

Finally, we do not agree that the consultation requirement infringes on the ability of an individual physician's judgement in the practice of medicine. As their name implies, practice ''guidelines'' are intended for general application rather than as procedures to be followed in every case independent of physician judgment.

3. Treatment of Subcontracted Networks (§ 422.202(c))

Under § 422.202(c), an M+C organization that uses subcontracted physician groups or other networks of health care professionals must provide M+C participation procedures that apply equally to these subcontracting groups.

Comment: Many commenters raised questions concerning the meaning and implications of the requirement under § 422.202(c), which states that when an M+C organization operates an M+C plan through subcontracted physician groups or other subcontracted networks, it must ensure that ''the participation procedures in this section apply equally to physicians and other health care professionals within those subcontracted groups.'' (Note that this provision was amended in our February 1999 final rule to limit its applicability to physicians.) Although some commenters supported this requirement as written, others were concerned that the requirement was too broad in scope. Several commenters suggested that we clarify that an M+C organization can comply with this provision by requiring subcontracting networks to have their own procedures for consultation and for participation appeals. They believe that it would be imposing ''unreasonable downstream responsibilities'' to require that the subcontractor's consultation and appeals procedures establish participation rights equivalent to those required under § 422.202. Other commenters recommended that we require the subcontracts to include the same specific appeals procedures as required at the M+C organization level. Finally, several commenters asked whether appeal rights extend to all physicians in a terminated group practice or to individual physicians. They recommended that the

subcontracting group practice exercise appeal rights on behalf of its employees.

Response: M+C organizations are contractually obligated to meet all requirements contained in the M+C regulations. They may meet these requirements either by directly providing the requisite health or administrative services or by entering into contracts for the provision of these services. Although we recognize the need for further clarification of how the provider participation rules and other provisions of the M+C requirements apply to subcontracting entities, the presence of a subcontract does not alter the underlying substance of those requirements. Note that § 422.502(i) of the M+C regulations contains a great deal of general information regarding the delegation of responsibility under subcontracts as well as some specific requirements (for example, with respect to provider credentialing). Please see section II.K of this preamble for a further discussion of many related issues. In addition, readers may wish to consult OPL #77, released on December 8, 1998, which offers extensive guidance in this regard (available through the HCFA website at www.hcfa.gov).

As spelled out under § 422.502(i), under any type of subcontracting arrangement, the M+C organization retains ultimate responsibility for ensuring that its subcontractors achieve full compliance with all terms and conditions of the organization's contract with us. This includes ensuring that activities performed by its subcontractors are consistent and comply with the M+C organization's contractual obligations. For activities that are delegated to contractors (such as provider appeals), the contract must specify that the subcontractor must comply with all Medicare laws, regulations, and instructions. Thus, a physician who is employed by a group practice that contracts with an M+C organization would have the same fundamental consultation and appeal rights as a physician who contracts directly with the M+C organization. Whether that physician exercises those rights at the subcontractor level, or directly through the M+C organization, would be left to the discretion of the M+C organization and its subcontractors. For example, an M+C organization could enter into a contract with a physician group under which all individual appeals of adverse participation decisions were adjudicated at the subcontractor level. However, the subcontractor's appeals process would need to meet the requirements established under redesignated § 422.202(d), as discussed above: all procedural rights established there would apply equally for the subcontracting physicians. For situations in which a subcontract with an entire group practice was terminated by an M+C organization, we would expect that the appeal rights would fall to the subcontracting group practice to exercise on its physicians' behalf.

Similarly, with respect to the consultation requirements, we can envision various ways in which the requirements could be met under subcontracting arrangements, such as through direct representation for the subcontractor's providers on M+C organization committees, or through committees convened by the subcontractor, with its consultative input channeled to the M+C organization. In either case, though, the underlying requirement must be met that practice and utilization management guidelines be developed in consultation with contracting physicians.

In general, our policy to date has been to afford extensive flexibility to M+C organizations in meeting subcontracting requirements. In 1999, for example, we required risk contractors that became M+C organizations to submit a plan demonstrating how they would work toward executing new or revised provider or administrative service contracts, with full compliance required by January 1, 2000. Again, for further information on the ways in which an organization can demonstrate compliance with provider contracting requirements, please see OPL 77.

4. Provider Antidiscrimination (§§ 422.100(j), 422.204(b), new 422.205)

Sections 422.100(j) and 422.204(b) both relate to the provision set forth in section 1852(b)(2) of the Act that precludes M+C organizations from discriminating against providers based on their licensure or certification. Section 422.204(b), for the most part, simply incorporates the statutory prohibitions on discrimination based on provider licensure or certification, but also provides that these prohibitions do not preclude the ''use of different reimbursement amounts for different specialties.'' Section 422.100(j) states that if more than one type of practitioner is qualified to furnish a particular service, the M+C organization may select the type of practitioner to be used.

Comment: Numerous commenters addressed the provider antidiscrimination provisions set forth at §§ 422.100(j) and 422.204(b). Commenters generally believed that additional guidance beyond that offered in the June 1998 interim final rule was necessary to clarify our interpretation of the antidiscrimination provisions of the statute (section 1852(b)(2) of the Act). Commenters differed in their views on how these provisions should be interpreted and implemented, however.

In general, commenters representing M+C organizations supported the inclusion of the choice-of-practitioners provision (§ 422.100(j)); they believe that this provision establishes that M+C organizations are not required to adopt an ''any willing provider'' policy, but rather have the flexibility to choose the practitioners that participate in an organization's provider network. In contrast, commenters representing physicians and other health care professionals believe that the choice-of-practitioners provision is unnecessary and confusing; they see the provision as undermining the antidiscrimination provisions of the statute and the M+C regulations. These commenters particularly objected to the wording in § 422.100(j) that allows an M+C organization to select the ''type of practitioner'' to be used. These commenters offered various recommendations, including: (1) delete the provision in its entirety; (2) add a requirement that an M+C organization employ a ''representative range of providers'' (comparable with the available range of providers under original Medicare); (3) amend the provision so that it would focus on the availability of all Medicare-covered ''benefits'' (many of which can be furnished only by qualified practitioners), rather than ''services''.

Commenters displayed similar perspectives with regard to the antidiscrimination prohibitions set forth under § 422.204(b). As noted above, the only portion of this section that is not taken directly from the statute is the provision under existing § 422.204(b)(2)(ii) that indicates that an M+C organization is not precluded from use of different reimbursement amounts for different specialties. Commenters representing M+C organizations generally supported the addition of this language, although one commenter believed that it unnecessarily restricted an M+C organization's ability to negotiate with physicians or other practitioners. This commenter stated that the regulations do not give an organization sufficient leeway to take into consideration the reputation, volume, or experience of a practitioner, or alternative payment methods, in establishing compensation.

Other commenters representing various types of physicians and other health care professionals objected to this

provision because they believe that it confers too much authority on M+C organizations. They argued that permitting an M+C organization to pay different amounts for different specialties was inconsistent with legislative intent. They also contended that this language was inconsistent with the Supreme Court's decision in *Bowen* v. *Michigan Academy of Family Physicians,* 476 U.S. 667 (1986), which they characterized as requiring that Medicare ''reimburse similar services in an equal manner regardless of who performs the service.'' These commenters believed that we should require that payment rates be tied to the services provided, as under the fee schedules used in original Medicare. One commenter suggested that we revise § 422.204(b)(2)(ii) to clarify that payment differences are permissible only if they ''result from competition or other legitimate factors,'' rather than differences based solely on licensure or certification.

Response: The statutory antidiscrimination provision is intended to ensure that health care providers are not arbitrarily excluded from participation under a managed care plan's provider network solely on the basis of their license or certification. We recognize that the existing regulations, which refer to this prohibition on discrimination in both §§ 422.100(j) and 422.204(b), have created the potential for confusion.

To assist in clarifying the relevant requirements, we believe it is appropriate to consolidate the regulations concerning antidiscrimination and choice of providers into a new, separate § 422.205, Provider antidiscrimination. This section will begin with the general rule prohibiting discrimination based solely on licensure or certification, consistent with the law. We then will specify that in choosing its practitioners, an M+C organization must ensure that all Medicare-covered services must be available to a plan's enrollees. We are also incorporating under § 422.205(a) a revised version of the existing provision regarding choice of practitioners that eliminates any reference to ''type of practitioners.'' Thus, the general rule will continue to permit M+C organizations the flexibility to choose their practitioners, consistent with the statute's antidiscrimination constraints, which are set forth under § 422.205(b). At the same time, this provision will emphasize the mandatory availability of all Medicare-covered services (such as physical therapy or manual manipulation of the spine to correct a subluxation).

Finally, we are adding at, § 422.205, a requirement that when an M+C organization declines to include a given provider or group of providers in its network, it must notify the provider(s) of the reason for its decision. Although this provision does not impart any appeal rights, we believe it is both a reasonable business practice and a means of ensuring that such decisions are subject to our monitoring efforts.

Our goal in implementing these changes is to strike a balance between our responsibility to ensure that M+C organizations are employing all the types of health care professionals needed to ensure that required Medicare-covered services are available to their enrollees, and our aversion to limiting organizations' flexibility in providing these services. Over the next few years, we intend to closely monitor organization compliance with the antidiscrimination provisions, including examining encounter data as it becomes available and tracking organizational participation decisions, to determine the degree to which all Medicare-covered services are made available under different plans.

We believe that the statute is not intended to preclude an M+C organization from negotiating appropriate, market-based, payment rates with its providers. It is quite possible, for example, that the ''market rate'' that must be paid to get a particular type of specialist to participate in an M+C organization's network may be higher or lower than that dictated by the market with respect to another type of practitioner. Section 1852(b)(2) of the Act expressly provides that its antidiscrimination rule ''shall not be construed to prohibit a plan from * * * measure[s] designed to * * * control costs. * * *'' Paying no more than the market rate for a given provider is clearly a component of cost control. We believe that establishing requirements concerning the comparative rates M+C organizations pay for contracting provider services would be inconsistent with the overall design of the M+C program, under which we pay a fixed amount to ensure that Medicare beneficiaries receive the services to which they are entitled, but M+C organizations have wide discretion in managing enrollee care and establishing provider networks. Inherent to this design is the premise that payment rates should be established through negotiated contracts rather than micro-managed by the Federal government. Thus, new § 422.205(b) specifies that an organization may use different reimbursement amounts for different specialties, or different practitioners within the same specialty.

Further, we do not agree with the commenter that the payment rules established under original Medicare's fee schedules necessarily represent the appropriate model for payment under the M+C program, or that it would be appropriate or feasible to establish a requirement that an M+C organization's provider network reflect the identical mix of providers participating in Medicare generally. Beneficiaries have the option of returning to original Medicare if they place a premium on being able to receive services from any provider they wish, or are not satisfied with being limited to a defined network established by an M+C organization.

In addition to addressing measures designed to control costs, section 1852(b)(2) of the Act also makes clear that the antidiscrimination rule therein shall not be construed to prevent an M+C organization from taking measures to ''maintain quality'' of services. For example, we would not want to preclude higher payments to providers for demonstrating quality improvement, or preclude an M+C organization from imposing quality-related requirements, such as using only board-certified physicians.

Finally, section 1852(b)(2) of the Act makes clear that its antidiscrimination provision ''shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees.'' If an M+C organization can provide all physicians' services through a doctor of medicine, it may not ''need'' to contract with another practitioner who can provide only a discrete subset of physicians' services (such as a podiatrist or a chiropractor who under section 1861(r) of the Act are considered physicians under Medicare only for specified purposes). As long as all Medicare-covered services are available in the plan, there may be no ''need'' to assume the additional administrative costs of contracting with another practitioner when an existing contractor is able to perform the services the additional practitioner would be providing. This would not constitute discrimination based ''solely'' on the basis of license or certification, but rather, not contracting with practitioners not ''needed'' to provide the full Medicare range of benefits.

With respect to the choice-of-practitioners provision, this right has always been inherent in the managed care model of health care delivery. While a practitioner is not to be discriminated against *solely* due to his or her license, we believe that M+C

organizations must have the flexibility to deliver services through the most cost-effective practitioner who is qualified to perform the service in question. Again, this is a ''cost control'' measure authorized under the last sentence in section 1852(b)(2) of the Act.

We do not understand the commenter's reference to the Supreme Court's *Michigan Academy* decision, since this decision did not involve a ruling on the merits of any reimbursement issue. Rather, the issue in *Michigan Academy* was whether certain types of claims were subject to judicial review. Even if the decision did hold what the commenter suggested, rules that apply to payments under original fee-for-service Medicare do not apply to payments by M+C organizations to contracting providers.

Comment: Commenters asked how we intended to enforce the antidiscrimination requirements, noting that strong enforcement was particularly necessary in view of the specific preemption of State laws dealing with the inclusion of providers. Several commenters asked how a provider would pursue an antidiscrimination claim, and they urged us to establish an administrative review process for investigating allegations of discrimination based on licensure or certification. To facilitate the reviews, these commenters suggested that the regulations require that notices of adverse participation decisions include a statement of the reasons for the determination.

Response: Although we do not intend to establish a separate administrative review process for investigating allegations of discrimination against providers, we intend to place a strong emphasis on verifying that M+C organizations are in compliance with the antidiscrimination provisions. This will occur both through our scheduled monitoring activities and under our authority to conduct complaint investigations when we believe there is credible evidence of violations.

In addition, as noted above, § 422.205 will now incorporate the requirement that an M+C organization must state in writing its reasons for declining to include any given provider or group of providers in its provider network. This should enhance our ability to identify violations of the antidiscrimination requirements, for example, by detecting situations in which organizations exhibit a pattern of repeated refusal to contract with certain types of practitioners. If a prospective provider has evidence of discrimination on the basis of licensure, the appropriate avenue to raise this concern is the HCFA regional office in the relevant area.

Comment: One commenter expressed concern that without further clarification, the choice-of-practitioners provision at existing § 422.100 could be construed as giving an M+C organization complete and final authority over an enrollee's choice of health care provider. The commenter recommended that we clarify that an enrollee may appeal a plan's decision not to allow access to a specialist, or a specific provider, that the enrollee believes is necessary to furnish adequate services.

Response: The regulations concerning choice of practitioners are not intended to limit in any way the appeal and grievance rights of enrollees under subpart M of the M+C regulations. If an enrollee is denied access to a specialist, the enrollee clearly has the right to a timely organization determination and, if necessary, a reconsideration of this determination. Situations involving whether a specific provider is necessary are more likely to be subject to either the organization's grievance procedures or possibly to external review by a PRO if quality issues are involved.

5. Provider Credentialing (§ 422.204(a))

Ensuring that providers have the proper credentials for the services they are providing is a key component of an overall ''ongoing quality assurance program for health care services,'' as required under section 1852(e)(1) of the Act. Section 422.204(a) accordingly sets forth basic requirements that an M+C organization must follow with respect to the credentialing and recredentialing of the providers and suppliers with whom it enters into participation agreements. The M+C organization must ensure that providers and suppliers meet applicable State and Federal requirements. Basic benefits must be provided through, or payments must be made to, providers that meet applicable requirements of title XVIII and part A of title XI of the Act. Also, in the case of providers meeting the definition of ''provider of services'' in section 1861(u) of the Act, § 422.204(a)(3)(i) specifies that basic benefits may only be provided through such providers if they have a provider agreement with us permitting them to provide services under original Medicare. An M+C organization may not employ or contract with providers excluded from participation in Medicare.

Comment: Although commenters generally supported the flexibility built into the M+C credentialing provisions, several commenters suggested that the credentialing standards used by the NCQA be incorporated into the M+C regulations because these commenters believe that they are clear and adequate to protect M+C beneficiaries. Several commenters contended that many of the M+C credentialing standards were somewhat vague; one commenter identified as particularly unclear the requirement under § 422.204(a)(2)(iii) to establish a process to ''receive advice'' from contracting health care professionals with respect to credentialing criteria. Another commenter asked if, in general, an M+C organization that complies with NCQA credentialing standards would also be in compliance with the M+C requirements. The commenter asked for confirmation that, like under the NCQA standards, the following categories of practitioners are not subject to the credentialing requirements: (1) hospital-based practitioners that provide care for an M+C organization's enrollees only as a result of members being directed to the hospital, and (2) practitioners who provide care only under the direct supervision of a contracting physician. Another commenter asked for additional clarity as to what types of practitioners must be credentialed and suggested following NCQA standards. One commenter argued that the credentialing provisions should include substantive criteria governing which physicians will be credentialed in the network, which excluded, and on what grounds.

Response: In view of these comments, we have reexamined the existing credentialing provisions and are making several changes. First, as discussed above, we have removed both the antidiscrimination and the provider appeals provisions from § 422.204. Section 422.204 will now be entitled ''Provider selection and credentialing'' and will include a new § 422.204(a) to establish the general rule that an organization must have written policies and procedures for the selection and evaluation of providers. These policies and procedures must conform with the existing credentialing requirements, which will be redesignated as § 422.204(b), as well as the antidiscrimination procedures now contained under new § 422.205. These changes do not impose new substantive requirements on M+C organizations, but we believe they constitute both a necessary reorganization of the existing requirements, and a means of clarifying in the regulations the inherent purpose of the credentialing rules—the need for a systematic approach to provider selection. We note that both the NCQA standards and our QISMC standards

already incorporate the underlying concept that an organization's credentialing requirements are an integral component of its provider selection policies.

This change in no way obviates our awareness that an organization's selection criteria, and thus its credentialing policies and procedures, should be tailored to take into account the individual characteristics of each M+C organization. The process of provider selection also should be integrated with the process of establishing and maintaining an adequate provider network to assure enrollee access to plan services. Thus, we do not intend to add to the regulations greater specificity concerning the procedures an M+C organization must follow for credentialing and recredentialing purposes, or establish detailed criteria as to what constitute adequate credentials. Instead, the regulations will continue to require that M+C organizations follow a ''documented process'' for these activities that meets the relatively flexible existing standards.

With respect to the question about whether meeting NCQA standards would constitute compliance with M+C requirements, we are currently evaluating this question in the context of the ''deeming'' provisions discussed in section II.D above. If we find that NCQA, or any other private accreditation organization, applies and enforces standards that are at least as stringent as those set forth in § 422.204, then satisfying NCQA standards would constitute compliance with M+C requirements. Until we make such a determination, however, meeting NCQA credentialing standards does not necessarily achieve compliance with the M+C requirements. We note that we agree with NCQA that credentialing is not required for health care professionals who are permitted to furnish services only under the direct supervision of a physician or other provider, or for hospital-based health care professionals (such as an emergency room physician, anesthesiologist, or certified registered nurse anesthetist (CRNA)) who provide services to enrollees only incident to hospital services. (This exception does not apply if the practitioner contracts independently with the M+C organization or is promoted by the organization as being part of its provider network.)

Finally, we agree that the requirement that an M+C organization's process include ''receiving advice'' from contracting health care professionals could be misconstrued. We are changing this requirement to indicate that the organization must have a process for consulting with its contracting health care professionals on its credentialing and recredentialing criteria.

Comment: Several commenters suggested technical changes to the regulations in subpart E. For example, one commenter recommended that the credentialing provisions consistently refer to suppliers as well as providers, noting that the subpart E basis and scope section (§ 422.200) explicitly mentions both providers and suppliers, while § 422.204(a)(3)(i) only refers to the furnishing of basic benefits through ''providers.'' The commenter also recommended that pharmacies be considered as providers. Another commenter suggested that we add ''or certification'' to the licensure verification requirement under § 422.204(a)(2)(i), and asked whether Joint Commission on Accreditation of Health Care Organizations/Community Health Accreditation Program or Medicaid certification of an HHA was sufficient to meet the provider credentialing requirements, as has been the case in the past for Medicare managed care.

Response: The definition of providers that applies for purposes of the M+C program is found at § 422.2 and includes both entities that would be considered providers and suppliers for other Medicare purposes. However, to avoid any possible confusion, we are adopting the commenter's recommendation that suppliers be explicitly mentioned under existing § 422.204(a)(3)(i) (now redesignated as § 422.204(b)(3)(i), as discussed above). Pharmacies, thus, are considered ''providers'' for purposes of the M+C program. We are also amending the regulations to indicate that initial credentialing should include verification of licensure or certification.

Existing § 422.204(a)(3)(i) requires that in the case of providers of services that meet the original Medicare definition of ''providers'' under section 1861(u) of the Act (such as HHAs or SNFs), that provider must have a provider agreement with us in order to be permitted to furnish basic benefits under an M+C plan. Under this requirement, neither accreditation nor approval under the Medicaid program is necessarily sufficient to enable an HHA to furnish services under an M+C plan, unless the HHA is Medicare-certified. The objective of this policy is to ensure that M+C enrollees are guaranteed services of a quality level at least equal to that available to other Medicare beneficiaries. We continue to believe that the existence of a provider agreement with us is the best way to ensure that HHAs providing services to M+C enrollees meet uniform standards in all States and are subject to Federal enforcement authority. Thus, we believe it would be inappropriate to create an exception for HHAs to the general rule that ''providers of services'' as defined under section 1861(u) of the Act must have a provider agreement that permits them to furnish services under original Medicare.

Comment: One commenter stated that the credentialing requirements appeared to require individual credentialing for physicians in group practices. The commenter believed that this requirement is too inflexible and could delay a physician's inclusion in a network. Instead, the commenter recommended that an M+C organization have the option of credentialing a group practice as network participants, and then transferring the obligation to credential new members of the practice to the practice itself.

Response: When an M+C organization contracts with a group practice, it has an obligation to ensure that all members of that practice meet its credentialing standards. Consistent with the discussion of subcontracting rules above (and with the subcontracting requirements of § 422.502(i)(4)), subsequent credentialing may be carried out either by the M+C organization itself or be delegated to the subcontracting organization (that is, the group practice). If delegated, however, the M+C organization must review and approve the credentialing process, and audit the process on an ongoing basis.

Comment: One commenter objected to several aspects of the credentialing requirements, and urged that they be modified to take into account the varying characteristics of M+C networks such as PPOs. The commenter recommended that the requirement for site visits be eliminated for PPOs, and that the requirement for recredentialing every 2 years be modified in favor of permitting M+C organizations to determine when recredentialing was appropriate depending upon the size and stability of the provider network.

Response: Under the existing regulations, site visits are required ''as appropriate'' for initial credentialing; thus, sufficient flexibility already exists in this regard. We believe that recredentialing every 2 years is a reasonable time frame and note that it coincides with NCQA standards. We believe it would be inappropriate for each M+C organization to substitute its judgment for a national standard as to when it should recredential its practitioners. If the provider network is

small and stable, the administrative burden associated with the recredentialing process should be relatively small.

Comment: One commenter noted that the prohibition on entering into contracts with providers that are excluded from participation in the Medicare program (under existing § 422.204(a)(3)(ii)) is impossible to implement unless the HCFA website includes a Social Security number (SSN).

Response: As noted in the interim final rule, M+C organizations are expected to consult the Office of Inspector General's (OIG) website (www.dhhs.gov/progorg/oig) to access the list of providers that are excluded from participation in the Medicare program. For privacy reasons, this listing does not include SSNs. However, we also maintain an internal excluded provider list (HCFA Publication 69) that includes unique identifying information for the providers in question. This publication generally is available to all of our contractors, including M+C organizations. We suggest that any M+C organization that needs this information contact either its regional or central office plan manager, or HCFA's Office of Issuances to obtain the latest version of Publication 69.

6. Prohibition on Interference With Health Care Professionals' Communication With Enrollees (§ 422.206)

Consistent with section 1852(j)(3)(A) of the Act, § 422.206(a) prohibits an M+C organization from interfering with the advice of a health care professional to an enrollee who is his or her patient. Thus the health professional may act within his or her scope of practice in advising the enrollee about his or her health status, all relevant medical or treatment options available regardless of whether care or treatment is provided under the plan. Section 422.206(b) incorporates the requirements of section 1852(j)(3)(B) of the Act. The regulations state that the prohibition against interference with the content of advice a health care provider has given to enrollees regarding medical treatment should not be construed as requiring counseling by a professional, if the M+C organization objects, based on moral or religious grounds, and fulfills certain notification requirements to prospective and current enrollees. The regulations incorporate the notification process and time frames included in the law and clarify that the plan must also notify us at the time of application and within 10 days of submitting its ACR proposal. We received 12 comments addressing the provisions set forth under § 422.206.

Comment: The majority of the commenters simply expressed their support for this provision, which has been referred to as the ''anti-gag rule.'' One commenter asserted that an M+C organization should not be forced to provide care that is not medically effective, approved by the Food and Drug Administration (FDA), or covered under the enrollee's plan. A commenter also suggested that M+C organizations be prohibited from requiring health care professionals to sign ''gag rule'' clauses that interfere with full disclosure of all treatment options, regardless of whether theses options are covered under a plan. Another commenter noted that § 422.206(d) states that an M+C organization is subject to intermediate sanctions for violations of these provisions, and recommended that the regulations also specify that we will not renew the contract of an M+C organization that substantially violates the provisions in § 422.206.

Response: As indicated in the June 1998 interim final rule, a health care professional's freedom to inform an enrollee about available treatment options in no way implies that all of the possible treatment options (for example, experimental or noncovered alternatives) are covered under the enrollee's M+C plan. In other words, the prohibition on interference with provider-enrollee communications does not affect the M+C benefit and coverage requirements. Clearly, these rules prohibit an M+C organization from requiring health care professionals to sign a ''gag rule'' clause, such as that mentioned by the commenter. Finally, we note that under § 422.506(b)(1)(iv) of the M+C contracting regulations, an M+C organization that commits any acts that can support the imposition of intermediate sanctions is also subject to nonrenewal of its contract.

Comment: One commenter representing health insurance agents recommended that the regulations include a prohibition on physicians ''advising seniors on M+C plans.'' The commenter asserted that only individuals with health insurance licenses should be permitted to proffer such advice.

Response: Although we recognize that there are situations where it would be inappropriate for physicians or other health care professionals to ''steer'' beneficiaries to particular health care plans, we do not believe that prohibiting patients from seeking advice from physicians regarding insurance coverage choices is either necessary or practical. For example, a physician should be able to disclose to a patient the M+C plans in which he or she is a network provider. (For additional discussion of this issue, please see the portion of section II.B of this preamble that discusses M+C marketing requirements at § 422.80.)

Comment: Two commenters recommended that we either delete or clarify the requirement in § 422.206(a)(2) that health care professionals provide information regarding treatment options in a ''culturally competent manner.''

Response: We recognize that the term ''culturally competent'' can be subject to various interpretations, as discussed in detail above in section II.C of this preamble concerning M+C access requirements. For the purposes of this provision, our intent is that M+C organizations establish and maintain effective communication with enrollees, including informing them of treatment options in a language they can understand.

Comment: Two commenters raised concerns related to the conscience protection exceptions set forth in § 422.206(b). One commenter strongly supported the provisions, but recommended that the final rule clarify that: (1) nothing in the conscience protection provisions be construed as limiting the range of services to which Medicare beneficiaries are entitled; (2) an enrollee may terminate enrollment and choose another M+C plan if he or she receives notification under this section that an M+C organization will not cover or pay for a particular counseling or referral service; and (3) like other disclosure requirements, notifications required under § 422.206(b)(2) must be provided in a clear, accurate, and standardized form, consistent with the special needs of individual enrollees.

Another commenter asserted that there was a potential conflict between the conscience protection provisions and the information disclosure rules in § 422.111 and recommended that we establish an exception to the advance disclosure rules for ''duly adopted religious policies.'' The commenter noted that the conference agreement to the BBA indicates the Congress' intent that the Secretary not ''impose burdensome regulatory, legal, or stylistic requirements with respect to this notice requirement.'' (House Report, 105–217, pg. 607.)

Response: As the commenter points out, the conscience protection provisions in no way diminish or otherwise affect the range of benefits or services to which Medicare beneficiaries are entitled. As discussed in section II.C

above, the conscience protection in section 1852(j)(3)(B) of the Act affects only obligations under section 1852(j)(3)(A), not obligations that arise elsewhere in the statute, such as the obligation under section 1852(a)(1) to provide all Medicare-covered services available in the area served by the M+C plan. To the extent that the operation of the right to advice and counseling under section 1852(j)(3)(A) would obligate an M+C organization to cover counseling or referral services that it would not otherwise be obligated to cover, section 1852(j)(3)(B) allows the organization to decline to provide such service on conscience grounds if notice is provided to beneficiaries. However, if the service is one that the organization is obligated to provide independent of section 1852(j)(3)(A), it could not be affected by a provision that by its own terms affects only the way that ''[s]ubparagraph (A) [of section 1852(j)(3)] shall * * * be construed.'' It in no way affects obligations that arise elsewhere in the statute. Therefore, an M+C organization could not rely upon section 1852(j)(3)(B) or § 422.206(b) in an attempt to avoid coverage of services that it is obligated under section 1852(a)(1) to cover. We note, however, that in the case of abortion-related services, the Congress has provided M+C organizations with certain conscience protections independent of that in section 1852(j)(3)(B) of the Act. Specifically, under section 216 of the fiscal year 1999 appropriations legislation (Pub. L. 105–277), we are prohibited from denying an M+C contract to an entity on the grounds that it refuses on conscience grounds to cover abortions. Beneficiaries, nevertheless, retain the right to such services, and Medicare must cover them. We are required, however, to make appropriate adjustments to such an entity's M+C capitation payments to cover our costs in providing Medicare-covered abortion services outside the M+C contract.

We agree that the disclosure provisions under § 422.206(b) should be read consistently with other disclosure provisions in the regulations, and thus M+C organizations must take into account the special needs of individuals who are blind, disabled, or cannot read or understand English. The notification requirements set forth in § 422.206(b)(2) are not intended to result in an M+C organization being put in the position of being required to furnish counseling or referral services that violate a duly adopted religious policy. Experience indicates that neither changes in Medicare coverage policies nor in ''duly adopted'' religious policies take place so quickly as to preclude an M+C organization from providing advance notice to us, and then to enrollees, concerning service restrictions based on such policy changes. Thus, we believe that only very rarely, if ever, would a conflict exist between the advance disclosure requirement of § 422.111(d) and the provision that permits an organization to implement a conscience exception, provided that it notifies its enrollees of such changes within 90 days after adopting the change. Consequently, we do not view the advance disclosure procedure as a burdensome requirement.

7. Physician Incentive Plans (§§ 422.208 and 422.210)

Sections 422.208 and 422.210 outline the limitations and disclosure rules for physician incentive plans. Specifically, § 422.208 applies to an M+C organization and any of its subcontracting arrangements that use a physician incentive plan in their payment arrangements with individual physicians or physician groups. With the exception of the deletion of a requirement that information on expenditures of capitation payments be reported to us, the provisions in these sections are essentially the same as those that previously applied to Medicare risk plans under § 417.479. We received several comments regarding physician incentive rules.

Comment: A commenter contended that the 25 percent threshold for substantial financial risk is too high, noting that we have acknowledged that this represents an outlier approach, and that risk arrangements in the range of 10 to 15 percent are far more prevalent than those in excess of 25 percent. This commenter argued that the 25 percent threshold may render the rule irrelevant as applied to the majority of M+C organizations. In addition, the commenter is concerned that because the exemption level is set so high, the effect of the exemption may be to discriminate against plans that are in the process of growth, thus giving the larger plans a competitive advantage.

Response: As we indicated in the preamble to the physician incentive plan regulation published on March 27, 1996 (61 FR 13430), we believe that the 25 percent risk threshold is appropriate because of the outlier methodology that we used. The median withholds are in the 10 to 20 percent range. This was the best methodology in formulating the risk threshold. Actuarial analyses also supported the 25 percent risk threshold. Furthermore, many physicians typically give discounts in the 25 percent range.

The majority of arrangements that exceed the threshold are capitation arrangements, where 100 percent of the income is put at risk. For these arrangements, the precise amount at which we set the threshold will not make a difference, they will exceed any reasonable risk threshold.

Comment: One commenter pointed out a conflict in the regulatory language. At § 422.208(c)(2), the regulation specifies that the M+C organization provides stop-loss protection; while at § 422.208(f), it specifies that the M+C organization must assure that all physicians and physician groups have stop-loss protection.

Response: The commenter is correct and we are revising the incorrect language in § 422.208(c)(2) to eliminate this discrepancy. We note that paragraph (f) incorporates the language from § 417.479 (the physician incentive regulation that applied to section 1876 contracts) that we indicated in the preamble to the physician incentive regulation that we intended to adopt.

Comment: One commenter contended that the physician incentive plan requirements are excessively detailed, prescriptive, and confusing. The commenter argued that the detailed stop-loss insurance requirements impose additional costs on the delivery of health care, costs that are increasingly borne by the physician practices, not M+C organizations. The commenter urged us to monitor the stop-loss insurance market carefully, and provide prior review of panel size, and deductible limits set forth in the rule to ensure that they are not necessarily restrictive.

Response: In the preamble to the December 31, 1996 final rule (61 FR 69034) containing the section 1876 physician incentive requirements upon which §§ 422.208 and 422.210 were based, we presented a regulatory impact analysis. In that analysis, we concluded that only a small number of organizations and physician groups would need to increase their stop-loss protections, and that this increase would be small relative to the total amount of income. Furthermore, stop-loss insurance is required by statute where substantial financial risk is imposed, and it provides increased protection to physicians that helps reduce possible incentives to deny necessary care. These requirements have been in place for 3 years, and do not appear to have caused any significant problems for M+C organizations or their predecessors.

Comment: A commenter requested that these rules should apply to Federally Qualified Health Centers

(FQHCs) and all associated health care providers. The commenter pointed out that these rules appear limited to individual physicians, physician groups, and intermediate entities acting as subcontractors.

Response: If the FQHC is an intermediate entity, subcontractor, or a physician group as specified in these regulations, then the provisions apply.

Comment: One commenter wanted to know if we review disclosures for both the Medicare and Medicaid programs.

Response: The regulations require that M+C organizations that participate in the M+C program must disclose incentive plan arrangements to us, while managed care organizations that participate in the Medicaid program disclose incentive plan arrangements to the State Medicaid Agencies. We review the monitoring activities of State Medicaid Agencies.

Comment: One commenter indicated support for the methodology for disclosing incentive plans, but requested that we make clear that we do not require the precise formula and payment amounts be disclosed.

Response: Section 422.210(b) requires that an M+C organization must provide the following information to any Medicare beneficiary who requests it: (1) Whether the M+C organization uses a physician incentive plan that affects the use of referral services; (2) the type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) if the M+C organization was required to conduct a survey, a summary of the survey results.

As we indicated in guidance provided in December 1996 to section 1876 contractors, M+C organizations do not have to disclose to beneficiaries the precise formula and payment amounts involved, nor do they have to provide incentive plan information for individual physicians or physician groups. Only summary information needs to be reported. However, the M+C organizations are required to report more detailed information to us or the State Medicaid Agencies.

8. Special Rules for Services Furnished by Noncontract Providers (§ 422.214)

Consistent with sections 1852(k)(1) and 1866(a)(1)(O) of the Act, § 422.214 requires that any health care provider that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an M+C coordinated care plan must accept, as payment in full, the amounts that they could collect if the beneficiary were enrolled in original Medicare (less the amounts specified in §§ 412.105(g) and 413.86(d) of the regulations on hospital graduate medical education payments, when applicable). Any statutory provisions (including penalty provisions) that apply to payment for services furnished to a beneficiary not enrolled in an M+C plan also apply to the payment described in § 422.214(a)(1) of our regulations. We received three comments regarding this section.

Comment: Several commenters suggested that we revise § 422.214 to provide that payment to a noncontracting provider must equal the amount that provider would be allowed to collect under original Medicare. These commenters believe that M+C organizations should only be permitted to pay the billed amount when this is the same amount that Medicare would pay under original Medicare.

Response: Section 422.214 implements section 1866(a)(1)(O) of the Act, with respect to services furnished by a ''provider of services'' as defined in section 1861(u), and section 1852(k)(1), with respect to other services. Neither of these provisions requires an M+C organization to pay a provider more than the amount of the provider's bill, or even impose obligations on M+C organizations at all. Rather, these provisions serve as a limit on the amount the provider can collect from the M+C organization. Specifically, each of these provisions states that a provider ''shall accept as payment in full'' the amount (less the amounts specified in §§ 412.105(g) and 413.86(d) of the regulations) that it would receive under original Medicare, including cost sharing and permitted balance billing (''the Medicare payment amount''). While this means that under these provisions the provider cannot collect *more* than the Medicare payment amount if its billed amount is *higher*, this obligation to ''accept'' the Medicare amount as payment in full does not obligate the M+C organization to pay this amount if the provider's bill is *lower*. Thus, in the case of emergency services and certain other services referred to in section 1852(d)(1)(C) of the Act furnished to an enrollee in a coordinated care plan, the provider or providers must accept the Medicare payment amount for the services if their billed amount is higher, but would have no right under sections 1852(k)(1) or 1866(a)(1)(O) to be paid more than the amount of their bill if the billed amount is lower than the Medicare payment amount.

We note, however, that a provision in the BBA does give providers furnishing services to coordinated care plan enrollees the right to be paid the Medicare payment amount under certain circumstances. Section 1852(a)(2) provides that where an M+C organization chooses to furnish services through providers that do not have contracts with the organization in order to meet its obligation under section 1852(a)(1) to make Medicare services available, it must provide for payment ''equal to at *least*'' the Medicare payment amount. (Emphasis added.) This new provision, unlike section 1866(a)(1)(O) or section 1852(k)(1), establishes a ''floor'' for payment when it applies. This ''floor,'' combined with the ''ceilings'' under sections 1866(a)(1)(O) and 1852(k)(1), essentially requires that the Medicare payment amount be paid where section 1852(a)(2) applies. Because section 1852(a)(2) refers to an M+C organization's furnishing services in fulfillment of its obligations under section 1852(a)(1), we are interpreting section 1852(a)(2), in the coordinated care plan context, as providing M+C organizations with the opportunity to arrange to provide nonemergency services through noncontracting providers. Under this interpretation, the ''minimum payment'' requirement in section 1852(a)(2) would only apply where the M+C organization has arranged for the services in question to be provided by a noncontracting provider. In the coordinated care plan context, therefore, payment for emergency services and those services referred to in section 1852(d)(1)(C) would continue to be subject only to the rules in sections 1852(k)(1) and 1866(a)(1)(O). In the private fee-for-service plan context, however, section 1852(k)(2)(B)(i) of the Act provides that all services furnished by noncontracting providers are subject to the ''minimum payment rate'' in section 1852(a)(2).

To summarize our position, in the case of services arranged by an M+C organization to be furnished by a noncontracting provider to a coordinated care plan enrollee, or any services furnished by a noncontracting provider to a private fee-for-service plan enrollee, section 1852(a)(2) applies, and the M+C organization must pay the Medicare payment amount. In the case of emergency services (referred to in section 1852(d)(1)(E)), urgently needed services (referred to in section 1852(d)(1)(C)(i)), renal dialysis services provided out of the M+C plan's service area (referred to in section 1852(d)(1)(C)(ii)), and maintenance care or poststabilization services (referred to in section 1852(d)(1)(C)(iii)) furnished to a coordinated care enrollee by a noncontracting provider, the provider is required to accept the Medicare

payment amount as payment in full, but the M+C organization is not required to pay more than the billed amount.

Comment: One commenter suggested that we should clearly lay out the process and requirements for compliance with the provisions of § 422.214. In order to implement the payment limits in § 422.214 and not overpay noncontracting providers, M+C organizations will have to develop a process that would apply applicable Medicare payment limits to charges for services furnished to enrollees by noncontracting providers. M+C organizations will need detailed information from us describing each of Medicare's payment limits, how each limit is applied, and which limits apply to which provider.

Response: The comment addresses the need for a process to implement the payment limits contained in § 422.214. We understand that any process used to apply Medicare payment limits will require a significant amount of data and will be relatively complex. However, we do not feel that the requirements for such a process should be set forth in regulation. Each M+C organization should be allowed to develop a process that will satisfy that organization's needs.

As discussed in further detail in section II.Q of this preamble, we anticipate that the organizations offering M+C private fee-for-service (PFFS) plans may have a particular need for such a process, both to pay non-contracting providers who must be paid at least the amount they could collect under original Medicare, and to pay contracting and deemed contracting providers, assuming that the M+C organization offering the PFFS plan has chosen to meet access requirements by paying contracting providers ''no less than'' the amount paid under original Medicare. Therefore, we have decided to permit M+C organizations offering PFFS plans to establish ''proxies'' for use in paying services for which no Medicare prospective payment system or fee schedule exists, provided that the proxy methodology has been approved by us as not being less than the expected Medicare payment amount.

We emphasize that the proxy methodologies will be designed to provide an accurate estimate of the Medicare payment amount, including possible beneficiary cost-sharing under original Medicare. In some cases (for example, for Medicare-certified hospitals, SNFs, or HHAs, or for Medicare-participating physicians), this is the amount that a noncontracting provider is required to accept as payment in full from the M+C organization. In other cases, the amount that a noncontracting provider may collect is not limited to the Medicare payment amount but could include allowable balance billing amounts under original Medicare. In such a case, the provider has a right to collect more from the M+C organization than the Medicare payment amount reflected in the proxy (and in the case of a non-contracting provider furnishing services to a PFFS plan enrollee, the M+C organization may have an obligation to pay more than the proxy amount).

Comment: One commenter asked whether the statement in the preamble that ''the M+C organization must hold beneficiaries harmless against any such balanced billing'' means that an M+C organization must pay billed charges to noncontracting providers regardless of the Medicare fee schedule.

Response: No. Section 422.214 clearly states that a noncontracting provider must accept as payment in full what the provider could collect under original Medicare (less any payments under §§ 412.105(g) and 413.86(d)). Please note that some providers may be entitled to receive an amount that is in excess of the Medicare fee schedules, but that does not exceed the limiting charge.

9. Exclusion of Services Furnished Under a Private Contract (§ 422.220)

An M+C organization may not pay, directly or indirectly, on any basis, for services (other than emergency or urgently needed services as defined in § 422.2) furnished to a Medicare enrollee by a physician (as defined in section 1861(r)(1) of the Act) or other practitioner (as defined in section 1842(b)(18)(C) of the Act) who has filed with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts with the beneficiary under section 1802(b) of the Act. An M+C organization must pay for emergency or urgently needed services furnished by a physician or practitioner who has not signed a private contract with the beneficiary.

Comment: One commenter contended that it is difficult to exclude private contracting physicians and practitioners from payment because there is no central list of private contractors. This commenter believes that we should list these physicians and practitioners on our website, and include unique identifiers, like the physician or practitioner's SSN.

Response: We recognize that it is difficult for M+C organizations to acquire timely and accurate information on ''opt out'' physicians with whom they do not have a contract, and we are working on a way of making this information available to them as soon as possible. M+C organizations offering coordinated care plans could seek this information from the provider or supplier before they authorize the use of a noncontracting physician or practitioner. Moreover, we do not anticipate that the absence of such knowledge would be a problem in cases of emergency or urgent care since in those cases, the services of the opt-out physician or practitioner are covered (unless the enrollee/beneficiary has previously signed a private contract).

As part of our effort to streamline the flow of information on opt-out physicians and practitioners, we are also considering what information can be placed on a list or made available through a website. Some information such as the SSN cannot be disclosed under the Privacy Act.

Currently, M+C plans should contact the Medicare carrier with jurisdiction over the payment of claims under original Medicare in their service area to work out a mutually agreeable means of receiving this information on a timely basis. Disputes should be referred to the HCFA regional office for resolution.

With respect to contracting physicians, M+C organizations may, through their contracts, require contract providers to notify them immediately when they enter into private contracts under section 1802(b). This will provide the information more timely than any process that might be arranged with Medicare carriers or through a listing prepared by us, and will permit the M+C organization to cease payment immediately to the contracting physician or practitioner who has opted out of Medicare.

Comment: One commenter urged that we monitor the disease type and severity of diseases of beneficiaries who privately contract with physicians to determine what future program changes are appropriate.

Response: We are required by section 4507 of the BBA to provide a report to the Congress by October 1, 2001 on the effect of private contracting and to provide recommendations for legislation in this regard. We are conducting a broad study of claims data that will be used to prepare that report.

Comment: A commenter suggested that the private fee-for-service plan discussion of deemed and non-contracting providers be revised to indicate that these payment restrictions do not apply if the provider has opted out under § 422.220.

Response: We have included a clarification by cross reference.

Comment: A commenter believes that beneficiaries need to be advised in both HCFA and M+C plan information that no payment can be made by the M+C organization for services provided under private contract with a physician who has entered into a contract under section 1802(b).

Response: We agree that it is important that M+C plan enrollees know that no payment can be made under the M+C plan for services of physicians and practitioners who have entered into contracts under section 1802(b). Section 1802(b) and private contracting regulations at § 405.400 both require that a private contracting physician or practitioner have the beneficiary (enrollee in the case of M+C plans) sign a private contract that notifies him or her that no Medicare payment will be made for the services of the opt-out physician or practitioner, and that he or she accepts full responsibility for payment of the opt-out physician or practitioner's services (except in cases of emergency medical condition or urgent care in which the physician or practitioner cannot ask the beneficiary to sign a private contract and Medicare will pay for the care). Hence, the plan enrollee should be specifically aware of the effect of receiving services from an opt-out physician or practitioner before he or she receives these services. We will, however, also consider adding a discussion of private contracting to the model evidence of plan coverage.

10. M+C Plans and the Physician Referral Prohibition

The physician referral prohibition in section 1877 of the Act concerns M+C organizations, although the implementing regulations are located in subpart J of part 411 rather than in part 422. Under section 1877, if a physician or a member of a physician's immediate family has a financial relationship with a health care entity (through an ownership interest or a compensation relationship), the physician may not refer Medicare patients to that entity for any of 11 designated health services, unless an exception applies. Under section 1877(b)(3) of the Act and § 411.355(c) of the regulations, services furnished by section 1876 contractors to their enrollees were exempted from the physician referral prohibition. In the June 1998 interim final rule, we revised § 411.355(c) to similarly exclude from the physician referral prohibition services furnished under an M+C coordinated care plan to an enrollee. We did not exclude services furnished by private fee-for-service plans or MSA plans from the physician referral prohibition. Subsequently, section 524 of the BBRA amended section 1877(b)(3) of the Act by adding a new subparagraph (E) to exempt an M+C organization offering an M+C coordinated care plan from the physician referral prohibition. The comments and responses regarding this subject are discussed below.

Comment: One commenter argued that services furnished under an MSA plan or private fee-for-service plan should also be excluded from the physician referral provisions. The commenter believed that while there are differences between these types of plans and coordinated care plans, patients who elect coverage under an MSA plan or a fee-for-service plan do so knowing that their out-of-pocket liabilities are not controlled to the same degree as in a coordinated care plan. In the commenter's view, concerns about beneficiaries should be addressed in the context of disclosures by the M+C organization offering the MSA plan or private fee-for-service plan, prior to enrollment, rather than by the section 1877 provisions. At most, this commenter would require only that M+C organizations offering plans of these types disclose financial interests in entities that furnish designated health services in return for an exception from the prohibition in section 1877.

Response: As we understand the argument, the commenter has suggested that we should exclude M+C private fee-for-service plans and M+C MSA plans from the prohibition on referrals under section 1877 because the concerns addressed by section 1877, that, in general, a physician should not profit from his or her referrals for certain services, has already been accommodated. The commenter believes that beneficiaries already understand that in these plans their out-of-pocket liabilities are not controlled to the same degree as in a coordinated care plan, and that any problems that still might exist can be addressed by more disclosure.

We do not understand why a beneficiary's knowledge of the differences between coordinated care plans and private fee-for-service/MSA plans addresses the concerns behind our decision not to exempt services furnished under the latter plans from the prohibition in section 1877. Under section 1877, we can create a new exception only if the Secretary determines, and specifies in regulations, that a financial relationship between a physician and an entity to which the physician refers does not pose a risk of program or patient abuse. Pursuant to this authority, we exempted services furnished under coordinated care plans because the Congress had already exempted the identical type of arrangement when it exempted services furnished under section 1876 contracts, (and likely inadvertently failed to make a conforming change to this exception when M+C contracts replaced section 1876 contracts), and because we did not see a potential for program or patient abuse in the case of coordinated care plans. This latter conclusion was based on the facts that, as in the case of a section 1876 risk contractor: (1) A physician working with an M+C organization offering a coordinated care plan has no incentive to order unnecessary care, since physicians are not paid for ordering additional services; (2) the organization has control over its network of providers, and provides incentives for its network providers to avoid unnecessary care; and (3) incentives to deny necessary care are addressed by physician incentive plan requirements limiting the risk that can be imposed on physicians. These are the same physician incentive plan requirements that are incorporated in a section 1877 provision permitting certain risk arrangements that would otherwise be subject to the referral prohibition. (See section 1877(e)(3)(B) of the Act.)

In contrast, under M+C MSA plans or private fee-for-service plans, individual providers, including physicians, are paid on a fee-for-service basis for services provided, and thus have the same kind of incentives to provide unnecessary services that gave rise to the enactment of section 1877. Although this would not result in more Medicare funds being expended during the year in question, it could harm beneficiaries in two ways. First, it could result in higher cost-sharing paid by beneficiaries in the current year. Second, it could result in the M+C organization offering less in benefits the following year than it would otherwise be able to offer if its expenses were not as high. For these reasons, we do not believe that the exception from the physician referral prohibition that we have created for services furnished under coordinated care plans should apply to services under M+C private fee-for-service plans or MSA plans. We note that the Congress implicitly endorsed our position through the amendments to section 1877 included in section 524 of the BBRA. This section explicitly exempted M+C coordinated care plans from the physician referral prohibitions, but did not include any changes related to other types of plans.

F. Payments to M+C Organizations

1. General Provisions

Part 422 Subpart F sets forth rules that govern payment to M+C organizations, including the methodology used to calculate M+C capitation rates. These rules are based primarily on section 1853 of the Act. (For a complete discussion of these requirements, see the June 26, 1998 interim final rule at 62 FR 35004.)

One of the more significant payment changes in section 1853 of the Act is a gradual transition from rates based on local Medicare costs to ''blended'' rates based on a 50/50 mix of local and national costs. Under the Adjusted Average Per Capita Cost (AAPCC) payment methodology that applied to section 1876 risk contracts, payment was based on Medicare fee-for-service expenditures in the county in which the enrollee resided. These fee-for-service expenditures were adjusted for demographic factors (that is, age; sex; institutional, welfare, and employment status).

The AAPCC was criticized for its wide range of payment rates among geographic regions: in some cases payment rates varied by over 20 percent between adjacent counties. It was also criticized for its poor risk adjustment capabilities and inappropriate provision of graduate medical education funds to some Medicare risk plans. Moreover, the AAPCC was criticized for setting erratic annual payment updates, which often made it difficult for contracting health plans to engage in long-term business planning. The BBA introduced a new payment methodology that addressed these and other concerns.

''Greatest of'' Payment Rate: Since January 1, 1998 (when the M+C payment methodology under section 1853 was made applicable to section 1876 risk contractors pursuant to section 1876(k)(3) of the Act), the Medicare capitation rate for a given county has been the greatest of: (1) The above-referenced blended capitation rate; (2) a ''minimum amount'' rate established by statute; or (3) a minimum percentage increase. These county rates are then adjusted by demographic factors (and after 2000, by risk adjustment factors) to determine the actual payment amount.

- The blended capitation rate is a blend of the area-specific (local) rate and the national rate, with the latter adjusted for input prices. The blended capitation rate is then adjusted by a budget neutrality factor designed to ensure that payment is not higher than it would be under purely local rates.
- The minimum amount rate was $367 per month per enrollee in 1998 for all areas in the 50 States and the District of Columbia. Outside the 50 States and the District of Columbia, the rate was limited to 150 percent of the 1997 AAPCC for the area in question, if this amount was lower than $367. The minimum amount rate is adjusted each year using the update factors described in § 422.254(b).
- The minimum percentage increase is 2 percent. The minimum percentage increase rate for 1998 was 102 percent of the 1997 AAPCC. Thereafter, it is 102 percent of the prior year's capitation rate.

With the exception of payments under M+C MSA plans, we pay M+C organizations monthly payments for each enrollee in an M+C plan they offer 1/12th of the annual M+C capitation rate for the payment area described in § 422.250(c). Except for ESRD enrollees, these payments are adjusted for such demographic risk factors as an individual's age, disability status, sex, institutional status, and other factors determined to be appropriate to ensure actuarial equivalence. Since January 1, 2000, these rates also have been adjusted for health status as provided in § 422.256(c). For 2000, only 10 percent of the capitation payment will be risk adjusted, with the other 90 percent determined based on the 1999 methodology.

Comment: Several commenters contended that section 1853(c) of the Act set forth artificial and arbitrary limits on capitation rate increases. Because the budget neutrality adjustment applies only to the ''blended rate,'' and the final rate is based on the greatest of the three rates specified, it was not possible to achieve budget neutrality in 1998 or 1999. Once the blended rate was lowered below at least one of the other two rates in each county, no further savings could be achieved through a budget neutrality adjustment. As a result of the adjustments made in an attempt to achieve budget neutrality, however, capitation rates in 1998 and 1999 were all based either on the minimum percentage increase of 2 percent from the prior year, or the new minimum payment rate. The commenters argued that the effect of this would be that M+C organizations would withdraw from Medicare, either entirely or in low payment areas. These commenters suggested that we propose legislative changes to section 1853 of the Act in order to change the formula used to calculate the county payment rates.

Response: The commenter's suggestions concerning changes in legislation are outside the scope of this rulemaking. In this rulemaking, we are charged with implementing the BBA as enacted (and in this final rule, as revised by the BBRA).

However, passage of the BBRA may alleviate some concerns of the commenters. The BBRA requires several modifications to the payment calculations set forth in the BBA, including: lowering the reduction of the national per capita growth percentage defined in § 422.254(b), offering bonus payments to eligible M+C organizations as described in § 422.250(g), and revising our original schedule for transitioning to risk-adjusted payments to providing for an even more gradual introduction of risk adjustment. (See Section I.C for a full discussion of the BBRA provisions.)

Comment: One commenter wanted to know if adjusted excess amounts (determined through the Adjusted Community Rate process identified in § 422.312) affect the computation of the county payment rates if these amounts are placed in a stabilization fund, described in § 422.252.

Response: Amounts deposited in a stabilization fund reduce the payment to the M+C organization for the year in which the funds are deposited (the organization gives up that amount to use it for benefits in a future year), but do not affect the county payment rates.

Comment: Some commenters argued that funding for the ESRD network (§ 422.250(a)(2)(B)) should not be taken from capitation payments to M+C organizations.

Response: Section 422.250(a)(2)(B) implements section 1853(a)(1)(B) of the Act, which specifically requires this reduction in payment rates for enrollees with ESRD. We have, however, changed the wording of our regulations to ensure that the amount taken from the capitation payments remains consistent with the amount required under section 1881(b)(7) of the Act. This does not change our current policy in any way; it merely allows that, if the amount mandated by changes in section 1881 of the Act changes for any reason, our regulations at § 422.250(a)(2)(B) will remain consistent with such a change.

Comment: One commenter requested clarification on the application of the budget neutrality adjustment contained in § 422.250(e)(3).

Response: Section 422.250(e)(1) allows a State's chief executive to request a geographic adjustment of the State's payment areas for the following calendar year. The chief executive may elect to change the area in which a uniform rate is paid from a county to one of the three alternative payment

areas identified in § 422.250(e)(1). Specifically, the governor may choose to have—(1) a single Statewide M+C payment area, (2) a single non-metropolitan payment area, with a separate payment area including metropolitan areas defined in one of two ways, or (3) consolidation of non-contiguous counties. Section 422.250(e)(3) requires us to make a budget neutrality adjustment to all payment areas within that state regardless of which payment area designation is selected by the chief executive. The budget neutrality adjustment is designed to limit the aggregate Medicare payment for Medicare enrollees residing in that state to what would have been paid absent any geographic adjustment.

Comment: One commenter proposed a statutory change that would permit a budget neutrality adjustment to be made to the final capitation rate, not just the ''blended rate,'' as currently provided. Such a change could result in lower payment rates.

Response: The full impact of the BBA and the subsequent revisions included in the BBRA are not yet known; thus, it may be too soon to give Congress recommendations that would have a major effect on our payment to managed care organizations. Therefore, we are not pursuing such a statutory change at this time.

Comment: One commenter suggested that we provide for increased payments to an M+C organization for Part B services provided by contract with federally qualified health centers, and require the increased payment be passed on these centers.

Response: The statute does not authorize us to pay certain M+C organizations differently than others, other than the special rules that apply to determining payments made to an M+C organization offering an M+C MSA plan. Payment for services furnished by a contracting federally qualified health center is limited to the amount negotiated by the two entities.

Comment: One commenter suggested that payment rates should be structured on a regional basis instead of a county by county basis.

Response: Section 1853(d) of the Act defines what is considered an M+C payment area. For Medicare enrollees without ESRD, the payment area is a county. For Medicare enrollees with ESRD, the payment area is a State. The only exception to these rules would be a State that has exercised its right under section 1853(d)(3) of the Act to request an alternative payment area in accordance with § 422.252(e).

Comment: A commenter believes that it is important that M+C organizations have the opportunity to validate our calculations and methodology in calculating payment rates. The commenter accordingly suggested that we cooperate with interested parties by releasing sufficient data to allow those parties to validate our calculations.

Response: We agree. We have complied, and will continue to comply, with all reasonable requests for all relevant and releasable data. M+C organizations must keep in mind that we use a significant amount of confidential data that cannot be released to the public.

2. Risk adjustment and encounter data (§§ 422.256 through 422.258)

Section 1853(a)(3) of the Act required implementation of risk adjustment for payment periods beginning on or after January 1, 2000. In the June 26, 1998 rule, we provided for such risk adjustment in § 422.256(d). We also provided that, in the period prior to the implementation of risk adjustment, we would continue to apply the demographic adjustments used under the old AAPCC methodology.

On September 8, 1998, we published a **Federal Register** notice describing our preliminary risk adjustment methodology and requesting public comments (53 FR 173, pp. 47506 *et seq.*). On January 15, 1999, we published an advance notice, as provided under § 422.258(b) of the regulations, describing the risk adjustment methodology that we implemented for 2000. This advance notice included a detailed description of the new risk adjustment methodology that is in effect in 2000, and information on how risk adjustment will be implemented, including an explanation of the transition method that would be employed. It also responded to comments received in response to the September 8, 1998 **Federal Register** notice. Briefly, the approach we used to meet the year 2000 mandate for risk adjusted payments was:

(1) Based on inpatient data;

(2) Applied individual enrollee risk scores in determining fully capitated payments;

(3) Utilized a prospective PIP–DCG risk adjuster to estimate relative beneficiary risk scores;

(4) Applied separate demographic-only factors to new Medicare enrollees for whom no diagnostic history is available;

(5) Applied a rescaling factor to address inconsistencies between demographic factors in the rate book and the new risk adjusters;

(6) Used 6-month-old diagnostic data to assign PIP–DCG categories (the ''time shift'' model, as opposed to using the most recent data and making retroactive adjustments of payment rates part way through the year);

(7) Allowed for a reconciliation after the payment year to account for late submissions of encounter data;

(8) Phased-in the effects of risk adjustment, beginning with a blend of 90 percent of the demographically-adjusted payment rate, and 10 percent of the risk-adjusted payment rate in the first year (CY 2000); and

(9) Implemented processes to collect encounter data on additional services, and move to a full risk adjustment model as soon as is feasible.

On March 1, 1999, we published the annual Announcement of Calendar Year (CY) 2000 Medicare+Choice Payment Rates, as provided under § 422.266(a) of the regulations. In this announcement, we informed Medicare+Choice organizations of the county rates and factors that were employed for payment in calendar year 2000, including the rescaling factors for use with the risk adjusted portion of payment, and tables of risk and demographic adjustment factors. We also responded to questions and comments on the January 15 notice. (These notices are available on the HCFA Web site, at http://www.hcfa.gov/stats/hmorates/aapccpg.htm.)

Section 1853(a)(3)(B) of the Act provided for the collection from M+C organizations, of encounter data needed to implement the risk adjustment methodology. The BBA required the collection of inpatient hospital data for discharges beginning on or after July 1, 1997, and allowed the collection of other data for periods beginning on or after July 1, 1998. We were prohibited from requiring the actual submission of data before January 1, 1998. This data submission requirement appeared in section 1853(a)(3) of the Act, which was titled ''Establishment of Risk Adjustment Factors.'' (See § 422.256(d).)

Requirements concerning collection of encounter data apply to M+C organizations with respect to all M+C plans, including private fee-for-service plans. Instructions for the collection of hospital encounter data were sent to M+C organizations in December 1997 (OPL 97.064) and May 1998 (OPL 98.71). Hospital discharges for the period July 1, 1997 through June 30, 1998 have been collected and used for estimating the impact of risk adjustment at the contract level and in the aggregate. We announced in the January 15, 1999 notice of methodological changes that comprehensive risk adjustment would be implemented for

payments beginning on January 1, 2004. We will soon be providing M+C organizations with guidance concerning requirements for submission of outpatient, physician, and other non-inpatient encounter data.

There are two different ways encounter data are used for risk-adjustment purposes. To calculate payment rates, encounter data are necessary to tie payment to expected patient resource use using diagnosis codes. (The initial risk-adjusted payment will be based on inpatient hospital encounter data. However, we are developing a more comprehensive risk-adjustment methodology that uses diagnosis data from physician services and hospital outpatient department encounters.) Encounter data are also necessary to ''recalibrate'' any risk-adjusted payment model. Recalibration adjusts payment models for changes in resource requirements that derive from such factors as technological change and improved coding.

While these are the primary purposes collecting the encounter data, we discussed other possible uses of these data in the June 1998 interim final rule. These other uses include identification of quality improvement targets and monitoring the care received by M+C enrollees through targeted special studies (such as an examination of post-acute care utilization patterns). Encounter data will also be useful for program integrity functions, both by providing additional utilization norms for original Medicare billing and by providing additional information regarding M+C organizations' behavior.

As noted above, the notices of January 15, 1999, and March 1, 1999, contained detailed discussions of the risk adjustment methodology and responses to comments. Similar notices, reflecting BBRA changes, and our methodology and rates for 2001, were published in January and March of 2000. Here we respond formally to comments submitted on the June 26, 1998 rule.

Comment: A number of commenters recommended that we not adopt a risk adjustment system based solely on hospital encounter data. As a matter of public policy, the commenters objected that basing the initial risk adjustment methodology solely on inpatient data would create inappropriate incentives to hospitalize patients, skew payments toward plans with higher hospitalizations, and penalize plans that have appropriately reduced inpatient services by focusing on outpatient care. Other commenters requested a phase-in of the methodology to minimize the disruption on M+C organizations, and allow time to assess the impact of the new methodology.

Response: We do not believe it would be desirable to delay implementation of risk adjustment until data other than inpatient data are available. We have analyzed the PIP–DCG system sufficiently to be confident that it represents an improvement over the current system of demographic-only adjustment, that it provides an appropriate interim step toward a comprehensive risk adjustment model, and that it provides appropriate levels of payment for different classes of beneficiaries. We believe that the blend transition methodology should relieve concerns about disruption of payments, especially since the initial blend percentage for the risk-adjusted portion is 10 percent.

Even if we believed that delaying risk adjustment were desirable, we do not have the authority to do so. The Balanced Budget Act specifically required ''implementation of a risk adjustment methodology * * * no later than January 1, 2000.'' In order to meet that deadline, we were constrained to employ a model based on hospital encounter data alone in the interim until the data to implement a comprehensive risk adjustment methodology can be provided by all plans and processed by us. The Medicare+Choice legislation (section 1853(a)(3)(B) of the Act) provided for the collection of non-inpatient data for periods beginning on or after July 1, 1998, a full year later than the date for which inpatient data would be collected. This provision envisioned that a hospital-only system would be implemented initially, both because it seemed more feasible for M+C organizations to produce inpatient data only in the short term, and because the effect of a hospital-only system on payments would be smaller than a system based on comprehensive encounter data. (The Medicare+Choice regulations further provided that we would collect physician, outpatient hospital, SNF, or HHA data no earlier than October 1, 1999. See § 422.257(b)(2)(i).) However, the statute grants us broad authority to develop a risk adjustment methodology, and does not prohibit us from including a transition or ''phase-in'' period as a component of the methodology we develop.

We therefore included a transition period as a component of our risk adjustment methodology, initially using a blend of payment amounts under the current demographic system and the PIP–DCG risk adjustment methodology. Under a blend, payment amounts for each enrollee would be separately determined using the demographic and risk methodologies (that is, taking the separate demographic and risk rate books and applying the demographic and risk adjustments, respectively). Those payment amounts would then be blended according to the percentages for the transition year.

In order to provide adequate safeguards against abrupt changes in payment, our transition mechanism initially provided for a low blend percentage of the risk-adjusted payment rate. Specifically, first year blend percentages will be 90 percent of the demographically adjusted rates, and 10 percent of the risk-adjusted payment rate. We are also contemplating a five-year transition, which would culminate in full implementation of comprehensive risk adjustment, using all encounter data, in the fifth year. Our initial transition schedule, announced in the January 5, 1999, Advance Notice of Methodological Changes for the CY 2000 Medicare+Choice Payment Rates was:

	Demographic method	Risk method
CY 2000	90 percent	10 percent.
CY 2001	70 percent	30 percent.
CY 2002	45 percent	55 percent.
CY 2003	20 percent	80 percent.
CY 2004	100 percent comprehensive risk adjustment (using encounter data from multiple sites of care).	

Subsequently, passage of Section 511(a) of the BBRA has revised the original transition schedule, providing for an even more gradual introduction of risk adjustment. Specifically, the legislation provides that the blend percentages will be:

	Demographic method	Risk method
CY 2000	90 percent	10 percent.
CY 2001	90 percent	10 percent.
CY 2002	at least 80 percent	no more than 20 percent.

In order to implement comprehensive risk adjustment in CY 2004, we will soon be providing M+C organizations with guidance concerning requirements for submission of outpatient, physician, and other non-inpatient encounter data.

Comment: Some commenters emphasized that implementation of risk adjustment could inject uncertainty and reduce the predictability of payments to M+C plans.

Response: Our most recent estimate, based on the 285 organizations that were active in September, 1998, and that did not terminate their contracts with Medicare in 1999, (including 10 organizations that merged into other active M+C organizations as of January 1, 1999), was that aggregate payments would decrease 0.6 percent, taking into account the blend percentages in effect for 2000, (90 percent demographic adjusted amount, 10 percent risk adjusted amount). While the impact on specific organizations will vary, our analysis suggests that, except for highly unusual circumstances (for example, a high proportion of working aged enrollees), the maximum decrease in payment to any organization from risk adjustment alone will be less than 2 percent. The analysis did not suggest that smaller organizations, or any other specific category, would experience a disproportionate impact. We will, however, continue to monitor the impacts on organizations throughout the transition period. We believe that our transition mechanism should alleviate concerns about large and abrupt changes in payment.

Comment: One commenter expressed concern about the effect on people with Alzheimer's disease of a risk adjustment methodology based solely on hospital encounter data. Because Alzheimer's and dementia are often not included in the recorded diagnoses of hospitalized beneficiaries, hospital data alone cannot support accurate conclusions about the cost of hospital care for these beneficiaries. Several other commenters expressed similar concerns about the implications of the initial risk adjustment methodology for beneficiaries with other chronic conditions.

Response: Our validation tests on the PIP–DCG model actually show that this model offers a substantial improvement over the system of demographic-only adjustments that has been previously in use. One measure of a model's accuracy is its ability to predict mean expenditures for groups correctly. Health Economics Research (HER), which served as a contractor to HCFA in developing the PIP–DCG model, measured the predictive ratios, (that is, the ratio of mean predicted expenditures to mean actual expenditures), for groups of Medicare beneficiaries that are of policy or technical interest. Among the groups used in this validation analysis were chronic condition groups, defined by ambulatory as well as inpatient diagnoses. HER found that, while the PIP–DCG model underpredicted for many chronic disease groups, this model performed better than the demographic model. For example, the predictive performance for persons with dementia (which includes individuals diagnosed with Alzheimer's) increased from 0.91 under the demographic system to 1.07 under the PIP–DCG model. Further detail on the validation analyses can be found in our ''Report to Congress: Proposed Method of Incorporating Health Status Risk Adjusters into Medicare+Choice Payments,'' and in the HER report ''Principal Inpatient Diagnostic Cost Models for Medicare Risk Adjustment,'' which is appended to it. The reports can be found on our Web site (http://www.hcfa.gov/ord/rpt2cong.pdf).

Comment: One commenter objected that the risk adjustment system does not account for secondary diagnoses. A patient with two acute diagnoses could be more ill and more costly than a patient with the same primary diagnosis, but a less severe secondary diagnosis. Another commenter supported the development of an initial risk adjustment methodology based on inpatient data alone, since inpatient costs represent the largest expense item of health plans. But this commenter recommended that such a methodology should account for both primary and secondary diagnoses, since secondary diagnoses are necessary to account for the higher costs of beneficiaries with multiple health problems and chronic conditions that are more expensive to treat.

Response: The analysis conducted in the early stages of developing an inpatient-based risk adjustment model included consideration of incorporating secondary diagnoses. The analysis concluded that secondary diagnoses did not contribute significantly to predictive accuracy in the context of an inpatient model. As noted above, the inpatient hospital model represents a significant improvement in predictive accuracy over the demographic adjustments that have been in use. However, it is only an interim step toward a comprehensive risk adjustment system. We anticipate that the comprehensive risk adjustment model under development will base risk scores on multiple diagnoses from disparate sites of care.

Comment: One commenter recommended that we develop the capability to use diagnosis data from all sites of care as quickly as possible in the risk adjustment system. Other commenters expressed concern about the costs and burdens of collecting the physician, outpatient hospital, skilled nursing facility, and home health agency encounter data that will be necessary for the implementation of comprehensive encounter data in 2004. Several commenters objected that the time frame contemplated for the submission of these data is too short to allow M+C organizations to procure and install the required systems. One commenter urged that, in preparing for submission of encounter data from physician offices, mechanisms should be established for the transition from paper claims to electronic bills for those practices that ''have not entered the electronic age.''

Response: The PIP–DCG model represents a substantial improvement over the current system. Because it identifies a subset of seriously ill beneficiaries for increased payment and because the effect of a hospital-only system on payments is smaller than a system based on comprehensive encounter data, the PIP–DCG model is an appropriate interim step toward comprehensive risk adjustment. A comprehensive model is nevertheless preferable, and we plan to move toward implementing such a model as expeditiously as possible. However, implementation of the comprehensive risk adjustment model is not operationally feasible for 3 to 4 years, because of data constraints on both plans and on us. The transition plan announced in the January 15, 1999

notice therefore provides for implementation of comprehensive risk adjustment in 2004, without ever reaching full payment under the PIP–DCG system. In the interim, the PIP–DCG model offers a substantial improvement over the current system.

In providing for payment under a comprehensive risk adjustment system in 2004, we have taken into account the costs and burdens necessary for organizations to develop the capacity for collecting and submitting physician, outpatient hospital, skilled nursing facility, and home health agency encounter data. This is the most ambitious schedule that we believe we can adopt consistent with allowing sufficient time for organizations and the agency to prepare.

Comment: A number of commenters objected that the collection of encounter data is burdensome and expensive. Some commenters asserted that this requirement may deter new managed care contractors, especially smaller organizations, from participating in the M+C program. Several commenters observed that not all the data required for submission of encounter data are necessary for computing risk adjustment. Another commenter urged us to monitor the trade-off between risk adjustment accuracy and risk adjustment data-collection requirements, and seek opportunities to streamline the burdens of encounter data collection. One commenter recommended that we explore alternatives to collection of all encounter data, such as survey-based approaches.

Response: We have made every effort to minimize the burden of collecting encounter data, and to assist M+C organizations with problems that have arisen in collecting and processing these data. In the initial stages of collecting encounter data, we are permitting organizations to use an abbreviated version of the standard UB–92 form employed in hospital billing. Data elements in the abbreviated UB–92 form have been restricted to those items necessary to calculating risk scores and pricing the discharge, as well as some document identification items that are normally generated automatically in electronic processing. (As we discuss below, pricing of discharges is necessary to allow recalibration of the model.) Use of the abbreviated UB–92 form will be allowed for discharges at least through June 30, 2001.

The legislation mandating risk adjustment also provides for the collection of inpatient and other encounter data. The legislation therefore contemplates a risk adjustment system based on encounter data rather than surveys. We believe that the greater accuracy of a system based on full submission of encounter data justifies the additional burdens that this requirement entails.

A range of problems in the submission of encounter data have arisen. These problems have included: not following the required UB–92 format, difficulties in accurately tracking counts of discharges, failure to arrange hospital submission of encounter data, difficulties in understanding Fiscal Intermediary reports, and HCFA/FI and FSS processing problems. Plans themselves may have problematic data processing systems in-house. We have worked with Medicare+Choice organizations, managed care associations, and other parties to address many specific issues that have arisen concerning data transmission and processing, and we will continue to do so. We have taken a number of specific steps to facilitate and improve the encounter data submission process. These activities have included the following:

- Encounter Data Reconciliation Analyses—We have shared with M+C organizations analyses of their individual M+C plan level data. The data have been successfully posted at our offices. We have further conducted analyses upon request at the provider level and by the different methods of submission to help explain discrepancies. We are in the process of sharing these analyses with the plans. The detailed provider level analyses are requiring additional time to conduct, and the results of these analyses will be shared with plans over the coming weeks.
- Onsite Consultations—Our contractor conducted a series of onsite consultation visits to 20 M+C organizations in order to learn more about the process of data submission. The majority of the 20 organizations selected for the visits were those that experienced problems with encounter data submission. The information gained during these visits will be used to assist plans to identify and resolve problems.
- HCFA Data System Fixes—Processing problems have been identified that relate to beneficiaries who change from one M+C plan to another. The estimated number of affected encounters from all plans is less than 3,000. These problems will be fixed over the next 2 months, and they are not expected to impact the March 1 rate estimates, which, in any case, will not be used to make direct enrollee payments.
- Communication with the FIs—We have shared data problems raised by M+C organizations with the FIs. Furthermore, discussions between us, FI's, and plans have been encouraged in order to address problems.

Comment: Several commenters objected that we should not place the burden of collecting encounter data and assuring their accuracy solely on M+C organizations, but rather on the providers submitting the data to the organizations. Some of these commenters suggested imposition of a requirement on providers that they cooperate with M+C organizations in collecting encounter data.

Response: We did not include requirements on providers in the interim final rule because we traditionally have tried to minimize the adoption of measures that would insert our requirements into the contractual relationships between managed care organizations and providers. We therefore suggested to M+C organizations that they modify their contracts with hospitals to ensure that managed care discharges are identified, and the appropriate records are provided to the organization by the hospital. We also have taken every opportunity to inform hospitals and hospital associations of the encounter data requirements and the importance of collecting complete and accurate encounter data to assure correct payment. Collection of encounter data for the ''start up'' year of July 1997 through June 1998, which was the basis for estimating the impacts of risk adjustment, was quite successful, and we have every reason to believe that collection of data for the next year, which will be used to determine actual risk adjustments in 2000, will go at least as well.

However, M+C organizations have informed us that some providers are either failing to submit encounter data at all, or submitting data that do not conform to quality standards for submission to our systems (for example, that the coding often fails to meet standards required to pass the coding edits). To the extent usable data are not submitted, M+C organizations are denied the benefit of any risk adjustment that might be justified based on the costs in question. We are therefore proposing to make several changes to the rules that are designed to give M+C organizations greater leverage in obtaining adequate cooperation from providers to submit complete and accurate data.

First, we will make explicit in § 422.257 that M+C organizations are required to obtain from providers,

suppliers, physicians, or other practitioners information sufficient to submit the required encounter data. (Currently the regulation states that M+C organizations must submit encounter data, but leaves the requirement of obtaining the necessary information from providers and others to inference.)

Second, we will specifically state in the rules that M+C organizations may include a requirement for submission of complete and accurate encounter data, conforming to the format used under original Medicare, in their contracts with providers, suppliers, physicians, and other practitioners. Contracts with providers and others may impose financial penalties, including withholding payment, for failure to submit complete and accurate data conforming to all requirements for submission. We have revised § 422.257 of the regulations to reflect these two changes.

Third, as discussed below in section K, we have modified the definition of ''clean claim'' in § 422.500 to specify that a claim must include information necessary for purposes of encounter data requirements, and must conform to the requirements for a clean claim under original Medicare. This will exempt claims that do not, for example, meet accurate coding requirements from the application of the ''prompt payment'' standard that applies to claims submitted by non-contracting providers. This standard requires that ''clean claims'' submitted by non-contracting providers be paid within 30 days, or interest will be owed. M+C organizations will therefore be able to withhold payment in cases in which non-contracting providers submit claims with inadequate coding or other deficiencies that make the claims impossible to use for encounter data purposes.

Fourth, we are providing a reconciliation process which will give M+C organizations additional time to submit encounter data before final payment determinations are made. M+C organizations have approximately 3 months after the end of a data collection year to submit the encounter data that will be used to develop beneficiary risk scores to their fiscal intermediary. For example, M+C organizations must submit encounter data for the period July 1, 1998 through June 30, 1999 to their fiscal intermediary by September 17, 1999. If organizations submit encounters after this date, they will not be incorporated into payments for CY 2000. However, in response to concerns expressed by M+C organizations over this short time frame, we expect to institute a reconciliation process that will take into account late data submissions. M+C organizations should attempt to have all data in by the annual deadline of September 10. However, if organizations receive UB–92s from hospitals after this date, they may submit the encounter to their fiscal intermediary and the data will be processed. M+C organizations should note that the deadline for submission of all data from a payment year will be June 30 of the payment year for the period ending the previous June 30 (for example, the final deadline for the period of July 1, 1998 to June 30, 1999, which is used for payment in 2000, will be June 30, 2000). After that date, the fiscal intermediary will no longer accept these data. After the payment year is completed, we will recalculate risk factors for individuals who have late encounters submitted. Then, we will determine any payment adjustments that are required. This reconciliation will be undertaken after the close of a payment year and will be a one-time only reconciliation for each payment year. We are adding § 422.256(g) to provide for this reconciliation process.

Comment: Some commenters expressed doubts about the completeness and accuracy of the encounter data submitted during the ''start up year,'' which was used to develop estimates of the impact of risk adjustment. Some expressed concern that systems problems have impeded the posting of complete and accurate data. Several commenters expressed doubts that sufficiently complete and accurate encounter data could be available in time to begin risk-adjusted payment on January 1, 2000.

Response: Hospital encounter data were collected from managed care organizations for discharges between July 1, 1997 and June 30, 1998. Approximately 1.5 million encounters were submitted to us for over 5.7 million beneficiaries. The volume of data received is sufficient to generate an estimate of the impact of risk adjustment, and to conduct other analysis in order to prepare for implementation of risk adjustment. Based on this experience, we are confident that sufficient data will be generated to calculate beneficiary risk scores and other information necessary for implementation of the PIP-DCG model.

Comment: One commenter requested clarification of the statement in the preamble that encounter data may be used for purposes other than calculating risk adjustments.

Response: We commonly use data collected in the course of calculating payments for other purposes. These purposes include monitoring program integrity, studying utilization patterns and quality of care, and a variety of research purposes. Our use of data is always governed by consideration of privacy concerns and confidentiality of business operations.

Comment: Several commenters asked for further information concerning how we intend to recalibrate risk-adjusted payments to account for upcoding. Another commenter questioned whether use of the full UB–92 is necessary for this recalibration, and suggested that we consider other approaches.

Response: As we discussed above, recalibration is necessary to adjust the payment models for changes in resource requirements that derive from such factors as technological change and improved coding. Upcoding may occur if plans improve coding of beneficiary diagnoses and, as a result, the average use of resources for enrollees in a particular category may be less than when the relative payment rates were determined. When this happens, the average actual expenditures per enrollee for these diagnoses may be less than the average expenditures used to assign the original payment weights. The result is overpayment for some diagnoses in the risk adjustment model. On the other hand, technological changes, which often result in more intensive use of resources for certain diagnoses, can lead to underpayment for certain diagnoses unless the model is recalibrated. Recalibration is a standard feature of well-established payment systems, such as the hospital prospective payment system. We have not yet developed a specific timetable for recalibrating the PIP–DCG model. We will not recalibrate the model until we have sufficient data from Medicare+Choice organizations to incorporate managed care practice patterns into the recalibration.

Comment: Several commenters expressed concern about the attestations required of M+C organizations, with respect to the accuracy and completeness of encounter data. One of these commenters expressed the view that the requirement for an attestation that submitted encounter data are ''accurate, complete, and truthful'' is designed more as a legal trap for those that might innocently submit incomplete or inaccurate data, than as good public policy. Another commenter recommended that the attestation allow for honest mistakes and unavoidable margins of error.

Response: Attestation of encounter data has been a contentious issue. Attestation of encounter data is essential for guaranteeing the accuracy and

completeness of data submitted for payment purposes, and to allow us to pursue penalties under the False Claim Act, where it can be proven that a plan knowingly submitted false data. However, in response to concerns from M+C organizations, we have restricted the attestation requirement to confirmation of the completeness of the data and the accuracy of coding. Since this is information that M+C organizations are, or should be, in the position to know, the attestation requirement is thus in no way a legal trap.

Comment: One commenter recommended that we develop mechanisms, with the assistance of consumer representatives, to make encounter data available to Medicare beneficiaries and their representatives.

Response: The commenter did not identify the ''beneficiary representatives'' to whom encounter data would be made available, nor the purposes for which the data would be used. We would consider specific requests for data in the light of privacy and other considerations which normally govern the use of data gathered for official purposes in the program.

Comment: Several commenters expressed concern about the short time frame for submission of Adjusted Community Rate proposals after the release of county rates, rescaling factors, and risk adjustment impact estimates on March 1. The commenter urged disclosure of key information such as the rescaling factors earlier in order to give plans the opportunity to base their rate and benefit submissions on more complete financial information.

Response: Section 516 of the BBRA extended the ACR deadline to July 1, and applied that extension retroactively to 1999. Therefore, we have changed our regulations at § 422.306(a)(1) to reflect this statutory change, which has addressed the commenter's concerns.

3. Special Rules for Hospice Care (§ 422.266)

Comment: One commenter requested clarification on reporting institutionalized members who have elected hospice care, and how the M+C organizations will determine whether a new member is in hospice care.

Response: Medicare enrollees who have elected hospice care should not be reported as institutionalized. Medicare beneficiaries that have elected hospice, and subsequently elect an M+C plan will be identified by our system.

Comment: One commenter requested clarification of the M+C organization's responsibility in arranging for the provision of hospice care for those enrollees who have elected hospice care.

Response: Section 422.266 requires the M+C organization to inform each Medicare enrollee eligible to elect hospice care about the availability of hospice care in the area or outside the area, if it is common practice to refer patients accordingly. An M+C organization is not required to arrange for hospice services when the hospice election has been made.

Comment: One commenter requested further clarification on our payment for a Medicare enrollee when the enrollee elects hospice.

Response: Our monthly capitation is reduced to the adjusted excess amount developed in the ACR. The amount of the reduction is the ACR value (less the actuarial value of Medicare's deductibles and co-insurance) for Medicare-covered items and services. For Medicare-covered items and services, the M+C organization or provider furnishing the service would bill us using Medicare's normal billing rules under original Medicare. Also, hospice services are billed under original Medicare rules.

G. Premiums and Cost-Sharing

1. General Provisions

Part 422, subpart G is based on the provisions found in section 1854 of the Act. These provisions were discussed in detail in the June 26, 1998 interim final rule (63 FR 35007). This subpart addresses how limits on M+C plan enrollee premiums and other cost-sharing are established through the Adjusted Community Rate (ACR) approval process. The ACR process is applicable to all M+C plans except M+C MSA plans. M+C organizations offering an M+C MSA plan are not required to submit an ACR for that plan, but they are required to submit other information for our review using the ACR process.

Section 422.300(b) provides that for contract periods beginning before January 1, 2002, M+C organizations may modify an M+C plan by adding benefits at no additional cost to the M+C plan enrollee; lowering the premiums approved through the ACR process; or lowering other cost-sharing amounts. Also prior to January 1, 2002, under § 422.504(d), contracts may be for a longer period than 12 months, and may begin on a date other than January 1. In the case of such contracts, under § 422.300(b)(2), ACRs must be submitted on the date specified by us. The transition rules for this period are found in § 422.300(b).

Comment: One commenter suggested a revision of the ACR form used to establish the pricing structure for an M+C plan. The commenter suggested that the new form produce more accurate information. The commenter urged that we monitor data submitted in the ACR form to determine whether established policies should be revisited.

Response: We agree. We are developing various systems to capture ACR data for policy analysis. We intend to use the data to determine the effect of established policies so that we can examine policies that need revision.

Comment: One commenter suggested that we consider alternatives to the ACR for private fee-for-service and MSA plans.

Response: Under the June 1998 interim final rule, we do not review or approve premium amounts submitted for private fee-for-service plans or MSA plans. In addition, in the case of an MSA plan, an M+C organization does not complete those parts of the ACR form that request cost information. Thus, in essence, there is an ''alternative'' arrangement in place for these types of plans.

Comment: One commenter suggested that we, in consultation with industry representatives, develop acceptable standards for cost accounting to be used by M+C organizations to complete its ACR form.

Response: We agree that M+C organizations should be using uniform cost accounting standards to complete the ACR form. Therefore, we specified in § 422.310(a)(5) that generally accepted accounting principles (GAAP) should be used instead of other accounting principles (for example, statutory). We have not ruled out the establishment of a standardized accounting system at this time. However, we feel that the existing accounting systems based on GAAP developed by M+C organizations should produce sufficiently accurate information for ACR purposes. We will monitor the accuracy of the ACR data produced by the M+C organizations' accounting systems through audit and other monitoring procedures.

Comment: One commenter suggested that we should either allow M+C organizations to modify their M+C plan after the M+C plan has been approved, or make the transition period rules described in § 422.300(b) permanent. The commenter felt this would benefit the Medicare beneficiary.

Response: After 2002, Medicare beneficiaries will be ''locked in'' to their M+C plan choice for the last 9 months of the year (6 months in the case of 2002 only). The beneficiary will be locked in

for the entire year if he or she wants to remain in the M+C program, and no other M+C plan in the area is open during January, February, and March. The choice of an M+C plan during the annual November open enrollment period thus will be extremely significant, since, in most cases, it will determine enrollment for the entire following calendar year. We believe that under this program design, it is important that beneficiaries have complete information in November about what the benefits will be in each M+C plan in their area for the full following calendar year. If M+C organizations were permitted to change plan benefits mid-year, this could result in a beneficiary deciding that an M+C plan that is changing benefits would have been a better choice had he or she known in November that this change would be made, but it would be too late for the beneficiary to enroll in that plan after April 1.

We accordingly believe that beginning in 2002, (when beneficiaries will be locked in for the last 6 months of the year), benefits for a given calendar year should be established in advance of the November open season. This will allow beneficiaries to make informed decisions about which M+C plan they will choose for the following calendar year. In order for this to happen, the benefits that will apply throughout the following calendar year must be included in the ACR submission filed with us, so that these benefits can be approved by us in time to provide reliable information to beneficiaries.

Our decision to require uniform benefits throughout the calendar year after a transition period is further supported by the nature of the ACR process under M+C. As under the section 1876 risk program, the ACR process under the M+C program serves three important purposes. First, we are required to examine an M+C organization's ACR proposal for each M+C plan to determine if Medicare beneficiaries are entitled to receive additional benefits as a result of Medicare payments that are higher than the organization's charge (adjusted for differences in utilization characteristics of the Medicare population) to a non-Medicare enrollee for a Medicare-covered benefit. Second, we are required to review ACR proposals to determine whether the pricing structure (premiums and cost-sharing charged to beneficiaries) is within the limits established by law as required under section 1854(b)(1) of the Act, and is applied uniformly to all Medicare enrollees as required under section 1854(c) of the Act. Third, we review benefit package information to determine if the benefit package is in compliance with the requirements contained in subpart C. Once this process is complete, M+C organizations are allowed to market the M+C plan as approved.

Under the M+C program, we focus on an entire calendar year in performing the above tasks. Our approval of the pricing structure of an M+C plan is based on the appropriate actuarial value of furnishing the items and services for the entire calendar year. Limits on the amount of premiums (section 1854(b) of the Act), and on the liability of the Medicare beneficiary (section 1854(e) of the Act), are based on a 12 month period. In addition, the capitation payments that will be made to the M+C organization under section 1853(a) of the Act for the M+C plan is an integral part of establishing the value of additional benefits that must be offered under section 1854(f) of the Act. Capitation payments are based on the annual M+C capitation rate for the county (that is, the amount for the full calendar year), adjusted for various demographic and other risk factors. Section 1853(c)(1) of the Act clearly states that capitation rates are based on a contract year consisting of a calendar year. We believe that this entire scheme assumes that benefits will be the same over the 12 month period at issue. This is another reason why we believe our decision to eliminate mid-year changes after a transition period is appropriate.

2. Rules Governing Premiums and Cost-Sharing (§ 422.304)

This section implements provisions of the BBA relating to premiums paid by or on behalf of beneficiaries. The beneficiary in an M+C plan, other than an M+C MSA plan offered by an M+C organization, pays the monthly basic premium plus the monthly supplemental premium, if any. In the case of an M+C MSA plan, the beneficiary must pay the monthly supplemental premium, if any. The M+C monthly basic beneficiary premium, the M+C monthly supplemental premium, and the monthly MSA premium may not vary among individuals in the M+C plan, unless the M+C organization offering the plan has elected to apply this rule to individual segments of a plan service area, as provided in section 515 of the BBRA (See section I.C of this preamble). Also, the M+C organization cannot vary the level of cost-sharing (copayments, coinsurance, or deductibles) charged for the basic benefits or supplemental benefits, if any, among the individuals enrolled in the M+C plan, again unless the M+C organization has elected to apply this rule to segments of the plan service area, as provided in section 515 of the BBRA.

As discussed in section I.C above, under section 515, the premium and cost-sharing uniformity requirements may be applied only within segments of an M+C plan's service area, with premiums or cost-sharing varying between such segments, provided: (1) a separate, and complete ACR is filed for each such segment; and (2) each segment is composed of one or more M+C payment areas. We have revised § 422.304(b) to add a new paragraph (b)(2) that provides for this option.

Comment: A commenter noted that some M+C organizations offer enrollees economic incentives to use mail-order pharmacies by imposing a copayment on all prescriptions dispensed in the community pharmacies, but do not charge a copayment if the same prescription is mailed to the enrollee. The commenter wanted to know whether this practice is prohibited under the uniform cost-sharing rule in § 422.304(b).

Response: The practice the commenter has described is not prohibited, since all enrollees under the plan would pay the same cost-sharing for drugs not ordered by mail, and the same cost-sharing for drugs ordered by mail. However, an M+C organization would not be permitted to impose a structure of cost-sharing that would have the effect of denying access, as described in section 1852(d) of the Act, to an item or service advertised by the organization as being available to the enrollee.

3. Submission Requirements for Proposed Premiums and Related Information (§ 422.306)

This section reflects the original BBA version of section 1854(a)(1) of the Act, which prior to the BBRA provided that each M+C organization, and any organization intending to contract as an M+C organization in the subsequent year, submit specified data for every plan it intends to offer no later than May 1 of each year.

Comment: Many commenters recommended that the May 1 deadline for the submission of the ACR proposal be changed.

Response: As discussed in section I.C above, section 516 of the BBRA extended the ACR deadline permanently to July 1, and applied that extension retroactively to 1999. Therefore, we have changed our regulations at § 422.306(a)(1) to reflect this statutory change.

4. Limits on Premiums and Cost-Sharing Amounts (§ 422.308)

Section 422.308(a) imposes a limit on the amount that an M+C organization can charge as a basic beneficiary premium for a coordinated care plan, or impose as cost-sharing under such a plan. Specifically, the basic premium (multiplied by 12), the actuarial value of any cost-sharing, or a combination of these two forms of beneficiary liability, may not exceed the annual actuarial value of the deductibles and coinsurance that would be applicable on average to beneficiaries entitled to Medicare Part A and enrolled in Part B if they were not enrollees of an M+C organization. For those M+C enrollees who are enrolled in Medicare Part B only, the monthly basic premium (multiplied by 12), plus the actuarial value of cost-sharing, may not exceed the annual actuarial value of the deductibles and coinsurance that would be applicable to beneficiaries enrolled in Medicare Part B if they were not enrollees of an M+C organization. With respect to supplemental benefits under coordinated care plans, the monthly supplemental beneficiary premium (multiplied by 12) charged, plus the actuarial value of its cost-sharing, cannot exceed the ACR for such services.

In the case of a private fee-for-service plan, there is no limit on premium charges. However, under § 422.308(b), the actuarial value of any cost-sharing imposed under the plan may not exceed the actuarial value that would apply to beneficiaries entitled to Medicare Part A and enrolled in Part B if they were not enrolled in an M+C plan as determined in the ACR. In the case of supplemental benefits, the actuarial value of cost-sharing may not exceed the ACR amounts for the benefits. Additionally, if inadequate data is available to determine actuarial value, we can make the determination with respect to all M+C eligible individuals in the same geographic area or State or in the United States on the basis of other appropriate data.

Comment: One commenter suggested that the limits on premiums in § 422.308 should not apply in the case of dual eligibles, to the extent that the Medicaid program is paying the premiums.

Response: We do not agree. Section 422.308 limits the amount that can be charged to Medicare enrollees, or anyone on their behalf, for the M+C plan. However, we recognize that the Medicaid program may pay additional amounts for Medicaid-covered benefits not included in the M+C plan. Therefore, we have clarified our jurisdiction over Medicaid benefits for dual eligibles in § 422.106. (See the discussion in section II.C of this preamble.)

Comment: One commenter requested clarification of the limit on charges to a Part B-only member for Part A services.

Response: If an M+C organization chooses to include in the B-only M+C plan an equivalent Part A benefit, it may do so as an additional, mandatory supplemental, or as an optional supplemental benefit. There is a limit on what is allowed to be charged for this benefit: the lesser of the ACR for the benefit, our payment amount, (or, in the case of a working individual (or spouse) for whom Medicare is secondary, the amount Medicare would pay if Medicare was not secondary), increased by the actuarial value of Medicare's Part A deductible and coinsurance, or the amount we charge for coverage of Part A services to those individuals that are not otherwise eligible for those services.

Comment: One commenter requested clarification of § 422.308, Limits on premiums and cost-sharing amounts, that the commenter believes to be a new provision. Another commenter asked about a limit on amounts actually collected in cost-sharing.

Response: The limit on premium and cost-sharing charges in section 1854(e) is not new, and in the case of coordinated care plans, is the same as the limit that applied in the case of section 1876 risk contracts. As discussed above, in the case of a coordinated care plan, section 1854 of the Act specifically limits the amount, regardless of source, a Medicare beneficiary may be charged for the M+C plan elected. This would include premiums and cost-sharing collected by the M+C organization or any provider (either contracting or non-contracting with the M+C organization) furnishing services covered by the plan. This limit is applied to the actuarial value of the cost-sharing provided for under the M+C plan. Specifically, in the case of a coordinated care plan, the premium and the actuarial value of cost-sharing cannot exceed the actuarial value of original Medicare cost-sharing. Thus, as noted above, in approving the ACR, we will not approve of beneficiary cost-sharing for Medicare covered services if the actuarial value of the cost-sharing exceeds the actuarial value of the deductible and coinsurance imposed under original Medicare.

Once we have approved cost-sharing amounts specified in an ACR, however, an M+C organization is permitted to collect those amounts, even if the actual amount collected turns out to exceed the amount projected in the original estimate of the cost-sharing's actuarial value. While some of our guidance has indicated that a ''cap'' would be imposed on the aggregate cost-sharing amount actually collected, we have determined, in examining the language in section 1854(e)(1) of the Act in response to this comment, that the limit on cost-sharing was intended to limit the amount of cost-sharing that can be provided for under an M+C plan, not on the amount that is actually collected. The statute provides that the ''actuarial value'' of M+C plan cost-sharing (and any premium charged) cannot exceed the ''actuarial value'' of cost-sharing under original Medicare. Since we do not keep track of cost-sharing actually collected under original Medicare, but instead rely only on the ''actuarial value'' projected up front, we believe that the same approach should apply to the M+C plan side of the equation.

We note that, as discussed above, in the case of private fee-for-service plans, the limit on beneficiary liability applies only to cost-sharing. The actuarial value of cost-sharing for Medicare services may not exceed the actuarial value of the deductible and coinsurance imposed under original Medicare.

Comment: One commenter suggested that we set a limit on the amount that may be charged to low-income beneficiaries and beneficiaries with disabilities.

Response: Section 1854(c) of the Act requires that premium charges be uniform for all enrollees in an M+C plan (or in a segment of a plan service area as provided for in section 515 of the BBRA). As a result, a separate limit for low income beneficiaries would not be permissible. The statute also specifies the overall limits on beneficiary liability, and we do not have the discretion to change them. We note, however, that M+C organizations may not design or market M+C plans in a manner that discriminates against low-income or disabled beneficiaries.

Comment: One commenter suggested that we should prohibit the imposition of a deductible for Federally qualified health center (FQHC) services.

Response: The actuarial value of the cost-sharing imposed by an M+C organization for Medicare-covered items and services cannot exceed the actuarial value of Medicare's deductible and coinsurance under original Medicare. We establish this amount using data on all Medicare beneficiaries that did not elect a managed care organization, regardless of where the beneficiary received the item or service. Therefore, data on items and services that do not have a deductible or coinsurance were taken into account, and M+C enrollees

already have received the benefit of the fact that there is no deductible for FQHC services.

5. Incorrect Collections of Premiums and Cost-Sharing Amounts (§ 422.309)

Section 422.309 requires an M+C organization to refund all amounts incorrectly collected from its Medicare enrollees, or from others on behalf of the enrollees, and to pay any other amounts due the enrollees or others on their behalf. We further stated that amounts incorrectly collected include: (1) Exceeding the limits imposed by § 422.308 (that is, exceeding the amounts approved in the ACR as falling within these limits); (2) in the case of an M+C private fee-for-service plan, exceeding the M+C monthly basic premium or monthly supplemental premium; (3) in the case of an M+C MSA plan, exceeding the M+C monthly supplemental premium, or the deductible for basic benefits; and (4) amounts collected from an enrollee who was believed ineligible for Medicare benefits but was later found to be entitled. In addition, ''other amounts due'' include amounts due for services that were considered an emergency, urgently needed, or other services obtained outside the M+C plan; or initially denied, but upon appeal, found to be services that the enrollee was entitled to have furnished by the M+C organization.

Comment: A commenter believes that an M+C organization should be permitted to collect additional amounts if, as a result of utilization patterns, it collects less than the amount actuarially projected in its ACR. The commenter notes that if an M+C organization collects more than the amounts permitted in the M+C plan approved in the ACR process, it has to refund amounts to enrollees, and believed that this same principle should permit the organization to collect additional amounts if it collects less than the amount projected.

Response: We do not agree. There is no indication in section 1854 of the Act that the Congress intended to allow an M+C organization to collect additional amounts from Medicare enrollees when the amount it collects ends up being less than the amount projected in its ACR. An M+C organization, when it submits its ACR, should be providing its best estimate of its charges and collections within the confines of the statute. If we accept this estimate, the M+C organization should be held to the amounts estimated. As noted above, we agree that HCFA also should be held to an estimate we have approved in the ACR process, and will not attempt to limit the aggregate amount an M+C organization can actually collect as long as it collects only approved cost-sharing amounts from any given enrollee. We believe there is a distinction between the process of projecting enrollee liability for the purpose of establishing a premium and cost-sharing structure and the question of whether charges are made in excess of this established structure. Once the premium and cost-sharing structure is established, a charge in excess of the amounts provided for under this structure is impermissible, and grounds for sanction. A refund is appropriate. If the organization inadvertently charged less than the cost-sharing amounts approved in the ACR, it could collect the balance of the approved charge from the beneficiary. To the extent the commenter was referring to our earlier guidance discussing a limit on the aggregate amount that an organization can collect in premiums, as noted above, we have decided not to impose such a limit. This premise of the commenter's point accordingly is no longer valid.

6. ACR Approval Process (§ 422.310)

The June 1998 interim final rule requires that, except M+C MSA plans, each M+C organization must compute a separate ACR for each coordinated care or private fee-for-service plan offered to Medicare beneficiaries. If an M+C organization opts to apply uniformity requirements to segments of an M+C plan service area, a separate ACR must also be submitted for each such segment. We also stated in the June 1998 interim final rule that, in computing the ACR for years beginning in 2000, the M+C organization calculates an initial rate according to the specifications in § 422.310(b), that represents the ''commercial premium'' that the M+C organization would charge its general non-Medicare enrollees for Medicare-covered benefits and any supplemental benefits covered by the M+C plan. The M+C organization would also calculate a separate ACR value for each optional supplemental benefit it offers under the plan. Then, the organization either adjusts the initial rate by the factors specified in § 422.310(c), or requests that we adjust the rate.

Section 422.310(b) dictates that the initial rate for each M+C plan is calculated on a 12-month basis for non-Medicare enrollees, using either a community rating system or a system approved by us, under which the M+C organization develops an aggregate premium for each M+C plan for all non-Medicare enrollees of that M+C plan that is weighted by the size of the various enrolled groups and individuals that compose the M+C's enrollment in that plan. Regardless of the method the M+C organization uses to calculate its initial rate, the rate must equal the premium that the M+C organization would charge its non-Medicare enrollees on a yearly basis for services included in the M+C plan.

The June 1998 interim final rule also established special rules in § 422.310(d) for M+C organizations that do not have non-Medicare enrollees or sufficient Medicare enrollment experience to sufficiently calculate ACR values. We have amended § 422.310(d) because the interim final rule used incorrect citations in describing how such an M+C organization may estimate ACR values.

Comment: One commenter suggested that we test the new ACR methodology before implementation.

Response: We do not agree. The new ACR process requests data from organizations that should be readily available in an organization that has an adequate accounting system used to track the costs and revenues of the products it sells. In addition, we intend to develop a mechanism designed to identify unexpected problems. The form implementing the new ACR methodology allows M+C organizations to identify specific problems. We intend to gather information from our review, approval, and audit processes to develop manual instructions, clarify the ACR instructions, and modify the ACR form, if necessary.

Comment: One commenter suggested that the component of the ACR formula attributable to revenues in excess of expenses (''the additional revenue component,'' or ''profit'' in the case of a for-profit company) should be the same percentage of the Medicare ACR amount as it is in the case of the initial rate (the ''commercial premium'').

Response: We do not agree. Each product an organization offers may have a different additional revenue or profit margin. This would include each of the non-Medicare products included in the base cost figures and the initial rate. To use the same percentage of additional revenue margin included in the initial rate for the ACR for Medicare enrollees would apply an ''average'' additional revenue margin for non-Medicare enrollees to all Medicare enrollees. In addition, using a percentage method, as suggested, would increase the amount of the additional revenue margin for Medicare enrollees if Medicare health care costs were higher. (If costs are higher, the profit margin percentage can be lower while producing the same amount in profit.) We believe actual

additional revenues received in a prior period are the best measure of the amount of additional revenue an organization would expect in a future period, absent some changed circumstances or variables.

While we do not agree with the commenter's specific proposal, in light of this comment, we have reconsidered the relative cost ratio formula contained in the regulations at § 422.310(c)(3). Since additional revenues are produced when revenues exceed expenses, we believe the best way to project additional revenues for a benefit or group of benefits is to first project total revenues of that benefit or group of benefits and, then, subtract projected total expenses of that benefit or group of benefits. Therefore, we have modified the formula in § 422.310(c)(3) to project total revenues using a relative cost ratio of revenues charged in a base period for Medicare enrollees compared to revenues charges to non-Medicare enrollees of the same period and, then, subtracting projected expenses. We have used the calendar year prior to the calendar year the ACR is submitted as the ''base year'' for this purpose. If an M+C organization believes the computation produced under this formula does not adequately reflect the future period for an M+C plan, the organization may, with adequate justifying documentation, make an expected variation adjustment to the amount calculated.

Comment: One commenter interpreted § 422.310(c)(4) to provide that adjustments to additional revenues, after application of the relative ratios, are allowed to reduce the ACR value, but not increase the ACR value.

Response: The language of § 422.310(c)(4) was incorrect as published in our June 1998 interim final rule. On October 1, 1998, we published a technical revision to this section (63 FR 52614) to clarify that adjustments may increase or decrease the amount of additional revenue included in the ACR value of the service or services. These adjustments would be allowed as long as the organization submitted sufficient documentation to justify the need to increase or decrease the ACR values so calculated.

Comment: One commenter suggested that we allow M+C organizations to use representative data to develop ACR values for an M+C plan.

Response: The new ACR process requires M+C organizations to report the costs it incurs for an M+C plan using GAAP. Organizations in business routinely review the costs of each product it sells for various reasons, (for example, budget analysis, profitability). The new ACR method does not create a new process to determine those costs. We have designed the ACR process to require the least amount of information needed to price an M+C plan without creating a new accounting process. We are relying on GAAP since these principles are widely known and are in use by most M+C organizations. We feel M+C organizations should not encounter significant problems in capturing the costs of the Medicare and non-Medicare populations of a prior period using accounting systems already in use to track each of the products it sells. Using representative data would not be as accurate as using costs actually incurred.

Comment: One commenter suggested that some group and staff model M+C organizations may not be able to provide cost data in the form and detail required in the ACR form.

Response: We do not agree. The regulations and the ACR form used to implement those regulations allow for a significant amount of flexibility. The instructions are very clear that there are a limited number of line items that must be reported. Most of the remaining entries will be dependent on the accounting system of the organization. Staff and group models may need to use an apportionment strategy to segregate costs between Medicare and non-Medicare enrollees. These apportionment strategies should be based on the same statistics currently being submitted for the ACR form under section 1876 of the Act.

Some organizations have argued that their accounting systems cannot segregate the revenues and cost of providing services to Medicare enrollees between different service areas and among various products sold. These organizations should discuss these matters with their HCFA-assigned plan manager. Since the M+C ACR process is still relatively new, we expect to grant some flexibility to M+C organizations. M+C organizations unable to comply with ACR requirements would be required to submit a plan of action designed to bring the organization in compliance with the regulations.

7. Requirement for Additional Benefits (§ 422.312)

Section 422.312(b) requires that the M+C organization provide additional benefits if there is an adjusted excess amount for the plan it offers. The actuarial value of these additional benefits, less the actuarial value of any cost-sharing associated with the benefit, must at least equal the adjusted excess amounts. We received no comments on this provision, but are making a technical change to § 422.312(b) to use the term ''cost-sharing'' rather than copayment or coinsurance because the term cost-sharing has been previously defined in § 422.2 to include copayments and coinsurance.

H. Provider-Sponsored Organizations (Subpart H)

Among the new options available to Medicare beneficiaries is enrollment in a provider-sponsored organization (PSO). A PSO is described in section 1855(d) of the Act as a public or private entity—

- That is established or organized, and operated, by a health care provider or group of affiliated health care providers;
- That provides a substantial portion of the health care items and services directly through the provider or affiliated group of providers; and
- With respect to which the affiliated providers share, directly or indirectly, substantial financial risk for the provision of these items and services, and have at least a majority financial interest in the entity.

The PSO regulations at §§ 422.350 through 422.390 include definitions, solvency standards (developed through negotiated rule making), and waiver requirements that have been established through three previous **Federal Register** publications. On April 14, 1999, we published an interim final rule with comment, titled ''Definition of Provider-Sponsored Organization and Related Requirements'' (63 FR 18124), setting forth the PSO definition, clarifying certain terms, and establishing related requirements. On May 7, 1998, we published an interim final rule with comment, titled ''Waiver Requirements and Solvency Standards for Provider Sponsored Organizations'' (63 FR 25360), establishing solvency requirements that apply to PSOs that obtain a waiver of the M+C State licensure requirements, and setting forth procedures and standards that apply to requests for the waivers. The solvency portion of the PSO regulation was based on the work of the PSO negotiated rulemaking committee, as required at section 1856(a) of the Act. On December 22, 1999, we published a final rule titled ''Solvency Standards for Provider-Sponsored Organizations'' (64 FR 71673), that addressed the comments we received on the PSO solvency standards and waiver requirements. In this final rule, we are responding to comments on the April 14, 1998 PSO definitions interim final rule.

Comment: A commenter believes that the interim final rule did not sufficiently ensure that a PSO is actually

controlled by providers. Another commenter thinks that effective control is defined too loosely in the regulation.

Response: We believe that the existing regulatory requirements are sufficient to ensure that PSOs are organizations that are owned and controlled by health care providers. Among the basic requirements for PSOs at § 422.352(a)(3) is the requirement that to be considered a PSO for purposes of the Medicare+Choice program, an organization must be controlled by a health care provider or, in the case of a group, by one or more of the affiliated providers that established and operate the PSO. Under the definitions at § 422.350(b), we define control as meaning ''that an individual, group of individuals, or entity has the power, directly or indirectly, to direct or influence significantly the actions or policies of an organization or institution.'' This definition is essentially the same as the long-standing definition of control that is used for purposes of providers in the Medicare fee-for-service program (see § 413.17). We believe that the general definition for control we have adopted, which will result in case-by-case determinations by us, will ensure that PSOs are controlled by providers.

Comment: A commenter requested that we exempt PSOs formed by community health centers from the requirement in § 422.352(b)(1) that a non-rural PSO must deliver 70 percent of the health care services and items through the provider or affiliated providers responsible for running the PSO.

Response: We do not believe that a special exemption from § 422.352(b)(1) for community health centers is warranted. As we will note below, we do allow a lower percentage of health care services delivery for rural PSOs as compared to non-rural PSOs. However, because the percentage of health services delivery is in part designed to ensure that the PSO will remain solvent, we believe it would not be prudent to reduce the percentage for different types of organizations such as community health centers. To put our response in perspective, we will briefly discuss the PSO requirement that the PSO providers deliver a substantial proportion of health care services, and the reasons we have selected 70 percent for non-rural PSOs and 60 percent for rural PSOs.

The M+C regulations at § 422.352(b) specify that a PSO must deliver a substantial proportion of the health care items and services through the provider or affiliated group of providers responsible for operating the PSO. We have concluded that setting the substantial proportion requirement at 70 percent for a non-rural PSOs and 60 percent for rural PSOs balances two key interests. These interests are, specifically: (1) That we not set the proportion of services so high as to prevent participation by all but the most sophisticated provider organizations; and (2) that the substantial proportion threshold be sufficient to ensure that a PSO have a well-developed capacity to deliver services, thus meeting the financial stability objective explicit in the statute, and increasing the prospects for successful development and solvent operation of a PSO. There is no indication in the PSO provisions in Part C that the Congress intended that a different standard be applied to community health centers, or any other entity. We see no basis for doing so.

Comment: A commenter recommends that we measure substantial proportion based on encounters rather than expenditures.

Response: As discussed in the previous response, § 422.352(b) requires that a PSO deliver a substantial proportion of the health care items and services through the providers or affiliated providers responsible for operating the PSO. In calculating the substantial proportion percentage, we considered what would be the best method for comparing the proportion of items and services furnished by a PSO-affiliated provider with the overall amount of items and services furnished through the PSO. The two possible approaches we identified involved either the use of Medicare encounter data or Medicare expenditure data. Based on discussions with the health care industry, we learned that using expenditure data generally would not be burdensome for PSOs, because it is already commonly collected for management purposes. Furthermore, expenditure data may also produce a measurement more in line with the intent of the substantial proportion requirement. For example, the expenditures associated with an acute hospital visit would reflect a higher draw upon the PSO's resources than a physician office visit. Likewise, with expenditure data, the dollar amounts associated with each physician office visit, home care visit, etc., will reflect resource use and the ability of PSO providers to manage medical utilization. Therefore, based upon its immediate availability and arguably greater relevance and significance, we have concluded that use of expenditure data is the better approach for determining compliance with the substantial proportion requirement.

Comment: A commenter recommended changing the language in § 422.376 from ''the waiver is effective for 36 months, or through the end of the calendar year in which the 36 months period ends'' to ''the waiver is effective for 36 months.''

Response: We do not believe it is appropriate, as suggested by the commenter, to change § 422.376(b) so that it reads, ''the waiver is effective for 36 months.'' The reason we have chosen to allow a waiver to remain in effect until the end of the calendar year in which the 36 month period ends is that this ensures that the PSO's Medicare contract also remains in effect through the calendar year. To do otherwise could require a mid-year contract termination with significant disruption for beneficiaries enrolled in the PSO.

I. Organization Compliance with State Law and Preemption of Federal Law

1. State Licensure and Scope of Licensure (§ 422.400)

Section 1855 of the Act requires that a potential M+C organization be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits in every State in which it wishes to offer an M+C plan. (An exception to the licensure requirement is made for PSOs, as provided for in part 422, subpart H.) Section 1855(b) of the Act specifies that, with limited exceptions, an M+C organization must assume full financial risk for the cost of the health services it provides under its contract. Thus, the licensure requirement is a two-pronged requirement, and any potential M+C organization must meet both prongs, such that it is licensed, and is assuming the appropriate risk level for its license.

To establish the licensure status of potential M+C organizations, and in particular to determine compliance with the requirement that the organization's M+C contract falls within the scope of its licensure, we require that new M+C applicants supply documentation from the appropriate State regulatory authorities that the organization meets both the licensure and scope of licensure requirements. In the case of noncommercially licensed entities, § 422.400(b) requires that they obtain a certification from the State that they meet appropriate solvency standards.

Comment: With regard to the scope of licensure requirements, one commenter has asked for clarification as to whether managed care organizations with enrollment limited to Medicaid beneficiaries are eligible for M+C contracts. Another is concerned about States licensing organizations to offer

more than one M+C plan, noting that States may not have the resources to monitor multiple plans from multiple organizations. Other commenters have asked for clarification as to what happens if a State does not license insurers to offer high-deductible MSA plans, or does not license preferred provider organizations (PPOs). These commenters wish to know how MSA and PPO plans would be available in States which do not authorize these types of options. A commenter also asked whether States may require, for licensure purposes, that M+C organizations offer only products with ''gatekeepers.'' The commenter believes that these requirements should be preempted in order to permit managed care organizations to offer more choices to Medicare beneficiaries.

Response: Section 1855(a)(1) of the Act requires that an M+C organization be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits in any State in which it offers an M+C plan. As discussed in detail in the interim final rule (63 FR 35011), an entity does not have to have a commercial license to offer the type of M+C plan it seeks to offer under the M+C program. Rather, the entity must demonstrate that it is authorized by the State to assume the risk involved in offering the type of plan it wishes to offer. Thus, in the case of an organization that is authorized by the State to assume risk under a Medicaid contract, but is not commercially licensed, the State in which the organization wishes to offer an M+C plan would have to certify that the organization has authority to assume the risk involved in offering the M+C plan in question (*e.g.,* by meeting State solvency requirements). In some States, Medicaid-contracting managed care organizations are operated under the authority of the State Medicaid agency, and the State may take the position that this authority is limited to assuming risk for Medicaid beneficiaries. Since the statute requires that M+C organizations (with the exception of PSOs) be licensed by the State, the State has the discretion to make this decision.

With regard to State monitoring of M+C organizations that they license, we do not have the authority to second guess a State's judgment concerning the sufficiency of its resources to monitor M+C plans for which it has given authorization. The States have the sole authority for licensure of M+C organizations, and can set their own standards for monitoring conditions of licensure.

The question of availability of MSA plans in States that do not approve high-deductible plans again goes back to the question of licensure. An organization wishing to offer an MSA plan must be licensed as a risk-bearing entity eligible to offer health insurance or health benefits in the State in question. If the organization wishes to offer a high-deductible policy as part of an MSA plan, the organization must be authorized by the State to assume risk, and under § 422.400(c)(1), must demonstrate that it is authorized to offer a high-deductible policy to Medicare beneficiaries under an M+C contract. This does not mean that it must be authorized by the State to offer such a policy commercially in the State.

With regard to the availability of PPOs in States that do not have a category of licensure into which PPOs would fit, the organization again would have to demonstrate that it was licensed as a risk-bearing entity or otherwise authorized to assume risk, and that it was authorized by the State to offer a PPO product to Medicare enrollees. (We note that under new section 1852(e)(2)(D), for purposes of the applicability of certain quality assurance requirements, a PPO is defined as an entity that is not licensed as an HMO.) If a State does not have a category for a PPO product, an organization may not offer a PPO product in that State unless it is able to demonstrate that the State has authorized it to do so in the context of an M+C contract. This same analysis applies to the question of whether a State may only allow products with ''gatekeepers.'' If the State only has licensure categories for ''gatekeeper'' products, then only those products may be offered in the State, absent State authorization of an alternative product in the M+C context.

The only exception to the above requirements that the State authorize the M+C organization to offer the type of plan at issue is the exception provided by Congress for PSOs that are unable to obtain a State license.

2. Federal Preemption of State Law (§ 422.402)

a. General Preemption (§ 422.402(a))

Section 1856(b)(3)(A) of the Act reflects the general principle that under the supremacy clause of the constitution, State laws are ''preempted'' when they conflict with applicable Federal laws. Specifically, section 1856(b)(3)(A) of the Act provides that ''any State law or regulation'' with respect to M+C plans is superseded ''to the extent such law or regulation is inconsistent'' with M+C standards. This general preemption authority does not extend to non-M+C enrollees or non-M+C lines of business or activities. We apply this provision in the same manner that Executive Order 12612 on Federalism was applied to managed care organizations with contracts under section 1876 of the Act prior to the BBA. Under that Executive Order (recently superseded by Executive Order 13132; see section VI.1 below), the requirements of section 1876 of the Act did not preempt a State law or standard unless the law or standard was in direct conflict with Federal law. Put another way, if a State law required a managed care organization to do something that it would be permitted to do under section 1876 of the Act, there was no preemption. As discussed below, new Executive Order 13132 (64 FR 43255) contains this same standard for general preemption. The general preemption rule in section 1856(b)(3)(A) of the Act is implemented in § 422.402(a).

Comment: A commenter asked whether State laws that are more restrictive than Federal laws are preempted under our general preemption authority at § 422.402(a).

Response: In its description of the House bill's provision for preemption of State laws ''inconsistent with'' the new BBA standards, the BBA Conference Report (H. Rept. 105–217, page 637) makes clear that this provision (which was retained in the conference agreement) ''should not be construed as superseding a state law or regulation * * * that provides consumer protections in addition to, or more stringent than, those provided under [the BBA].'' We thus believe it is clear that Congress expected the States, in some cases, to have more rigorous or more comprehensive standards for quality and consumer protection that would enhance, rather than be subsumed under, the M+C standards for quality and consumer protection. Except when one of the ''specific preemptions'' discussed below applies, State laws or standards that are more strict than the M+C standards would not be preempted unless they are in conflict with (for example, would preclude compliance with) M+C requirements.

Comment: One commenter representing many plans argues that our interpretation of general preemption is too narrow, and that it should be broadened to encompass State laws that the commenter believes serve as obstacles to the purposes and objectives of the M+C program. This commenter suggests that there are situations in which compliance with both a Federal

law and a State law is theoretically possible, but the administrative burdens associated with dual compliance would be tremendous, making compliance counterproductive in terms of meeting the goals of the M+C program. In these situations, the commenter believes that the State requirements should be preempted, thus relieving the burden of dual compliance.

Response: As just noted above, the legislative history of section 1856(b)(3)(A) of the Act makes clear that Congress contemplated that M+C organizations would be subject to State requirements that were ''more stringent'' than M+C standards. We believe that Congress intended in section 1856(b)(3)(A) of the Act to incorporate the basic principles of Federalism, as applied to section 1876 contractors at the time the BBA was passed. We do not believe that the fact that a burden may be involved in complying with State laws makes those laws ''inconsistent'' with Federal requirements. We therefore believe that under section 1856(b)(3)(A) of the Act, only State standards that prevent compliance with Federal standards are preempted under this general preemption provision. As noted earlier, this position is also consistent with new Executive Order 13132.

Comment: Many commenters sought clarification of the basic principles of general preemption, and asked whether specific issues are covered under the general preemption authority of section 1856 of the Act. Some of these commenters suggested that consumer protection standards should be left to the States. For example, a commenter representing many States believes that the following types of standards are not subject to general preemption: Market conduct evaluation; complaint handling (except to the extent specifically preempted by the BBA as discussed below); enforcement of unfair claim settlement practice standards (except to the extent specifically preempted by BBA); enforcement actions generally; filing and review of policy forms and rate filings; filing and review of advertising and marketing materials; provider access standards; credentialing standards; filing and review of provider contracts; utilization review programs and standards; quality assurance programs; supplemental benefits and cost-sharing arrangements; network adequacy; enforcement of loss ratio standards; standards and enforcement of commission limitations; and provider licensing and regulation. In addition, other commenters have asked for clarification as to whether or to what extent Medicare Secondary Payer mental health parity requirements are preempted. Another commenter suggested that we interpret general preemption as covering all State laws except for financial solvency standards.

Response: We agree that the areas mentioned by the commenter would not be preempted under the general preemption rule in section 1852(b)(3)(A) of the Act, as long as the State law did not conflict with an M+C requirement. In most of the areas mentioned, if an M+C organization could comply with State law without compliance resulting in a violation of an M+C requirement, there would be no preemption. While the commenter has recognized that some of the above-referenced areas of State regulation are subject to the specific preemption provision discussed below (see the second and third items in the above list), there are other areas among those identified by the commenter that are subject to specific preemption as well. For example, State regulation of supplemental benefits would be preempted under the specific preemption of State laws relating to benefits. In addition, some ''provider regulation'' could be preempted under the specific preemption of laws relating to the inclusion or treatment of providers. Thus, while we agree with the commenter that laws in the specified areas would not be preempted under section 1856(b)(3)(A) of the Act absent a conflict with M+C standards, the commenter should consult the discussion below concerning specific preemption of State laws in the areas referenced in section 1856(b)(3)(B) of the Act. With respect to the comment that all areas should be subject to general preemption except solvency, we disagree with this comment. As noted above, we believe that general preemption would only apply in the case of a specific conflict with M+C requirements.

Comment: A commenter asked for clarification as to whether and how State M+C laws apply to employee groups.

Response: As noted in the preamble to the June 26, 1998 M+C interim final rule (63 FR 35013), there is neither general nor specific Federal preemption of State requirements that apply to arrangements between employers and M+C organizations for the provision of negotiated group benefits not covered under an M+C plan. These are purely private benefits that fall outside the scope of the M+C program and the ACR process. Thus, if there are applicable State laws not preempted by the Employee Retirement Income Security Act of 1974, these State laws could apply to employer group benefits, and would not be preempted by M+C standards. M+C standards apply only to M+C plan benefits, including: (1) Medicare-covered benefits; (2) additional benefits paid for with Medicare payments; and (3) both optional and mandatory supplemental benefits for which a premium is charged.

Comment: A commenter asked whether State confidentiality laws are preempted.

Response: General preemption applies to confidentiality requirements. Thus, just as with other consumer protection standards, State requirements that are more stringent than the new M+C standards would not be preempted, unless compliance with the State confidentiality requirements made compliance with the Federal requirements impossible.

b. Specific Preemption (§ 422.402(b))

There are three areas in which section 1856(b)(3) of the Act provides for specific (rather than general) Federal preemption of State law: benefit requirements; requirements relating to treatment and inclusion of providers; and coverage determinations (including related appeals and grievance processes.) In the BBA Conference Report (H. Rept. 105–217, page 638), the conferees noted that benefit requirements, provider participation requirements, and coverage determinations (and related appeals mechanisms) are governed exclusively by Medicare standards under original Medicare, and expressed their view that this should be the case under the M+C program as well. That is, under original Medicare, States cannot specify what must be included as a Medicare benefit; States do not specify the conditions of participation for Medicare providers (though they license providers and practitioners and determine their scope of practice); States may not specify how a coverage determination is made with respect to whether or not the Medicare program covers a benefit; and States do not determine the type of appeal mechanism that is used to appeal a coverage decision made by a Medicare carrier or intermediary with respect to a Medicare benefit. In the specific preemption provisions in section 1856(b)(3)(B) of the Act, Congress provided that States similarly cannot regulate M+C plans in these areas. As in the case of general preemption, these specific preemption provisions do not extend to non-M+C enrollees, activities, or lines of business of the managed care organization.

In the interim final rule (63 FR 35012), we stated our intention to adopt a narrow interpretation of the

applicability of the three areas of specific preemption, thus giving States maximum flexibility within the parameters of the statutory language. (As discussed below, this view is consistent with new Executive Order 13132 on Federalism.) We identified the following examples of areas in which State standards would be preempted:

- Benefit mandates (note that we did not interpret a limit on cost-sharing to be a ''benefit'').
- Appeals and grievances with respect to M+C coverage determinations.
- Requirements relating to the inclusion of providers (such as ''any willing provider'' laws or requirements to included specific types of providers within a plan's provider network). We note that State laws providing enrollees with a right to directly access providers are considered to provide a ''benefit'' to enrollees, and to affect the ''inclusion'' and the ''treatment of'' providers, and thus also are specifically preempted.

Comment: In the interim final rule, we solicited comments on whether the specific preemption of benefits should be extended to cost-sharing requirements, and if there were particular types of cost-sharing that should, or should not, be included under the benefits preemption. We received many comments on this issue. Most industry commenters recommended that we include all State cost-sharing standards within the benefit preemption. They believe that cost-sharing is an integral part of a benefit; that the cost to a beneficiary for a particular service weighs on how much of a benefit he or she is actually receiving; and that the cost-sharing formula is what gives a benefit its market value. Commenters also argued that preempting State cost-sharing requirements would reduce variation in benefit packages, thus making comparison easier for beneficiaries, and easing the administrative burden on organizations that offer plans across State lines. They asserted that not preempting State cost-sharing standards would severely impede M+C organization's efforts to offer national plans. Another commenter wrote that it was unclear whether a State could continue to apply some of its benefit-related provisions, such as limits on copayments, State coordination of benefits and subrogation rules, and required benefit differentials for PPOs.

In contrast, commenters representing the States and beneficiary advocacy groups recommended that we continue to construe the benefit preemption as narrowly as possible, and thus not change our policy to consider cost-sharing a part of a benefit for preemption purposes. They supported our existing policy of generally not preempting State cost-sharing requirements. One commenter believed that even benefit requirements should not be preempted, however, arguing that if States cannot mandate certain benefits, then beneficiaries in M+C plans might have different, lesser benefits than beneficiaries with original Medicare and a Medigap policy.

Response: In the interim final rule, we stated that the specific preemption of benefit requirements does not extend to State cost-sharing standards (63 FR 35013). As discussed in detail in that rule, our position was that a State law establishing limits on cost-sharing generally, or limits on cost-sharing that can be imposed for a particular benefit, would not fall under the benefit preemption as we have defined the term ''benefit.'' We recognize that this is a narrow interpretation of the term ''benefit,'' and that we could have interpreted ''benefit requirements'' to extend to limits on cost-sharing. However, we wanted to minimize the extent to which beneficiary protections enacted by a State were preempted by Federal law. This decision is consistent with our support for beneficiary rights, as well as new Executive Order 13132 on Federalism, which calls for granting States the maximum flexibility permitted under Federal law. If the benefit to which State cost-sharing limits apply is not a Medicare-covered benefit, the State standard would apply only if the M+C organization chooses to offer the benefit, since any State mandate that the benefit be offered would be specifically preempted. Thus, to the extent that limits on cost-sharing are linked to a benefit mandate, the State cost-sharing limits could be seen to be ''indirectly'' preempted, in that the obligation to provide the benefit to which they apply is preempted. To the extent that an M+C organization offers the benefit to which State cost-sharing limits apply (whether as part of the package of Medicare-covered services, or as an additional or supplemental benefit), State cost-sharing standards would remain in effect unless they would be preempted under the general preemption authority discussed above.

Comment: Several commenters representing the State of Massachusetts wrote to request that we reconsider our position that the BBA prohibits State-mandated benefit laws, particularly when such a benefit is neither required by, nor funded by, the Federal government. These commenters believe that where Federal money is not involved, there is no preemption of State law, and that the M+C regulations should be modified accordingly. These commenters were particularly concerned about the effect of Federal preemption on Massachusetts' mandated prescription drug benefit, and pointed out that M+C enrollees in the State will not have access to a comprehensive prescription drug benefit in the absence of the State mandate. The commenters noted both that there is no Federal prescription drug benefit, and that the cost of the Massachusetts benefit is borne in no way by the Federal government.

Response: Throughout the development of the interim final rule and during the summer of 1998, we discussed in depth with Massachusetts officials the effect that Federal preemption would have on the prescription drug benefit in Massachusetts. Although we recognized the State's concerns, we did not believe that the statute permitted any discretion on the issue, absent a legislative amendment. We believe that the reference to ''benefit requirements'' must refer to non-Medicare benefits like those at issue in Massachusetts, since, as noted above, States have never been permitted to mandate what is covered by Medicare. In September of 1998, the Massachusetts Association of Health Plans sued the Commonwealth of Massachusetts, in an attempt to resolve the apparent conflict between the State and Federal regulatory approaches. A Federal court ruled that the specific preemption in section 1856(b)(3)(B) of the Act did apply to the Massachusetts drug benefit. The State appealed, and on October 8, 1999, the ruling was affirmed by the United States Court of Appeals for the First Circuit. *Massachusetts Assn. of HMOs* v. *Ruthardt,* 194 F.3d 176 (1st Cir., Oct. 8, 1999). The Court found that the M+C regulations ''dominate these particular fields, leaving no room therein for State standard-setting'' for benefit requirements (194 F.3d, at 183). We agree with the Court's conclusions.

Comment: Several commenters have asked us to revise § 422.402 to exempt State ''return home'' laws from preemption under sections 1856(b)(3)(B)(i) or (ii) of the Act. These laws generally allow a hospitalized beneficiary, who lived in a retirement home that includes a Medicare-approved nursing facility, to return to this ''home'' facility for post-hospitalization skilled nursing services, even if that facility is not part of his/her managed care plan's network. Commenters argued that these types of provisions are not benefits requirements and are not related to treatment and

inclusion of providers, but rather are consumer protection requirements.

Response: As discussed above, section 1856(b)(3)(B)(ii) of the Act clearly establishes Federal preemption for requirements relating to the inclusion or treatment of providers. We believe that a law granting an enrollee the right to coverage from a particular provider would certainly have to be considered a requirement ''relating to the inclusion or treatment of providers,'' since it requires that the provider in question be ''included'' in the network of providers through which covered services may be obtained.

As a matter of policy, we believe that return home laws have value for beneficiaries, families, and communities, and we encourage M+C organizations to offer a return home option where it would not adversely affect quality or continuity of care, and does not pose an unreasonable administrative burden. However, absent legislative change, we do not believe that the statutory preemption provisions permit any alternative interpretation that would allow enforcement of these State laws for M+C enrollees. We are exploring developing a legislative proposal to establish a limited exception to the M+C preemption provisions to accommodate State return home laws.

Comment: Several commenters offered differing opinions of our interpretation that section 1856(b)(3)(B) of the Act preempts direct access laws. Again, some commenters believe that these requirements are contract or consumer protection laws, and should not be subject to specific preemption; other commenters believe that direct access laws are clearly and specifically preempted. One commenter asked for clarification on the specific preemption of State standards related to the ''treatment and inclusion of providers and suppliers.'' Specifically, this commenter asked for clarification on the following situations: (1) Whether the preemption applies to State standards on how providers are paid; (2) whether State standards that are more stringent than the M+C provider antidiscrimination provisions in existing § 422.204(b) are preempted; (3) whether State requirements that certain categories of health professionals must be treated the same as other providers by an HMO or insurer are preempted.

Another commenter asserted that ''any willing provider laws,'' specific benefit requirements, and requirements for the inclusion of specific types of providers should not be preempted. This commenter believes that if State standards are more stringent than Federal standards and not inconsistent with them, they should not be preempted, regardless of whether these standards relate to the areas specifically preempted by Congress.

Response: In the interim final rule, we indicated that direct access laws and any willing provider laws were illustrative of the types of laws that we believe Congress intended to preempt through the BBA's specific preemption provisions. Although we recognize that these types of State standards may be viewed as consumer protections, we believe that such standards clearly also involve both plan benefits and the treatment and inclusion of providers, and therefore are specifically preempted. With regard to the specific questions raised by the commenter, these standards all appear to involve the inclusion or treatment of providers. In order to make a final determination, however, we would have to review the specific State law in question.

Comment: A commenter asked for clarification regarding whether certain aspects of State law, such as State definitions of medical necessity, and requirements that subscribers be notified of the right to file complaints with State regulators, would be preempted under § 422.402(b)(3), which preempts State requirements for coverage determinations, including appeals and related grievances.

Response: For the purposes of coverage determinations, a State definition of ''medical necessity'' is preempted under § 422.402(b)(3) because any such definition is integral to the determination of coverage. A State's general complaint process, as distinct from a process for appealing coverage decisions, would be subject only to general preemption under § 422.402(a), not specific preemption under § 422.402(b)(3). The State should indicate, however, that its process is separate, and that if the complaint involves a coverage determination, the sole mechanism for resolution is the Federal appeals process outlined in subpart M of part 422. For more information on this issue, please see guidelines issued by the National Association of Insurance Commissioners (NAIC).

Comment: A commenter who was generally supportive of Federal preemption argued that the regulations fail to clarify the ramifications of such preemption at the State level. The commenter requested that we ''formalize the process'' with the relevant State entities, so that managed care organizations are not held liable by a State for noncompliance with a State mandate when the organization is acting in accordance with Federal regulations.

Response: The NAIC and our staff have developed guidelines for use by the States in developing and implementing their managed care regulations and operational policies. We believe that these guidelines should address the commenter's concerns about formalized guidance for States.

Comment: Many commenters support a broader interpretation of Federal preemption such that State law related to grievance procedures would be preempted. Other commenters believe that Congress intended to specifically preempt State grievance procedures.

Response: The statute says only that grievances related to coverage determinations are subject to specific preemption; therefore, we do not believe that Congress intended to preempt all State grievance procedures. We believe that Congress recognizes that many States use the term ''grievance'' to describe a complaint or define a process that constitutes an ''appeal'' under Medicare. Thus, we believe that the intent of the statute was to specifically preempt State requirements for grievances related only to coverage determinations, and to apply general preemption to State requirements for all other types of grievances. Thus, the State requirement would stand so long as it is not inconsistent with a Federal requirement, as discussed in detail above.

Since enrollees may have complaints that involve matters unrelated to coverage determinations, there needs to be a mechanism in place to address other types of complaints involving the manner in which enrollees receive care. Therefore, M+C organizations are required to have a grievance process in place to handle complaints unrelated to coverage determinations.

The preamble to the interim final rule alerted the public that we would establish a grievance procedure through proposed rulemaking, and sought comments on ways to make it meaningful. Until publication of that proposed rule, M+C organizations should look to State requirements for resolving complaints unrelated to coverage determinations.

Comment: A commenter asked for clarification as to whether a State law requiring the external review of all coverage determinations where the independent reviewer's decision would be binding on the M+C organization would be preempted under the specific preemption rules.

Response: Specific preemption would apply in that situation. The M+C appeals process is the only method that can result in a binding decision on the M+C organization. A State may choose

to require external review of coverage determinations for monitoring or licensure purposes, but the requirement would be preempted to the extent that it requires a decision by any entity other than one prescribed under the M+C appeals process.

Comment: A commenter asked that we revisit our position that State tort or contract remedies may be available to beneficiaries whose coverage determination dispute goes through the Medicare appeals process. This commenter believes that coverage determination cases are contract disputes, and therefore should be the sole province of the Medicare appeals process.

Response: In some cases, a case that is cast as a State contract claim may amount to a claim that services are covered under an organization's M+C contract. We agree with the commenter that in that case, the claim would be pre-empted. However, there are other tort or State contract law, or consumer protection-based claims that would be entirely independent of the issue of whether services are required under M+C provisions. For example, a State consumer protection law may provide that certain claims made by an HMO in advertising give rise to particular obligations under State law, that exist independent of the question of what the HMO's M+C contract requires. In other cases, a tort action may exist independent of the question of whether services are covered under an M+C contract. We believe that under principles of Federalism, and Executive Order 13132 on Federalism, which requires us to construe preemption narrowly, a beneficiary should still have State remedies available in cases in which the legal issue before the court is something other than the question of whether services are covered under the terms of an M+C contract.

3. Prohibition on State Premium Taxes (§ 422.404)

Section 1854(g) of the Act provides that ''no State may impose a premium tax or similar tax with respect to payments to M+C organizations under section 1853.'' This prohibition does not apply to enrollee premium payments made to M+C plans, which are authorized under section 1854 of the Act. Section 402.404(a) sets forth the statutory provision, and specifies that the term ''State'' includes any political subdivision or other governmental authority within a State.

Section 422.404(b) clarifies the scope of what constitutes a prohibited premium tax, establishing that the prohibition generally does not apply to a generally applicable tax on the net income or profits of any business. As noted in the preamble to the interim final rule, if the tax applies to premium revenue specifically, there is no exception to the prohibition of such a tax, based on the purpose of the tax.

Comment: One commenter agreed with our interpretation that the term ''State'' should include all political subdivisions, and recommended that we retain the regulatory language prohibiting State-levied taxes on payments made by Medicare to M+C organizations.

Response: We agree with the commenter. Since counties and other political subdivisions of a State derive their powers from the State, we believe this broad interpretation of the term ''State'' is the intended and necessary interpretation of the statutory provision. Thus, any prohibitions of State actions contained in Federal statute should be interpreted as prohibitions on actions at any level of State government or any State or local governmental body within the State.

Comment: One commenter noted that section 1854(g) of the Act prohibits only a ''premium tax or other similar tax,'' and argued that this does not support our inclusion of ''fees and other similar assessments'' in the regulatory language at § 422.404(a). The commenter argued that assessments to fund State high risk pools should be permitted.

Response: We believe that any mandatory fee or assessment imposed on premium revenues clearly would fall within the reference to a premium tax or ''other similar tax.'' As noted in the preamble to the interim final rule, we considered whether to exempt an assessment that is used for purposes of an insolvency insurance pool, but determined that if the assessment was mandatory, it amounted to a tax. We noted, however, that an M+C organization that wished to rely on the proceeds from such a pool as part of its plan for insolvency protection could voluntarily contribute to such a pool.

Comment: A commenter objected to statements in the preamble to the interim final rule (63 FR 35014) suggesting that an M+C organization may participate in a ''guaranty fund'' by paying premium taxes voluntarily. The commenter pointed out that the NAIC Life and Health Insurance Guaranty Association Model Act excludes managed care organizations from its definition of a ''membered insurer.'' The commenter recommended that we clarify that State life and health insurance guaranty associations are excepted from the preamble discussion of ''guaranty funds,'' or at least note that under many States' life and health guaranty association laws, M+C organizations would not be considered member insurers.

Response: To the extent the commenter is referring to a guaranty fund operated by a private association, the prohibition on premium taxes would not apply. Our reference in the preamble to voluntary contribution to a guaranty fund involved a State mandated insurance pool established and operated by the government. In this case, the mandate to contribute premium revenue would be preempted, but an M+C organization could voluntarily participate.

4. Medigap

Section 1882 of the Act governs the sale of Medicare supplemental (''Medigap'') policies, private health insurance policies that are designed to cover certain out-of-pocket costs incurred by Medicare beneficiaries. With minor exceptions, a Medigap policy cannot be sold in any State unless it conforms to one of ten standardized benefit packages, labeled plans ''A'' through ''J''.

Before enactment of the BBA, Federal law provided for only one opportunity for a Medicare beneficiary to purchase a Medicare supplemental (''Medigap'') policy on a ''guaranteed issue'' basis. (Generally, this term means that the Medigap insurer cannot deny the application, delay the issuance or effective date of the policy, or charge an additional amount based on the individual's health status.) This opportunity occurs only during the 6-month period beginning with the date the beneficiary is both age 65 or older and enrolled in Medicare Part B.

Section 4031 of the BBA amended section 1882(s) of the Social Security Act to specify additional situations in which beneficiaries are able, as of July 1, 1998, to buy specific types of Medigap policies on a guaranteed issue basis, if they apply within 63 days of losing certain other types of health coverage, and if they submit evidence of the date that the prior coverage terminated. The law also requires that the entity that provided the prior coverage advise the beneficiary of these rights. While the M+C regulations do not implement the Medigap provisions of the BBA or the BBRA, it is important to understand the implications for M+C organizations, since some situations addressed by the Medigap provisions involve beneficiaries who leave M+C plans and return to original Medicare.

The situations that give rise to the obligation to notify the beneficiary include, for example, termination of

coverage by an M+C plan, reduction in an M+C plan's service area, termination of the M+C plan's contract by us, or loss of coverage under an M+C plan due to a change in the beneficiary's place of residence. As mentioned previously, section 501(a) of the BBRA amended section 1882(s)(3) of the Act to allow an individual to choose between two options: (1) Voluntarily disenrolling before coverage under the M+C plan is terminated involuntarily, and applying for a Medigap policy no later than 63 days after being *notified* by the M+C organization of the impending termination or service area reduction; or (2) waiting and applying no later than 63 days following the date of the involuntary termination or service area reduction. In these instances, the beneficiary is guaranteed the right to buy Medigap plans A, B, C, or F, subject to availability of those policies from insurers selling in the State.

With regard to availability, we note that not all 10 standardized Medigap plans may be available in all States, and all plans available in a State might not be offered by every insurer. Wisconsin, Minnesota, and Massachusetts have alternative forms of standardized policies under a waiver granted them by the Omnibus Budget Reconciliation Act of 1990 (OBRA). Federal law does not generally require sale of Medigap policies to beneficiaries under age 65 (eligible for Medicare by reason of disability or ESRD). However, State law may require insurers to sell to these populations under certain circumstances. Also, some insurers voluntarily sell policies to the disabled, usually on an underwritten basis. Where an insurer has filed in a State to sell to the under 65 population, these policies are subject to the BBA guaranteed issue protections.

The beneficiary may also have the right to guaranteed issue of a broader selection of Medigap policies if he or she either: (1) Directly enrolls in an M+C plan upon first becoming entitled to Medicare at age 65; or (2) enrolls for the first time in an M+C plan after previously having been covered under a Medigap policy, and, in both instances, later disenrolls from the M+C plan within 12 months of the effective date of the M+C enrollment. Beneficiaries who were previously enrolled in original Medicare and who purchased a Medigap policy, who disenroll from the M+C plan before the 12-month ''trial'' period has expired, are guaranteed the right to return to their old Medigap policy, if it is still available from their former insurer; (otherwise they have the choice of plans A, B, C, or F from any insurer). Alternatively, if an M+C plan was their first choice as newly entitled Medicare beneficiaries at age 65, and they disenroll during the first 12 months after enrolling, they have their choice of all 10 Medigap plans, including plans H, I, and J, which provide some outpatient prescription drug coverage. This broader array of choices for beneficiaries who elected an M+C plan when they first became entitled to Medicare at 65, in effect, compensates them for having forgone their 6-month Medigap open enrollment opportunity, which began when they reached age 65.

In all these cases of voluntary or involuntary terminations from an M+C plan, beneficiaries must apply for the Medigap policy of their choice, from among the options available to them, within 63 days. If they fail to act within this time period, they lose both their guaranteed issue right to purchase the policy of their choice at the standard premium rate, and their protection from pre-existing exclusion periods. Outside of this guaranty issue period, they may be able to find some Medigap insurers who are willing to sell to them, but they may not be able to purchase the policy they want. Additionally, the insurer can apply a pre-existing condition exclusion period of up to 6 months and/or charge them an additional amount based on their health status.

Because the Medigap provisions establish specific deadlines for beneficiaries who wish to take advantage of these new rights, prompt action by the M+C organizations to notify beneficiaries of their rights, or by us to provide accurate evidence of recently terminated coverage, is essential. We are committed to providing beneficiaries whose M+C coverage is terminated with timely and accurate evidence of the recently terminated coverage. To this end, we will provide M+C plans with, among other things, a model final termination letter that must be sent 90 days prior to termination of a contract. This letter will contain detailed information about beneficiaries' rights to Medigap under BBA and the BBRA.

We urge M+C organizations to keep in mind that they are obligated to notify beneficiaries whose coverage terminates of their rights under the Medigap provisions. Those provisions are complex, and beneficiaries will be entitled to guaranteed issue of Medigap policies at standard premium rates and with no preexisting condition exclusion periods only under certain circumstances. As noted above, their choice of Medigap policies will depend on the precise reason for, and timing of, the termination of their coverage under the M+C plan. It also matters whether they disenroll voluntarily or wait to be involuntarily disenrolled. However, if their initial 12-month trial period will expire before the M+C plan's contract will terminate, they have the option of disenrolling before the 12-month period has expired if they wish to obtain the broader selection of Medigap policies that may be available to them.

Further guidance is available to beneficiaries from their State Health Insurance Assistance Program (SHIP) or State insurance department.

Comment: A commenter has asked whether Medigap coverage is still applicable when a beneficiary chooses to privately contract for health services.

Response: Medigap policies cover two basic types of costs. The first includes costs such as deductibles and coinsurance that apply with respect to services *covered by Medicare.* The second includes costs of non-covered items and services such as outpatient prescription drugs. Medigap insurers are only required to make payment for the first type of services if a bill is submitted to and processed by Medicare. When a beneficiary privately contracts with a physician or practitioner under section 1802(b) of the Act to receive services that would otherwise be covered under Medicare, the services are excluded from Medicare payment under section 1862(a)(19) of the Act, and the beneficiary agrees not to submit a bill. As the beneficiary acknowledges in the private contract, as required by section 1802(b)(2)(B)(iv) of the Act, the Medigap policy will not pay for costs related to these services.

The policy may, however, be required to make payment with respect to the types of costs that are not otherwise covered by Medicare.

Comment: Commenters asked for clarification of the effective date of the BBA guaranteed issue requirements for Medigap A, B, C, and F plans, and for clarification of the rights of disabled beneficiaries with regard to guaranteed issue.

Response: As discussed above (and in greater detail in the **Federal Register** on December 4, 1998 and February 17, 1999, 63 FR 67078 and 64 FR 7968, respectively), the BBA's guaranteed issue provision took effect for all insurers on July 1, 1998. In addition, as noted previously, any Medigap policy that is available to beneficiaries under age 65 under any other circumstances must be offered to beneficiaries under age 65 who meet the criteria for BBA guaranteed issue protections.

Comment: One commenter was concerned about the wide variation in premiums of the 10 Medigap plans, and

was worried about beneficiaries being overcharged.

Response: It is true that there is wide variation in the premiums charged for the 10 standardized Medigap policies, both within States and from State to State. Regulation of Medigap insurance rates is ultimately within the discretion of the States, although federal Medigap law imposes some general requirements. In particular, Medigap policies must meet certain loss-ratio standards that are intended to ensure that policies provide refunds or credits if aggregate premiums exceed aggregate benefits by too high a margin. In addition, during the initial open enrollment period, and when the BBA guaranteed issue situations are in effect for a beneficiary, the insurer cannot increase the premium based on the beneficiary's health status.

Comment: Commenters voiced concern over the possibility of a beneficiary being penalized when a health plan terminates without timely enough notice for the beneficiary to find the appropriate Medigap insurance. Commenters also believe that we should provide plans with information as to which States have Medigap policies without pre-existing condition limitations as of January 1, 1999, and in general that plans need more information on Medigap.

Response: We have developed a clear termination policy and systems to provide for timely beneficiary notification, so that beneficiaries will be aware of their rights and protections if a plan terminates. In addition to developing internal processes, we are working with the States and M+C organizations to develop model language that will clearly and timely inform beneficiaries of their rights and protections.

In addition, we are working with the NAIC and the States to develop the Medigap Compare database, which will identify available Medigap policies and allow beneficiaries to compare costs and benefits. Beneficiaries and M+C plans will be able to access this database to gain the appropriate information a beneficiary needs when seeking Medigap insurance.

J. Subpart J, Part 422

Subpart J of part 422 has been reserved for future use.

K. Contracts with M+C Organizations (Subpart K)

Subpart K sets forth provisions relating to the contracts that are entered into by M+C organizations, including a description of terms that must be included in the contract, the duration of contracts, provisions regarding the nonrenewal or termination of a contract, and minimum enrollment, reporting, and prompt payment requirements.

1. Definitions (§ 422.500)

Comment: As discussed above in section II.F.2, we received comments suggesting that we impose requirements on providers to cooperate with M+C organizations in their collection of encounter data to be used in implementing risk adjustment.

Response: As discussed in section II.F.2, in response to this comment, we have taken several steps to facilitate the cooperation of providers in supplying valid data that can be used by M+C organizations to comply with encounter data requirements. In the case of contracting providers, we have specified under § 422.257 that M+C organizations may include in their provider contracts provisions requiring submission of valid data. Therefore, an M+C organization could provide in its contract that it will not make payment if claims do not meet the standards specified. In the case of noncontracting providers, however, § 422.520 requires M+C organizations to pay 95 percent of ''clean claims'' within 30 days, or pay interest on the amount. Also, based on the existing definition of ''clean claims,'' an M+C organization could not withhold payment based on a failure to submit a claim in the form required for use in complying with encounter data requirements. As noted in section II.F.2, we are revising the definition of ''clean claim'' in § 422.500 to require that clean claims include the substantiating documentation needed to meet the requirements for encounter data submission, and meet the original Medicare ''clean claim'' requirements. This change will, in effect, also require noncontracting providers submitting claims to an M+C organization to provide the organization with the information it needs to be able to use the claim in encounter data submissions, by exempting claims that do not meet these requirements from application of the 30-day ''prompt payment'' standards articulated at § 422.520. M+C organizations will therefore be able to withhold payment longer than the 30-day prompt payment standard in cases where noncontracting providers submit claims that do not contain substantiating documentation necessary for encounter data submissions or have other deficiencies (for example, inadequate coding). We believe that this clarification of the clean claim definition at § 422.500 is consistent with section 1957(f)(1) of the Act, which incorporates the Medicare fee-for-service prompt payment provisions in sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Act, and simply fleshes out the concept in the existing definition that a claim is not clean if it lacks ''any required substantiating documentation.'' Providers should note that submission of claims with complete and accurate encounter data is ultimately in their best interest, since M+C organizations must submit complete and accurate encounter data in order to get the full payment to which they are entitled under the risk adjustment system. While HCFA does not regulate payments to providers by M+C organizations, we believe that M+C organizations should share appropriately with providers any gains under the risk adjustment system.

2. National Contracting

The BBA does not specifically define or directly address the issue of national contracting. It facilitated such contracting, however, when it provided in section 1857(a) of the Act that an M+C contract ''may cover more than 1 Medicare+Choice plan,'' and, in section 1851(h)(3) of the Act, provided that marketing material need only be approved once to the extent it is consistent from area to area. While we are interested in national contracting, we similarly have not expressly provided for it in the regulations. One national contracting approach we would be willing to consider would permit an M+C applicant to request that we enter into a national contract with the applicant if the applicant holds license as a risk-bearing entity in each State where it intends to operate. The applicant would have the option of adopting a single M+C plan across the country, with one service area and a national ACR proposal, or offering different M+C plans in different areas under the same national contract.

While we have not at this time entered into a national contract with any M+C organization, HCFA has entered into national ''agreements'' with national chain organizations that hold M+C contracts. These arrangements apply to those chain organizations that enter into separate contracts in multiple States. These agreements allow a chain organization to establish a uniform policy across all of its States as to marketing, quality assurance, utilization review, claims processing, etc. HCFA pre-approves these national policy procedures. We continue to contract separately with individual, albeit related, M+C organizations affiliated through common ownership or control. We likewise continue to monitor operational activities for each organization in each State, but, having approved national policy, the need for

review at the State and local level is reduced.

Nine commenters addressed national contracting for M+C organizations. While most of the public comments favored extending the option of national contracting to M+C organizations and applicant organizations, commenters generally linked their support for the concept to a request that we provide additional information on the specifics of any national contracting policy.

Comment: While several commenters that supported national contracting raised individual concerns, (in most instances related to the need for HCFA to provide additional information), one commenter raised concerns that national contracting would undermine our ability to adequately monitor the performance of M+C organizations. Another commenter raised concerns that national contracting would provide M+C organizations the ability to bypass existing limits pertaining to the provision of cross-state and national radiology services.

Response: We continue to believe that national contracting has potential advantages for Medicare beneficiaries, M+C organizations, and HCFA. Indeed, we have already observed the benefits of allowing M+C organizations that operate in many markets throughout the county to establish uniform operational functions in the areas of marketing, quality assurance and claims processing. However, some issues pertaining to national contracting, (for example, monitoring and oversight, enforcement actions, etc.), require additional study. While HCFA continues to explore these issues, we are not able to provide detailed guidance. At such time as additional guidance is developed, we anticipate notifying the public through an operational policy letter.

3. Compliance Plan (§ 422.501(b)(3)(vi))

As a condition for entering into an M+C contract with HCFA, applicant organizations must demonstrate that they have certain administrative and management arrangements in place. There are six specific administration and management requirements at § 422.501(b)(3). One of these requirements is that M+C organizations have in place a compliance plan for meeting all applicable Federal and State standards. The regulations list the required elements of the compliance plan, which generally follow the standards applied under the U.S. Sentencing Commission's Federal Sentencing Guidelines in determining whether the existence of a compliance plan should mitigate penalties. We received nine public comments on the M+C compliance plan requirement.

Comment: Although some commenters agreed with the spirit of the compliance plan requirement, most objected to its mandatory nature, especially in light of OIG guidance on compliance plans for M+C organizations.

Response: We believe that the unique financial incentives and health care delivery systems of M+C organizations justify the compliance plan requirement. Medicare beneficiaries who enroll in plans are essentially ''locked in'' to that plan's benefit structure and provider network and may not obtain services under original Medicare. M+C organizations are responsible for a significantly broader range of program activities than original Medicare providers, including marketing, enrollment, appeals and grievances, utilization management, and claims payment. Each of these activities presents the potential for noncompliance that could directly and adversely affect a beneficiary's rights under the Medicare program. For example, an M+C organization's failure to report enrollment data properly to HCFA may result in incorrect payments to that organization.

While HCFA and the OIG conduct ongoing M+C program monitoring and enforcement activities, the number and variety of M+C operational requirements presents a significant regulatory challenge to both of these agencies. As a result, we believe that the additional level of scrutiny imposed by a compliance plan is a reasonable requirement.

While the OIG stated in its November 1999 guidance that the document was intended only to provide assistance for M+C organizations, the OIG did note that it ''believes an effective compliance program provides a mechanism that brings the public and private sectors together to reach mutual goals of reducing fraud and abuse, improving operational quality, and ensuring the provision of high-quality cost-effective care.'' The OIG also stated that a compliance plan is a tool for an M+C organization ''to ensure that it is not submitting false or inaccurate information to the Government or providing substandard care to Medicare beneficiaries * * *.'' We agree with the OIG's judgement with respect to the utility of the compliance plan tool and have adopted this requirement to protect the integrity of the M+C program.

Comment: Several commenters asked when M+C organizations are responsible for meeting the compliance plan requirements stated at § 422.501(b)(3)(vi), and noted that no detailed guidance on compliance has been issued by HCFA in connection with the interim final rule.

Response: The requirements in § 422.501(b)(3)(vi), as revised in this final rule, are in effect and must be met by M+C applicants and M+C organizations. Pending any further guidance, M+C organizations are free to reasonably interpret the provisions in § 422.501(b)(3)(vi), and should be prepared to demonstrate, upon request, how the organization meets each compliance plan element, as specified at § 422.501(b)(3)(vi), *et seq.*

Comment: Many commenters addressed the requirement at § 422.501(b)(3)(vi)(H) that M+C organizations develop ''an adhered-to process for reporting to HCFA and/or the OIG credible information of violations of law by the M+C organization, plan, subcontractor, or enrollee for determination as to whether criminal, civil, or administrative action may be appropriate.'' Commenters generally stated that this requirement was too vague, and should be more clearly defined to enable organizations to demonstrate compliance to HCFA. Several commenters requested that we specify what ''credible information'' means within the context of requiring M+C organizations to submit information to HCFA and/or the OIG. Commenters also requested that we specify: (1) Exactly what information must be self-reported; (2) to which agency; and (3) pursuant to violations of which laws. Commenters also noted that while paragraphs (A) through (G) correspond to provisions found in the Federal Sentencing Guidelines, paragraph (H) appears to be an M+C requirement only. These commenters believe that it is unfair to subject M+C organizations to a self-reporting requirement that does not apply to other sectors of the health care industry.

Response: Commenters correctly point out that the first seven elements of the mandated compliance plan guidance at § 422.501(b)(3)(vi) *et seq.* reflect the areas identified in the U.S. Federal Sentencing Guidelines. We previously added the eighth element in an attempt to ensure an enhanced level of program safeguard through self-reporting. We recognize, however, that it is arguably unfair to impose a self-reporting requirement on M+C organizations but not on other types of health care providers and suppliers participating in the Medicare program, and we have eliminated any requirement of self-reporting.

Nevertheless, we believe that the existence of voluntary self-reporting procedures of potential misconduct is an appropriate part of an M+C organization's compliance program. While this rule does not make any type of self-reporting mandatory, M+C organizations may wish to consider the following suggestions, as a matter of voluntary good business practice. These suggestions are not mandatory. Where the M+C organization discovers evidence of misconduct related to payment or delivery of health care items or services under the M+C contract, the M+C organization may conduct a timely, reasonable inquiry into the misconduct. After the reasonable inquiry, if the organization has determined that the misconduct resulted in an overpayment, the M+C organization is encouraged voluntarily to report the overpayment to HCFA. If the M+C organization has determined that the misconduct may violate the statutes of direct concern to the HHS Office of Inspector General, it is encouraged voluntarily to report the existence of the misconduct to that office. Finally, the M+C organization is encouraged voluntarily to initiate and implement appropriate corrective actions to ensure the problem does not recur.

While we are withdrawing all requirements for self-reporting in this rule, we believe that the required reporting of overpayments is an effective tool for promoting Medicare program integrity generally. Accordingly, HCFA intends to develop policies through separate notice and comment rulemaking in cooperation with the HHS Office of Inspector General that would require all Medicare providers, suppliers and contractors to report overpayments to HCFA.

Comment: Some commenters considered the M+C compliance plan requirements at § 422.501(b)(3)(vi) to be overly prescriptive, and asserted that they would result in M+C organizations being forced to ''reinvent the wheel,'' even though they may have existing compliance structures in place that meet the intent of the regulations. Many of these same commenters questioned our authority to prescribe these requirements in the M+C final rules.

Response: It is not our intent through these rules to require M+C organizations with effective compliance plans in place to make major changes. We believe that the requirements in § 422.501(a)(3)(vi) based on the Federal Sentencing Guidelines are sufficiently broad and general in nature that an effective compliance plan currently in place should satisfy M+C requirements. However, we do want some assurances that M+C organizations will have procedures in place to ensure compliance with Federal laws and requirements. We believe that our compliance plan requirements include the basic framework required for organizations to prevent and detect activities that will render the organization out of compliance. Moreover, the elements of the Federal Sentencing Guidelines from which these requirements are drawn are present in other guidances issued by the OIG over the last several years and should be familiar to most M+C compliance officials.

M+C organizations and contract applicants have broad discretion under § 422.501(b)(3)(vi) to design their compliance plan structure to meet the unique aspects of each organization. We recognize that there is no one best way for an organization to take steps to ensure that it is operating in compliance with all applicable regulations and requirements. Thus, we intend to work with M+C organizations and contract applicants to apply a flexible standard in reviewing M+C compliance plans, while still ensuring that these compliance plans serve their intended purpose: to detect and prevent compliance problems, in addition to identifying aspects of the organization that may be vulnerable to such problems.

We believe that one way for us to determine if an organization's corporate compliance plan is effective is to evaluate and audit the performance of the organization according to the M+C requirements articulated in the M+C contract and regulations. Since we have an established monitoring process for M+C organizations, we believe that the infrastructure is already established that may assist HCFA in its efforts to assess the effectiveness of organizations' compliance plans based in part on the results of our monitoring efforts.

4. Access to Facilities and Records (§ 422.502(e))

Under § 422.502(e) of the regulations, an M+C organization must agree to allow access to HHS or the Comptroller General to evaluate the quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract; the facilities of the M+C organization; and the enrollment and disenrollment records for the current contract period, and 6 prior contract years. We received two comments regarding access to M+C organization records.

Comment: A commenter asked what an M+C organization's obligations are in relation to information concerning nonplan providers, with whom an M+C organization has no contract. The commenter questioned how M+C organizations could be expected to provide access to governmental entities for nonplan provider records in order to meet the requirements of § 422.502(e).

Response: We recognize that HHS, the Comptroller General or their designees can require only M+C organizations and their subcontractors to make available their facilities and records. If an M+C organization does not have a contract or other suitable written arrangement with a provider, it cannot compel the provider to provide the same access that an M+C organization or its subcontractors must provide under the terms of their M+C contract with HCFA. In order for HHS or the Comptroller General to gain access to the facilities and records of noncontracting providers, these agencies would be required to resort to other available legal remedies, such as subpoenas.

We would add, however, that as a general principle, if Federal funds are going to a provider of Medicare or Medicaid services, appropriate Federal officials have a right to review that provider's facility or books as a condition of receipt of those Federal funds.

Comment: A commenter suggested that the 6-year time period for which data must be retained under the regulations should be tied to the end of the year in question, and not the date of the completion of the audit, as provided in § 422.502(e)(4).

Response: The 6-year period specified for retention of records was established in reliance on the 6-year ''statute of limitations'' that generally governs the initiation of a civil action by the Government, either under the False Claims Act (FCA) or the Civil Monetary Penalties Law (CMPL). A statute of limitations specifies the time period during which the Government may initiate an action. Generally, a statute of limitations begins to run on the date that an audit was completed. For this reason, we are requesting that books and records be kept for at least 6 years from either the end of a contract or the completion of an audit, whichever is later.

For purposes of clarity, we also point out that the 6-year record retention requirement requires M+C organizations to keep a specific year's records for 6 years, after which the organization is free to dispose of any records they deem appropriate. This is to clarify one misconception that M+C organizations must maintain 6 years of records for an additional 6-year period. We instead

envision the obligation for M+C organizations to retain records to expire on a rolling basis, with M+C organizations having the right to discard each year the records from more than 6 years earlier. For example, in 2000, M+C organizations could discard records from 1993 or earlier. In 2001, M+C organizations could discard records from 1994, etc. Under this system of record retention, if the Government has not audited or determined any wrongdoing within a 6-year period following the year when records were developed, the Government would be otherwise precluded under law from taking any action against an M+C organization.

5. Disclosure of Information (§ 422.502(f)(2)(v))

Pursuant to authority at section 1851(d) of the Act, § 422.502(f)(2) describes the information that M+C organizations must submit to HCFA. We specify that this information is necessary for us to fulfill our responsibilities in evaluating and administering the program. Our dissemination of some of this information to current and prospective Medicare beneficiaries enables them to exercise informed choice in obtaining Medicare services. We received one comment on this section of the interim final rule.

Comment: One individual commented on the requirement in § 422.502(f)(2)(v) that M+C organizations submit to us information about beneficiary appeals and their disposition. The commenter recommended that we amend this section of the regulations to include the additional requirement that M+C organizations disclose to HCFA information regarding beneficiary grievances and their disposition.

Response: Consistent with section 1852(c)(2)(c) of the Act, § 422.111(c)(3) of the regulations distinguishes between information that an M+C organization must provide to a Medicare enrollee annually, and information that the M+C organization must disclose to any M+C eligible individual upon request. The requirement states that M+C organizations must disclose to M+C eligible individuals, upon request, the aggregate number of disputes, and their disposition, including both grievances and appeals. Thus, Medicare beneficiaries have access to information on M+C organization grievances.

Also, pursuant to both sections 1851(d)(3) and 1852(c)(2)(C) of the Act, § 422.502(f) requires that M+C organizations disclose to us the appeal data that they are required to disclose upon request to beneficiaries. We believe that this is necessary so that we can begin to capture important baseline data on the appeals process. Our contractor (the Center for Health Disputes Resolution) is responsible for making reconsideration decisions when an enrollee files an appeal, and these decisions are appealed to HHS administrative law judges and the Departmental Appeals Board. In addition, HCFA enforces decisions made by these entities, which necessarily involve the critical question of whether services will be covered by the M+C organization.

While the regulations provide for beneficiary access to information on an M+C organization's grievance process, we do not at this time believe that it is necessary for HCFA to collect this information for administrative purposes. We would advise M+C organizations, however, that while we are not requiring that M+C organizations disclose grievance data to us at this time, we intend to propose additional requirements pertaining to M+C grievances, including quality of care grievances, in a notice of proposed rulemaking to be published later this year. Thus, we anticipate that M+C organizations may be required to report grievance data in the future.

6. Beneficiary Financial Protection (§ 422.502(g))

In the interim final rule, we addressed enrollee financial protection provisions at § 422.502(g). These provisions are designed to protect enrollees from incurring liability for payment of any fee for which M+C organizations are legally obligated. Section 422.502(g) incorporates enrollee financial protections that were in place before the BBA in § 417.122(a)(1), which applies to all section 1876 contractors under § 417.407(f). Section 422.502(g)(1) is intended to protect enrollees from being held financially responsible for fees for which the M+C organization is legally liable; § 422.502(g)(2) addresses M+C organizations' obligation to provide for continued coverage of health care benefits, and § 422.502(g)(3) sets forth the mechanisms M+C organizations can employ to provide the required enrollee protections. We received three comments regarding § 422.502(g).

Comment: A commenter suggested that we provide appropriate ''hold harmless'' language for inclusion in M+C organizations' contracts because different States have different requirements regarding hold harmless language. (By ''hold harmless'' language, the commenter is referring to language included in an M+C organization's contract with a provider that protects enrollees from being charged for services, (other than pursuant to M+C plan provisions that allow for cost-sharing), furnished by the provider, even if the provider has not received payment from the M+C organization for the services.)

Response: Implicit in the commenter's request is recognition that many States have adopted hold harmless contract language requirements for managed care organizations operating within a given State. We generally recommend that M+C organizations adopt the National Association of Insurance Commissioners' (NAIC) model hold harmless language. However, given the wide variety of individual State requirements loosely categorized under member or enrollee protections, we do not believe that it is prudent to *require* M+C organizations to adopt the NAIC model language, because that requirement may well place some M+C organizations at odds with State provisions. The NAIC-approved language is available through most State insurance commissioners' offices, or by contacting the NAIC directly.

Comment: One commenter recommended that we strengthen the beneficiary protection provisions in subpart K by explicitly prohibiting providers from bringing ''collection actions'' against M+C enrollees, as a means of preventing providers from billing beneficiaries enrolled in M+C plans for fees that are the legal obligation of the M+C organization. The commenter also suggested that we define the word ''fees'' for purposes of this section of the regulations.

Response: Section 422.502(g)(1) is designed to ensure that beneficiaries are not held liable for fees for which the M+C organization is legally responsible. As discussed above, under § 422.502(g)(1)(i), contracts with M+C plan providers must contain language that prohibits these providers from holding beneficiary enrollees liable for payment of fees that are the obligation of the M+C organization. (This language is commonly referred to as ''hold harmless'' language.) Under § 422.502(g)(1)(ii), M+C organizations are responsible for indemnifying enrollees for payment of any fees that are the legal obligation of the M+C organization to pay when services are furnished by providers that do not have a contract or other acceptable written arrangement with the M+C organization. We believe that these two provisions generally are adequate to ensure that M+C enrollees are not held responsible for fees for which an M+C organization is liable.

In instances where providers do bill M+C enrollees for amounts beyond those approved in an M+C plan, we believe that it is the responsibility of the M+C organization to take appropriate steps, such as recovering these amounts from the providers, to see that beneficiary enrollees are made financially whole. If they fail to do so, we would take appropriate action against the M+C organization. We believe it would be inappropriate for us to engage in activities directed at individual providers.

We note, however, that even in situations, (such as insolvency or other financial difficulties), where an M+C organization fails to satisfy its responsibility to pay a provider for services furnished to an M+C enrollee, the principle that the beneficiary is protected still applies. Although we believe this principle is inherent in the existing regulations, to clarify this point, we are revising § 422.502(g)(1) to indicate that the applicable beneficiary financial protections apply in situations such as insolvency or other financial difficulties.

We believe that the term ''fee'' is commonly understood, and does not need a special definition. In this context, the term refers to the fees charged by a provider (for example, a physician's fee for services provided). M+C organizations are responsible for payment of such fees, except for applicable enrollee cost-sharing amounts specified under the M+C plan, which are the obligation of the Medicare enrollee.

Comment: A commenter contended that there is an inconsistency in the language in §§ 422.502(g)(2), (g)(3), and (i)(3)(i)(B). Section 422.502(g)(3) gives M+C organizations several options for meeting requirements in § 422.502(g) (other than the ''hold harmless'' requirement in § 422.502(g)(1)(i)), including the options of providing for continuation of benefits through contractual arrangements, insurance, financial reserves, or other arrangements acceptable to HCFA. Section 422.502(i)(3)(i)(B), however, effectively requires that continuation of benefits be provided for in contract language.

Response: We agree with the commenter that the language in these sections is inconsistent. Accordingly, we are revising §§ 422.502(i)(3)(i) to eliminate the requirement that the continuation of benefits protection be addressed through contractual arrangements. In conjunction with this technical change, we also are revising § 422.502(g)(3) to clarify that the alternative arrangements spelled out there are linked only to the indemnification provision in § 422.502(g)(1)(ii) and to the continuation of benefits provision in § 422.502(g)(2).

7. Requirements of Other Laws and Regulations (§ 422.502(h))

Section 422.502(h) requires that contracts reflect the M+C organization's obligations under other laws, specifically, the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, other laws applicable to recipients of Federal funds, and all other applicable laws and rules.

Comment: Several commenters wanted us to define ''other laws applicable to recipients of Federal funds'' and ''other applicable laws and rules'' as used in § 422.502(h).

Response: These references are intentionally broad and all-encompassing. We have already identified various specific laws. These references are intended to encompass laws that may be enacted in the future, or current laws that we might inadvertently omit if we were to attempt to be more specific in this regulation. It is important to note, however, that these references only apply to laws that are, by definition and by their own terms, ''applicable'' to an M+C organization. Thus, these provisions of the regulations do not result in an organization being required to comply with any laws that do not already apply to them. Rather, they simply call for a commitment to comply with these laws.

8. Contracting/Subcontracting Issues (§ 422.502(i))

The requirements found at § 422.502(i)(3) pertaining to M+C contracting requirements with providers, suppliers, and administrative service entities were developed pursuant to our authority under section 1856(b)(1) of the Act to ''establish'' M+C ''standards.'' We developed these rules in recognition of the fact that managed care organizations commonly enter business relationships with entities that they place under contract to perform certain functions that would otherwise be the responsibility of the M+C organization. Section 422.502(i)(3) establishes these requirements in three broad categories: enrollee protection provisions, accountability provisions, and a provision that assures that services performed by other entities are carried out in a manner that complies with the M+C organization's contractual obligations to us. We received three comments concerning the subcontracting issues addressed in § 422.502(i)(3).

Comment: Two commenters believe that HCFA should provide additional guidance on its contracting/subcontracting requirements; they suggested that HCFA apply a flexible standard in holding M+C organizations accountable for meeting these requirements in a timely manner. A third commenter wanted to know if our subcontracting guidance would compel entities with whom M+C organizations contract to comply with HCFA's Y2K systems compliance requirements.

Response: We are cognizant of the importance of providing detailed contracting guidance to M+C organizations, and to individuals and entities that might choose to contract with them. We have issued significant guidance in the past and intend to continue doing so as needed in the future. For example, in OPL 98.077 we addressed two major issues. First, we clarified the contracting requirements that affect M+C organizations, applicant organizations, contractors, and subcontractors. Second, we addressed implementation guidance for organizations that wished to begin operation as an M+C-contracting organization. We believe that this OPL sufficiently addresses concerns raised by the managed care industry concerning the need for a higher degree of specificity regarding contracting and subcontracting requirements. We likewise believe that OPL 98.077 established flexible implementation standards in recognition of the labor-intensive nature inherent in activities aimed at amending or otherwise establishing contracts and subcontracts that follow the standards specified in the M+C regulations and elsewhere in OPL 98.077. Commenters and other interested parties may access OPL 98.077 on the Internet at http://www.hcfa.gov.

Regarding the question on Y2K requirements, this issue is moot, since all contracting M+C organizations appear to have succeeded in avoiding related problems. We would note, however, that to the extent an M+C organization provided services through subcontractors, it was responsible for ensuring the Y2K compliance of those subcontractors to the extent necessary to ensure overall Y2K compliance.

Comment: Some commenters expressed confusion regarding use of the terms ''related entities, contractors, and subcontractors'' in § 422.502(i)(1), and the applicability of these terms. Some have pointed out that although the term ''related entity'' is defined at § 422.500, the terms ''contractor'' and ''subcontractor'' are not defined.

Response: In response to the confusion suggested by this comment, we now recognize that the terms ''contractor'' and ''subcontractor'' are somewhat amorphous, and could mean different things to different parties. For instance, a contract between an M+C organization and members of an IPA might be considered a ''contract'' by one party and a ''subcontract'' by another party. Likewise, organizations or individuals might sometimes call a contract between the IPA and its member physicians a ''subcontract,'' while in other instances call it a ''provider participation agreement.'' We have consulted with the managed care industry about terms that may be universally recognized, and have also considered developing new terminology with clear definitions.

As a result, and in response to the comment, we have added two terms—''first tier'' and ''downstream''—to the list of definitions at § 422.500. We believe these definitions will clarify the types of entities to which the M+C contracting requirements described at § 422.502(i) apply. We began using the terms ''first tier'' and ''downstream'' in OPL 98.077, and believe that both terms satisfactorily enhance the description of entities or individuals that are the intended audience for satisfying the requirements found at § 422.502(i).

9. Certification of Data That Determine Payment/Certification of the Accuracy of ACR Information (§ 422.502(l))

Under § 422.502(l), M+C organizations must certify to the accuracy, completeness, and truthfulness of the data used to calculate payments to the organizations. These data include enrollment information, encounter data, and the information included in an M+C organization's ACR proposal. In the preamble to the interim final rule, we noted that in submitting these data, M+C organizations are making a ''claim'' for payment from HCFA, since this information directly affects the calculation of payment rates and amounts. We stated that the certifications would help ensure accurate data submissions and assist us in maintaining the integrity of the Medicare program.

Comment: Several commenters suggested that the certification requirement should include a ''good faith'' standard. Given the significance of the penalties that HCFA, OIG, and the Department of Justice (DoJ) may potentially impose in the case of a ''false claim,'' and the complexity of the data required, these commenters believe that it would be unfair and unrealistic to hold M+C organizations to a ''100 percent accuracy'' certification standard.

Response: We first addressed this issue during the drafting of the 1999 M+C coordinated care plan contract. In developing the certification forms M+C organizations would use to meet the payment data certification requirement, we consulted with OIG and DoJ in drafting language that requires the M+C organization to certify the accuracy, completeness, and truthfulness of this data based on ''best knowledge, information, and belief.'' This language was included in the 1999 contract forms in recognition of the fact that M+C organizations cannot reasonably be expected to know that every piece of data is correct, nor is that the standard that HCFA, the OIG, and DoJ believe is reasonable to enforce.

In presentations to industry, HHS representatives have emphasized that simple mistakes will not result in sanctions. Generally, the Federal government can bring an action only when one of three states of mind exists: (1) Actual knowledge of falsity of a claim or information; (2) reckless disregard; or (3) deliberate ignorance of information supporting the truth or falsity of a claim or other information (42 CFR 1003.101). However, no specific intent to defraud is required. The ''best knowledge, information, and belief'' standard of the M+C contract certification forms is consistent with these standards.

It is appropriate that the M+C regulations be consistent with the standard of knowledge reflected in Federal fraud statutes. Therefore, we are modifying § 422.502(l) as needed to reflect the ''best knowledge, information, and belief'' certification standard.

Comment: Several commenters suggested that the signatory authority for payment certifications should not be limited to the chief executive officer (CEO) and chief financial officer (CFO) of an M+C organization. The commenters noted that as a practical matter, it is difficult to obtain a CEO or CFO signature on a monthly basis, given the workload and travel obligations of these officers. Therefore, the regulations should permit a CEO or CFO to designate another individual in the M+C organization to sign the certifications.

Response: We agree that the CEO/CFO signature requirement can create operational difficulties for M+C organizations in their efforts to comply with the payment certification requirements of § 422.502(l). However, we believe that it is important that certifications be made by a high level individual who has authority to obligate the M+C organization, or someone who has been delegated the authority of such an individual. Therefore, we are modifying § 422.502(l) to require the ''CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such an officer,'' to certify the M+C organization's enrollment data, encounter data, and ACR proposal information.

Comment: A commenter contended that M+C organizations should not be required to certify the accuracy of the encounter data they receive from third parties. Rather, this commenter believes that organizations should be required to certify only that they have not altered the data, and that they have transmitted it to HCFA as they received it from the provider. The commenter asserted that M+C organizations do not control the operations of those providing encounter data, and that the volume of data is such that no M+C organization has the resources to verify the accuracy of these submissions.

Response: Under the M+C program, encounter data will be used as a factor in calculating payments to M+C organizations. Therefore, encounter data submissions, like enrollment data and ACR information, represent a ''claim'' for payment. As such, M+C organizations have an obligation to take steps to ensure the accuracy, completeness, and truthfulness of the encounter data.

We acknowledge that encounter data come into M+C organizations in great volume and from a number of sources, presenting significant verification challenges for the organizations. However, we believe that M+C organizations have an obligation to undertake ''due diligence'' to ensure the accuracy, completeness, and truthfulness of encounter data submitted to HCFA. Therefore, they will be held to a ''best knowledge, information, and belief'' standard. Therefore, M+C organizations will be held responsible for making good faith efforts to certify the accuracy, completeness, and truthfulness of encounter data submitted.

10. Effective Date and Term of Contract (§ 422.504)

Section 1857(c)(3) of the Act provides that the effective date of an M+C contract is to be specified in the M+C contract, and section 1857(c)(1) requires that contracts be for a term of at least one year. The Secretary was provided the discretion under section 1857(c)(1) to provide for contracts to be ''automatically'' renewable in the absence of notice.

Section 1857(c)(2) of the Act authorizes us to terminate an M+C contract if we determine that an M+C organization substantially fails to carry out its M+C contract, carries out the contract in a manner that is inconsistent with the effective and efficient administration of the M+C program, or fails to continue to meet the M+C requirements.

Section 422.504 of the June 1998 interim final rule implements section 1857(c)(1) and (3) of the Act. Section 422.504(b) provides that contracts generally are for a 12-month period beginning January 1 and ending December 31. Section 422.504(d) provides for a limited exception to this rule, permitting HCFA the discretion, prior to January 1, 2002, to approve a contract for longer than 12 months beginning on a date other than January 1. This decision permits us to accept M+C applications on a continuous ''flow'' basis until the beginning of the lock-in periods contemplated under the BBA starting in 2002. We received one comment pertaining to the effective date and term of the M+C contract.

Comment: A commenter expressed concerns regarding the effect of open enrollment requirements on our requirements governing the effective date and term of M+C contracts. In particular, the commenter had concerns about the elimination of the right to disenroll (and enroll) in an M+C plan at any time. The commenter believes that this shift in enrollment policy contributed to our decision no longer to approve contract applications on a continuous ''flow'' basis after 2002, since most Medicare beneficiaries, (excluding newly eligible beneficiaries and those beneficiaries eligible to make an election based upon a special enrollment period), would not otherwise be able to enroll in the new M+C organization until the beginning of the next annual open enrollment period. The commenter suggested that M+C organizations retain the ability to enroll Medicare beneficiaries on an ongoing basis without regard to the annual lock-in periods contemplated by the BBA at section 1851(e).

Response: This comment raises two related issues. The first pertains to enrollment and disenrollment policies, and the second pertains to HCFA's rationale for considering a policy that would establish a cutoff date for making contracts effective on a date other than January 1. We believe the statute clearly indicates that continuous open enrollment and disenrollment may continue only through the end of 2001. Currently, M+C organizations are only required to be open for enrollment in November of each year, to newly Medicare-eligible individuals, and during specified ''special election periods.'' (See § 422.60(a).) Thus, it is not necessarily the case even now that there is ''continuous'' open enrollment, though the right to disenroll exists all year. During the first 6 months of the transition year of 2000, a beneficiary will be able to disenroll without cause, and enroll in any M+C plan open for enrollment, with a limit of one change in enrollment status during this period. This same situation will apply to the first 3 months of every year after 2002, with a limit of one change in elections during this 3-month period. Other than this, beneficiaries will only be permitted to enroll or disenroll during the annual November open enrollment period, a special election period, or upon first becoming eligible for Medicare (with the exception of institutionalized individuals, consistent with section 501 of the BBRA). These enrollment limitations will, in effect, limit the number of Medicare beneficiaries that an M+C organization can enroll mid-year. Yet, after considering the comments, we do not believe that the enrollment policies pursuant to the BBA necessarily preclude us from entering into contracts on dates other than January 1 beginning 2002. While we recognize the inherent enrollment limitations for M+C organizations that will result from a mid-year enrollment eligibility pool that will be comprised largely of individuals that become newly eligible for Medicare, we nevertheless believe that enrollment and the term of an M+C contract are distinct issues that can be considered independent of each other. Regarding the term of an M+C contract, we further believe that the statute permits us to continue to approve mid-year contracts post-2002. Since section 1857(c)(1) requires that contracts be for a term of at least one year, HCFA may continue to enter contracts that may begin on dates other than January 1 for terms longer than 12 months. We have modified § 422.504 to reflect this policy.

11. Nonrenewal of M+C Contracts (§ 422.506)

Section 422.506 specifies the process that M+C organizations and HCFA must use should HCFA decide not to renew the organization's contract, or should the organization give HCFA notice that it does not want its contract to be renewed. We received four comments addressing our M+C contract renewal policy.

Comment: Some commenters believe that requiring M+C organizations to notify HCFA of their intent to nonrenew their M+C contract(s) by May 1 does not provide enough time for organizations to conduct the requisite analysis necessary to decide whether the organization should remain in the M+C program.

Response: We agree with the commenter that the May 1 deadline does not provide organizations enough time to decide whether to remain in the M+C program. We recognize that the May 1 deadline affords organizations only 60 days from the date such organizations received the upcoming year's M+C payment rates to make business decisions affecting their participation in the M+C program. Congress recently recognized this problem when it amended section 1854(a)(1) of the Act to change the deadline for submitting an ACR from May 1 to July 1. (See section 516 of the BBRA and section I.C of this preamble.) In light of the commenter's concern, and the change in the ACR deadline enacted by Congress, we are revising § 422.506(a)(2)(i) to permit an M+C organization until July 1 to notify us of its intent not to renew its M+C contract for the upcoming contract year. An M+C organization that does not signify its intent not to renew its M+C contract by July 1, and that has not otherwise been notified by HCFA of our intent not to renew the M+C organization's contract by May 1, will be obligated to contract for the upcoming contract year.

Comment: One commenter questioned our authority under § 422.506(b)(ii) to decide not to renew M+C contracts based on our assessment that an M+C organization's level of enrollment or growth in enrollment threatens the viability of the organization under the M+C program. This commenter likewise questioned the authority under which we could decide not to renew a contract based upon our assessment that lack of enrollment could be viewed as an implied measure of dissatisfaction with a particular M+C organization.

Response: We believe that HCFA should be a prudent purchaser of health care services on behalf of Medicare beneficiaries. This entails a fiduciary responsibility to Medicare beneficiaries and tax payers to maintain contracts with organizations that display a sustained and ongoing commitment toward meeting the highest quality standards, and that offer a product attractive enough to attract Medicare beneficiaries to enroll. In promulgating § 422.506(b)(1)(ii), we determined that it might not be worth the costs associated with contracting with an M+C organization if that organization fails to attract or keep at least some level of Medicare enrollment.

However, in response to the commenter's concern, we have determined that the standard outlined at § 422.506(b)(1)(ii) for declining to renew an M+C contract may be too vague to enforce; therefore, we are deleting § 422.506(b)(1)(ii).

12. Provider Prior Notification and Disclosure (§§ 422.506(a), 422.508, 422.510(b), and 422.512)

We address M+C contract determinations in several sections throughout subparts K and N of the M+C regulations. As noted above, § 422.506 contains provisions governing our decisions and M+C organization decisions concerning whether to renew an M+C contract. Section 422.508 specifies that HCFA and an M+C organization may together elect, upon mutual consent, to modify an M+C contract. Sections 422.510 and 422.512 describe M+C contract termination procedures when initiated by either HCFA or an M+C organization. When M+C contract determinations occur, either the organization initiating the determination, or the organization impacted by the determination, must meet certain notification requirements described in §§ 422.506, 422.508, 422.510, and 422.512. The notice requirements compel either HCFA or the M+C organization to notify: (1) The party affected by the contract determination (for example, if HCFA elects to terminate a contract, HCFA must notify the M+C organization of our determination); (2) the Medicare beneficiaries from the affected M+C organization's M+C plans; and (3) the general public.

Comment: Several commenters suggested that we consider developing a requirement that would compel HCFA and/or an M+C organization to notify providers affected by M+C contract determinations about the contract determination, regardless of which party initiates the contract determination action. The commenters contended that the notice is necessary to grant providers sufficient time to react to contract determinations that may adversely affect them. (A related section of regulations that the commenters did not reference, but would logically be affected by the recommendations of the commenters, is § 422.641 of subpart N.)

Response: We believe there are several reasons why separate provider disclosure and notification is unnecessary. First, we do not believe that notifying an M+C organization's network providers of an M+C contract determination is feasible for HCFA, since we do not routinely maintain this information at a level of specificity that would be necessary to provide such notice. Further, we do not believe that it is necessary to require M+C organizations to provide such notice, since we believe that they would necessarily have to notify affected providers that their contracts were being nonrenewed.

In any event, since M+C organizations and/or HCFA are already required to disclose specified information to the general public, a subset of which are the M+C organization's providers, pursuant to an M+C contract determination, we believe that any additional notification requirements may be duplicative and unnecessary.

13. Mutual Termination of a Contract (§ 422.508)

Section 422.508 provides that M+C organizations and HCFA may mutually agree to modify or terminate an M+C contract. When a contract is terminated by mutual consent, M+C organizations must provide notice to affected Medicare enrollees and the general public. If the contract terminated by mutual consent is replaced on the following day by a new M+C contract, the notice requirements do not apply.

Comment: One commenter expressed concerns that our policy, as outlined at § 422.508, does not provide enough beneficiary protection, and may potentially compromise beneficiary continuity of care. Further, the commenter recommended that mutual contract termination should automatically trigger a special enrollment period for affected Medicare beneficiaries, as outlined at § 422.62(b).

Response: We believe that § 422.508 provides Medicare beneficiaries affected by mutual consent contract termination with the protections necessary for affected beneficiaries to choose new Medicare health service delivery options. In particular, the requirement that M+C organizations provide Medicare beneficiaries and the general public with a notice of termination to conform to the 60-day notice requirement in §§ 422.512(b)(2) and (3) should enable affected Medicare beneficiaries to arrange for alternative health care coverage, such as returning to original Medicare, or choosing a different M+C plan before the effective date of termination.

We agree with the commenter that a termination (and not modification) of an M+C contract by mutual consent should trigger a special election period as described at § 422.62(b), and we believe that the existing language at § 422.62(b)(1) supports this position. In stating ''HCFA has terminated * * * or the organization has terminated * * * the [M+C] plan in the service area or continuation area in which the [Medicare eligible] individual resides * * *,'' we believe that termination of a contract by mutual consent of the two aforementioned parties is consistent with the intent of the provision at § 422.62(b)(1). Thus, we believe that any change to the regulation language at § 422.508 or § 422.62(b)(1) is unnecessary.

14. Termination of Contract by HCFA (§ 422.510)

Section 422.510 implements the provisions in section 1857(c)(2) of the Act pertaining to our authority to terminate an M+C organization's contract if we determine that the organization: (1) Fails to substantially carry out the contract; (2) is carrying out the contract in a manner inconsistent with the efficient and effective administration of Medicare Part C; and/or (3) no longer substantially meets the applicable conditions of Part C. In § 422.510(a), we set forth the above standards, as well as several specific circumstances that we believe constitute a substantial failure to carry out the contract, justifying termination. The procedures under which we would take action to terminate an M+C contract are described in section 1857(h) of the Act. In general, we may terminate an M+C contract after: (1) We provide the M+C organization with an opportunity to correct identified deficiencies; and (2) we provide the organization with notice and opportunity for a hearing, including the right to an appeal of an initial decision.

We received three comments on § 422.510. One commenter requested further explanation regarding the termination process, for which we refer the commenter to subpart N of the regulations. The other comments are addressed below.

Comment: Two commenters requested that we define what we mean by the term ''substantially fails to comply,'' as used throughout § 422.510(a).

Response: In the June 1998 interim final rule, and at § 422.510(a)(4) through (11), we identify circumstances that we believe constitute examples of what the statute identifies as substantially failing to carry out an M+C contract. They are: the M+C organization commits or participates in fraudulent or abusive activities affecting the Medicare program; the M+C organization substantially fails to comply with requirements in subpart M relating to grievances and appeals; the M+C organization fails to provide us with valid encounter data as required under § 422.257; the M+C organization fails to

implement an acceptable quality assessment and performance improvement program as required under subpart D; the M+C organization substantially fails to comply with the prompt payment requirements in § 422.520; the M+C organization substantially fails to comply with the service access requirements in §§ 422.112 or 422.114; or the M+C organization fails to comply with the requirements of § 422.208 regarding physician incentive plans.

We have longstanding compliance standards for Medicare managed care contractors. In addition to those set forth in the statute and regulations, compliance standards are set forth in our Medicare Managed Care Performance and Monitoring protocol. We use this document when conducting performance/monitoring evaluations of contracting Medicare managed care organizations, including M+C organizations. Pursuant to these reviews, each contracting organization must demonstrate that it again complies with all applicable statutory, regulatory and contract requirements that apply to M+C organizations. These reviews result in findings as to whether a failure to comply with requirements constitutes a ''substantial failure'' for purposes of § 422.510(a). In determining whether a failure is ''substantial,'' we consider both the frequency and the seriousness of the noncompliance. In the case of a serious violation that could put the health of an enrollee at risk, even a single violation might be considered substantial. In the case of a less serious violation, the noncompliance would have to be more pervasive or systematic in order to be considered substantial.

Comment: Some comments reflected confusion regarding § 422.510(c), and its reference to subpart N of part 422. Section 422.510(c) indicates that if we make a determination to terminate an M+C contract, we must first allow the affected M+C organization the opportunity to submit a corrective action plan in accordance with ''time frames specified at subpart N'' of part 422. The commenter noted that subpart N does not contain any time frames that apply specifically to activities related to corrective actions.

Response: We agree that subpart N does not contain time frames that appear applicable to an opportunity to take corrective action, and that this reference is an error. We accordingly are deleting this reference from § 422.510(c).

15. Minimum Enrollment Requirements (§ 422.514)

Section 1857(b) of the Act specifies that we may not enter into a contract with an M+C organization unless the organization has at least 5,000 enrollees (or 1,500 if it is a PSO), or at least 1,500 enrollees (or 500 if it is a PSO) if the organization primarily serves individuals residing outside of urbanized areas. Section 1857(b)(3) creates a transition standard for meeting this requirement by allowing us to waive the minimum enrollment requirement during the M+C organization's first 3 years.

Comment: A commenter asked if we would consider a permanent minimum enrollment waiver for ''smaller scale service models.''

Response: A review of both the statute at section 1857(b) of the Act and the Conference Committee report indicates that the Congress intended for the minimum enrollment waiver to apply only during the first 3 contract years for any organizations. The minimum enrollment thresholds themselves are necessary to enable organizations to adequately spread risk across enrolled populations.

16. Reporting requirements (§ 422.516)

The M+C regulations contain various provisions that specify information disclosure requirements. The requirements address both information to be provided by M+C organizations to HCFA (see §§ 422.64, 422.502, and 422.512), by M+C organizations to beneficiaries (see §§ 422.80 and 422.111), and by HCFA to beneficiaries (under existing § 422.64). Section 422.516 specifies requirements that M+C organizations must meet regarding disclosure of statistics and information to HCFA, M+C enrollees, and the general public.

Comment: A commenter requested that we expand the reporting requirements specified at section § 422.516 to require M+C organizations to report the statistics and other information specified in § 422.516 *et seq.* directly to the organization's network health care providers.

Response: The commenter seeks to carve-out a separate category of individuals, providers, to receive statistics and other information that M+C organizations are already obligated to disclose to HCFA, to M+C plan enrollees, and to the general public. We believe that it is unnecessary for M+C organizations to report statistics and other information separately to providers. Since M+C organizations (or HCFA) are already required to disclose specified information to the general public, (a subset of which is the M+C providers), any additional requirement to disclose information separately to an organization's providers is duplicative and unnecessary. Moreover, we are concerned about the administrative burden that such a requirement could impose upon M+C organizations, which may contract with thousands of providers. Further, we suspect that many organizations already voluntarily furnish providers with much of the information required under § 422.516, such as information on health plan benefits, premiums, quality and performance measurements, and utilization control mechanisms.

17. Prompt Payment by M+C Organization (§ 422.520(a))

Section 422.520 indicates that contracts between M+C organizations and HCFA must specify that the M+C organization agrees to provide prompt payment of claims that have been submitted by providers for services and supplies furnished to Medicare enrollees when these services and supplies are not furnished by an organization-contracted provider. Specifically, 95 percent of ''clean claims'' must be paid within 30 days of receipt. While this provision closely follows requirements already in place for section 1876 contractors, (including provisions pertaining to interest to be paid if timely payment is not made), section 1857(f) of the Act extends similar prompt payment requirements to claims submitted by Medicare beneficiaries enrolled in M+C private fee-for-service plans. Section 422.520(a) incorporates this requirement of new section 1857(f), as well as the general 30-day requirement that applied to noncontracting providers under section 1876. In the preamble to the June 1998 interim final rule, we indicated that pursuant to our authority under section 1856(b)(1) to establish standards under Part C, M+C organizations would be required to act upon (either approve or deny, not necessarily pay) all claims not subject to the 30-day standard within 60 calendar days from the date of request.

Comment: Commenters noted that the ''approve or deny'' language in § 422.520(a)(3) was inconsistent with rules regarding M+C organization determinations and reconsiderations as described in subpart M. Also, it has been brought to our attention that the requirement that ''non-clean'' claims (and up to 5 percent of clean claims) be ''approved or denied,'' but not necessarily paid, within 60 calendar days from the date of the request for payment, is inconsistent with the

standard that applied to contractors under section 1876 of the Act. Under the Medicare risk program, HCFA traditionally required that HMOs or CMPs with Medicare risk contracts *pay* or deny non-clean claims within 60 calendar days from the date of the request for payment. The ''approve or deny'' language may permit gaps of time between when an organization approved a claim for payment and when the organization actually paid a claim.

Response: After further review of this issue, we agree that M+C organizations should be required to either pay or deny non-clean claims (and clean claims not subject to the 30-day standard) within 60 calendar days from the date of the payment request. This standard removes the possible ambiguity associated with ''approving'', but not necessarily paying, a claim for payment, and any related ambiguities pertaining to M+C organization determination and reconsideration policies articulated in subpart M of this final rule. Thus, we are revising § 422.520(a)(3) to indicate that claims for services that are not furnished under a written agreement between M+C organization and its network providers, and that are not paid within 30 days, must be either paid or denied within 60 calendar days from the date of the request.

L. Effect of Change of Ownership or Leasing of Facilities During Term of Contract (Subpart L)

The provisions set forth in subpart L of part 422 by the June 1998 interim final rule merely constituted a redesignation of the provisions in part 417 on change of ownership or leasing of facilities. However, since the June 1998 interim final rule was published, it has come to our attention that M+C organizations have serious concerns about language in the italicized title to § 422.550(a)(2) which has been construed to present an impediment to an asset sale by one corporation to another. Section 422.550(a) sets forth what constitutes a ''change of ownership'' for purposes of provisions in § 422.552 which permit an M+C contract to be transferred to a new owner under certain circumstances (for example, the new owner must meet the requirements to qualify as an M+C organization). Because this italicized title refers to an ''unincorporated sole proprietor,'' it suggests that a ''[t]ransfer of title and property to another party'' does not constitute a change of ownership if the assets are transferred by a corporation, rather than a sole proprietor. This has presented problems in cases in which transactions that would benefit Medicare beneficiaries by keeping a M+C plan option available do not appear to fall within the definition of change of ownership. If an M+C contract accordingly could not be transferred as part of an asset sale, this could prevent the sale from going forward, or limit the sale to commercial or Medicaid lines of business, in either case, potentially depriving Medicare beneficiaries of an M+C plan option they would otherwise have.

The italicized language in question was adopted from rules in section 1876 of the Act, which in turn were adopted from longstanding original fee-for-service Medicare change of ownership regulations containing identical language (see § 489.18(a)). These original Medicare change of ownership regulations apply to a change of ownership in the case of a Medicare provider, and address the assumption of a Medicare provider agreement, rather than an M+C contract. However, the language in § 489.18(a)(2) is identical to that in § 422.550(a)(2). In the original Medicare context, this language has consistently been interpreted to encompass an asset sale from one corporation to another. This interpretation was applied by the U.S. Court of Appeals for the Fifth Circuit in *U.S.* v. *Vernon Home Health Care Inc.,* 21 F.3d 693 (5th Cir.), *cert. denied,* 115 S. Ct. 575 (1994). While we have determined that the current M+C change of ownership regulation containing identical language should similarly be interpreted to encompass an asset sale by a corporation, we believe that it would be helpful to eliminate the reference in the title of § 422.550(a)(2) to a ''sole proprietorship'' in order to avoid confusion. We therefore are changing this title in this final rule to read ''Asset sale.''

M. Grievances, Organization Determinations, and Appeals (Subpart M)

1. Background and General Provisions (§§ 422.560 through 422.562)

Subpart M of part 422 implements sections 1852(f) and (g) of the Act, which set forth the procedures M+C organizations must follow with regard to grievances, organization determinations, and reconsiderations and other appeals. Under section 1852(f) of the Act, an M+C organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any other entity or individual through which the organization provides health care services) and enrollees in its M+C plans. Section 1852(g) of the Act addresses the procedural requirements concerning coverage (''organization'') determinations and reconsiderations and other appeals. Only disputes concerning ''organization determinations'' are subject to the reconsideration and other appeal requirements under section 1852(g). In general, organization determinations involve whether an enrollee is entitled to receive a health service or the amount the enrollee is expected to pay for that service. All other disputes are subject to the grievance requirements under section 1852(f) of the Act. For purposes of this regulation, a reconsideration consists of a review of an adverse organization determination (a decision that is unfavorable to the M+C enrollee, in whole or in part) by either the M+C organization itself or an independent review entity. We use the term ''appeal'' to denote any of the procedures that deal with the review of organization determinations, including reconsiderations, hearings before administrative law judges (ALJs), reviews by the Departmental Appeals Board (DAB) and judicial review.

For the grievance, organization determination, and appeal requirements, an M+C organization must establish procedures that satisfy these requirements with respect to each M+C plan that it offers. These requirements generally are the same for each type of M+C plan—including M+C non-network MSA plans and M+C PFFS plans. (Please refer to the preamble material on M+C appeals and grievances in the June 26, 1998 interim final rule (63 FR 35021) for a detailed discussion of the specific requirements under Subpart M.)

Additional regulatory improvements to the M+C appeal and grievance processes are currently under development. We included in the M+C interim final rule those improvements that were practical within the short time frame allotted for completing that interim final rule. As we indicated in the preamble to the M+C interim final rule (63 FR 35030), we intend in the near future to publish a proposed rule implementing a variety of other improvements to the M+C dispute resolution process, including both appeals and grievances.

Sections 422.560 and 422.561 contain the basis and scope and the relevant definitions for subpart M. Section 422.562, General Provisions, provides an overview of the rights and responsibilities of M+C organizations and M+C enrollees with respect to grievances, organization determinations, and appeals. The responsibilities of M+C organizations, under § 422.562(a), essentially parallel those applicable to

HMOs under § 417.604(a), with the added provision that, if an M+C organization delegates any of its responsibilities under subpart M to another entity or individual through which the organization provides health care services, the M+C organization is ultimately responsible for ensuring that the applicable grievance and appeal requirements are still met.

Section 422.562(b) explains the basic rights of M+C enrollees under subpart M, and provides regulatory references to the sections that fully explain the relevant rights. This section does not establish any rights beyond those previously provided for HMO enrollees under part 417, but consolidates general information about enrollees' rights into a central location in the regulations.

Like the part 417 regulations, § 422.562(b) contains provisions addressing the applicability of other regulations that implement Social Security appeals procedures under title II of the Act.

2. Grievance Procedures (§ 422.564)

Section 1852(f) of the Act requires that each M+C organization provide ''meaningful procedures for hearing and resolving grievances.'' We have defined this term in § 422.561 as any complaint or dispute other than one that involves an ''organization determination'' (as described under § 422.566(b)). (This definition retains the meaning of grievance used in part 417.) An enrollee might file a grievance if, for example, the enrollee received a service but believed that the demeanor of the person providing the service was insulting or otherwise inappropriate. Also, as specified under §§ 422.570(d)(2)(ii) and 422.584(d)(2)(ii), grievance procedures would apply when an enrollee disagrees with an M+C organization's decision not to grant an enrollee's request to expedite an organization determination or a reconsideration.

Under § 422.564(a), an M+C organization must resolve grievances in a timely manner using procedures that comply with any guidelines which we establish. Section 422.564(c) clarifies that the PRO complaint process under section 1154(a)(14) of the Act addresses quality issues, but is separate and distinct from the M+C organization's grievance procedures. Thus, there are three different complaint processes (grievance, appeals and PRO processes) available to an enrollee in an M+C organization.

3. Organization Determinations (§§ 422.566 through 422.576)

Section 1852(g) of the Act requires an M+C organization to establish procedures for hearing and resolving disputes between the organization and its Medicare enrollees concerning organization determinations. In accordance with section 1852(g)(1) of the Act, § 422.566 specifies that an M+C organization must have a procedure for making timely organization determinations regarding the benefits an enrollee is entitled to receive and the amount, if any, that an enrollee must pay for a health service. Also, an M+C organization's refusal to provide services that the enrollee believes should be furnished or arranged for by the M+C organization is an action that constitutes an organization determination. Disputes involving additional benefits, as well as mandatory and optional supplemental benefits, also constitute organization determinations and are subject to the appeals process.

Section 422.566(b) lists actions that are organization determinations, and with two exceptions, follows the previous HMO regulation at § 417.606(a). The exceptions involve the inclusion as organization determinations of decisions involving—(1) optional supplemental benefits, and (2) payment for post-stabilization services.

Section 422.568 includes the standard time frame and notice requirements for organization determinations. Under § 422.568(a), an M+C organization must make a determination with respect to an enrollee's request for service as expeditiously as the enrollee's health status requires, and in no case later than 14 calendar days after the organization receives the request. An M+C organization may extend the time frame by up to 14 calendar days if the enrollee requests the extension, or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee; (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). The M+C organization must include a written justification for the extension in the case file.

Section 422.568(b) specifies that time frames for requests for organization determinations on payment issues are identical to the ''prompt payment'' requirements set forth under § 422.520. Thus, for issues relating to payment, the requirements are as follows: (1) For ''clean claims,'' an M+C organization must make a determination regarding the claim within our current ''clean claim'' rules, that is, 95 percent of clean claims must be paid within 30 calendar days after receipt of the request for payment; (2) for all other claims, an M+C organization must make a determination regarding the claim within 60 calendar days after receipt of the request for payment. (Under existing § 422.500, ''clean claims'' are claims that have no defect, impropriety, lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payment. See section II.K of this preamble for a further discussion of rules regarding clean claims and prompt payment.)

Consistent with section 1852(g)(1)(B) of the Act, § 422.568(c) and (d) require that an M+C organization issue written notification for all denials of a request for services, including the specific reasons for the denial in understandable language, information regarding the enrollee's right to either an expedited or standard reconsideration, and a description of both the expedited and standard review processes, as well as the rest of the appeals process.

Sections 422.570 and 422.572 set forth the requirements for M+C organizations with respect to expedited determinations. Sections 422.570(a) (for expedited organization determinations) and 422.584(a) (for expedited reconsiderations) allow either an enrollee or a physician to request an expedited organization determination or reconsideration, regardless of whether the physician is affiliated with the M+C organization. Under § 422.570(a), any physician can request an expedited organization determination. Section 422.584(a) provides that a physician who requests an expedited reconsideration must be acting on behalf of the enrollee as an authorized representative.

Section 422.570(b)(2) specifies that a physician may provide written or oral support for a request for expedition, and under § 422.570(c)(2)(ii), requests for expedited organization determinations that are made or supported by a physician must be granted by the M+C organization if the physician indicates that the enrollee's health could be jeopardized.

Under § 422.568(d)(1), an M+C organization must automatically transfer a denied request for an expedited organization determination to the standard 14-day time frame described in § 422.568(a), and § 422.570(d)(2)(ii) requires an M+C organization to inform the enrollee of the right to file a grievance if he or she disagrees with the

M+C organization's decision not to expedite. We also require under § 422.570(c)(1) that an organization establish an efficient and convenient means for individuals to submit oral or written requests for expedited organization determinations and document any oral requests. We clarify under § 422.570(b)(1) that procedures may involve submitting a request to another entity responsible for making the determination, as ''directed by the M+C organization.''

Section 422.572(a) requires an M+C organization to notify the enrollee (and the physician involved, as appropriate) of an expedited determination as expeditiously as the enrollee's health condition requires but no later than 72 hours after receiving the request. Under § 422.572(b), an M+C organization may extend the 72-hour deadline for expedited review by up to 14 calendar days if the enrollee requests the extension or if the organization finds that additional information is needed and the delay is in the interest of the enrollee. Also under this section, an M+C organization must notify an enrollee of a determination as expeditiously as the enrollee's health care needs require but no later than upon expiration of the extension.

Provisions in both §§ 422.570(f) and 422.584(f) prohibit an M+C organization from taking or threatening to take any punitive action against a physician acting on behalf or in support of an enrollee in requesting an expedited organization determination or reconsideration.

Section 422.574 identifies the parties to an organization determination, which include the enrollee, certain physicians and other providers who are assignees of the enrollee, legal representatives of a deceased enrollee's estate, and any other entity (other than the M+C organization) determined to have an appealable interest in the proceeding.

4. Reconsiderations by an M+C Organization or an Independent Review Entity (§§ 422.578 through 422.616)

If a decision regarding a request for payment or service is unfavorable (in whole or in part) to the enrollee, the enrollee or any other party to an organization determination as listed in § 422.574 who is dissatisfied with the organization determination may request that the M+C organization reconsider the decision. Reconsiderations represent the first step in the appeals process. The reconsideration process encompasses both standard and expedited reconsiderations, as described under §§ 422.582 and 422.584. The time frame and notice requirements for reconsiderations are set forth under § 422.590.

Section 422.590(a)(1) requires that, with respect to standard reconsiderations concerning requests for service, an M+C organization must issue any determination that is entirely favorable to the enrollee as expeditiously as the enrollee's health condition requires but no later than 30 calendar days after it receives the request for reconsideration. As with organization determinations, § 422.590(a) also provides that the M+C organization may extend the time frame by up to 14 calendar days if the enrollee requests the extension, or if the organization justifies a need for additional information, and how the delay is in the interest of the enrollee. Under § 422.590(b)(1), for standard reconsiderations involving requests for payment, the M+C organization must issue any fully favorable determination no later than 60 calendar days from the date it receives the request for the reconsideration.

In the case of expedited reconsiderations (which involve only requests for services), § 422.590(d)(1) requires that an M+C organization issue any determination that is entirely favorable to the enrollee as expeditiously as the enrollee's health condition requires but no later than 72 hours after it receives the request for expedited reconsideration, again with the possibility of a 14-day extension as described in § 422.590(d)(2). If, however, the M+C organization's reconsideration results in an affirmation, in whole or in part, of its original adverse organization determination, this decision is automatically subject to further review by an independent entity contracted by us. (Again, the time frame within which an M+C organization must reconsider a standard or expedited case has been tied to the enrollee's health needs for service requests, subject to either a 30-day or 72-hour maximum (with a possible 14-day extension), while the time frame remains at 60 days for reconsideration requests involving payment.)

Section 1852(g)(4) of the Act requires us to contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm, in whole or in part, an M+C organization's denial of coverage. Thus, unless an M+C organization completely reverses its coverage denial, it must prepare a written explanation, and refer the case to the independent review entity for a new and impartial determination concerning the payment or service at issue.

Section 422.590(a)(2) provides that for standard requests for services, an M+C organization that makes a reconsidered determination affirming, in whole or in part, its adverse organization determination, must send the case file to the independent review entity as expeditiously as the enrollee's health requires, but no later than 30 calendar days from the date the M+C organization receives the request for a standard reconsideration (or the date of an expiration of an extension). For standard requests for payment, § 422.590(b)(2) allows the M+C organization 60 calendar days from the date it receives the request to send the case to the independent review entity. In instances involving expedited requests for reconsideration, § 422.590(d)(5) requires that the M+C organization forward its decision to the independent entity as expeditiously as the enrollee's health condition requires, but not later than within 24 hours of its affirmation of the adverse expedited organization determination.

Section 422.590(g)(2) requires that any reconsideration that relates to a determination to deny coverage based on a lack of medical necessity must be made only by a physician with expertise in the field of medicine that is appropriate for the services at issue.

For the most part, the procedures outlined above were carried over into the M+C requirements from the existing part 417 standards. We also implemented several changes in the reconsideration requirements that are analogous to those described for organization determinations, such as the requirement under § 422.584(d)(1) that an M+C organization automatically transfer a denied request for an expedited reconsideration to the standard 30-day time frame described in § 422.590(a). In addition, § 422.590(e) requires that if an M+C organization refers a case to the independent entity, it must concurrently notify the enrollee of that action.

Consistent with section 1852(g)(4) of the Act, §§ 422.592 and 422.594 address reconsiderations by an independent entity. If the independent review entity's reconsidered determination is not fully favorable to the enrollee, subsequent review possibilities include ALJ and Departmental Appeals Board (DAB) hearings, as well as judicial review. Provisions addressing these forms of review are set forth in §§ 422.600 through 422.616.

5. Effectuation of a Reconsidered Determination (§ 422.618)

Section 422.618 established effectuation requirements for payments

and services. For reconsiderations of requests for payment, when an M+C organization reverses its adverse organization determination, it must pay for the service no later than 60 calendar days after the date that the M+C organization receives the request for reconsideration. For reconsiderations of requests for service, when an M+C organization reverses its adverse organization determination, it must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days after the M+C organization receives the request for reconsideration, or no later than upon expiration of a 14 calendar day extension. When the M+C organization is reversed by the independent review entity or higher review level, the M+C organization must pay for, authorize, or provide the service as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days from the date the M+C organization receives notice reversing its organization determination.

6. Notification of Noncoverage in Inpatient Hospital Settings (§§ 422.620 and 422.622)

Sections 422.620 and 422.622 pertain to M+C organizations' responsibilities in connection with inpatient hospital care. The existing provisions clarify that inpatient services continue to be covered only until written notice of noncoverage in situations in which the hospital admission was authorized in the first instance by the M+C organization, or in which the admission constituted urgent or emergent care. This notice now is issued to enrollees by the M+C organization, either directly or through the hospital, with the concurrence of the attending physician responsible for the enrollee's hospital care. Section 422.622 provides enrollees with the right to seek PRO review by noon on the day after the receipt of the notice if the enrollee believes that he or she is being discharged too soon. The enrollee bears no additional financial liability for care furnished during the period of PRO review, regardless of the proposed date of discharge. If the enrollee misses the noon deadline for requesting PRO review, the enrollee may file an expedited appeal with the M+C organization. Unlike the PRO review process, there is no financial protection afforded to the beneficiary while the M+C organization conducts its review.

Subpart M Comments and Responses

7. Definitions and General Provisions

Comment: One commenter suggested that the definition of appeal should read as follows: ''Appeal means any of the procedures that deal with the review of adverse organization determinations on the health care or health care services an enrollee is entitled to receive, including delay in providing or approving the health care or health care services. * * *''

Response: We generally agree with the commenter and are revising the definition in § 422.561 to incorporate most of the commenter's suggested language. We are omitting ''health care'' as we believe the language duplicates and is inferred in the meaning of ''health care services.'' We are adding the term ''arranging for'' to the definition. Therefore, we are adopting the following revision to the appeals definition: ''Appeal means any of the procedures that deal with the review of adverse organization determinations on the health care services the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service, as defined under § 422.566(b). These procedures include reconsiderations by the M+C organization, and if necessary, an independent review entity, hearings before ALJs, review by the Departmental Appeals Board (DAB), and judicial review.''

8. Grievances (§§ 422.564, 422.570, and 422.584)

Comment: Two commenters contended that we should not establish prescriptive grievance procedures, while several supported establishing standards. One commenter stressed that any grievance requirements we imposed should be consistent with those applied by accrediting organizations, so that M+C organizations would not have to change current procedures to a great extent. The commenter expressed concern about State privacy requirements, as M+C organizations currently are prevented under State law in some cases from providing specific information on how grievances have been resolved. Rather, in these cases, organizations are only allowed under State law to inform enrollees that the complaint has entered the tracking system. One commenter stated that grievance procedures should be flexible, given our interpretation of preemption provisions. One commenter strongly encouraged establishing mandatory time frames for the resolution of grievances as soon as possible, and suggested that the time frames and notices mirror those applicable to organization determinations (including expedited time frames). Two commenters suggested a 30-calendar day time frame to render a grievance decision, with an opportunity for a 14-calendar day extension for peer review. Both commenters stated that for non-quality of care grievances, both oral and written, M+C organizations should be encouraged to provide personalized service. One commenter believes that if a denial of expedited consideration is considered a grievance, then the grievance procedure must have a mechanism to resolve the dispute within 24 hours, so that an inappropriately denied request for expedited consideration can proceed quickly. Additionally, a commenter asserted that M+C organizations should be required to provide clear, accurate and standardized information concerning grievance and appeal procedures. One commenter asked who will determine which route is more appropriate for the beneficiary in pursuing a remedy to a complaint, since we acknowledge that the same claim or circumstances that give rise to an appeal may have elements of a grievance. This may cause the beneficiary to be unclear as to which route is most appropriate.

Response: Currently, M+C organizations are required under section 1852(f) of the Act and § 422.564 to provide ''meaningful procedures'' for hearing and resolving grievances. In the interim final rule (63 FR 35030), we requested comments on whether to establish requirements for grievance procedures, and indicated that we would consider prescribing specific requirements for grievances through a forthcoming notice of proposed rulemaking. As anticipated, commenters indicated varying approaches to organization-level grievance procedures. As noted in the interim final rule, we believe that all parties would benefit from subjecting proposed grievance procedures to public notice and comment, and we will do so as part of the notice of proposed rulemaking we are in the process of developing. Thus, we are not including additional grievance requirements in this final rule.

Comment: One commenter disagreed with treating a denial of an expedited determination as a grievance rather than permitting an appeal of such a denial. The commenter argued that such a denial should be considered an adverse organization determination on the

health care services an enrollee is entitled to receive, and should be appealable. This commenter contended that denying a request for an expedited determination is not analogous to the example of a grievance provided in the preamble to the interim final rule.

Response: The preamble to the interim final rule cites the regulatory definition of a grievance at § 422.561—that is, a grievance is ''any complaint or dispute other than one involving an organization determination.'' The revised definition of organization determination at § 422.566(b) (discussed in detail below) includes determinations regarding payment or services that the enrollee believes should be furnished or arranged for by the M+C organization, and discontinuations of a service if the enrollee believes that the service continues to be medically necessary. In this context, we believe that the term ''services'' clearly refers to health care services, as opposed to member or customer services, that the M+C organization provides under its contract. Expedited review is a process provided by the M+C organization versus a health care service which is subject to appeal, such as mandatory and optional supplemental benefits. We believe there is a clear distinction between a substantive decision whether benefits should be covered and a procedural decision as to the timing of making such a substantive decision. Indeed, we do not believe that the latter type of determination falls within the statutory language establishing the reconsideration and appeals process, which refers to situations in which the enrollee believes he or she is entitled to services, and to the amount of enrollee liability for services. Therefore, we will continue to require that an organization's denial of expedition generally will be subject to the organization's grievance procedures. We intend to monitor the frequency with which M+C organizations deny requests for expedited determinations.

Comment: One commenter believes that a beneficiary should be able to appeal a disenrollment by an M+C organization, rather than simply being able to utilize the grievance process, as provided in § 422.74(d)(2)(ii). In addition, the commenter asserted that decisions on disenrollment should not be left to the M+C organization. Another commenter suggested that we permit a beneficiary to appeal a decision as to whether he or she is entitled to a special enrollment period, and that an M+C organization's decision regarding enrollment or disenrollment, based on the circumstances in § 422.62, should be considered an organization determination subject to appeal.

Response: While we do not believe all disenrollment decisions require an appeals process, we recognize the need in some instances, in particular, when a M+C organization disenrolls an individual for disruptive behavior. Accordingly, in § 422.74(d)(2), M+C organizations must forward all proposed disenrollments for disruptive behavior to HCFA for administrative review. M+C organizations may not disenroll an individual unless HCFA approves of the decision. With respect to the other, limited circumstances under which a M+C organization has the option to disenroll an individual (that is, failure to pay premiums, or fraud), the enrollee has a right to file a grievance if he or she disagrees with an M+C organization's decision. We believe that this approach to these issues has been proven to be sufficient over the years. As indicated above, we will monitor M+C organizations' implementation of their grievance procedures to ensure that they are meaningful. Our monitoring will include investigating a complaint from a beneficiary who believes that the M+C organization did not properly handle a complaint about one of the issues discussed by the commenters above.

9. Organization Determinations (§ 422.566)

Comment: We received numerous comments on various aspects of the definition of an organization determination, including requests for clarification of whether specific types of situations constitute organization determinations. For example, several commenters suggested that reductions in service should be included in the list of actions that constitute organization determinations. The commenters asserted that when services are reduced, beneficiaries receive no notice and are completely unaware of their ability to contest this reduction through the appeals process. Some commenters noted that the vacated 1997 *Grijalva* order expressly required written notice for a reduction of services. One commenter believes that notice of a reduction in services is of particular importance in the delivery of home care and therapy services. Some commenters believe that § 422.566(b)(4), which provides for notice of a termination only if the enrollee disagrees with the determination that the service is no longer medically necessary, is inconsistent with other Medicare regulations, which the commenter believes require written notice for discontinuation of inpatient services both in a hospital or a skilled nursing facility, regardless of whether the beneficiary agrees with the decision. One commenter suggested that the regulations require M+C organizations to send notices one day in advance of termination, reduction, suspension or delay in services. One commenter suggested that § 422.566(b) should include a fifth category indicating that the failure of the M+C organization to approve or provide health care or health care services in a timely manner, or to provide the enrollee with timely notice of an organization determination, constitutes an organization determination. Additionally, some commenters suggested that if, in the future, we require that notices of appeal rights must be given in instances in which the current definition of organization determination is not met, we should incorporate the requirement into the regulations.

Response: As these commenters suggested, we believe there is a need to revise § 422.566(b) to provide additional clarity as to the types of situations that constitute an organization determination and thus give rise to the pursuant appeal rights. Therefore, we are revising § 422.566(b) as follows:

- Paragraph (b)(1), which concerns payment for out-of-plan services, is revised by adding payment for out-of-area renal dialysis to the existing list of such services (which already included emergency, urgently needed, and post-stabilization services);
- Paragraph (b)(3) includes additional language to clarify that an organization's refusal to pay for or provide services ''in whole or in part, including the type or level of services'' can constitute an organization determination if the enrollee believes they should be furnished or arranged for;
- Paragraph (b)(4) is restructured to indicate that a discontinuation of services when an enrollee believes that the services continue to be medically necessary constitutes an organization determination (thus eliminating any implication that an organization must make a formal determination as to medical necessity to give rise to appeal rights); and
- New paragraph (b)(5) is added to specify that another situation that constitutes an organization determination is an MC organization's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or failure to provide the enrollee with timely notice of a determination, if such a delay would adversely affect the health of the enrollee.

Thus, we agree that a reduction in services can be considered an

organizational determination that is subject to appeal. To the extent that a reduction results in an enrollee no longer receiving services to which the enrollee believes he or she is entitled, this would be subject to appeal under the language in the first sentence in section 1852(g)(5) of the Act, which addresses appeals based on failure to receive a health service. Also, since a reduction in services could constitute a ''[d]iscontinuation'' of services to the extent they were no longer being provided, these cases could fall within the language in § 422.566(b)(4). Finally, to the extent that the organization was refusing to continue to provide all or part of the services the enrollee believes should be furnished, and the enrollee has not received the services, this would also fall within the language in § 422.566(b)(3).

Examples of other situations that are intended to fall within the clarified definition of an organization determination include:

- A physician requests approval of 10 home health visits, but the organization approves only five visits (even though Medicare allows more than five visits);
- An organization approves a referral to a specialist, but the specialist it designates does not have experience in treating the enrollee's rare condition;
- A physician requests inpatient surgery for a patient because of the patient's history of complications with anesthesiology, but the organization will approve only outpatient surgery; or
- Although an organization agrees to pay for an in-network service, it imposes greater cost-sharing than the enrollee believes is permissible.

We believe that each of these examples fit within the statutory language at section 1852(g)(1)(A) and (B) of the Act that establishes that an M+C organization must have an appeals procedure for determinations as to whether an enrollee ''is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service.'' Thus, the purpose of the revisions to § 422.566(b) is not to expand on our interpretation of what types of situations constitute organization determinations but rather to provide additional insight into how we continue to interpret the intent of the applicable statutory provisions.

As we explained above, we are developing a proposed regulation that would provide additional specific guidance as to when a reduction in services gives rise to the obligation to provide a written notice. This has been an extremely difficult issue to resolve, and despite extensive consultations with beneficiary advocates, industry representatives, and State officials, we still have not been able to reach conclusions as to standards beyond those already in the statute and regulations and quoted above. Again, we will address the issue in connection with a separate rulemaking that is being developed in close consultation with all affected groups. Finally, as commenters suggested, if in the future we believe that it is necessary to require notices of appeal or other rights for situations other than organization determinations, we would do so through notice and comment rulemaking.

Comment: Some commenters requested confirmation that a discontinuation on grounds other than medical necessity is not an organization determination.

Response: As noted above, we have made a minor change to § 422.566(b)(4) to clarify that any discontinuation situation in where the enrollee believes that the services continue to be medically necessary constitutes an organization determination, rather than only those situations where a formal medical necessity determination is involved. Moreover, § 422.566(b)(3) continues to cover any refusal to provide services (including a refusal to *continue* to provide services) that the enrollee believes should be provided. While many cases may involve a medical necessity judgment, others may involve a question of how a limit on benefits (including additional or supplemental benefits) applies to given facts. In some cases, the case for noncoverage on grounds other than medical necessity may be so clear-cut that an appeal would not be requested. For example, in a case in which a service is expressly limited to a fixed number of days, and there is no dispute as to how many days the service has been provided, it is unlikely that the enrollee would ''believe'' that the M+C organization is obligated to cover days beyond the limit. In other cases, however, there may be ambiguities as to how a limit on benefits is to be interpreted, or applied to a given set of facts, or there may be a dispute as to facts relevant to whether the benefit is covered. In these cases, the beneficiary should have the right to a reconsideration of a denial, so that these issues could be addressed on appeal.

10. Written Notice (§§ 422.566, 422.568, 422.572, and 422.620)

Comment: Several commenters believe that the regulations at §§ 422.566 and 422.568 do not make clear that a written notice is required for discontinuations of services.

Response: Except in the case of inpatient hospital care, written notice currently is not required for all discontinuations in services. We believe that our policies on what constitutes a denial in the case of a discontinuation of service (other than in the case of inpatient hospital care) are set forth in the regulations concerning organization determinations. According to revised § 422.566(b)(4), discontinuation of a service is considered to constitute an organization determination ''if the enrollee believes that continuation of the services is medically necessary.'' Therefore, if an M+C organization discontinues coverage, and an enrollee indicates that he or she believes that the services continue to be necessary, this action would constitute an organization determination for which a written notice must be provided. We recognize that there may be circumstances that make it difficult to tell whether a written notice is required in a particular case. We therefore are developing a notice of proposed rulemaking that would address this issue, and clarify rules for M+C organizations and beneficiaries.

Comment: Several commenters suggested that written notice should take place in all instances where services are reduced or discontinued, not only in instances where the enrollee has indicated disagreement. One reason provided for this suggestion is that it would ensure that enrollees always would receive notice of their appeal rights, even if they have not formally objected to the reduction or discontinuation. Another reason given was that this would make the rule consistent with the rule that applies to hospital inpatient discharges. Other commenters suggested that M+C organizations should provide written notice when services actually terminate, or when services discontinue prior to the time for which the M+C organization initially authorized services. Two commenters suggested that we require notice when there are financial implications to the enrollee.

Other commenters supported the current requirement that the M+C organization provide notice when the enrollee disagrees that the services are no longer medically necessary. One commenter stated that where there is no disagreement, it is wholly inappropriate to provide notice and appeal rights. Instead, it is more appropriate to provide notice at the beginning of a course of treatment. One commenter recommended that we provide advance notice for reductions and terminations in writing, describing the basis for the decision and appeal rights. Some

commenters stated that providing detailed notice in all situations would be confusing, burdensome, and intrusive upon the physician/patient relationship. Two commenters recommended we include in this subpart notice requirements for discharge from a SNF.

Response: We recognize that the issue of when it is appropriate for M+C organizations to issue written notice for organization determinations that involve reductions and discontinuations of services is a controversial one. As stated in the preamble to the June 26, 1998 interim final rule (63 FR 35030), we are developing proposed regulations that would further clarify these requirements. At this time, however, we believe that the current regulations serve to balance the need for adequate notice with the potential for inappropriate burdens or beneficiary confusion that might ensue if notice were provided in all cases.

To eliminate confusion, we want to point out that written notice is always required for inpatient hospital discharges regardless of whether the enrollee agrees with the discharge decision. The issuance of a notice to an enrollee prior to an inpatient hospital discharge required under § 422.620 is a separate requirement that should not be confused with the provisions at §§ 422.566(b)(4) and 422.568(c). We will address the SNF issue in the forthcoming proposed rule.

Finally, as the commenters suggested, we recognize the potential compliance difficulties and burden associated with existing § 422.568(c), which requires that if an M+C organization denies services or payment, in whole or in part, it must give the enrollee a detailed written notice that meets the content requirements of § 422.568(d) (such as stating the specific reason for the denial and describing the available appeals procedures). We understand that in practice, plan practitioners generally are responsible on behalf of M+C organizations for issuing these detailed notices to their patients, given that most care decisions about future care are made at the practitioner level; and we agree that this practice may be unnecessarily burdensome and intrusive on the practitioner/patient relationship. Moreover, we can understand that requiring M+C organizations to ensure that appropriately detailed notices are given to enrollees in practitioners' offices may be difficult to monitor and enforce in all circumstances.

Therefore, we have revised the provisions at §§ 422.568(c) through (e) to establish a process under which—(1) practitioners routinely notify enrollees at each patient encounter of their right to receive a *detailed* notice about their services from the M+C organization itself, and (2) when an enrollee requests an M+C organization to provide a detailed notice of a practitioner's decision to deny a service in whole or in part, or if an M+C organization decides to deny service or payment in whole or in part, the M+C organization must give the enrollee a detailed written notice of the determination, consistent with existing content requirements.

The practitioner's notification must inform enrollees of their right to receive a detailed notice from the M+C organization and provide enrollees with all information necessary in order to contact the M+C organization. Consistent with other notification requirements set forth in subpart M (for example, under existing § 422.568(d)(4) or under § 422.572(e)(2)(ii)), we also specify that the content of the practitioner's notification must comply with any other requirements established by HCFA. We are now developing standardized language for use by affected practitioners, and will provide an opportunity for public comment through OMB's Paperwork Reduction Act process. Once that process is completed, we intend to provide further guidance on the content and form of the required practitioner notice. We believe that this requirement will serve to improve M+C organizations' ability to assure implementation of the requirement for detailed written notices while at the same time reducing the administrative burden on practitioners by freeing them from the obligation to routinely provide such detailed notices to their patients.

11. Time Frames (§§ 422.568, 422.572, 422.590, 422.592, 422.618)

Comment: Several commenters asserted that the standard determination time frames are too long, with some commenters specifically suggesting the time frame of 5 working days that was adopted by a district court judge in a since-vacated March 3, 1997 order in *Grijalva* v. *Shalala* (a class action lawsuit filed by Medicare HMO enrollees in 1993, challenging, among other things, the appeals procedures that applied under section 1876 of the Act and part 417). One commenter suggested that upon receipt of complete information, a decision should be rendered within 2 business days. Other commenters stated that the M+C time frames are too short. One commenter suggested that we require M+C organizations to make a good faith effort to meet time frames as opposed to a requirement that M+C organizations must meet absolute time frames. A number of other commenters supported the time frames established through the M+C interim final regulation.

Response: Before deciding to incorporate into the interim final rule reductions in the time frames within which M+C organizations are expected to render standard organization determinations and reconsiderations for service requests, we consulted with representatives of the managed care industry and beneficiary advocacy community, and conducted extensive research on the subject of organization-level resolution time frames. All groups with which we consulted agreed that the 60-day time frames provided for under the HMO regulations in part 417 were too long. Reports from independent organizations, such as the Physician Payment Review Commission, the General Accounting Office, and medical journals also advocated the reduction of standard time frames. Additionally, we realized the 60-day time frames in part 417 were based on the original fee-for-service Medicare appeals process, which is mostly retrospective. We were aware that new time frames needed to account for the fact that pre-service requests for organization determinations exceed the number of retrospective requests, and that reduced time frames are of critical importance when an individual is awaiting prior authorization for a service. Further, public comments received prior to publication of the M+C interim final rule indicated strong support for a reduction in time frames.

In view of the range of opinions contained in the comments on the M+C interim final rule, we believe that we succeeded in establishing an appropriate middle ground for the maximum time frames. It has also been reported to us that the majority of organizations make decisions within our reduced time frames. Only one commenter contended that the 14-day time frame could not be met as a general rule. We believe that the opportunity for up to a 14-day extension to the time frames for service-related requests allows the M+C organization adequate time in which to render a determination. We also believe that the new 14 and 30 calendar day time frames are appropriate from both consumer protection and industry feasibility standpoints. The medical exigency standard, which requires that decisions be rendered as expeditiously as an enrollee's health requires, provides for a quicker response where appropriate. Likewise, the opportunity for up to a 14-day extension for both organization determinations and reconsiderations

permits M+C organizations additional time to make a coverage decision when appropriate; for example, an M+C organization may extend the time frame at an enrollee's request, or if additional medical documentation is necessary and the M+C organization justifies the reason for the extension.

Comment: Another commenter who advocated reductions to reconsideration time frames suggested that we also reduce the time frame within which M+C organizations are permitted to forward case files to the independent review entity under the standard appeals process.

Response: M+C organizations must forward standard reconsideration cases to the independent review entity within the time frames permitted for resolution of standard requests. That is, when an M+C organization makes a reconsidered determination that affirms, in whole or in part, its adverse organization determination, it must make the determination and send the case file for external review as quickly as the enrollee's health condition requires but no later than within 30 calendar days for service requests, or within 60 calendar days for payment requests. Time frames begin on the date the organization received the request for a standard reconsideration. Since time frames for submitting case files to the independent entity are incorporated into the resolution time frames, and we are not reducing time frames for standard reconsiderations, it would not be appropriate to reduce the time frames for submitting information to the independent review entity.

Comment: One commenter stated that we should provide a definition of ''good cause'' for extensions of time frames. Another commenter suggested that we should clarify that a 14-day extension may be granted in any instance where an organization determination demonstrates a need for additional information.

Response: The regulations for both expedited and standard requests for organization determinations (§§ 422.568(a) and 422.572(b)) permit an M+C organization to obtain an extension ''if the organization justifies a need for additional information and how the delay is in the interest of the enrollee''. We believe that this standard is largely self-explanatory. As indicated in the preamble to the M+C interim final rule, the M+C organization must include written justification of the extension in the enrollee's case file. Although forthcoming operational instructions will provide further clarification of the M+C organization's ability to grant itself an extension, we would like to clarify that a 14-day extension for service-related requests may be granted where an organization finds and notes in the enrollee's case file that it needs additional information to make a determination.

Moreover, to further clarify the grounds on which an M+C organization may seek an extension, and to ensure an enrollee is adequately advised of the M+C organization's use of an extension, we are adding language to both §§ 422.568(a) and 422.572(b) that requires an M+C organization to notify the enrollee in writing of the reasons for the extension, and to inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision. Relatively few enrollees utilize the appeals process, and most organizations are able to make determinations on requests for services within 30 days. Therefore, we do not foresee that requiring M+C organizations to notify enrollees upon initiating an extension will create an undue burden on M+C organizations.

Comment: Some commenters supported the requirement that M+C organizations must make decisions ''as expeditiously as the enrollee's health requires'' (the ''medical exigency'' standard). In contrast, other commenters stated that the medical exigency standard was vague and uncertain, and likely to cause every reconsideration to become expedited.

Response: We believe that the ''medical exigency'' standard is needed to ensure that M+C organizations will not routinely avail themselves of the maximum time frames for all decisions. Although the expedited review process incorporates the medical exigency standard, this standard is separate and distinct from the process M+C organizations use to handle cases in which a physician or the M+C organization determines that an enrollee's life, health or ability to regain maximum function could be jeopardized in applying the standard time frames.

In our consultations with the public before publishing the M+C interim final rule, industry representatives advised us that each request is different; where some organization determinations are likely to require a 14-day time frame, and possibly 14 additional days, other decisions require less resolution time. Likewise, resolution of some reconsiderations will take up to 30 calendar days, and may require more time to gather additional information. The medical exigency standard requires M+C organizations to prioritize those cases where waiting for a decision is more likely to affect an enrollee adversely. We interpret this standard as requiring that the M+C organization or the independent entity apply, at a minimum, established, accepted standards of medical practice in assessing an individual's medical condition. Evidence of the individual's condition can be demonstrated by indications from the treating provider or from the individual's medical record (including such information as the individual's diagnosis, symptoms, or test results). We established the medical exigency standard by regulation to ensure that M+C organizations would develop a system for determining the urgency of both standard and expedited requests for services, and give each request priority according to that system. That is, we intend that M+C organizations treat every case in a manner that is appropriate to its medical particulars or urgency, rather than systematically use the maximum time permitted for service-related decisions.

Also, as indicated in the preamble to the interim final rule (63 FR 35028), we continue to believe that the emphasis on the health needs of the individual enrollee is consistent with the statutory requirement that determinations be made on a timely basis. Thus, the fact that an organization makes a determination on a service-related issue within 14 days does not necessarily constitute compliance with the law or regulations if there is evidence that an earlier determination was necessary to prevent harm to the enrollee's health.

We intend to issue additional guidance on the medical exigency standards in a future operational policy letter.

Comment: Several commenters suggested shortening the maximum time frame for M+C organizations to pay for, or provide, services once the independent review entity has ruled in the beneficiary's favor. One commenter suggested the effectuation time frame should be reduced to 15 days. Another commenter expressed concern that the effectuation requirements in § 422.618 do not provide for shorter implementation periods for expedited appeals. One commenter observed that if an M+C organization completely reverses its organization determination on reconsideration of a request for service, the organization must authorize, or provide the service; however, given the fact that the enrollee must seek the service, it may prove difficult to ensure that the service has actually been provided. Thus, this commenter suggested that a letter authorizing the service should be sufficient.

Response: We agree with the commenters concerning the need for a reduction of effectuation time frames for both standard cases overturned upon review by the independent review entity, and expedited cases overturned by the M+C organization or the independent review entity. However, we believe that since M+C organizations are permitted to authorize, provide or pay for the service in order to effectuate the decision, there is no need to establish a separate requirement for an authorizing letter. Based on these comments, we are revising § 422.618 to reduce the time frame within which M+C organizations must pay for, authorize or provide services to enrollees following a decision rendered by the independent review entity. For service-related requests, the revised language states that ''the M+C organization must authorize the service under dispute within 72 hours from the date it receives notice reversing the determination, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days from that date.'' For requests regarding payment, we are reducing the time frame to effectuate the independent review entity's determination from ''no later than 60 calendar days'' to ''no later than 30 calendar days.'' We continue to maintain a distinction for payment-related appeals because most billing practices are on a 30-day cycle.

We also agree with the comments that expedited effectuation requirements should be incorporated into the regulations. To promote consistency in implementation, and to ensure enrollees receive the services they need as quickly as possible, we are establishing a new § 422.619 to require M+C organizations to effectuate overturned, expedited determinations as quickly as necessary, but no later than within 72 hours. Under the new provision, if the M+C organization reverses its original adverse organization determination, in whole or in part, the M+C organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives the request for the determination.

Where the independent entity reverses, in whole or in part, the M+C organization's initial expedited determination, the M+C organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. In instances where the independent review entity expedites certain cases on its own accord (for example, where an enrollee or physician did not originally request an expedited appeal at the M+C organization level, but the independent review entity determines an expedited appeal is warranted), the expedited effectuation requirements of § 422.619 still apply.

If the ALJ or higher level reviewer reverses the independent review entity's expedited reconsidered determination, the M+C organization must authorize or provide the service under dispute as expeditiously as the enrollee's health requires, but no later than 60 calendar days from the date of the decision.

Comment: Several commenters urged that we incorporate the review time frames for the independent review entity into the regulations text. Section 422.592(b) provides that an independent outside entity must conduct reconsideration reviews ''as expeditiously as the enrollee's health condition requires but must not exceed the deadlines specified in the contract.'' One commenter noted that the contract with the independent outside entity may change each time it is negotiated, and that the general public is not informed of such negotiations, or the time frames produced by these negotiations. Thus, this commenter believes that regulations should specifically impose appropriate time limits on the independent review entity, and the time limits should be consistent with those specified in the vacated 1997 *Grijalva* order. One commenter expressed concern that the public has no remedy when the independent review entity fails to comply with time frames in the contract. This commenter added that the public plays no role in contract negotiation through which the independent review entity's time limits will be determined; and therefore, there is no assurance that an appropriate time limit will be imposed. One commenter recommended that we contract with PROs for the expedited review process instead of our current contractor, the Center for Health Dispute Resolution (CHDR). (PROs are organizations under contract with us to perform utilization and quality review of Medicare services generally, and review of the quality of services furnished by M+C organizations to their enrollees.) There was also concern about the notices provided by the independent review entity. Some commenters suggested that § 422.594 specify that the notice should be written in ''understandable language,'' as provided in § 422.568. Additionally, these commenters believe that the notice should also inform the enrollee about the PRO complaint process under section 1154(a)(14) of the Act.

Response: The time frames for the independent entity's review currently are the same as those time frames within which M+C organizations are required to decide standard and expedited cases, as detailed in the chart provided in the interim final rule (63 FR 35024). The time frames appear in our contract with the independent entity (as opposed to the regulation), however, to provide flexibility in the case of an unanticipated increase in the volume of appeal cases—since the independent contractor reviews cases from organizations nationwide. We have provided public notice of the time frames in the interim final rule and again in this rule. We agree with the commenters that beneficiaries should be informed of any changes that we might make to the current time frames, and will inform beneficiaries if these time frames are changed.

Additionally, we agree with one of the recommended changes to the independent entity's reconsideration notice, and are amending § 422.568 to require that the notice be written in ''understandable language.'' We also will consider issuing instructions to require the independent entity to advise an enrollee of his or her right to review by the PRO for quality of care concerns; (the same requirement on M+C organizations is set forth via model notice instructions).

12. Expedited Organization/Reconsidered Determinations (§§ 422.570, 422.572, 422.584, and 422.590)

Comment: Several commenters expressed concern with § 422.572(d), which provides that the 72-hour time period under § 422.572(a) does not begin until medical information is received from noncontract providers where such information is required. One commenter stated that such an open-ended requirement poses an unreasonable risk of delay for the enrollee; especially in cases where time is of the essence, this provision could allow a decision to be postponed indefinitely. Another commenter suggested that M+C organizations should be required, at a minimum, to contact the noncontract provider within 24 hours of the initial request for an expedited reconsideration in order to request the necessary information from the noncontract provider and provide a fax number where the information can be submitted. Additionally, the commenter suggested that the enrollee, the representative, and the physician should be contacted to: Explain the

delay, inform them of the information needed, and provide them with a fax number. One commenter stated that the regulations should place the burden on the M+C organization to make prompt, good faith efforts to communicate with the noncontract provider to obtain the needed information. Additionally, information from noncontract providers should be provided within the 14-day extension period and under the same conditions that an extension would be granted in other circumstances. However, one commenter stated allowing an M+C organization to grant itself a 14-day extension beyond the 72-hour time frame gives the M+C organization too much additional discretion. This commenter stressed that an M+C organization will always state that it needs more than 72 hours, particularly if treatment will be expensive.

Response: We largely agree with the commenters, and are revising the regulation text to ensure that M+C organizations must make determinations within the same expedited time periods for cases involving noncontract providers. Accordingly, we are revising §§ 422.572(d) and 422.590(d)(4) to eliminate the provisions indicating that the 72-hour period begins when the organization receives information from the noncontracting provider. Instead, the regulations will require the organization to meet the same time frames set forth in §§ 422.572(a), (b), and (f) for expedited organization determinations and §§ 422.590(d) and (f) for expedited reconsiderations regardless of whether the M+C organization must request information from noncontracting providers. We agree that in situations where either a physician or the M+C organization has already determined that an expedited decision is crucial, open-ended time frames may put the enrollee at risk. We likewise are incorporating into § 422.572(d) the recommended provision for expedited reviews that requires the M+C organization to request any necessary information from the noncontract provider within 24 hours of the initial request for expedition. We continue to require noncontract providers to make ''reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the M+C organization in meeting the required time frames.'' We believe an opportunity for an M+C organization to take up to a 14-day extension under the 72-hour expedited review process provides the M+C organization with a reasonable opportunity to obtain information from non-contract providers. We will monitor M+C organizations to ensure M+C organizations do not routinely, or unnecessarily, avail themselves of the 14-day extensions. Where appropriate, M+C organizations must notify the physician involved; M+C organizations are always required to notify enrollees of the decision, whether the decision is adverse or favorable to the enrollee, in accordance with the regulation. However, we do not agree that the M+C organization must always contact or notify the enrollee's physician.

Comment: Several commenters stated that the criteria for deciding whether a determination must be expedited may be too rigorous. Some commenters suggested that we revise §§ 422.570(c)(2) and 422.584(c)(2) to reflect language from the district court's vacated order in the *Grijalva* case, under which reconsiderations were to be expedited ''when services are urgently needed.'' The district court provided the examples of when acute care services are being denied or terminated, certain types of nursing facility care, certain types of home health and therapy services, and denials of certain types of non-cosmetic surgery. This commenter suggested that the regulation state that expedited consideration may be granted, in certain circumstances, upon lay evidence and without a request by the physician. One commenter contended that the regulations should clearly articulate what constitutes ''seriously jeopardizing the enrollee's life, health, or ability to regain maximum function.'' The commenter argued that a more specific definition should be provided that takes into account both a substantial risk of an adverse outcome, and a small (but significant) risk of a serious and adverse outcome such as permanent disability or death. Some commenters expressed concern that if an enrollee does not obtain physician support to expedite a determination, the M+C organization has broad discretion in deciding whether to expedite.

Response: We do not believe that the adoption of the ''urgently needed'' standard from the vacated *Grijalva* order would be appropriate. First, we believe it is too broad and vague. Second, the term ''urgent'' is already used in connection with ''urgently needed services'' (for which enrollees do not need to obtain prior authorization). Using the same term here could cause unnecessary confusion. We also believe that the ''serious jeopardy'' standard is sufficiently clear. It is unclear how we could expand on what is meant by ''serious jeopardy'' to an enrollee's ''life'' (that is, could put his or her life in serious jeopardy), ''health'' (that is, could put his or her health in serious jeopardy), or ''ability to regain maximum function'' (that is, could put his or her ability to regain maximum function in serious jeopardy). We believe that the commenter's suggestion that the requirement to expedite a case in which there is a ''significant'' risk of a ''serious and adverse outcome such as permanent disability'' is already addressed in language referring to ''seriously jeopardizing the enrollee's * * * ability to regain maximum function.'' With respect to the commenter's suggestion that the regulations provide for cases to be expedited based on ''lay evidence'' (that is, in the absence of the involvement of a physician), this is already required under section 1852(g)(3)(B)(ii) of the Act ''if the request indicates that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.'' The interim final rule and this final rule similarly provide for expedition without the need for a physician's involvement. (*See* §§ 422.570(a) through (b), and 422.584(a) through (b).) Although this decision is made by the M+C organization in the absence of a physician's involvement, the decision is subject to the grievance process, and we will monitor M+C organizations closely to ensure that they are expediting cases where appropriate.

Comment: Several commenters strongly urged the removal of the requirement that physicians requesting an expedited appeal must be acting as an enrollee's authorized representative. Commenters contended that the regulation as written is inconsistent with their view of statutory intent, intrudes in the doctor-patient relationship, and could present a problem for incapacitated enrollees.

Response: We agree that a physician who requests an expedited reconsideration on behalf of an enrollee should not have to be formally appointed as the enrollee's authorized representative. We initially included this provision based on our belief that the physician served a different role in the context of an organization determination versus an appeal. In the case of an organization determination, we regarded the physician as a provider who is requesting a service for his or her patient. On the other hand, in the context of a reconsideration, we viewed the physician as serving as the enrollee's representative in the first

level of the appeals process. Thus, we believed the physician would need to be appointed by the enrollee in the same manner as any one else who served as a representative. However, in response to the above comments, we have reconsidered our position, and recognize the operational problems with requiring that physicians be authorized representatives when requesting expedited reconsiderations on an enrollee's behalf. For example, under the M+C program, each appeal request requires completion of a separate authorized representative form, which may cause an undue burden on physicians. For this reason and those set forth in the comment above, we have decided to revise § 422.584(a) by eliminating this requirement. Therefore, physicians may request expedited reconsiderations on a patient's behalf without being appointed as the enrollee's authorized representative.

We want to make clear, however, the distinction between a physician acting on behalf of the enrollee, and a physician who meets the conditions for being a party in his or her own right. When a physician seeks either a standard or expedited organization determination for services on behalf of the enrollee, the physician does not need to be an authorized representative. But, if the physician seeks a standard reconsidered determination for purposes of obtaining payment, then the physician must sign a waiver of liability, consistent with § 422.574(b).

Comment: One commenter suggested that the ability to request an expedited organization determination should be expanded. The commenter suggested the following options for expansion: (1) All health care professionals, (2) health care professionals that have been designated by a physician to carry out such tasks, or (3) all health professionals providing care in medically underserved areas. Another commenter suggested that we should permit an ''authorized representative'' to request an expedited determination.

Response: The statute explicitly lists enrollees and physicians as those permitted to request expedited organization determinations and expedited reconsiderations, (*see* sections 1852(g)(3)(a)(1) and (2) of the Act). We note that authorized representatives may request expedited determinations or reconsiderations, since the definition of ''enrollee'' in § 422.561 includes the enrollee's authorized representative. Therefore, the regulations already permit health care professionals who enrollees authorize as their representatives to request expedited organization determinations and expedited appeals. As described in the previous comment, physicians now may make requests without being authorized representatives. We do not believe it would be appropriate, however, to grant health care professionals other than the enrollee's physician the right to make requests on the enrollee's behalf absent an authorization. There are so many potential health care professionals involved in a patient's care, this could create confusion, and potentially cause duplicate or conflicting requests.

Comment: One commenter suggested that we incorporate a separate notice requirement provision whereby, before deciding whether to expedite a determination, the M+C organization must notify the enrollee of the M+C organization's obligation to expedite any request for a determination that was accompanied by a physician's statement that ''applying the standard time frame for making a determination could seriously jeopardize the life of the enrollee or the enrollee's ability to regain maximum function.'' Several commenters requested that we define ''prompt oral notice'' of a denied request for expedition, as provided in § 422.570(d)(2). This section provides that, if the M+C organization denies a request for an expedited determination, it must give the enrollee prompt oral notice of the denial and follow up within 2 working days with a written letter explaining their right to file a grievance. One commenter asked whether this meant the enrollee is supposed to receive the written notice within 2 working days of the decision, or that the organization is to mail it within 2 working days. Additionally, the commenters suggested that this section also specify that the enrollee be given the right to make an oral, immediate request for a reconsideration when given oral notice of denial, followed by written verification of the reconsideration request.

Response: M+C organizations are required under § 422.111(a)(8) to provide notice of grievance and appeal rights upon enrollment and at least annually thereafter. Thus, all enrollees should receive notice of the right to automatic expedition of determinations and reconsiderations when a physician supports the request. However, in a case in which an enrollee submits a request for an expedited organization determination or an expedited appeal, but does not indicate that the request was supported by a physician, we recognize that the enrollee may not have read the required notice carefully, and thus be unaware that a physician's support would make the expedition of the request automatic. We therefore are revising §§ 422.570(d)(2) and 422.584(d)(2) to require that when an M+C organization denies a request for an expedited determination or reconsideration, its notification letter must inform the enrollee of the right to resubmit the request with a physician's support.

As noted above, upon denial of an enrollee's request for expedited review, existing regulations require an M+C organization to provide the enrollee with ''prompt oral notice'' of the denial, and follow up with a written letter within 2 working days. We believe that this is a reasonable requirement which indicates that an M+C organization must contact and advise the enrollee of the denial without delay. As suggested by the commenter, we are clarifying the regulations to indicate that subsequent to providing oral notice of the denial, M+C organizations must ''deliver'' to the enrollee, within 3 calendar days, a written letter that includes the information listed in the regulation at §§ 422.570(d)(2) and 422.584(d)(2). We interpret this provision as requiring an M+C organization to first orally notify an enrollee of a denial, and subsequently deliver written notice to the enrollee within 3 days after the decision. Note that we have revised the regulations at §§ 422.570(d)(2), 422.572(c), 422.584(d)(2), and 422.590(d)(3) to establish a requirement of 3 calendar days, rather than 2 working days. We believe this is a reasonable amount of time within which to require M+C organizations to deliver written notice enrollees (following the oral notice) of a denied expedited request, and that the change to calendar days will eliminate confusion over what constitutes a working day. This change is consistent with the general replacement of standards related to ''working days'' with ''calendar day'' standards throughout the M+C regulations.

We also wish to clarify that if an enrollee's request for an expedited organization determination is denied, the M+C organization will automatically transfer and process the enrollee's request under the standard process. If the M+C organization denies the request in whole or in part, the enrollee (or a physician on the enrollee's behalf) then has a right to orally request expedited reconsideration. The M+C organization continues to be responsible for documenting all oral requests in writing and maintaining the documentation in the case file.

13. Authorized Representative (§§ 422.561 and 422.574)

Comment: A commenter suggested that § 422.574, which addresses parties to the organization determination, should include surrogates under State law as a possible party to an organization determination. This commenter added that by excluding such surrogates, enrollees who are incapacitated and cannot appoint representatives may lack persons authorized to handle appeals on their behalf. Similarly, two other commenters stated that the ''authorized representative'' definition should be expanded to allow individuals who can act on behalf of an individual under State law to be authorized representatives. This commenter believes that the current definition is limited to an individual appointed under the Social Security Act, and requires completion of the Appointment of Representative form. The commenter believes that this requirement makes it difficult for those who have written Durable Power of Attorney to act in place of the beneficiary. Several commenters suggested that the definition of ''enrollee'' should not include an authorized representative. One commenter argued that an authorized representative is not the enrollee, since an enrollee is someone who is entitled to health services. Further, the commenter recommended that an authorized representative receive copies of all communications sent to the enrollee concerning the appeal.

Response: We agree with the commenters concerning the need to include those individuals appointed under State law (such as surrogates) in M+C requirements, as well as those with Durable Power of Attorney. For this reason, we are amending the definition of authorized representative at § 422.561 to include an individual authorized by an enrollee, ''or under State law,'' to act on his or her behalf in obtaining an organization determination, or in dealing with any of the levels of the appeals process, subject to the rules described in 20 CFR part 404, subpart R, unless otherwise stated in subpart M. We believe that the revised definition of an authorized representative includes those individuals with Durable Power of Attorney. Therefore, an individual authorized to act as a surrogate of an enrollee and those who have written Durable Power of Attorney are permitted to act on behalf of an enrollee in the organization determination, reconsideration and appeal processes. By adding individuals authorized under State law to the definition of authorized representative, such individuals are included as one of the parties to an organization determination listed at § 422.574, since the definition of an enrollee (who is a party) includes the enrollee's authorized representative. Thus, a surrogate authorized by the State is not only a party to the organization determination, but is permitted to act on behalf of the enrollee under all provisions of subpart M.

We disagree with the commenters who requested that the definition of ''enrollee'' exclude an authorized representative. Although we recognize that an authorized representative is not an enrollee in the literal sense of being entitled to health services, we believe that to ensure authorized representatives are always permitted to act on behalf of an enrollee, the regulations should include an authorized representative in the definition of ''enrollee'' under subpart M. We note that § 422.561, which sets forth the definitions used in the appeals regulations contained in subpart M, specifies that the definitions are only ''as used in this subpart, unless the context indicates otherwise.''). An authorized representative thus would not be considered an enrollee for general M+C program purposes, such as under enrollment or financial liability provisions, but would be able to exercise the rights available to an enrollee for appeal and grievance purposes, such as the right to act on behalf of an enrollee in requesting an appeal or to receive applicable notifications.

Comment: One commenter commended our appeal and grievance rights as providing substantial protection, yet expressed concern over access for enrollees with special health care needs (the disabled and/or chronically ill). One commenter stated that M+C organizations will face a challenge in serving the increasing population of beneficiaries with questionable, fluctuating or diminished capacity, and further stated that M+C organizations need to identify enrollees who have surrogates in order to keep them informed. This commenter stated that the regulation should require information and notices be sent to surrogates of incapacitated beneficiaries, and surrogates should be listed as requesters of expedited decisions.

Response: As noted above, to the extent that such a surrogate is authorized under State law to act on the beneficiary's behalf, he or she would be considered an authorized representative who is included in the definition of enrollee and permitted to make requests on the beneficiary's behalf. With respect to other additional procedural protections for enrollees with special health care needs, we believe that such additional protections for enrollees with special health care needs should be included in a notice of proposed rulemaking to provide the public with ample opportunity for input on final standards. We plan in this rulemaking to address the issue of special protections for beneficiaries with limited capacity, and consider possible additional notice requirements for surrogates in such cases.

14. Other Appeal Rights (§§ 422.596, 422.600, 422.602, 422.608, 422.612, and 422.616)

Comment: One commenter suggested that we revise § 422.596 to clarify that an M+C organization cannot appeal to an Administrative Law Judge (ALJ). However, two commenters argued that M+C organizations should have the right to appeal to an ALJ.

Response: Section 422.600 addresses the ''Right to a hearing.'' Section 422.600(a) provides that ''any party to the reconsideration (*except the M+C organization*) who is dissatisfied with the reconsidered determination has the right to a hearing before an ALJ.'' (Emphasis added.) Section 422.600(a) then expressly states that ''[t]he M+C organization does not have the right to request a hearing before an ALJ.'' While we believe that the regulations thus are already clear on this point, we have no objection to the commenter's suggestion that § 422.596 be revised to also reflect this restriction.

The policy limiting ALJ appeal rights to Medicare enrollees has been in place since the inception of the Medicare risk contracting program under section 1876 of the Act. As noted above, under section 1856(b)(2) of the Act, M+C standards are to be based on standards established under section 1876 of the Act to the extent consistent with M+C rules. More importantly, the M+C statute expressly grants a right to a hearing only to an enrollee, with the M+C organization given the right to: (1) Be made a party to such a hearing; and (2) appeal from an ALJ. Section 1852(g) of the Act sets forth a three step process for appeals of coverage determinations. Section 1852(g)(1) of the Act establishes the process for making initial organization determinations and providing notice of appeal rights. Section 1852(g)(2) of the Act provides for the reconsideration process, which is conducted initially by the M+C organization. (Section 1852(g)(3) of the Act provides for M+C organizations to

expedite certain organization determinations under section 1852(g)(1) of the Act and reconsiderations under section 1852(g)(2) of the Act; and section 1852(g)(4) of the Act provides for review by an independent review entity as part of the reconsideration process established under section 1852(g)(2) of the Act). It is section 1852(g)(5) of the Act which provides for the ALJ level of review if the amount in controversy is at least $100, and for ultimate judicial review. Under section 1852(g)(5) of the Act, ''[a]n *enrollee* with a Medicare+Choice organization * * * is entitled (if the amount in controversy is $100 or more) to a hearing before the Secretary * * * and in any such hearing the Secretary shall *make the [M+C] organization a party*.''

Comment: A commenter suggested that some denied services that do not reach the $100 threshold represent legitimate disputes that could adversely affect patients. This commenter believes that patients should be able to request ALJ hearings for denials of services needed to maintain or regain health or physical functions, without regard to the cost involved. Another commenter similarly asserted that an enrollee's ability to obtain an ALJ hearing and seek judicial review should not be based on the amount in controversy, because this could arbitrarily prevent some enrollees with legitimate disputes from appealing. This commenter suggested modifying the provision to allow a decision to be appealed if the amount in controversy meets the identified threshold, or if the patient's life or health may be jeopardized as a consequence of the decision.

Response: Although we are sensitive to the concerns of the commenters, amount in controversy (AC) requirements in the case of appeals under the M+C program are set forth in the statute at section 1852(g)(5) of the Act. A statutory change would be required to alter the current threshold levels; therefore, we are not modifying the M+C regulations.

Comment: A commenter expressed concerns about the process for obtaining judicial review. The commenter also requested clarification as to what constitutes the ''final decision of HCFA.'' The commenter believes that some enrollees may not have the resources to pursue their rights in court. This commenter recommended that the reimbursement of attorney fees or associated court costs be left to the discretion of the judge performing the judicial review.

Response: A decision by our agent, the independent review entity, becomes ''final'' and binding on all parties unless a party other than the M+C organization files a request for an ALJ hearing, or unless the decision is reopened and revised by the independent entity. This is the earliest ''final'' decision that involves us (through our agent), since organization determinations are made by M+C organizations. If this decision is not appealed or re-opened, it is in essence, a ''final decision of HCFA.'' A failure to appeal this decision, however, would mean that the right to further administrative and judicial review has been forfeited. An ALJ decision is similarly final and binding if it is not appealed by a party; (unlike a reconsidered determination, an M+C organization has the right to appeal an ALJ decision). If a timely appeal is filed, the ALJ decision is subject to further review by the Departmental Appeals Board (DAB). At this point, if the DAB declines to review the case, under § 422.612(a), the ALJ's decision becomes a ''final'' decision for purposes of the right to judicial review. If the DAB agrees to hear the case on appeal, the DAB's decision is the ''final decision of HCFA'' for purposes of judicial review.

We believe that the commenter's confusion about what constitutes a ''final decision of HCFA'' may be due to some confusing regulatory text in § 422.612(b). Section 422.612(b) provides that a decision of the DAB may be appealed to Federal court if ''(1) It is the final decision of HCFA; and (2) The amount in controversy is $1,000 or more.'' This implies that there is a distinction between a DAB decision and a ''final HCFA decision.'' In fact, a DAB decision constitutes a ''final decision'' on our behalf, since it is not subject to any further administrative review. We therefore are revising § 422.612(b) to provide that a DAB decision may be appealed to district court if the amount in controversy is $1,000 or more.

Comment: One commenter suggested that we include other rights found in State managed care laws, such as requiring M+C organizations to provide beneficiaries, on request, with clinical guidelines upon which a denial is based.

Response: M+C organizations must provide enrollees with written notice of the reasons for a denial, as set forth at §§ 422.568(c) and (d). This includes providing all the information necessary for the beneficiary to understand why the service was denied, including any Medicare coverage criteria or policies applied in making the decision, as well as specific clinical rationales if applicable. To the extent that particular guidelines or screens are used in the determination process, but are not determinative of coverage (for example, services falling outside certain screens will be given closer review, but still covered if coverage standards are met), we do not believe it is critical for beneficiaries to have access to these documents. We note that Medicare does not make similar documents used by carriers and intermediaries under the fee-for-service program available to the public.

15. Inpatient Hospital Notice of Discharge (§§ 422.580, 422.586, 422.620 and 422.622)

Comment: Two commenters urged that we simplify the language used in the notice of noncoverage (hereafter referred to as the Notice of Discharge & Medicare Appeal Rights (NODMAR)). One commenter suggested working with us to craft a notice outlining beneficiary rights of appeal while avoiding unnecessary paper work, especially since most of the NODMAR information is already contained in the ''Important Message From Medicare'' issued upon admission to a hospital. One commenter stated that the notice should be on a clear and readable form, in at least 12-point font, and in understandable language. One commenter stated that beneficiaries are confused by the content and intent of the notice, and that the notice should include a contact person at the M+C organization. Two commenters stated that this should be a form developed by HCFA.

Response: Shortly after the promulgation of the notice requirement, which is reiterated in § 422.620, we began receiving comments that the notices of noncoverage being issued to beneficiaries were confusing, contained a great deal of sophisticated ''legalese,'' were too long (the notices were ranging from five to nine pages), and that the many variations of the document posed administrative burdens. Therefore, we committed to drafting a more comprehensive and beneficiary-friendly notice.

We began consulting with industry groups, beneficiary advocacy groups, and peer review organizations in support of drafting a notice that would serve the intended purpose. On February 11, 1999, we issued OPL 99.082. This OPL conveyed: (1) Our new notice, the NODMAR; (2) our intent to consumer test and standardize the model language; and (3) our continued effort to find the best balance of beneficiary protections with administrative burden. The model language conveyed in the OPL contains language that is in 12 and 14-point fonts, is written in understandable language, and is only three pages in length.

The Important Message from Medicare (IMM) and the NODMAR are two documents that contain similar information. The IMM is currently given to the Medicare beneficiary at or about the time of admission, while the NODMAR is given in advance of the patient's discharge. We recognized the burden associated with issuing two notices with similar information. Therefore, we have developed a single document and process that allows patients to be informed about their inpatient hospital rights at a time and in a form that will be most beneficial to them and in a manner that reduces administrative burden. This single document is a revision to the existing Important Message from Medicare.

Accordingly, we have revised the IMM to provide for the inclusion of information on patients' inpatient hospital discharge rights. All Medicare beneficiaries will receive a revised notice, the ''Important Message About Medicare Rights: Admission, Discharge, & Appeals,'' as required under section 1866(a)(1)(M) of the Act.

This revised standardized form will be issued to all Medicare beneficiaries who are inpatients of a hospital at or about the time of their admission. Once a Medicare beneficiary's time of discharge is determined, an amended notice that includes the reasons for the discharge would again be provided to the beneficiary prior to his or her actual discharge. The revised Important Message About Medicare Rights: Admission, Discharge, & Appeals has been consumer-tested, and has received favorable feedback. (Pursuant to the Paperwork Reduction Act of 1995 (PRA), a notice outlining this document was published in the **Federal Register** on April 12, 2000, with public comments accepted through June 12, 2000. See 65 FR 19783.) The content of the revised notice (and amended follow-up notice) will meet the requirements of the PRA and section 1866(a)(1)(M) of the Act (the Important Message from Medicare), and the notice requirements set forth at § 422.620 that are now contained in the NODMAR.

Comment: One commenter stated that the notice should include standardized language that indicates that review by PROs is usually preferable to a plan review, and should clearly explain that the enrollee is obligated to make a request in this fashion under these tight time restraints in order to be protected from financial liability.

Response: As explained in the preamble to the June 26, 1998 interim final rule, there are advantages to filing for immediate PRO review. The most significant advantage in utilizing the immediate PRO review process is protection from financial liability for a continued hospital stay until noon of the calendar day following the day the PRO notifies the enrollee of its review determination. In addition, the immediate PRO review process offered the enrollee direct communication with the PRO and a decision that is generally rendered more quickly than an M+C organization's determination.

Therefore, when the model language, NODMAR, was drafted, we included language that would allow the enrollee to understand the significance of meeting the immediate PRO review deadline. Likewise, the revised Important Message stipulates that if the enrollee meets the deadline for filing for immediate PRO review, the enrollee's M+C organization continues to be responsible for paying the costs of the enrollee's hospital stay until noon of the day after the PRO notifies the enrollee of its official decision.

In addition to stating that the enrollee has financial protection if he/she meets the immediate PRO review deadline, we have included a section that explains what happens to the enrollee if he/she misses the deadline and has to appeal to the M+C organization.

Comment: One commenter strongly supported the M+C regulations that improve notice requirements for hospital discharges. The commenter stated that the requirement that hospitals provide notice at the time of discharge instead of at admission gives M+C enrollees an additional protection against premature discharges. One commenter stressed the importance of always issuing a notice with respect to termination of any form of inpatient care, even when the enrollee has not expressed disagreement, because these are such significant changes in circumstances. The commenter suggested that these notices must be given in advance of the termination, and inpatient care must continue, without financial liability to the enrollee, until the appeal is resolved.

Response: We agree with the commenter that a notice of appeal rights should be issued at discharge without regard to whether the beneficiary expresses disagreement with the termination of care. Section 422.620(a) already provides that an M+C enrollee has the right to continued coverage of inpatient hospital services unless a proper discharge notice is provided. We are concerned that the commenter appears not have understood the existing regulations to require a notice in all cases. This misinterpretation of our current requirements is consistent with what we have heard from beneficiaries discharged from hospitals during the year prior to consumer testing conducted on the NODMAR, who reported that they were unaware that they had the right to appeal the decision that it was time to leave the hospital, and left based on the belief that they had no choice in the matter. Given that the existing regulations text may not be sufficiently clear, we are responding to this comment by revising § 422.620(a) to expressly require that written notice be issued to enrollees in the case of all discharges and by revising the introductory clause in § 422.620(c) to provide that ''In all cases in which a determination is made that inpatient hospital care is no longer necessary, no later than the day before hospital coverage ends, each enrollee must receive a written notice that includes the following * * * .''

With respect to the commenter's suggestion that the enrollee not be financially liable until an appeal is resolved, as noted above, if the enrollee disagrees with a discharge decision, the enrollee may file for immediate PRO review by noon the day after a discharge notice is received. If such a timely request for review is filed, the enrollee is protected from financial liability until at least noon on the day after notice of the PRO's decision, if the PRO upholds the decision to discharge the enrollee. If the PRO decides that hospital services are still necessary, coverage would continue until a new discharge notice is issued.

Comment: Several commenters did understand the current regulations to require issuing the NODMAR to every enrollee prior to being discharged from an inpatient hospital setting, and indicated that they found this requirement difficult to administer. One commenter believes that M+C organizations need the cooperation of hospitals to fulfill this requirement, and contended that such cooperation was not always possible to obtain. Therefore, this commenter suggested that we reconsider our decision to require that a NODMAR be provided to every M+C organization member prior to discharge, or that we at least articulate this requirement as a ''good faith effort'' versus an absolute requirement. Two commenters said that in cases in which the responsibility for providing the notice has not been delegated by the M+C organization to the hospital, or where hospitals refuse to assist in this process, M+C organization staff would have to be available to visit each hospital on an ongoing basis 7 days each week, thereby creating a significant increase in the level of staffing. One commenter reported that in some cases,

hospitals are demanding compensation from M+C organizations for providing the notice to enrollees. Another commenter contended that it is inappropriate and unhelpful for hospitals to issue the notice, since there is no reimbursement from M+C organizations or Medicare, and it is impossible for hospital staff to explain decisions they did not make.

Response: We understand the burdens associated with an M+C organization directly providing notices in a hospital setting, and agree with the commenters who stated that hospitals are in the best position to give the discharge notice required under § 422.620. In light of the above comments, we have completed development of a single document that combines the NODMAR with the ''Important Message.'' (The Important Message is the document we have determined that hospitals are already required, under section 1866(a)(1)(M) of the Act, to issue to all Medicare beneficiaries, including M+C enrollees.) While this regulation is not the appropriate vehicle to impose requirements on hospitals, some of which do not contract with M+C organizations, we intend, through a more appropriate vehicle, to require that all hospitals provide discharge notices for all Medicare patients. Thus, we are revising § 422.620 to eliminate the existing requirement that M+C organizations issue the notice of noncoverage to M+C enrollees.

Lastly, we note that it is the responsibility of the entity that made the discharge decision to ensure that an enrollee's questions about the discharge decision be directed to someone within that entity who can provide assistance. Thus, where a discharge decision is made by an M+C organization, that organization should be available to answer questions, even though the notice is issued on the organization's behalf by a hospital.

Comment: Several commenters suggested that the requirement to issue a NODMAR to all enrollees prior to discharge should be repealed or significantly modified. Four commenters suggested that the NODMAR should be given only if the enrollee or the physician disagrees with the hospital's decision to discharge. One commenter contended that issuing a notice in cases where the enrollee agrees with the discharge decision is unnecessary, will confuse the enrollee, and may result in the delay of appropriate discharge or the increase in hospital costs.

Response: The intent of the notice requirement set forth at § 422.620, as with all notice requirements, is to provide enrollees with information that will help them make an informed decision about their health care at a time when it would be most needed and effectively received. The notice requirement is an important and necessary beneficiary protection.

Again, the revised Important Message has undergone extensive consumer testing. This has helped us to improve the content of the notice to make it less confusing to the beneficiary. Since the revised notice will be used to satisfy the requirement for notice of discharge/termination of coverage, beneficiaries will have the benefit of the consumer testing in this context as well.

Comment: One commenter supported an extension of the notice requirement to original Medicare beneficiaries, that is, all Medicare beneficiaries would receive a notice prior to being discharged from the hospital regardless of whether the beneficiary agrees with the decision. The commenter stated that until this requirement is extended, it will be very difficult to achieve full compliance, and urged that we defer any evaluation of plan compliance with this requirement until such an extension is secured.

Response: We have received many inquiries as to whether the M+C policy of issuing NODMARs in all cases will also apply to original Medicare beneficiaries. Currently, the practice has not been for hospitals to issue notices (that is, the Hospital-Issued Notices of Noncoverage (HINN)) to all original Medicare beneficiaries in advance of their hospital discharge, but to do so only in cases in which the beneficiary disagrees. We believe that it is in the best interests of all Medicare beneficiaries and the entities responsible for distribution of such notices to implement a uniform policy for M+C program and original Medicare purposes, and we intend to provide for this through an appropriate vehicle. This final rule, however, sets forth only those requirements that apply in the case of M+C enrollees.

Comment: One commenter contended that our inpatient hospital notice requirement generates ill will among M+C organizations, contracting providers, and beneficiaries. Two commenters opposed the notice requirement because they believe it would raise costs to hospitals.

Response: The intent of the notice requirement is not to supplant the doctor/patient relationship nor to harm the working relationships among M+C organizations, contracting providers, and/or beneficiaries. We believe that standardized instructions, and the eventual implementation of a uniform policy for original Medicare beneficiaries, will help to alleviate a great deal of contention between the various entities. In the long run, this should make the referenced relationships function more smoothly.

Comment: One commenter suggested that the regulation should make clear that if a notice is not issued, the M+C organization (not the hospital) is liable for services.

Response: We agree that if proper notice is not provided, the M+C organization is liable for coverage, unless the hospital has been delegated the authority to make coverage decisions on behalf of the M+C organization. This liability is provided for under § 422.622(c), which expressly addresses liability for services, and § 422.620(a), which makes clear that the enrollee is entitled to coverage until noon the day after notice is given.

Comment: One commenter suggested that the only information that should be reviewed in an appeal of a decision not to admit a patient to a hospital, or to discharge a patient, is that which was available at the time that the decision was made.

Response: We disagree with the commenter. We believe that the entity reviewing an inpatient hospital discharge decision, or decision not to admit an enrollee to the hospital, should base its review on all the facts and evidence available—regardless of whether such information was available at the time of the decision not to admit or to discharge. In particular, in the case of review by the M+C organization, § 422.586 provides the parties to the reconsideration with an opportunity to present related evidence and allegations of fact or law in person as well as in writing; (the regulation notes that such an opportunity may be limited in the case of expedited reconsideration). Further, § 422.580 defines a reconsideration as a review of an adverse organization determination, the evidence and findings upon which it was based, and any other evidence the parties submit or the M+C organization or we obtain. Thus, there is ample precedent for not limiting information to be reviewed in the case of an appeal, and we plan to continue that policy.

Comment: One commenter suggested that, in order to avoid stalemates, the M+C regulations (like the original Medicare regulations) should provide a process to resolve cases in which the physician and the M+C organization disagree about the discharge decision.

Response: We agree with the commenter that the existing regulations do not provide for a clear resolution process in situations where an M+C

organization determines that inpatient care is no longer necessary, but the physician who is responsible for the patient's hospital care does not agree. We are currently examining different methods to resolve these situations, such as a method comparable to the existing Medicare fee-for-service system. Under that system, if a hospital believes that an inpatient is ready for discharge, but cannot obtain the concurrence of the attending physician, the hospital may request PRO review of the case. We intend to discuss this issue in our forthcoming notice of proposed rulemaking.

16. Other Comments

Comment: As alluded to above, several commenters suggested that we modify the subpart M regulations to reflect the provisions of the 1997 district court order in *Grijalva* that was vacated by the Ninth Circuit on appeal in 1999. For example, several commenters suggested we provide for the continuation of coverage during the pendency of an expedited appeal as provided under that district court order. Two commenters suggested that we clarify the enrollee's right to submit evidence in person. Additionally, several commenters suggested that the regulation should state that the enrollee has the right to informal, in-person communication with the reconsideration decision maker and that telephone hearings could be conducted if appropriate. One commenter opposed the implementation of the provisions in the vacated *Grijalva* order as too burdensome on M+C organizations.

Response: In general, we intend to implement regulatory changes that stem from the *Grijalva* order through upcoming notice and comment rulemaking. Thus, several of the commenters' suggestions are not addressed here. We note, however, that in some respects, we believe that the improvements to the appeals process that have been made under the M+C program already incorporate several of the provisions in the vacated *Grijalva* order, and in many instances are stronger. For example, the *Grijalva* order would have required that organization determinations be rendered within 5 working days, with the possibility of a 60-day extension. Under this regulation, we require that when an enrollee requests a service, the M+C organization must respond as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days. The M+C organization may not extend the time frame beyond an additional 14 calendar days. More significantly, unlike under the *Grijalva* order, the M+C program provides an expedited 72-hour time frame for organization determinations in some cases that is shorter than the *Grijalva* time frame, and a similar expedited 72-hour time frame for the resolution of certain reconsiderations, while the *Grijalva* order provides neither. In another example illustrative of how our current M+C regulations meet or exceed the *Grijalva* order, at § 422.586, the M+C organization is required to provide parties to the reconsideration with a ''reasonable opportunity to present evidence and allegations of fact or law * * * in person.''

Comment: One commenter urged that we eliminate the phrase in § 422.574(b) which reads ''and formally agrees to waive any right to payment from the enrollee for that service,'' because this language demeans the role of physicians as patient advocates for medically necessary services.

Response: We do not believe changes are needed in § 422.574(b), which requires a physician or other provider who has furnished a service to an enrollee to formally agree to waive any right to payment from the enrollee for that service. The waiver is only required in the case of retrospective payment denials, where an enrollee has *already* received medically necessary services, but the noncontract physician or provider is seeking payment for furnishing those services; therefore, this phrase does not affect the role of physicians as patient advocates for medically necessary services. In the context of receipt of payment, the role of the physician or provider is no longer as a patient advocate for medically necessary services. Therefore, the M+C regulation does not adversely affect or demean a physician's role as an advocate in prospective instances where an enrollee has not yet received health care services.

Comment: A commenter asked whether we would offer clarification of respective Medicare/Medicaid authorities, particularly with respect to New York State's existing 1115 Medicaid demonstration project. Additionally the commenter wondered if we will establish an administrative linkage between the States and the Medicare review authority for the provision of reports on reviews of adverse determinations in M+C organizations also operating as a State-defined managed long term care plan. (The commenter noted that managed long term care plans will predominantly serve the dually eligible.)

Response: We agree that access of dual eligibles to both the Medicare and Medicaid external hearing process should be clarified. The external hearing process accessed depends upon the type of services being provided. For example, in original Medicare, enrollees who are dually eligible access Medicare services through the Medicare system. Therefore, appeals of Medicare services may be appealed through the Medicare external hearing process, if the beneficiary chooses to do so. Medicaid-only wraparound services (such as pharmacy services) must be accessed through Medicaid. Therefore, appeals of Medicaid-only services must be appealed through the Medicaid external hearing process. Likewise in capitated managed care, when a dually eligible enrollee is enrolled in a Medicaid MCO, the capitated rates are set based on an assumption that Medicare services are accessed through the Medicare system. Therefore, the Medicaid fair hearing system is accessed only for the Medicaid capitated services. The Medicare external hearing is accessed for the Medicare services outside of the Medicaid capitation contract. If a dually eligible individual is enrolled in an M+C organization, then the Medicare external hearing is accessed for the Medicare services within the capitation contract. The enrollee accesses the Medicaid State Fair Hearing only for services outside of the Medicare contract. The key to this example is that the enrollee and the M+C organization need to know whether the service provided is a Medicare- or Medicaid-covered service.

Comment: A commenter suggested that § 422.568(e), which addresses the effect of failure to provide timely notice of an organization determination, should be revised to specify that: (1) Failure to give timely and proper notice shall result in an automatic authorization/approval; and/or (2) failure to give timely and proper notice shall result in automatic sanctions by us. Furthermore, the commenter stressed that if an M+C organization fails to give proper notice, the M+C organization should be required to submit the file directly to an independent organization as described in § 422.590(c). Another commenter suggested that M+C organizations that fail to comply with grievance and appeal requirements should be subject to other intermediate sanctions.

Response: If we determine that an M+C organization substantially fails to comply with the notice requirements relating to grievances and appeals in subpart M, we have the option to terminate the contract under the requirements of § 422.510(b), impose intermediate sanctions as described in §§ 422.756(c)(1) and (c)(3), and/or

impose civil money penalties as described in § 422.758. We note that, depending on the seriousness of a violation (for example, in terms of the degree of risk to an enrollee's health), failure to comply with notice or appeal requirements in only one or two cases could constitute a substantial failure. Intermediate sanctions include the suspension of enrollment and marketing. We believe that these sanction requirements are most appropriately set forth in the sections of the M+C regulations dedicated to contract provisions (subpart K) and intermediate sanctions (subpart O).

We do not agree that we should add the requirement that an M+C organization's failure to give timely and proper notice shall result in an automatic authorization/approval, or that failure to give timely and proper notice shall result in *automatic* sanctions. In fact, we believe the first recommendation could seriously jeopardize the enrollee's health if, for example, an enrollee requested service that could be harmful to his or her health. We note that in the case of hospital and nursing home services already being provided, we have in part implemented the commenter's suggestion, in that the M+C organization is obligated to continue to cover the services until notice of noncoverage is provided. Also, as mentioned earlier, our sanction authority includes cases where we determine an M+C organization substantially fails to comply with the requirements relating to grievances and appeals in subpart M, including the organization's failure to provide the enrollee with timely and proper notice. Finally, where an M+C organization fails to give proper notice within the time frames required for resolution, § 422.590 requires the M+C organization to submit the file to the independent entity for review. We expect M+C organizations to provide enrollees with written notice for all denials (including the case of a discontinuation of a service where the enrollee disagrees (that?) the services are no longer medically necessary) according to the time frames and notice requirements set forth under subpart M and in operational instructions. However, we do not agree that it is practical, nor does the law mandate, that we require M+C organizations to automatically forward cases for independent review when content of the notice is at issue, and there has not been an adverse organization determination (that is, a coverage denial).

Comment: A commenter suggested that M+C organizations should be required to establish an independent appeals procedure for denials of care.

Response: The M+C statute requires that we contract with an independent review entity to independently review plan denials of care. We believe that this arrangement, along with the other M+C appeal requirements, provide Medicare enrollees with the rights they need, and the rights to which they are entitled.

Comment: Two commenters did not believe that the physician reviewing the reconsideration needed to be of the same specialty or sub-specialty as the treating physician. Requiring the same specialty as the treating physician unduly complicates the reconsideration process in this commenter's view. One commenter pointed out that the BBA Conference Report states that ''It is not the conferees intent to require that a physician involved in the reconsideration process in all cases be of the same specialty or sub-specialty as the treating physician.'' One commenter suggested that *expertise* should be defined in terms of board certification in the specialty, years of experience practicing in the specialty, and active practice. One commenter also suggested that physicians have qualifications other than expertise in the field of medicine that is appropriate for the services at issue. The commenter believes that the reviewing physician should also be formally qualified in the specialty treatment (licensed and actively practicing in the same jurisdiction) as the practitioner providing (or who would provide) the services, and have the appropriate level of training and experience to judge the necessity of the service. To ensure greater professional accountability, a commenter recommended that the reviewing physician's identity be accessible to the physician who recommended, rendered, or would have rendered the treatment under review. One commenter suggested that we also include other rights found in State managed care laws, such as requiring initial (organization) determination denials to be made or approved by a physician.

Response: We agree that a physician involved in the reconsideration process need not in all cases be of the exact same specialty or sub-specialty as the treating physician; therefore, we are revising § 422.590(g)(2) to make this clear. For example, we believe that there may be situations where only one specialist practices in a rural area, and therefore, it would not be possible for the M+C organization to obtain a second reviewer with expertise in the same specialty. In addition, we recognize that there may be some situations where there are few practitioners in highly specialized fields of medicine. Under these circumstances, it would not be possible to get a physician of the same specialty or sub-specialty involved in the review of the adverse organization determination.

With respect to the commenter who specified training that the commenter believes reviewing physicians should have, we believe that our standard of ''appropriate'' expertise addresses this comment. Nor do we believe that it would be appropriate for the reviewing physician's identity to be provided to the treating physician being reviewed. The treating physician has the right to challenge the M+C organization's decision on the merits through several levels of an appeals process. We believe that sufficient accountability exists for reviewing physicians through the appeals process, since a physician whose decisions are reversed on appeal would be accountable to his or her M+C organization. Providing the name of the physician making the initial decision for the M+C organization could result in needless personal harassment of that physician by the physicians he or she reviews.

Finally, we do not agree with the comment that organization determinations should be made or approved by a physician. We do not believe that it is necessary to require physician involvement in all organization determinations that are adverse. Nevertheless, we expect that where adverse determinations are based on a lack of medical necessity, M+C organizations will ensure that appropriate health care professionals will be involved in the decision-making. For example, a nurse practitioner could render an adverse organization determination without the need to involve a physician. Furthermore, if an enrollee believes that the lack of physician involvement was a central factor in an adverse organization determination, then the enrollee need only request a reconsideration since the reconsideration requirements (§ 422.590(g)(2)) specify that a denial of coverage based on a lack of medical necessity must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue. (We note that we have made a minor technical change to § 422.590(d) to clarify that the term ''medical necessity'' includes any substantively equivalent term used by an M+C organization to describe the concept of medical necessity.)

Comment: Several commenters provided suggestions on elements for grievance and appeal data.

Response: We appreciate the variety of comments we received concerning categories of meaningful data elements. The comments have provided valuable insight as we continue to work with the public to develop collection and reporting requirements related to organization-level appeals and grievances. Please note that OPLs 99.081 and 2000.114 provide guidance on the manner and form in which M+C organizations will be expected to comply with the requirement under § 422.111 for disclosing grievance and appeal data upon request to M+C-eligible individuals. Collection began April 1, 1999, and the first reporting went into effect on January 1, 2000.

N. Medicare Contract Appeals (Subpart N)

Subpart N of Part 422 addresses M+C contract determinations. There are three types of contract determinations addressed under Subpart N: (1) A determination that a contract applicant is not qualified to enter into a contract with us under Part C of title XVIII of the Act; (2) a determination to terminate a contract with an M+C organization; and (3) a determination not to authorize a renewal of a contract with an M+C organization. Regarding item (1), above, this type of contract determination likewise applies to service area expansion applications.

As indicated in the June 1998 interim final rule, pursuant to section 1856(b)(2) of the Act, most of what comprises subpart N was drawn from regulations in part 417 governing similar contract determinations involving contracts under section 1876 of the Act. We received nine public comments concerning subpart N of the interim final rule.

Comment: We received one comment on § 422.641. The commenter objected to the fact that subpart N, and § 422.641 in particular, does not provide for an appeal mechanism when we and an M+C organization disagree over a term of the organization's M+C contract. The commenter believes that because the Federal Acquisition Regulations (FAR) and contract disputes procedure in Subpart 33.2 of that regulation do not apply to M+C contracts, the M+C final rule should address how these disputes or disagreements will be resolved.

Response: The M+C statute does not contemplate a contract disputes procedure akin to the contract disputes procedure contained in Subpart 33.2 of the FAR. Unlike acquisition contracts subject to the FAR, the terms of M+C contracts are dictated by statute and regulations. M+C organizations have an opportunity for input on the regulations that govern what is included in M+C contracts through the notice and comment process. Ultimately, however, as a matter of Federal administrative law, we are charged with implementing the M+C statute in regulations, and with interpreting and applying its regulations. We attempt, through Operational Policy Letters and other means, to provide guidance to M+C organizations on our interpretations of regulatory provisions, and ultimately, M+C contract terms. In some cases, M+C organizations, or associations representing M+C organizations, have objected to our interpretations of the regulations or to M+C contract terms. In some of these cases, we have taken these objections into account, and we have made modifications. To the extent that an M+C organization remains uncomfortable with the terms of the M+C contract, or of our interpretation of these terms, it ultimately is free not to renew its contract for the following calendar year. We believe that this informal process has worked well, and that there is no need to create a formalized adjudicatory process for addressing disagreements between an M+C organization and us about an M+C contract issue.

Comment: We received several comments about the terminology used throughout subpart N. In particular, commenters noted that the terms used in describing the two categories of entities to which the subpart applies, that is, entities that hold M+C contracts and entities that apply to become M+C contractors, vary throughout the subpart. For example, §§ 422.650(c), 422.650(d), 422.656(a), and 422.660 use three different terms to describe contract applicants: ''entity,'' ''M+C contract applicant,'' and ''applicant entity.'' The commenter recommended that we standardize our use of terminology concerning contract applicants.

Response: We agree with the commenter that the varied use of terms to describe contract applicants is confusing and unnecessary. Therefore, we are revising the regulation text throughout subpart N to refer to organizations applying to become M+C organizations as ''contract applicants.''

Comment: One commenter indicated that in some instances, subpart N refers only to M+C organizations when it presumably should refer to contract applicants as well. For example, § 422.648(b) states that we will reconsider a contract determination if the *M+C organization* files a written request. Presumably, this provision should likewise apply to contract applicants since we also afford these organizations reconsideration rights under subpart N.

A similar issue exists at § 422.656 of the interim final rule. Paragraph (a) discusses giving both the M+C organization and the contract applicant written notice of the reconsidered determination, while paragraph (b)(1) refers only to the M+C organization. Paragraph (b)(3) returns to using both M+C organizations and contract applicants.

Response: We agree with the commenter that contract applicants are also entitled to seek reconsideration pursuant to a Medicare contract determination. Thus, we are revising § 422.648(b) to specify that we will reconsider a contract determination if a contract applicant or M+C organization files a written request for one. We likewise agree that § 422.656(b)(1) should be revised to specify that the provision applies to contract applicants as well as existing M+C organizations, and we are making the needed changes to the regulation text.

Comment: One commenter pointed out that subpart N appears to grant different rights to contract applicants than those available to M+C organizations. This is due, in part, to the provision at § 422.648(b) that states—in error—that we will reconsider contract determinations for M+C organizations, but not contract applicants. In conjunction with the § 422.660 citation mentioned above, this section indicates that applicant entities must seek reconsideration before requesting an appeal, while M+C organizations can appeal a termination or nonrenewal without first seeking a reconsideration. This too stands in contrast to the provision at § 422.662 that contemplates hearings taking place after the initial determination and reconsideration occur.

Response: As mentioned earlier, correcting the language at § 422.648(b) to include contract applicants correctly realigns the language in subpart N to convey that applicant entities and M+C organizations must first seek a reconsideration before proceeding to the hearing stage.

Comment: A commenter believes that the language provided at § 422.662(b) is confusing, because it appears to indicate that contract applicants who are denied a contract by us must file a request for a hearing within 15 days of the date of the contract determination without first receiving notice of our initial determination.

Response: We agree that the language at § 422.662(b) confuses our intent to provide for a contract appeals process that includes—in this order—(1) a

contract determination, (2) an opportunity for reconsideration of the initial contract determination, (3) a reconsidered determination, as necessary, (4) the right to a hearing, as applicable, and (5) for contract terminations, a review by our Administrator. We therefore are changing the language at § 422.662(b) to clearly specify that the affected party must file a request for a hearing within 15 days after the date of the reconsidered determination.

Comment: We received one comment on § 422.668 regarding the disqualification of a hearing officer. Paragraph (b) of this section states that the person designated to be the hearing officer must consider objections from any party to the hearing that relates to any potential bias of the hearing officer. The hearing officer may then proceed with the hearing or withdraw. The commenter suggested that allowing a hearing officer whose impartiality has been questioned the discretion to continue with the hearing is ill-advised. The commenter asserted that if a party believes that the officer is biased, it would be more expedient to resolve that issue immediately instead of proceeding with the hearing.

Response: We believe that in selecting an individual to serve as a hearing officer, the individual's ability to be fair and impartial would be taken into account. Should there be a suggestion of a possible bias, we believe that such an individual would be in a position to evaluate the situation, and determine whether he or she in fact could be impartial with regard to the case in question. Vesting the decisionmaker with this authority to make his or her own determination, subject to appeal only after the matter is heard on the merits, is the same approach used with respect to judges in court proceedings, and we believe is appropriate in this context as well. The alternative could permit an appealing party to delay hearings indefinitely by repeatedly challenging the impartiality of the hearing officer and appealing any rejection of such a challenge.

We believe that § 422.668 provides an adequate remedy to situations where bias of the hearing officer is questioned. This section states that the objecting party may, at the close of the hearing, present objections, request that the decision of the hearing officer be revised, or request a new hearing before a different hearing officer.

Comment: Commenters noted that § 422.692 limits the right to a review by our Administrator to situations involving M+C contract terminations. The commenters questioned whether we intended to deny this level of review in instances in which we nonrenew an M+C contract, or we deny a contract application.

Response: The additional layer of review by our Administrator is intended to apply only to contract termination decisions. This extra level of administrative review was included in the case of termination decisions in order to implement the requirement in section 1857(h)(1)(B) of the Act that M+C organizations have the ''right to appeal an initial decision'' following a termination decision. In providing for review of a hearing officer's decision by our Administrator, we have adopted procedures similar to those used for the Administrator's review of decisions of the Provider Reimbursement Review Board found at § 405.1875.

Comment: A commenter questioned the provision at § 422.696 under which reopening a contract or reconsideration determination is limited to our discretion, the Administrator, or the hearing officer. The commenter asked if the aggrieved party can petition for reopening in any instance.

Response: If an applicant or M+C organization believes it has a basis for re-opening a decision, it may request that the decisionmaker re-open the matter. The decision whether to act on such a request, however, is committed to the decisionmaker's discretion, and is not subject to appeal or further review of any kind. This is consistent with our general policies on re-opening decisions. See, for example, 42 CFR Part 405, Subpart R.

O. Intermediate Sanctions (§§ 422.750 through 422.760)

As stated in the interim final rule, M+C organization actions that are subject to intermediate sanctions include those specified at § 417.500 for contracts under section 1876 of the Act. The BBA also contained additional sanction authority not found in § 417.500, which we have implemented in subpart O. Specifically, section 1857(g)(3) of the Act provides that the Secretary can impose intermediate sanctions and civil money penalties based on a finding that the grounds in section 1857(c)(2) of the Act for terminating a contract are met. These grounds for termination are reflected in § 422.510(a), and are discussed in section II.K and II.N above. While intermediate sanctions based on the grounds for termination at § 422.510 generally are imposed on the same terms as sanctions for the violations specified in § 422.750(a), in the case of all grounds except a finding of fraud or abuse under § 422.510(a)(4), HCFA, rather than the OIG, imposes civil money penalties.

We received 3 comments on subpart O.

Comment: A commenter contended that the intermediate sanctions provisions do not provide Medicare contracting organizations with sufficient appeal rights before intermediate sanctions are imposed. Another commenter argued that the Congress originally intended intermediate sanctions to be an intermediate step less severe than a termination, and that instead suspension of payment for enrollees can be a worse penalty than termination. This commenter believes that the use of intermediate sanctions and civil money penalties has been incorporated as a program management tool, rather than an intermediate step to termination, which the commenter believes should follow sanctions.

Response: In the case of the imposition of a civil money penalty, extensive appeal rights are afforded, including the right to a hearing before the departmental appeals board (DAB). In the case of an ''intermediate sanction,'' however, the entire point of this authority is to allow the Secretary to take swift action to respond to a finding of a serious violation of M+C requirements. Since the sanction is temporary, and only remains in place until corrective actions have been taken, elaborate appeal rights were not contemplated by the Congress, and would not be appropriate. The Congress has demonstrated in section 1857(h) of the Act that it knows how to require specific appeal rights when it wishes to do so. We believe that an M+C organization's interests are sufficiently protected by giving the organization an opportunity to seek reconsideration of a decision to impose intermediate sanctions by demonstrating that the basis for the decision is incorrect, and giving the organization an opportunity to have the sanctions lifted when corrective action is taken. This approach is consistent with what is provided with respect to intermediate sanctions in the nursing home enforcement area. With respect to the second comment, we believe that intermediate sanctions are an ''intermediate step'' between no action and the drastic step of termination, yet do not agree that termination necessarily would follow, unless the organization fails to take corrective action in response to sanctions. Our experience generally has been that organizations respond favorably to sanction letters. The commenter's opinion that an intermediate sanction could be worse than termination may be based on a

misunderstanding of the nature of the sanction referenced by the commenter. The option of suspending payment for enrollees, under section 1857(g)(2)(C) of the Act, applies only to payments for individuals who enroll after the effective date of the sanction. This sanction option, which is available with respect to the violations specified in § 422.752(a), would only apply in a case in which HCFA decided not to impose the sanction of a suspension of enrollment. Finally, the commenter is correct that we view intermediate sanction and civil money penalty authorities as a program management tool that HCFA can employ in the event an organization is not meeting Medicare regulations. Through the use of this tool, HCFA can ensure compliance with regulations without depriving beneficiaries who may be happy with the M+C plan in which they are enrolled of that enrollment option.

Comment: A commenter suggested that HCFA expand intermediate sanctions to include all aspects of grievance and appeals violations.

Response: HCFA has the authority to impose intermediate sanctions for a substantial failure to comply with any grievance and appeal requirement set forth in subpart M. Specifically § 422.752(b) provides that HCFA may impose intermediate sanctions for any violation under § 422.510(a). Section 422.510(a)(6) in turn specifies a substantial failure to ''comply with the requirements in subpart M of this part relating to grievances and appeals'' as a sanctionable violation.

P. Medicare+Choice MSA Plans

1. Background

Among the types of M+C options authorized under section 1851(a)(2) of the Act is an M+C medical savings account (MSA) option, that is, a combination of a high deductible M+C insurance plan (an M+C plan) and a contribution to an M+C MSA. Section 1859(b)(3)(A) of the Act defines an MSA plan as an M+C plan that:

- Provides reimbursement for at least all Medicare-covered items and services (except hospice services) after an enrollee incurs countable expenses equal to the amount of the plan's annual deductible.
- Counts for purposes of the annual deductible at least all amounts that would have been payable under original Medicare if the individual receiving the services in question was a Medicare beneficiary not enrolled in an M+C plan, including amounts that would be paid by the beneficiary in the form of deductibles or coinsurance.
- After the annual deductible is reached, provides a level of reimbursement equal to at least the lesser of actual expenses or the amount that would have been paid under original Medicare, if the individual receiving the services in question was a Medicare beneficiary not enrolled in an M+C plan, including amounts that would be paid by the beneficiary in the form of deductibles or coinsurance.

2. General Provisions (Subpart A)

Sections 422.2 and 422.4 set forth several definitions for terms connected with M+C MSA plans, including ''M+C MSA,'' ''M+C MSA plan,'' and ''MSA trustee.'' We also distinguish between a ''network'' and a ''non-network'' M+C MSA plan. These definitions consist of general meanings for these terms as used in the BBA, and do not include specific requirements in the definitions themselves. The definition for an MSA does, however, reference the applicable requirements of sections 138 and 220 of the Internal Revenue Code, while the M+C MSA plan definition references the applicable requirements of part 422.

3. Eligibility, Election, and Enrollment Rules (Subpart B)

a. Eligibility and Enrollment (§ 422.56)

Any individual who is entitled to Medicare under Part A, is enrolled under Part B, and is not otherwise prohibited (such as an ESRD patient), is eligible to enroll in an M+C plan. However, the statute places several limitations on eligibility to enroll in an M+C MSA plan, and these limitations are set forth at § 422.56 of the regulations. Section 422.56(a) indicates that M+C MSA plans are authorized on a limited ''demonstration'' basis, and incorporates the statutory provisions of section 1851(b)(4), that is:

- No more than 390,000 individuals may enroll in M+C MSA plans.
- No individual may enroll on or after January 1, 2003, unless the enrollment is a continuation of an enrollment already in effect as of that date.
- No individual may enroll or continue enrollment for any year unless he or she can provide assurances of residing in the United States for at least 183 days during that year.

b. Election (§ 422.62)

Section 1851(e) of the Act establishes general rules concerning the time periods when a beneficiary could elect to enroll in an M+C plan (if one is offered in the beneficiary's area), with special rules for M+C MSA plans set forth at section 1851(e)(5) of the Act. Based on these provisions, § 422.62(d) specifies that an individual may elect an MSA plan only during one of the following periods:

- An initial election period, that is, the 7-month period beginning 3 months before the individual is first entitled to parts A and B of Medicare.
- The annual coordinated election period in November of each year.

4. Benefits (Subpart C)

a. Basic Benefits Under an M+C MSA Plan (§ 422.103)

Section 422.103 incorporates the statutory requirements for M+C MSA plans defined under section 1859(b)(3) of the Act, as outlined above. Thus, § 422.103(a) specifies that an MSA organization offering an MSA plan must make available to an enrollee, or provide reimbursement for, at least all Medicare-covered services (except for hospice services) after the enrollee's countable expenses reach the plan's annual deductible. Further, § 422.103(b) then indicates that countable expenses must include the lesser of actual costs or all the amounts that would have been paid under original Medicare if the services were received by a Medicare beneficiary not enrolled in an M+C plan, including the amount that would have been paid by the beneficiary under his or her deductible and coinsurance obligation.

Section 422.103(c) provides that after the deductible is met, an M+C MSA plan pays the lesser of 100 percent of either the actual expense of the services, or of the amounts that would have been paid under original Medicare if the services were received by a Medicare beneficiary not enrolled in an M+C plan, including the amount that would have been paid by the beneficiary under his or her deductible and coinsurance obligation.

Section 422.103(d), concerning the annual deductible, is based on section 1859(b)(3)(B) of the Act. As the statute specifies, the maximum annual deductible for an MSA plan for contract year 1999 was $6,000. In subsequent contract years, the maximum deductible may not exceed the maximum deductible for the previous contract year increased by the national per capita M+C growth percentage for the year. Thus, based on a national per capita growth percentage of 5 percent, the maximum deductible for 2000 is $6,300. In calculating the maximum deductible for future years, HCFA will round the amount to the nearest multiple of $50.

b. Supplemental Benefits (§§ 422.102 and 422.104)

Section 422.102 addresses the general M+C rules on supplemental benefits.

Unlike other M+C plans, MSA plans are not permitted to include any mandatory supplemental benefits, and are limited in terms of the optional supplementary benefits that can be offered. In accordance with section 1852(a)(3)(B)(ii) of the Act, § 422.104(a) specifies that an M+C MSA plan generally may not provide supplemental benefits that cover expenses that count toward the annual deductible. In addition, section 4003(b) of the BBA added new section 1882 to the Act to prohibit the sale of most supplementary health insurance policies to individuals enrolled in M+C MSA plans. The only exceptions to this rule are spelled out in section 1882(u)(2)(B) of the Act. Further, these exceptions apply both for purposes of the prohibition on selling freestanding supplementary health insurance (or ''Medigap'' insurance), and for purposes of ''optional supplemental benefits'' offered under M+C MSA plans. These exceptions are reflected in § 422.103(b)(2).

5. Quality Assurance (Subpart D)

Consistent with section 1852(e)(2) of the Act, a network model M+C MSA plan must meet requirements similar to those that apply to all other M+C coordinated care plans (with the exception of the achievement of minimum performance levels); the statute and regulations establish different requirements for non-network M+C MSA plans. These requirements are discussed in detail in section II.D of this preamble.

6. Relationships With Providers (Subpart E)

For the most part, subpart E of new part 422 does not establish any requirements that are specific to MSA plans. However, § 422.214, ''Special rules for services furnished by noncontract providers,'' does not apply to enrollees in MSA plans. Section 422.214 implements section 1852(k) of the Act, which contains limits on amounts providers can collect in the case of coordinated care plan enrollees (section 1852(k)(1) of the Act), and private fee-for-service plan enrollees (section 1852(k)(2) of the Act). As explained in the June 1998 interim final rule preamble, it is clear that Congress intended no such limits to apply to services provided to MSA plan enrollees.

7. Payments Under MSA Plans (Subpart F)

Section 1853 of the Act describes the method to be used to calculate the annual M+C capitation rate for a given payment area. We apply the same methodology in determining the annual capitation rate associated with each M+C MSA plan enrollee, though the actual amount paid to an M+C organization offering an M+C plan is not the amount determined under section 1853 of the Act.

The special rules concerning the allocation of the M+C capitated amount for individuals enrolled in M+C MSA plans are set forth at section 1853. In general, HCFA will allocate the capitated amount associated with each M+C MSA enrollee as follows:

- On a lump-sum basis at the beginning of the calendar year, pay into a beneficiary's M+C MSA an amount equal to the difference between the annual M+C capitation rate calculated under section 1853(c) of the Act for the county in which the beneficiary resides and the M+C MSA premium filed by the organization offering the MSA plan (this premium is uniform for all enrollees under a single M+C MSA plan, or segment of a plan service area, if authorized under section 1854(h). (See section I.C.7 for a discussion of the BBRA changes in this regard). This results in a uniform amount being deposited in an M+C MSA plan enrollee's M+C medical savings account(s) in a given county, since the uniform premium amount will be subtracted from the uniform county-wide capitation rate for every enrollee in that county.

- On a monthly basis, pay to the M+C organization an amount equal to one-twelfth of the difference, either positive or negative, between the risk adjusted annual M+C capitation payment for the individual and the amount deposited in the individual's M+C MSA.

Section 422.262 contains the regulations concerning the allocation of Medicare trust funds for enrollees in M+C MSA plans.

8. Premiums (Subpart G)

Section 1854 of the Act establishes the requirements for determination of the premiums charged to enrollees by M+C organizations. Like other M+C organizations, organizations offering M+C MSA plans in general must submit by July 1 of each year information concerning enrollment capacity and premiums. For M+C MSA plans, the information to be submitted includes the monthly M+C MSA plan premium for basic benefits and the amount of any beneficiary premium for supplementary benefits. These requirements are set forth under section 1854(a)(3) of the Act and § 422.306(c) of the regulations.

9. Other M+C Requirements

The remaining requirements under subpart 422 have few, if any, implications specific to M+C MSA plans. One issue that we discussed in the interim final rule, however, involves the provision of section 1856(b)(3)(B)(i) of the Act (and § 422.402(b)) that any State standards relating to benefit requirements are superseded. We recognize that this provision means that State benefit rules will not apply (for example, State laws that mandate first dollar coverage for particular benefits such as mammograms or other preventative services). Some States may not license entities to offer catastrophic coverage, and it is possible that M+C MSA plans could not be offered in that State. We invited public comment on this issue.

10. Responses to Comments

Comment: We had requested comments on the establishment of a minimum deductible for MSA plans. We had suggested the possibility of establishing the minimum deductible equal to the projected actuarial value of the average per capita copayment under original Medicare. For 1999, that amount would have been $1000. In response, we received three comments. One commenter supported a minimum deductible but recommended that it be higher, $2000—$3000. Two other commenters opposed the minimum deductible, stating that it would be counterproductive, and would preclude organizations from offering plans feasible for lower income beneficiaries.

Response: Since that there is neither clear consensus on the issue nor any actual experience under the demonstration, we do not believe it would be appropriate at this time to set a minimum deductible. Therefore, we will continue with only a maximum deductible as specified in the Act, but will include an analysis of the deductible issue in the evaluation of this program.

Comment: One commenter requested clarification of § 422.56 specifying how an MSA should be treated in the Medicaid eligibility process.

Response: We are not planning to address the issue of Medicaid eligibility in these regulations. However, this is a valid issue that needs to be addressed in Medicaid eligibility regulations.

Comment: One commenter expressed a concern that MSA enrollees may fail to pay physician claims, based upon experiences with existing deductibles under Medicare. Further, the commenter feared that enrollees might decrease their use of noncovered

elective services, such as elective screening and initial diagnostic examinations.

Response: Assuming that an M+C organization chooses to offer an MSA plan, beneficiaries would be advised before they enroll in the plan that they are responsible for initial medical expenses for the year, and each enrollee would have an MSA account to pay at least part of those expenses. Whether they would be able to meet all of their obligations would be considered in the evaluation. The purpose of the M+C MSA program is to permit beneficiaries to play a greater role in their health care purchasing decisions. The program does provide them with incentives to discourage the overutilization of health care services. We had considered requiring first-dollar coverage for services such as certain screening procedures, but decided that would be contrary to the intent of this demonstration.

Comment: One commenter stated that the maximum enrollment of 390,000 beneficiaries would be a disincentive for organizations to participate in the MSA demonstration. This would be too small a number to permit organizations to devote the resources to developing and marketing a high-deductible MSA policy.

Response: The limit of 390,000 enrollees over the course of the MSA demonstration was specified under section 1851(b)(4) of the Act. We are not at liberty to change that requirement by regulation. Nevertheless, as we previously stated, we do not believe that number would be reached over the course of the demonstration if an M+C organization chose to offer an MSA plan.

Comment: We had solicited comments regarding the issue of whether we should establish sample standardized MSA plans similar to the limited number of Medigap plans. Two organizations commented, both opposing standardized MSA plans as unnecessary and overly restrictive.

Response: We agree with the commenters that there is no need to establish standardized MSA plans under the demonstration.

Comment: Two organizations expressed concern that some States may not license insurers to provide high-deductible policies, thus limiting the availability of MSA plans.

Response: The Act requires that an M+C organization wishing to offer an MSA plan be licensed by the State as a risk-bearing entity, and that the State determine that it can reasonably assume the risk that it would assume under the M+C plan it proposes to offer. It does not require that the organization be licensed commercially to offer a high deductible policy. Therefore, an M+C organization could offer an MSA plan in a State in which the State does not commercially license high deductible plans. The M+C organization must have the State's approval to do so, however.

Comment: Two commenters asserted that the requirement to submit encounter data would be unduly burdensome for M+C organizations offering MSA plans, particularly for non-network MSA plans. Further, M+C organizations may not have access to claims incurred under the MSA deductible.

Response: This issue was discussed at length during the development of the M+C regulations. Of particular concern was the fact that non-network MSA plans may not see enrollee claims should those claims not exceed the deductible. The possibility of requiring enrollees to submit claims regardless of whether the insurer would have liability was discussed, but dropped as burdensome for enrollees. We believe it is in the interest of the Medicare program that the encounter data submission requirement be maintained for all M+C plans, including MSAs. Should an organization approach HCFA about offering an MSA plan, we would work with the organization on its compliance with these requirements. (For example, enrollees who reach the deductible probably would be required to submit documentation of claims totaling the deductible amount. This documentation might be used to supply encounter data.)

Comment: Four commenters addressed the quality performance measures and the required data submissions. One commenter offered support for the performance improvement projects for MSAs and other M+C plans. Two commenters found the health data requirements for MSAs to be unrealistic, particularly for non-network plans, and likely to deter the offering of MSA and PFFS plans. A fourth commenter recommended that if certain quality assurance data are not available for certain categories for MSAs and PFFS plans, beneficiaries should be made aware of this lack of information.

Response: M+C organizations offering MSA plans are required by statute to adhere to specified quality standards. Quality performance standards in the June 1998 interim final rule have been modified to accommodate the particular characteristics of an MSA, and the fact that a report will be done on the MSA demonstration (assuming that an M+C organization chooses to offer an MSA plan). We recognize the fact that non-network MSAs may not have access to an enrollee's claims unless that individual's total claims exceed the deductible. In addition, MSAs may not be structured to provide incentives to beneficiaries to obtain preventive and diagnostic services. HCFA is reviewing the quality requirements to make sure that they are feasible for the specific plan for which they are specified.

Comment: One commenter questioned the ''community-rated'' MSA contributions for all beneficiaries enrolled in an MSA plan, and the lack of balance billing protections for MSA enrollees. Another commenter described the payment methodology as arcane and confusing, and the possibility of a negative premium as absurd.

Response: After lengthy discussions with industry representatives and other officials, the fixed MSA contribution for all beneficiaries in a specific plan in a specific area seemed to be the approach most consistent with legislative intent. Also, HCFA made a point of clarifying that no balance billing restrictions were included in the statute, and that Congress intended that there be none. As has been previously stated, a negative premium is not impossible, but we would expect an MSA plan to set its premium in a given market at a level to avoid such a possibility.

O. M+C Private Fee-for-Service Plans

1. Background and General Comments

As noted above, one type of M+C option available under section 1851(a)(2) of the Act is an M+C private fee-for-service (PFFS) plan. Consistent with the statutory definition of an M+C private fee-for-service plan at 1859(b)(2)(A) of the Act, the regulations state that an M+C PFFS plan is an M+C plan that: Pays providers at a rate determined by the M+C organization offering the PFFS plan on a fee-for-service basis without placing the provider at financial risk; does not vary the rates for a provider based on the utilization of that provider's services; and does not restrict enrollees' choice among providers who are lawfully authorized to provide the services, and agree to accept the plan's terms and conditions of payment. The requirements M+C organizations must meet to contract with HCFA to offer an M+C PFFS plan generally are incorporated into the relevant sections of the M+C regulations. An M+C organization wishing to offer a PFFS plan must meet all of the requirements that apply with respect to offering any other type of M+C plan, except to the extent that there are special rules that apply to M+C PFFS plans.

Comment: One commenter contended that HCFA should examine alternatives to the ACR process for ensuring good value under PFFS and MSA plans. The ACR restriction on the premium may conflict with the role envisioned for these plans as paying high fees to providers to ensure unrestricted access.

Response: The commenter is mistaken in the belief that there are restrictions on premiums for M+C MSA and PFFS plans. There is no restriction on the premiums that may be charged for these plans (see § 422.306(e)(2)).

Comment: A commenter noted that the regulations create a loosely defined option in which the organization offering a PFFS plan fills in the details of the plan. The commenter questioned whether many beneficiaries would be motivated to join such a plan, whether insurers would be motivated to offer an option that could have such limited appeal. As currently constructed, the commenter believes that M+C PFFS plans are not likely to be viable, and therefore are not likely to be made available to beneficiaries. This in the commenter's view mitigates against the espoused concept of offering a meaningfully expanded range of options. The commenter suggested that HCFA work with the physician community to do demonstrations to explore what features of the M+C PFFS statute should be changed so that Medicare can offer a viable M+C PFFS defined contribution plan.

Response: We recognize that the statute created a loose structure for M+C PFFS plans, and that therefore M+C plans may vary greatly from one another in how they function. This is a direct consequence of the law. However, we believe that, as currently constituted, M+C PFFS plans are viable. We have received an application for a 30-State, largely rural M+C PFFS plan, and have reason to expect to receive more applications within the next year.

2. Beneficiary Issues

Comment: A commenter objected to the M+C PFFS plan option on the basis that the commenter believes it leaves the beneficiary vulnerable. The commenter's objections included the lack of a quality assurance program to protect beneficiaries, as well as the absence of a cap on premiums or out of pocket expenses, resulting in the possibility that beneficiaries could be charged up to 15 percent over the plan payment amounts. The commenter contended that beneficiaries would be better protected if the PFFS option were not offered.

Response: We recognize that some beneficiary protections provided for under the coordinated care plan option are not included for M+C PFFS plans. In some cases, such as certain quality assurance requirements, these protections may be less critical in an environment in which the enrollee has complete freedom of choice to use any provider in the country, and is not limited to a defined network of providers. We note that the quality assurance requirements that apply to coordinated care plans do not at this time apply to original Medicare either, which is also a ''fee-for-service'' arrangement. With regard to the absence of certain limits on beneficiary financial liability, we believe that this makes it particularly important that beneficiaries make a prudent consumer decision when choosing this option. However, we also believe that this alternative can provide a valuable alternative to original Medicare in areas that are not served by coordinated care plans, rural areas in particular. Moreover, we anticipate that, as we gain experience with M+C PFFS contracts, we will determine what changes we need to make to the regulations, or ask Congress to consider improving this M+C option, should we decide that such changes are needed. (We note that we have recently approved the first PFFS plan and intend to monitor its performance closely in order to identify and assess potential beneficiary protection issues.)

Comment: A commenter urged that marketing information to seniors and providers clearly differentiate between traditional Medicare and M+C PFFS plans, as there are substantially different payment schedules, balance billing rules, and premiums that can be charged for M+C PFFS purposes than for original Medicare.

Response: We agree that there is a significant potential for confusion between original Medicare and the M+C PFFS option, and we have tried to clarify the distinction between these options in our 1999 and 2000 Medicare handbooks (Medicare and You). We are also considering the best way to make this distinction clear in our model explanation of coverage for M+C PFFS plans. The model evidence of coverage document is created for an M+C organization to use as a model for the explanation they provide to beneficiaries about the plan's terms and conditions of coverage. We are currently adapting the existing Evidence of Coverage for coordinated care plans for use in the case of PFFS plans.

Comment: A commenter recommended that we require providers furnishing services to PFFS enrollees and MSA enrollees to give notice if they think the plan may not cover a service. The commenter believes that the same limitations on liability protection that apply in original Medicare should apply to M+C PFFS plans and MSA plan beneficiaries. Moreover, the commenter suggested providers be required to give enrollees of M+C PFFS plans a notice of the expected balance billing amounts that exceed $250 or more (not just the more than $500 notice required of hospitals).

Response: Unlike under original Medicare, the statute does not provide any protection against enrollee or provider liability for services that a M+C PFFS plan determines are not medically necessary to treat illness or injury, and the law does not require providers to give an advance notice to enrollees of the likelihood of plan noncoverage. Therefore, there is no basis in law to require an M+C organization to offer such protection in its plan. Of course, the organization may, if it chooses, build such protection into its plan, and we believe that doing so may be necessary to attract and keep enrollees. Moreover, an enrollee and provider clearly may seek an advance determination of coverage from the M+C organization under the organization determination regulations in part 422 subpart M. Thus, the enrollee and provider have the opportunity to seek a plan determination of coverage before receiving the service, and we encourage them to avail themselves of this option.

With respect to the notice of anticipated cost sharing, the law requires such a notice for hospital services, but not for other services. The M+C organization could, however require that contracting and deemed contracting providers of other types furnish such a notice in advance of providing care as a term and condition of payment, and could set whatever tolerance they chose for such a notice.

We chose the $500 threshold for a notice of out-of-pocket expenses that a hospital may collect from the enrollee because it mirrors the $500 threshold long established by law at section 1842(m)(1) of the Act. Section 1842(m)(1) of the Act requires that a nonparticipating physician who does not accept assignment on the Medicare claim must give the beneficiary advance notice if the actual charges that will be collected from the beneficiary equal or exceed $500. While the benefit to which the threshold applies is different, the concept of advance notice of amounts to be collected from the enrollee is the same, and therefore use of the same threshold is justified.

3. Provider Payment Issues

Comment: A commenter urged that HCFA establish standard payment deadlines, and contended that those for M+C PFFS plans should mirror those for original Medicare.

Response: We believe that the prompt payment provisions of § 422.520 largely accomplish this, since they apply to all claims submitted ''by, or on behalf of an M+C private fee-for-service enrollee.'' Since the benefits under a PFFS plan are the enrollee's benefits, we believe that any claim submitted on behalf of a PFFS plan enrollee is subject to the clean claim standard in § 422.520. While written agreements with PFFS plan providers must address this issue, and better terms may be negotiated, we have interpreted the reference to fee-for-service enrollees in section 1857(f)(1) of the Act to cover all claims involving PFFS enrollees. Under this standard, the M+C organization must pay 95 percent of the ''clean claims'' within 30 days of receipt, if they are submitted by or on behalf of an enrollee of the M+C PFFS plan, and are not furnished under a written agreement between the M+C organization and the provider. Moreover, the M+C organization must pay interest on clean claims that are not paid within 30 days as required by sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Act for original Medicare.

Comment: A commenter argued that the prompt payment rules at § 422.520 permit payers to ''game'' the clean claim policy by building in a float between the receipt of Medicare payment and the payment to the providers, and recommended that HCFA establish a standard that would apply for PFFS network providers where an organization offering an M+C PFFS plan effectively imposes a delay as a condition of getting the contract.

Response: The prompt payment provisions that apply to all PFFS plan claims ensure against a float of more than 30 days in the case of a ''clean'' claim.

Comment: A commenter suggested that HCFA require M+C organizations offering PFFS plans to give physicians 30 days notice of changes to fee schedules, and should require them to follow CPT coding conventions in the same manner as original Medicare.

Response: M+C organizations offering PFFS plans must pay noncontracting providers at least the amounts they would receive under original Medicare (less the enrollee's cost-sharing); therefore, there is no potential for changes to the payment rates other than through the annual Medicare fee schedule changes. Also, in order to meet access requirements without having a network in place that satisfies coordinated care plan rules, an M+C organization offering a PFFS plan must pay contracting providers (both those with signed and deemed contracts) at least the Medicare payment rate. In this case, again, providers could count on Medicare payment notices. In all cases, however, providers either will negotiate rates in written and signed contracts, or have the opportunity to learn payment information before providing services under a deemed contract.

4. Noncontracting Provider Issues

Comment: A commenter contended that the regulations should clarify whether a noncontracting provider is precluded from balance billing beneficiaries, and must accept as payment in full rates that are no less than what would be paid under original Medicare. The commenter believes it is not clear: (1) If those rates would include the limiting charge of 115 percent; (2) if noncontracting providers are entitled to direct payment from the M+C organization; or (3) what amounts may be balance billed. The commenter suggested that enhanced balance billing should have been provided as an incentive to sign a contract, but because of the deemed contract provisions, this basic premise for contracting is lost.

Response: The law permits, but does not require, an M+C PFFS plan to permit contracting providers (with both signed and deemed contracts) to balance bill up to 15 percent of the PFFS plan payment rate for the service, in addition to the cost-sharing established under the plan. The statute expressly applies this to deemed contractors as well. Therefore, the balance billing that an M+C plan may permit contracting and deemed contracting providers to collect will be set by the organization offering the plan. The M+C organization will pay under its terms and conditions of payment, and the contracting or deemed contracting provider may collect the cost sharing and any balance billing permitted by the plan (which cannot exceed 15 percent of the PFFS plan payment rate).

In the case of noncontracting providers (that is, providers that neither have a written contract with the M+C organization offering the PFFS plan nor meet the criteria for a deemed contract), there is no balance billing permitted; by law, the provider may collect no more than the plan's cost sharing. Under section 1852(k)(2)(B) of the Act, the beneficiary liability limits governing payment to noncontracting providers are the same for M+C PFFS plans as for M+C coordinated care plans. We have clarified this by indicating in § 422.214 that the special rules for payment to noncontracting providers that apply for M+C coordinated care plans also apply for M+C PFFS plans. Specifically, the provider must accept as payment in full the amount that it would be entitled to receive under original Medicare, and the plan must pay the provider the amount that the provider would collect if the beneficiary were enrolled in original Medicare, less the enrollee's cost-sharing. For example, if the physician participates in Medicare, the plan would pay the noncontracting physician the Medicare allowed amount less the plan's cost-sharing. In the case of a nonparticipating physician, the plan would pay the Medicare limiting charge less the enrollee's cost-sharing. In the case of an acute care hospital, the plan would pay the diagnosis-related group (DRG) payment less the enrollee's cost-sharing. In the case of a nonparticipating durable medical equipment, prosthetic and orthotics (DMEPOS) supplier, the plan would pay actual charges less the enrollee's cost-sharing.

While the law addresses the payments to providers and the payment liabilities of beneficiaries, it does not specify whether the M+C organization must pay the provider, or whether it may function as an indemnity plan and pay the enrollee, for services for which the enrollee has paid the provider. Moreover, the discussion of prompt payment by M+C plans at section 1857(f) of the Act contemplates that the M+C organization may make payment to the beneficiary. Hence, the M+C organization may determine to whom (provider or beneficiary) it will make payment for covered services. However, we anticipate that M+C organizations will want to make payment to providers of services, rather than to beneficiaries since we believe that minimizing beneficiary paperwork and confusion is necessary to attract and keep enrollees in the plan.

5. Quality Assurance (§§ 422.152 and 422.154)

As discussed in section II.D of this preamble concerning quality assurance requirements, M+C PFFS plans and non-network MSA plans (and now PPO plans) are exempt from some of the quality assurance requirements that apply to network model M+C plans. The statute also exempts these plans from external quality review if they do not have written utilization review protocols. As with all other requirements for M+C organizations and M+C plans, those provisions of regulations that are not identified as

limited to coordinated care plans or MSA plans also apply to M+C PFFS plans.

Comment: Commenters suggested that § 422.154 affirmatively states that M+C organizations, including those offering MSA plans and PFFS plans, must coordinate with an external entity's (that is, a PRO's) investigation of beneficiary quality of care complaints. These commenters believe that beneficiary complaints are an important indicator of quality of care problems, and that all M+C plans should have to cooperate in investigating them.

Response: The statute relieves an M+C organization offering a PFFS plan of responsibility for contracting for external quality review if it does not carry out utilization review with respect to services covered under the plan.

6. Access to Services (§ 422.214)

Like other M+C plans, an M+C private fee-for-service plan must offer sufficient access to health care. Section 422.114(a) specifies that an M+C organization that offers an M+C PFFS plan must demonstrate to HCFA that it has sufficient number and range of health care providers willing to furnish services under the plan. Pursuant to the specific instructions of the law, under § 422.114(a), HCFA will find that an M+C organization meets this requirement if, with respect to a particular category of provider, the plan has: Payment rates that are not less than the rates that apply under original Medicare for the provider in question; contracts or agreements with a sufficient number and range of providers to furnish the services covered under the plan; or a combination of the above. These access tests must be met for each category of service established by HCFA on the M+C organization application. Thus, if an M+C PFFS plan has payment rates that are no lower than Medicare, it need not address if it has a sufficient number of providers of services under written contract. However, where the plan's payment rates are less than the Medicare payment for that type of provider, the M+C organization must demonstrate that the plan has a sufficient number of providers of that type under written contract.

Medicare payment amounts are established in a variety of different ways. For many of the key services for which Medicare pays, Medicare has prospectively set payment amounts or fee schedules that are established by HCFA and published in the **Federal Register** each year. These include, but are not limited to, prospective payment systems for acute care hospital services, and skilled nursing care, and fee schedules for physician services (which includes care by many nonphysician practitioners and diagnostic tests), durable medical equipment, and clinical laboratory services. Moreover, HCFA is currently developing prospective payment systems or fee schedules for other key services including home health care, ambulance services, and outpatient hospital care, which we expect to be implemented within the next year or two.

However, for some services, Medicare payments are set retrospectively or concurrently by Medicare carriers and intermediaries. For example, until the prospective payment systems or fee schedules are implemented, home health care, outpatient hospital care, and ambulance services will be paid by carriers and intermediaries based upon a HCFA-specified national methodology that they apply either upon receipt of the claim (for example, ambulance services paid on a reasonable charge basis) or long after the service is furnished (for example, retroactive cost report settlement). Moreover, there are some services for which reasonable cost and reasonable charge payment will continue indefinitely. Examples of these services are critical access hospital care (which by law must be paid actual cost without limits) and carrier priced physician services (for which the service is too new or too rare to support a national fee schedule value).

Clearly, where there are national prospective payment systems and fee schedules, M+C organizations offering PFFS plans should have no problem in paying amounts no less than the Medicare payment amount for covered services since those amounts are clearly and prospectively published by HCFA. However, the question arises as to how the access test based on Medicare payment levels can be met with regard to services that are paid by Medicare intermediaries or carriers on a reasonable cost or reasonable charge basis. Moreover, consistent with section 1852(d)(4) of the Act and § 422.214(b), M+C organizations offering PFFS plans cannot restrict providers from whom the beneficiary can acquire care. Therefore, the M+C organization must have the capacity to pay no less than the Medicare-allowed amounts for any Medicare-covered service furnished by any provider in any area of the nation. Acquiring the payment amounts from individual Medicare intermediaries and carriers would be a cumbersome and difficult task, and would be likely to result in unwanted payment delays. Therefore, we have decided to permit M+C organizations offering PFFS plans to establish proxies for use in paying services for which no Medicare prospective payment system or fee schedule exists.

The law and regulations permit the use of HCFA-approved proxies as long as those proxies result in payment amounts that are ''not less than'' Medicare payment rates. If the payment amounts to be paid by the M+C organization are equal to or more than the Medicare payment amounts for those services, the requirement of the law and regulations are met and HCFA must find that the PFFS plan provides for adequate access to care for those categories of services. Therefore, in cases of services for which there is no prospective payment system or fee schedule amount, we will permit M+C organizations to pay proxy amounts under certain circumstances. These proxy amounts must be approved by HCFA as approximating as closely as possible what providers as a whole receive for certain services. Because we expect these payment proxies would be estimates, the M+C organization must also have a process for reviewing these amounts, if necessary, on a provider-by-provider basis. If a provider is able to demonstrate that the proxy amount is less than the amount Medicare would actually pay, the M+C organization must pay the latter amount.

Proxies will take different forms, depending upon what makes the most sense for the type of service being paid. For example, a hospital that is paid on reasonable costs subject to a limit may be paid a percent of charges that is taken from the provider's last settled Medicare cost report. Similarly, an ambulance supplier may be paid the prevailing charge adjusted for the IC that applies in the year in which the service is furnished. Where proxies are used, HCFA will require that a description of the proxy methodology must be included in the terms and conditions of plan payment for deemed contractors that must be made available to providers of services before they treat an PFFS enrollee (see § 422.216(h)(2)(iii)(B)). As nationally established prospective payment systems and fee schedules are developed and implemented by HCFA, the use of proxies should diminish. However, at this time, and for the foreseeable future, for a limited subset of Medicare-covered services, proxies will be necessary for organizations offering M+C PFFS plans that choose not to contract directly with providers. For the reasons discussed above, we believe that their use comports with both the spirit and intent of the law and regulations.

7. Physician Incentive Plans (§ 422.208)

In § 422.208(e), we specify that an M+C PFFS plan may not use capitated payment, bonuses, or withholds in the establishment of the terms and conditions of payment. This is necessary to implement that part of the definition of an M+C plan that specifies that the plan must pay without placing the provider at financial risk.

8. Special Rules for M+C Private Fee-for-Service Plans (§ 422.216)

As discussed in detail in our June 1998 interim final rule (63 FR 35040), § 422.216(a) addresses payment to providers. Specifically § 422.216(a)(1) provides that the M+C organization offering a PFFS plan must pay all contract providers (including those that are deemed to have contract under § 422.216(f)) on a fee-for-service basis at a rate, determined under the plan, that does not place the provider at financial risk. This reflects the statutory definition of an M+C PFFS plan. We also specify in § 422.216(a)(1) that the payment rate includes any deductibles, coinsurance, and copayment imposed under the plan, and must be the same for all providers paid pursuant to a contract whether or not the contract is signed or deemed to be in place. Section 422.216(a)(3) establishes the payment rate for noncontracting providers.

Section 422.216(b) addresses permissible provider charges to enrollees. Under § 422.216(b)(1), contracting providers (including deemed providers) may charge the enrollee no more than the deductible, coinsurance, copayment, and balance billing amounts permitted under the plan. Like payment rates, the plan deductible, coinsurance or copayments and other beneficiary liability must be uniform for services furnished by all contracting providers, whether contracts are signed or deemed to be in place. These two requirements are closely related, since permissible enrollee liability is linked by statute to the plan's payment rate. These cost-sharing amounts must be specified in the plan contract. The plan must have the same cost-sharing for deemed contract providers as for contract providers, and it may permit balance billing no greater than 15 percent of the payment rate for the service.

Other significant requirements set forth in § 422.216 address monitoring and enforcement of the payment and charge provisions (§ 422.216(c)), notifications to plan members concerning payment liability, including balance billing rules (§ 422.216(d)), and rules covering deemed contract providers, including enrollee and provider notification requirements associated with these providers regarding payment terms and conditions (§§ 422.216(f), (g), and (h)).

9. Deemed Contracting Providers

Comment: One commenter endorsed having the same standards for deemed and contracting providers so that an M+C PFFS plan does not become a PPO without the quality assurance standards of a PPO. Other commenters objected to the concept of deemed contracting providers, because they believe that it will reduce provider willingness to provide services in these plans, and because they believe it is unfair to physicians, particularly those who provide emergency care.

Specifically, a commenter indicated that M+C organizations offering PFFS plans will not be able to get providers to sign contracts because there is no incentive for a provider to bind itself to a contract when it is not promised a share of the market in the area, and when it will be paid like a contracting provider, whether it signs a contract or not, under the deemed contracting provisions. Commenters indicated that there will be problems determining the ''deemed contract'' vs. the noncontract status of providers, since it depends on what they knew at the time of service. A commenter said that HCFA should tighten the rules under which deeming can be presumed, and seek statutory modifications to limit the use of deeming.

Some commenters indicated that emergency department physicians should not be deemed contractors because the M+C organization could blanket an area with terms and conditions of plan payment, and thereby force them to accept terms and conditions with which they did not agree, since they must treat all patients who present in the emergency department. They commented that HCFA should stipulate that deeming is never presumed to have occurred when emergency services or urgent care are required, particularly when they are required under the Emergency Medical Treatment and Labor Act. Other commenters recommended that the deemed contract language should be amended to explicitly not apply to out of network service provided in an emergency department, and to require that all physicians who provide services in the emergency department be paid as noncontracting providers. Commenters believe that this is needed because, under the Medicare provider agreement anti-dumping rules, the hospital must ensure that all patients who present in the emergency room are seen and that, therefore, the physicians on duty have no ability to choose not to provide care to the enrollee. Under the deemed contracting provisions of the law, they are forced to accept the terms and conditions of plan payment when they treat the patient.

Response: We recognize that the law provides little or no incentive for a provider to sign a contract with an M+C PFFS plan because of the deemed contracting provisions. We also agree that the deemed contracting requirements of the law are problematic, particularly in emergency room settings, and will create disputes between M+C organizations and providers about what the provider knew and when it was known.

The statute specifies that the M+C organization must treat providers that do not have a contract with the plan as if they had such a contract, if the provider knew that the beneficiary was enrolled in the plan, and either knew the terms and conditions of plan payment, or had reasonable access to those terms and conditions.

In general, if the beneficiary has advised the provider of his or her plan enrollment (as is often requested by the provider before providing care), and the provider knows the terms and conditions of plan payment (for example, because the physician or the party to whom the physician has reassigned benefits has received the plan terms and conditions in writing), or has a reasonable opportunity to learn the terms and conditions of plan payment (for example, through a toll free phone number, a website, or by having been sent a copy of the terms and conditions of plan payment), in a manner reasonably designed to effect informed agreement by a provider, then the provider meets the statutory test of being a deemed contracting provider, and the law requires that he or she must be treated as such. The law and regulations presume that, if the provider meets the criteria as a deemed contracting provider and subsequently treats the enrollee, then the provider has implicitly demonstrated agreement to the terms and conditions of payment by treating the enrollee.

While the law does not provide an explicit exception to the deemed provider provisions for emergency or urgent care services, we acknowledge that there are special circumstances that surround services in an emergency department of a hospital that justify considering providers who have not signed a contract with the PFFS plan to be noncontracting providers when they furnish services in an emergency

department of a hospital. We have revised § 422.216(f) accordingly.

When a physician or hospital has not signed a contract with a PFFS plan but treats a plan enrollee in an emergency department of a hospital, the physician or hospital has no opportunity to refuse to treat the patient as the deemed contracting provisions of the law anticipate. Hence, we believe that it is appropriate to specify that a physician or hospital that furnishes services in the emergency department of a hospital on behalf of the hospital's obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA) cannot be deemed to be a contracting provider. Of course, if the physician or hospital has previously signed a contract with the PFFS plan, the physician or hospital is a contracting provider, and is bound by the terms and conditions of that contract. Moreover, once the services furnished in the emergency department of a hospital cease to be required under § 489.24, the criteria that determine whether the providers are deemed contracting providers or noncontracting providers would then apply.

III. Provisions of this Final Rule—Changes to the M+C Regulations

For the convenience of the reader, listed below are all significant changes to the M+C regulations that are set forth in this final rule. Please note that changes stemming from the BBRA, which—unlike those changes listed below—are subject to public comment, are all discussed in a discrete section of this preamble (section I.C) and thus are not listed here. In addition, we caution the reader that the list below is intended solely as a reference aid, rather than as a policy summary.

- In § 422.2, we are revising the definition of ''service area'', as well as making minor technical changes to several other definitions.
- We are revising § 422.50(a) to allow individuals and employer group members who become entitled to Medicare and live outside of the service area to convert to an M+C plan if they were previously enrolled in a commercial plan offered by the M+C organization, provided these individuals receive full plan benefits and M+C access and availability standards are met.
- To allow us the flexibility to vary the timeframes for the enrollment transmission schedule in the future, we are amending § 422.60(e)(6) to state ''upon receipt of the election form or from the date a vacancy occurs for an individual who was accepted for future enrollment, the M+C organization transmits within time frames specified by HCFA, the information necessary for HCFA to add the beneficiary to its records as an enrollee of the M+C organization.''
- We are revising § 422.60(f)(3) to state that ''upon receipt of the election form from the employer, the M+C organization must submit the enrollment within time frames specified by HCFA.''
- In order to avoid introducing confusion between responsibilities of M+C organizations and HCFA, we have eliminated material in § 422.64 concerning HCFA's information responsibilities and moved necessary material to § 422.111.
- We have modified § 422.66(b)(3)(i) to state that the timeframe to submit disenrollment transactions will be ''specified by HCFA,'' and have made a conforming change at § 422.66(f)(2), as opposed to within 15 days.
- At § 422.66(d) we are clarifying that an M+C organization must accept any eligible individual who is enrolled in a health plan offered by ''an'' M+C organization to apply to a specific M+C organization, namely the organization that offers both the commercial health plan in which the individual is enrolled and the M+C plan in which the individual will be enrolling.
- At § 422.74(b)(3)(ii) we are permitting an M+C organization that has reduced an M+C plan's service area to offer continued enrollment in one of its M+C plans to enrollees in all or a portion of the reduced area if enrollees agree to receive ''basic benefits'' exclusively at designated facilities within the plan's new service area.
- We are adding a provision to § 422.74(d)(1)(iv) that expressly provides an M+C organization the option to discontinue an optional supplemental benefit for which premiums are not paid, while retaining the beneficiary as an M+C enrollee.
- We are changing the requirement at § 422.74(d)(4) to state that the M+C must disenroll an individual, unless he or she chooses the continuation option, if the individual moves out of the plan's service area for over 6 months, rather than 12 months.
- We are adding wallet card instructions to the list of examples of marketing materials at § 422.80(b)(5)(v), to ensure that wallet card instructions to enrollees are consistent with the statute and regulations, particularly requirements that apply to emergency and urgently needed services.
- We are revising § 422.80(e) to permit more flexibility for providers in distributing materials to M+C enrollees.
- We are adding a new § 422.80(e)(1)(viii) that prohibits new M+C plan names that exclude the disabled population.
- We are removing the definition of post-stabilization services in § 422.100(b)(1)(iv) and instead including all post-stabilization requirements in new § 422.113. See section II.C of this preamble for a full discussion of changes in the post-stabilization requirements.
- We are specifying at § 422.100(b)(1)(vi) and § 422.113 that M+C organizations are required to cover ambulance services dispatched through 911 or its local equivalent when use of other forms of transportation would endanger the health of the beneficiary.
- We are adding a provision at § 422.101(a) to state explicitly that services may be provided outside of the service area of the plan if the services are accessible and available to enrollees.
- To promote beneficiary freedom of choice among providers, § 422.105 is revised to permit use of the POS option for in-network providers, rather than only for providers outside the plan network.
- To clarify our existing policy, we are clearly delineating HCFA's review authority in § 422.106 for employer group health plans and Medicaid plans.
- We are adding a new § 422.108(f) to clarify that a State cannot take away an M+C organization's Federal rights to bill or authorize providers to bill for services for which Medicare is not the primary payer.
- We are revising § 422.109(b)(5) to provide that M+C enrollees are responsible only for coinsurance amounts.
- We are revising § 422.111(e) to decouple the enrollee notice time frame from the ''issuance or receipt'' of a notice of termination and instead require that an M+C organization make a good faith effort to provide written notice at least 30 calendar days before the termination effective date.
- We are revising § 422.112(a)(3) to clarify that an M+C organization shall authorize out-of-network specialty care when its plan network is unavailable or inadequate to meet an enrollee's medical needs.
- At new § 422.113(b) we are specifying that ''urgently needed services'' are not ''emergency services.''
- We are clarifying at § 422.113(b)(2)(ii) that prior authorization may not be required from the beneficiary in wallet card instructions or in other enrollee materials . We are also specifying that instructions on what to do in an emergency should include a statement

specifying that in the event of an immediate and serious threat to health, the enrollee may call 911.

• We are revising § 422.113(b)(2)(iii) to expressly set forth the requirement that M+C organizations assume financial responsibility for services meeting the prudent layperson definition of emergency at § 422.2 regardless of final diagnosis.

• In order to clarify the distinction between a removal of deemed status by HCFA based on HCFA's own survey and a removal based on a determination by an accreditation organization based on its accreditation survey, we are revising § 422.156(a) to separate these two situations.

• We are revising § 422.157(a)(3) to relax the prohibition on the participation of managed care organization representatives in private accreditation organization activities.

• We are revising § 422.158(e) to provide that we will act within the same timeframes that apply to fee-for-service deeming.

• To help clarify that the appeals procedures apply only for adverse participation decisions, we are redesignating the provider appeals procedures from § 422.204(c) to new § 422.202(d).

• Section 422.204 has been re-titled ''Provider selection and credentialing'' and contains the general rule that an organization must have written policies and procedures for the selection and evaluation of providers.

• We are consolidating the regulations concerning antidiscrimination and choice of providers into new § 422.205. We reaffirm that M+C organizations are prohibited from discriminating against providers based solely on their licensure or certification, and specify that when an M+C organization declines to include a provider in its network, it must notify the provider of the reason for its decision.

• We have revised § 422.214 to clarify the rules concerning payments to noncontracting providers.

• We have revised § 422.216(f) to indicate that, for PFFS purposes, ''deemed contract'' providers are considered to be noncontracting providers when they furnish services in an emergency department of a hospital.

• We are revising § 422.257 to permit M+C organizations to require that their contractors provide them with complete and accurate encounter data.

• We are adding two terms—''first tier'' and ''downstream''—to the list of definitions at § 422.500 that we believe clarify the types of entities to which the M+C contracting requirements described at § 422.502(i) apply.

• We are revising the definition of ''clean claim'' in § 422.500 to require that claims include data for encounter data submission, and meet the original Medicare ''clean claim'' requirements in order to be considered a clean claim.

• In consultation with the Office of Inspector General, we are revising the compliance plan requirements under § 422.501 to eliminate mandatory self-reporting.

• In order to ensure that M+C enrollees are not put at financial risk in situations where provider groups or other entities ''downstream'' from an M+C organization become insolvent, we are revising § 422.502 to strengthen the protections for Medicare enrollees in situations where an M+C organization or its contractors encounter financial difficulties.

• Section 422.502(l), concerning certifications of the accuracy of payment data, has been modified to be consistent with the OIG's ''good faith'' standard, under which M+C organizations certify the accuracy of payment information to their ''best knowledge, information, and belief.'' We are also permitting the delegation of this responsibility to individuals other than the CEO or CFO of the M+C organization.

• We are revising § 422.506(a)(2)(i) to permit an M+C organization until July 1 to notify us of its intent not to renew its M+C contract for the upcoming contract year.

• We are deleting § 422.506(b)(ii) in response to a concern that the standard for declining to renew an M+C contract was too vague to enforce.

• We are adding a new § 422.510(a)(12) that would specify that a substantial failure to comply with marketing guidelines is grounds for termination, non-renewal, or intermediate sanction.

• We are changing the language at section § 422.520(a)(3) to indicate that non-clean claims and the remaining 5 percent of clean claims not paid within 30 days must be either paid or denied within 60 calendar days from the date of the request.

• We are revising the definition of an organization determination under § 422.566 to provide additional clarity as to the types of situations that constitute an organization determination and thus give rise to the pursuant appeal rights.

• To further clarify the grounds on which an M+C organization may seek an extension, and to ensure an enrollee is adequately advised of the M+C organization's use of an extension, we are adding language to both §§ 422.568(a) and 422.572(b) that requires an M+C organization to notify the enrollee in writing of the reasons for the extension, and to inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision.

• We are revising § 422.568(c) and (d) to modify the requirement concerning written notification of M+C enrollees when a service is denied in whole in or part.

• We have added new § 422.619 concerning effectuation of expedited reconsideration determinations.

• We have revised § 422.620 to eliminate the requirement that M+C organizations distribute to enrollees the notification of noncoverage of inpatient hospital care.

We have also made many minor technical and conforming changes to the M+C regulations to ensure that citation references are accurate, use more consistent terminology, and correct typographical errors in the current regulations.

IV. Collection of Information Requirements

Under the PRA, we are required to provide 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. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

• The need for the information collection and its usefulness in carrying out the proper functions of our agency.

• The accuracy of our estimate of the information collection burden.

• The quality, utility, and clarity of the information to be collected.

• Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the sections that contain information collection requirements.

Note: Unless otherwise noted below, all information collection requirements in this rule are currently approved under OMB approval #0938–0753, which currently expires August 31, 2000.

Section 422.60 Election Process

Paragraph (b) of this section states that M+C organizations may submit information on enrollment capacity of plans they offer by July 1 of each year as provided by § 422.306(a)(1). The

burden associated with this reporting provision is captured under § 422.306.

Section 422.74 Disenrollment by the M+C Organization

Paragraph (c) of this section requires that if the disenrollment is for any reason other than death or loss of entitlement to Part A or Part B, the M+C organization must give the individual a written notice of the disenrollment with an explanation of why the M+C organization is planning to disenroll the individual. Notices for reasons specified in paragraphs (b)(1) through (b)(2)(i) must include an explanation of the individual's right to a hearing under the M+C organization's grievance procedures. This requirement is currently approved under 0938–0763, which expires March 31, 2003.

Section 422.111 Disclosure Requirements

Paragraph (e) requires the M+C organization to make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days (revised from 15 days) before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating. The burden associated with this requirement has not changed.

Section 422.113 Special Rules for Ambulance Services, Emergency and Urgently Needed Services, and Maintenance and Post-Stabilization Care Services

Paragraph (b)(2) of this section requires that enrollees be informed of their right to call 911.

The burden associated with this disclosure provision is the time it takes an M+C organization to inform each beneficiary of his or her right. In addition, instructions to seek prior authorization for emergency services and/or before the enrollee has been stabilized may not be included in any materials furnished to the enrollee. We anticipate that these requirements will be provided as part of standard enrollment disclosures. Therefore, the burden associated with this requirement is contained in section 422.64.

Section 422.152 Quality Assessment and Performance Improvement Program

Paragraph (e) of this section requires that an organization offering an M+C plan, non-network MSA plan, or private fee-for-service plan to measure performance under the plan using standard measures required by HCFA and report its performance to HCFA. The standard measures may be specified in uniform data collection and reporting instruments required by HCFA and will relate to clinical areas including effectiveness of care, enrollee perception of care, and use of services and to nonclinical areas including access to and availability of services, appeals and grievances, and organizational characteristics.

The burden associated with this reporting provision is the time it takes an M+C organization to gather and submit the information. ''All Medicare+Choice organizations and an organization offering an M+C non-network MSA plan or an M+C private fee-for-service plan will be required to measure performance under their plans, using standard measures required by HCFA, and report their performance to HCFA. Reporting will be required annually. Currently the standard measures that will be required will most likely be those already captured in HEDIS and CAHPS, approved under OMB #0938–0701. The currently approved annual per plan burden is estimated to be 400.53 hours. Therefore, the total burden associated with this requirement is 180,239 hours (400.53 hours × 450 plans (100 new/350 current)).

Section 422.202 Participation Procedures

Paragraph (d) of this section requires that an M+C organization that suspends or terminates an agreement under which the physician provides services to M+C plan enrollees give the affected individual written notice as required by this section.

This section also requires that an M+C organization that suspends or terminates a contract with a physician because of deficiencies in the quality of care give written notice of that action to licensing or disciplinary bodies or to other appropriate authorities.

The burden associated with these reporting provisions is the time it takes an M+C organization to write the notice and give it to the practitioner and the appropriate licensing, or disciplinary bodies or to other appropriate authorities. We estimate that it will take 450 plans, 10 hours to produce and disclose 10 notices on an annual basis, for a national annual burden of 4,500 hours.

In addition this paragraph requires that an M+C organization and a contracting provider must provide at least 60 days written notice to each other before terminating the contract without cause.

The burden associated with this reporting provision is the time it takes an M+C organization and provider to write the notice and furnish it to the other party. We estimate that 450 entities will be required to write 10 notices, at 1 hour per notice, for a national annual burden of 4,500 hours.

Section 422.205 Provider Antidiscrimination Rules

The reporting requirement of this section requires that, if an M+C organization declines to include a given provider or group of providers in its network, it furnish written notice to the affected provider(s) of the reason for the decision.

The burden associated with this reporting provision is the time it takes an M+C organization to write and provide the required notice. We estimate that it will take 450 plans, 30 minutes to produce and disclose 20 notices on an annual basis, for a national annual burden of 4,500 hours.

Section 422.206 Interference With Health Care Professionals' Advice to Enrollees Prohibited

The reporting requirement in paragraph (b)(2) requires that, through appropriate written means, an M+C organization make available information on any conscience protected policies to HCFA, with its application for a Medicare contract, within 10 days of submitting its ACR proposal or, for policy changes, in accordance with § 422.80 (concerning approval of marketing materials and election forms) and with § 422.111. With respect to current enrollees, the organization is eligible for the exception provided in paragraph (b)(1) of this section if it provides notice within 90 days after adopting the policy at issue.

The revision to the information collection provisions requires the M+C organization to make available policy changes. We estimate that it will take 30 minutes for each of the 450 M+C organizations to comply, for a total of 2,225 hours nationally on an annual basis.

Section 422.257 Encounter Data

Paragraph (d)(1) of this section requires that M+C organizations must submit data that conform to the requirements for equivalent data for Medicare fee-for-service, when appropriate, and to all relevant national standards. M+C organizations must obtain the encounter data required by HCFA from the provider, supplier, physician, or other practitioner that rendered the services. In addition, M+C organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of

complete and accurate encounter data as required by HCFA.

The burden associated with this paragraph is currently approved under OMB approval #0938–0753.

Section 422.568 Standard Timeframes and Notice Requirements for Organization Determinations

Under paragraph (a) of this section, when a party has made a request for a service, the M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination. The M+C organization may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee. When the M+C organization extends the timeframe, it must notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision to grant an extension. The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

The revision to this provision is that requiring the M+C organization to notify the beneficiary of its reasons for delay and of the right to file a grievance.

We estimate that this requirement will add 40 hours for each of the 450 M+C organizations to the burden currently captured under 0938–0753, for an annual addition of 18,000 hours.

Under paragraph (c), at each patient encounter with an M+C enrollee, a practitioner must notify the enrollee of his or her right to receive, upon request, a detailed notice from the M+C organization regarding the enrollee's services. The practitioner must provide the enrollee with complete information, using approved notice language in a readable and understandable form, necessary to contact the M+C organization.

The burden associated with this reporting provision is the time it takes a practitioner to notify the beneficiary. We estimate that there will be 160 encounters per entity (450) and that each notification will take an average of 15 minutes to do so, for a national annual burden of 4,500 hours.

Under paragraph (d), if an enrollee requests an M+C organization to provide a detailed notice of a practitioner's decision to deny a service in whole or in part, or if an M+C organization decides to deny service or payment in whole or in part, it must give the enrollee written notice of the determination.

In addition to the currently approved burden under 0938–0753, the burden associated with this reporting provision is the time it takes to write the detailed decision and provide it to the beneficiary. We estimate that there will be 160 occasions per entity (450) for which a detailed decision must be provided and that each notification will take an average of 15 minutes for a national annual burden of 4,500 hours.

Under paragraph (e), the notice of any denial under paragraph (d) of this section must, in addition to currently approved requirements, (1) for service denials, describe both the standard and expedited reconsideration processes, including the enrollee's right to, and conditions for, obtaining an expedited reconsideration and the rest of the appeal process; and (2) for payment denials, describe the standard reconsideration process and the rest of the appeal process.

The burden associated with this reporting provision is the time it takes an M+C organization to add the required information to a notice. We estimate that it will take 450 plans 1 hour to produce and disclose the necessary language on an annual basis, for a national annual burden of 450 hours.

Section 422.570 Expediting Certain Organization Determinations

The information collection requirement in this section ((d)(2)(iii)) that is not currently approved under 0938–0753 requires that, if an M+C organization denies a request for expedited determination, it must take give the enrollee prompt oral notice of the denial and subsequently deliver, within 2 calendar days (proposed as 2 working days), a written letter that informs the enrollee of the right to resubmit a request for an expedited determination with a physician's support. The currently approved burden, associated with this requirement has not changed.

Section 422.572 Timeframes and Notice Requirements for Expedited Organization Determinations

The information collection requirement change to paragraph (b) requires that, when the M+C organization extends the deadline, it notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision to grant an extension.

The additional burden associated with this requirements set forth in this section is the time it takes an M+C organization to notify the beneficiary of the delay and the reasons for it. We estimate that 450 plans will provide extension notices to approximately 100 of their M+C enrollees on an annual basis and it will take an average of 5 minutes per notification. Therefore, the annual national burden is estimated to be 3,750 hours.

Section 422.584 Expediting Certain Reconsiderations

The information collection change to this section requires that, if an M+C organization denies a request for expedited reconsideration, it must give the enrollee prompt oral notice, and subsequently deliver, within 2 calendar days, a written letter that (in addition to currently approved disclosure requirements) informs the enrollee of the right to resubmit a request for an expedited reconsideration with a physician's support.

The one time burden associated with this disclosure requirement is the time it takes an M+C organization to add the requisite language to the letter it furnishes to the beneficiary. We estimate that it will take each M+C organization (450) an average of 30 minutes to add the language to its current letter for notifying beneficiaries, for a national annual burden of 2,250 hours.

Section 422.620 How Enrollees of M+C Organizations Must Be Notified of Noncoverage of Inpatient Hospital Care.

The information collection change to this section the clarification that in *all* cases in which a determination is made that inpatient hospital care is no longer necessary, no later than the day before hospital coverage ends, the hospital (as provided under paragraph (d) of this section) or M+C organization must provide written notice to the enrollee that includes the elements described in this section. The burden associated with this requirement is currently approved and captured under 422.622.

We have submitted a copy of this final rule to OMB for its review of the revised information collection requirements in §§ 422.60, 422.74, 422.111, 422.113, 422.152, 422.205, 422.206, 422.257, 422.568, 422.570, 422.572, 422.584, and 422.620. These revised 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 within 30 days of

this publication date directly to the following:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850. Attn: John Burke HCFA–1030–FC.

and,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Heron Eydt, HCFA Desk Officer.

V. Regulatory Impact Statement

A. Introduction

We have examined the impact of this rule as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, non-profit organizations and governmental agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 50 beds.

As a result of changes to the M+C regulations to reflect provisions of the BBRA, this rule has been determined to be a major rule as defined in Title 5, United States Code, section 804(2). We consider a major rule to be one with economic effects of $100 million or more in a given year, and as noted below in section V.B.8 of this regulatory impact analysis, the effects of the BBRA changes reach this threshold. Generally, a major rule takes effect 60 days after the date the rule is published in the **Federal Register**. In this case, however, as discussed in detail above in section I.C of this preamble, the BBRA included specific effective dates for its various M+C provisions. For the most part, the statutory changes are self-explanatory, and have already taken effect. Thus, except as provided under the BBRA, the provisions of this final rule with comment period take effect 30 days after publication in the **Federal Register**.

The Unfunded Mandates Reform Act of 1995 also requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before enacting any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more. This final rule with comment period will have no consequential effect on State, local, or tribal governments. We believe the private sector cost of this rule falls below these thresholds as well.

1. Summary of the Final Rule

As discussed in detail above, this rule implements only limited changes in the M+C regulations published June 26, 1998 (and further amended February 17, 1999). While we do not expect the changes contained in this final rule to have a significant economic impact, we believe that we have a responsibility to keep the public informed of the impact of inherent features of the M+C program, such as payment changes and the implementation of risk-adjusted payments. We attempted to describe the impacts of these payment changes in the interim final rule. However, after a year of experience administering the program, we now have a better understanding of the impact of the payment changes. This impact analysis will examine payment effects associated with these two items, and respond to public comments concerning the economic impact of M+C policies.

2. Summary of Comments on Impact of M+C Program

Although commenters on the interim final rule generally recognized that the payment methodology and rates associated with the M+C program were implemented as directed by the BBA, several commenters still expressed concern that resulting payments to M+C organizations were insufficient to keep pace with the costs of providing medical care. These commenters suggested that the new payment methodology, particularly when combined with the implementation of a risk adjustment mechanism in 2000, could have the unintended consequence of limiting, rather than expanding, the health plan choices available to Medicare beneficiaries. M+C organizations have withdrawn from some areas, and many beneficiaries have experienced growing premium increases or benefit reductions. Commenters also asserted that the M+C regulations contained discretionary provisions that added unnecessarily to the administrative burden on M+C organizations. In particular, commenters identified quality standards, provider participation requirements, and attestation procedures as examples of what they considered overly proscriptive rules that had the potential to raise health plan costs. In general, commenters urged us to evaluate more carefully the cumulative impact of the changes introduced by the M+C program.

We noted in our February 17, 1999 limited M+C final rule that we needed a statistically-based model to evaluate the total impact of payment changes for M+C organizations. We have subsequently developed a model that estimates the impact of risk-adjusted payments on M+C organizations. This impact analysis focuses on results from this model. When possible, we provide detail on impacts by geographic area and by organization size.

We then discuss some of the concerns raised by commenters about likely withdrawals from the M+C program. Finally, our analysis examines available information concerning the administrative burden associated with selected M+C requirements.

B. Payment Changes

1. Background

Prior to the BBA, Medicare's capitation rates for managed care plans had been set at 95 percent of expected costs based on actual fee-for-service costs. Because of the variation in fee-for-service expenditures for different counties due to different utilization patterns and cost structures, the Medicare managed care rates for different counties were also quite divergent. In addition, there was significant evidence that Medicare had paid more for enrollees in the Medicare managed care programs than it would have paid in the fee-for-service program. This was due primarily to the favorable selection that these plans have experienced.

The BBA made a number of changes in Medicare payments to managed care plans including:

- Increasing payments in counties that historically had the lowest payment rates (and generally have not had risk-based Medicare managed care plans) through the use of a payment floor and by introducing a blended payment rate.

• Reducing the rate increases in counties that historically had higher payment rates.

• Reducing M+C capitation rates by phasing in the removal of direct and indirect medical education payments from M+C capitation rates beginning in 1998 (and phasing in direct payment of these ''carved out'' amounts to the institutions providing care to M+C enrollees).

Payment increases from year to year after 1997 are based on an update factor that is the rate of increase in projected Medicare expenditures each year, less a statutorily specified reduction (reducing the rate to .8 percent less in 1998 and .5 percent less each year thereafter through 2002). However, all counties are guaranteed a minimum payment increase of 2 percent over the preceding year's base rates.

The BBA also mandated the introduction, by the year 2000, of risk-adjusted payments in the M+C program. Risk adjustment will have the effect of reducing payments to plans because, as a number of studies have shown, relatively healthier Medicare beneficiaries enroll in M+C plans. Projections on reduced payments assume a stable mix of enrollees. However, we assume that organizations will respond appropriately to the incentives to attract more seriously ill beneficiaries. As a result, organizations can do better under risk adjustment than they would if case mix stayed the same.

These M+C payment changes were intended to promote the three objectives which we discuss below in V.B.2, 3 and 4.

2. Promote the Availability of M+C Plans in Lower Payment Areas

The introduction of a ''floor'' on the payment rates for M+C organizations was intended to make the program financially viable in areas where the AAPCC appeared to be too low for any organization to recoup its costs. Beginning in 1998, the floor was set at $367 and was adjusted annually by the rate of growth of the overall Medicare program. By providing this floor payment level, M+C organizations are paid more than would otherwise be spent on the same beneficiaries in original Medicare.

Some county payment rates are raised through implementation of blended payments. These rates are calculated as a blend of national average rates adjusted for local input prices and area-specific rates. Area-specific rates are 1997 payment rates, adjusted for spending for graduate medical education, and updated using the national M+C update factor.

By raising the M+C payment levels higher than the spending amounts in original Medicare, it was hoped that M+C organizations would be attracted to these lower payment areas. In the chart below, we have compared the M+C county payment rates for 2001 to the area-specific rate in each county. In 2001, 3,020 counties will receive a payment rate higher than their area-specific rate. The payment rate for Arthur, Nebraska, will be 77 percent or $175 higher, the greatest improvement for any county.

The payment floor and the phased in blended payments were also designed to raise the payment level for more than just the lowest payment counties. Raising payments above the levels determined by the pre-BBA methodology was intended to give organizations that have operated in lower payment counties the opportunity to enhance their benefit packages, thereby increasing enrollment.

The largest improvements in payments are for areas with relatively small numbers of beneficiaries, and are largely achieved in most cases by applying the payment floor. Many more beneficiaries live in counties where the improvements are more modest (up to a 5 percent difference). These counties were primarily those paid under the blend mechanism in 2000, whose payment improvements were safeguarded by the minimum increase component of the formula for 2001.

Following is a breakout of the 3,147 U.S. counties by percentage improvement over their area specific rate:

TABLE 1.—PERCENT DIFFERENCE BETWEEN M+C PAYMENT RATES AND AREA-SPECIFIC PAYMENT RATES, 2001

Percentage difference	Number of counties	Number of beneficiaries (000s)	Payment is floor	Payment is blend	Payment is minimum increase
Negative	127	1,318	0	0	127
0 to 5	1,000	15,741	0	0	1,000
5 to 10	946	9,848	62	0	884
10 to 20	572	4,133	401	0	171
20 to 30	264	888	264	0	0
30 to 40	131	408	131	0	0
40 to 50	68	142	68	0	0
50 to 60	26	52	26	0	0
60 to 70	9	18	9	0	0
70 to 80	4	5	4	0	0
Total	3,147	32,554	965	0	2,182

Source: HCFA, CHPP.

Counties where M+C payment rates are lower than their area-specific payment rate tend to be those that have received the minimum increase for each of the four years that the M+C payment formula has been in place, and also had relatively little medical education spending. The cumulative four-year increase of the national update was approximately 9.3 percent, only a percentage point higher than the cumulative four-year increase of 8.2 percent for those counties receiving the minimum update each year. The area-specific payment rate in 2001 reflects a reduction to the 1997 rate of 80 percent of spending attributable to medical education. Thus, a county with relatively high medical education spending will have a higher M+C payment rate than area-specific payment rate even if it also had received the minimum update each year.

3. Reduce the Wide Disparities in Payments Between High and Low Payment Areas

By changing how payment rates are calculated, the BBA also sought to even out the wide disparity in Medicare managed care payment rates across

counties, an issue that had been a concern for lower-payment areas. Table 2 shows the percentage of counties that received the floor, a blended rate, or the minimum 2 percent increase for each year calculated using the BBA methodology.

TABLE 2.—PERCENT OF COUNTIES RECEIVING FLOOR, BLEND, OR 2 PERCENT INCREASE

Year	Floor counties (percent)	Blend counties (percent)	2 percent counties (percent)
1998	33.8	00.0	66.2
1999	39.7	00.0	60.3
2000	29.1	63.1	7.8
2001	30.7	00.0	69.3

Source: HCFA, CHPP.

There were only limited payment increases for 1998 and 1999, with counties receiving either the floor payment or the minimum 2 percent update. This was due primarily to the combined effects of the amount of the national update and the budget neutrality provision affecting calculation of the blended rate. In 2000, however, well over half the counties are receiving the blended rate. The enrollment-weighted average increases in M+C payments nationwide in the year 2000 over 1999 is slightly more than 5 percent. For 2001, all counties will receive the floor payment or the minimum 2 percent update, again because of the budget neutrality provision and a national update that reflects the extremely low rate of spending in original Medicare in 1999. Although most counties will receive the minimum increase in 2001, many of these had enjoyed relatively large increases due to the blended rates in 2000, which the minimum increase essentially will preserve.

As illustrated in the graph below (1997 Medicare+Choice Payment Rates Compared with 2001 Payment Rates), the new payment formulas have changed the distribution of payment rates across counties, although perhaps not as quickly as the Congress envisioned because of the unusually low national increases in spending. In 1997, county payment rates for aged beneficiaries ranged from $221 to $767. Through the implementation of the payment floor, blended payment rates, and minimum update, payments have increased substantially at the low end of the distribution, and increases at the high end have slowed. The range of payment rates in 2001 is only somewhat smaller: between $415 and $831, but the 2001 payment curve is straighter than the 1997 curve, indicating a narrower distribution.

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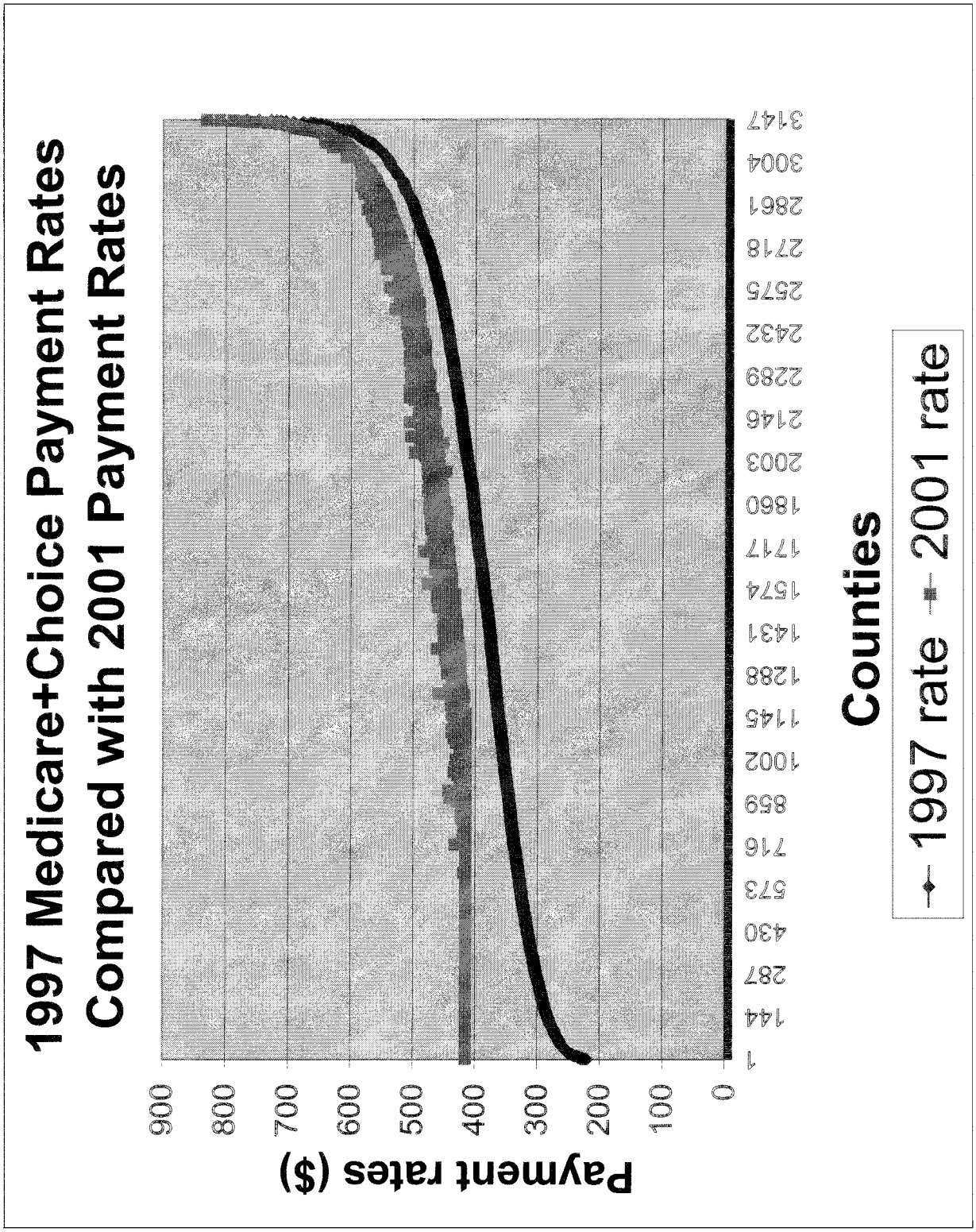

Source: HCFA, CHPP

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While national numbers show the overall pattern, the impact is highlighted when examining the effect of the BBA on the payment rates at the State level. Table 3 shows the effect of the payment changes in two States: Oregon and Florida. Both States have significant M+C enrollment penetration, but Oregon's rates are low, and Florida's are high.

The BBA payment changes have narrowed the regional difference. In 1997, prior to the BBA payment changes, Florida's weighted average payment rates were 149 percent higher than those of Oregon. (Florida's statewide average payments were at 114 percent of the national average, while Oregon's were at 76 percent.) In 2001, Florida's rates will be 136 percent of Oregon's, because many Oregon counties had benefited from blended payment rates in 2000, while many large Florida counties received the minimum update that year.

Lower-paid States such as Oregon receive relatively higher rates of payment increases than higher-paid States such as Florida. These differential payment increases will bring both States' average payments closer to the national average payment rate.

TABLE 3.—COMPARISON OF MEDICARE+CHOICE PAYMENT RATES IN OREGON AND FLORIDA

State	Weighted average payment rate 2001	Weighted average payment increase 97–01 (percent)	Payment rate as a percent of national 1997 (percent)	Payment rate as a percent of national 2001 (percent)
Oregon	$435.25	22.5	76	83
Florida	581.15	9.6	114	111
National	523.85	12.4	100	100

Despite the BBA changes, the levels of benefits and premiums between higher and lower payment counties continue to vary in 2000. In Oregon, for example, premiums range from $35 to $83 for benefit packages that do not include outpatient drug coverage, and between $81 and $123 for packages including drug coverage. In Florida the enrollment-weighted average monthly premium is $84 per month, and all enrollees in Florida M+C plans have drug coverage in their basic package. Over time, the BBA payment changes may narrow this difference.

4. Establish a Fairer Payment System

The BBA mandated that we ''implement a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payment [to M+C organizations] starting no later than January 1, 2000.'' The BBA also gives us the authority to collect inpatient hospital data for discharges occurring on or after July 1, 1997, and allows us to require additional data from M+C organizations for services occurring on or after July 1, 1998.

a. Description of the Inpatient Risk Adjustment Model. In implementing the BBA mandate, we selected the Principal Inpatient Diagnostic Cost Group (PIP–DCG) model as the risk adjustment method to implement in 2000. Under the PIP–DCG model, individuals are assigned to a single PIP–DCG group based on the principal inpatient diagnosis they were assigned during an inpatient stay, that has the greatest future cost implications. The model is prospectively based; in other words, base year inpatient diagnoses are used in the model to predict payment year health expenditures. The model also uses age, sex, original reason for Medicare entitlement (such as age or disability), and entitlement to state payments for Medicaid to derive a predicted expenditure level. This predicted expenditure amount is then converted to beneficiary relative risk factors by dividing an individual's predicted expenditures by the national mean. Because this model was developed and calibrated using a year of inpatient diagnoses, a full year of data is essential for assigning beneficiary risk factors. Beneficiaries ''new'' to Medicare (for whom no prior diagnosis information exists) have their payments based on the average expenditures for their age group. To determine risk adjusted monthly payment amounts for each M+C enrollee, individual risk factors will be multiplied by the appropriate payment rate for their county of enrollment.

We decided to include a transition period as a component of our risk adjustment methodology, initially using a blend of payment amounts under the current demographic system and the PIP–DCG risk adjustment methodology. Under a blend, payment amounts for each enrollee will be separately determined using the demographic and risk methodologies (that is, taking the separate demographic and risk rate books and applying the demographic and risk adjustments, respectively). These payment amounts would then be blended according to the percentages for the transition year. This transition to full risk adjusted payment will be phased in over 5 years. Following is the transition schedule to comprehensive risk adjusted payment as mandated by the BBRA:

Calendar year	Demographic method (percent)	PIP–DCG method (percent)
2000	90	10
2001	90	10
2002	80	20

b. Impact of Risk Adjustment. The impact analysis presented here employs a ''point in time'' approach. To estimate the payment impact of the risk adjustment change, we compared actual demographic-based payments to estimated risk adjusted payments for the exact same enrollees for September 1998. Aggregated to the M+C organization level, the difference in these amounts represents a reasonable estimate of change in payment due to risk adjustment. Projections on reduced payments assume a stable mix of enrollees. However, we assume that organizations will respond appropriately to the incentives to attract more seriously ill beneficiaries. As a result, organizations can do better under risk adjustment than they would if case mix stayed the same.

This analysis uses the best data available at this time. The data to be used for actual payments (beginning January 1, 2000) will be based on hospital discharge data for the calendar year beginning on July 1, 1998 and ending June 30, 1999. The actual impact of the risk adjustment system relative to the current demographic system at the time of implementation may differ, due primarily to potential changes in M+C organization enrollment profiles and possible improvement in the quality and completeness of M+C organization data.

The impacts presented here show estimated figures for both the full effects of the PIP–DCG based payment system (that is, with no transition period), and for the first implementation year during which a 10 percent phase-in was included as part of the methodology. To estimate impacts under phase-in years, full impact results can be multiplied by the appropriate proportion of the risk adjustment payments. For example, the first year risk adjusted payment phase-in level is 10 percent. Therefore, to estimate the impact under a 10 percent risk adjusted phase-in, the impacts can be multiplied by .10.

If our methodology did not include a transition period, payments to M+C organizations would decrease by approximately 5.7 percent. This is a revision over preliminary estimates of 7.6 percent, which were prepared using an earlier, more limited data set. The majority of M+C organizations would face payment decreases of between five and eight percent.

The table below presents the simulated impacts aggregated to our administrative regions. None of our regions will experience increased payments under the proposed system. The variation between regions is not considerable. Organizations in the Atlanta region will see an average .7 percent reduction, and organizations in the Seattle region will see less than a .4 percent reduction.

TABLE 4.—PAYMENT SUMMARY FOR SELECTED M+C ORGANIZATIONS BY HCFA REGION

Region	Enrollees	Percent difference (phase-in)	Percent difference (full impact)
Boston	359,819	−0.55	−5.50
New York	564,252	−0.35	−3.47
Philadelphia	583,740	−0.66	−6.61
Atlanta	895,021	−0.70	−7.00
Chicago	530,558	−0.50	−4.97
Dallas	472,627	−0.69	−6.93
Kansas City	154,223	−0.61	−6.14
Denver	128,069	−0.62	−6.25
San Francisco	1,710,117	−0.57	−5.69
Seattle	282,765	−0.35	−3.45
Total	5,681,191	−0.57	−5.74

In addition, we simulated impacts by M+C organization enrollment size. Table 5 reveals that the variation in impact between the small M+C organizations and the large M+C organizations does not appear to be systematic. M+C organizations of all sizes are very close to the national average, although smaller organizations will experience a slightly higher reduction.

TABLE 5.—PAYMENT SUMMARY FOR SELECTED M+C ORGANIZATIONS BY SIZE OF ENROLLMENT

Enrollment size	Enrollees	Percent difference (phase-in)	Percent difference (full impact)
Less than 500	5,115	−0.71	−7.10
500–2,999	88,594	−0.81	−8.10
3,000–4,999	993,829	−0.69	−6.87
5,000–9,999	354,271	−0.62	−6.22
10,000–24,999	1,177,118	−0.58	−5.79
25,000–49,999	1,029,859	−0.54	−5.41
50,000–99,999	1,471,009	−0.52	−5.23
100,000 or more	1,455,843	−0.61	−6.09
Total	5,681,843	−0.57	−5.74

5. M+C Organization Withdrawals

At the end of 1998, approximately 100 organizations dropped Medicare managed care contracts or reduced the number of counties in which a plan was offered. The result of these withdrawals was that nearly 50,000 beneficiaries were left with no remaining M+C plan in their county. Likewise, the analysis of 1999 health plan departures shows that approximately 79,000 additional M+C beneficiaries were forced to leave the program because there was no plan offered in their area.

Table 6 below shows the decline in beneficiaries' access to a M+C plan in their area (declining about 2 percentage points from the 1999 level of almost 70 percent).

TABLE 6.—PERCENT OF BENEFICIARIES WITH ACCESS TO M+C PLANS

1999			2000		
Urban	Rural	Total	Urban	Rural	Total
84.2	22.5	69.7	82.0	20.8	67.7

Of the 71 counties that had an M+C plan in 1999 but will no longer have an M+C option in 2000, 11 were considered high payment counties. In fact, the average increase in 2000 for these 71 counties is 6.2 percent. The county in this situation with the greatest increase was Clallum County, in Washington State, which received a blended rate increase of 12.8 percent over their 1999 rate.

Plan decisions to withdraw from M+C do not appear to be caused only by changes in payment amounts. Payment is rising in all counties this coming year by an average of 5 percent, and will rise by as much as 18 percent in some areas. BBA payment reforms were designed to increase payment in counties that had the lowest rates, and therefore the fewest number of plans. Yet counties receiving the largest increases under the BBA payment system are experiencing the most disruption. Plan withdrawals are affecting 11.1 percent of enrollees in counties where rates are rising by 10 percent, but affecting only 2.3 percent of enrollees where rates are rising by just 2 percent.

Table 7 shows the States with the largest percentage decrease since 1997 (the start of the M+C program) of Medicare beneficiaries with access to an M+C plan.

TABLE 7.—STATES WITH LARGEST PERCENT DECREASE IN ACCESS TO M+C OPTION IN 2000 FROM 1997

State	Total Medicare population	Decrease in beneficiaries	Percent decrease in beneficiaries
Utah	207,838	183,541	88
Louisiana	621,826	175,645	28
Virginia	894,573	246,274	28
New Hampshire	172,069	45,627	27
South Carolina	575,890	130,118	23
Maryland	652,599	119,392	18

While several States have experienced a significant loss of access to M+C plans, other States have seen access to M+C organizations increase. In addition, the M+C program continues to grow despite challenges that parallel those in the larger managed care market in the United States. As of January 2000, there were 6.2 million M+C enrollees representing over 16 percent of the more than 39 million seniors and disabled Americans in Medicare. Total Medicare managed care enrollment has more than doubled in the past four years from 3.1 million enrollees at the end of 1995 to 6.9 million enrollees as of April 1, 2000. (Total managed care enrollees consist of M+C enrollees and enrollees in Medicare Managed Care Cost Plans, Health Care Prepayment Plans, and managed care demonstrations.) However, the rate of growth has dropped significantly from earlier periods, and has grown by only 1 percent per month the last several months.

Table 8 below shows the States with the largest percentage increase since 1997 (the start of the M+C program) of Medicare beneficiaries with access to an M+C plan.

TABLE 8.—STATES WITH LARGEST PERCENT INCREASE IN ACCESS TO M+C OPTION IN 2000 FROM 1997

State	Total Medicare population	Increase in beneficiaries	Percent increase in beneficiaries
Maine	219,944	138,067	63
Iowa	488,180	171,017	62
South Dakota	122,220	118,493	29
Oklahoma	519,239	114,185	24
West Virginia	345,587	65,794	20
North Carolina	1,149,374	54,040	18

6. Premium Increases

In our Impact Analysis that accompanied the Interim Final Rule we stated that ''Reductions in capitated payment amounts in what are now relatively higher payment areas may result in reduced benefits for beneficiaries.'' While higher premiums and reduced benefits were not intended effects of the BBA, they are also not surprising given the reduced payment increases in higher cost areas. While benefits, premiums, and cost sharing remained relatively stable in 1999, year 2000 has been different.

Analysis of the Adjusted Community Rate proposals submitted in July show that premiums for 2000 have increased, especially in rural areas. For example, in 1999, the enrollment-weighted average premium for a basic plan was $5.35. For 2000, this amount will almost triple to $15.84.

Table 9 shows the percent of M+C beneficiaries living in the designated areas that have access to a plan with the associated premium. While the percent of beneficiaries with access to zero dollar premium plans is expected to be reduced by more than 3 percentage points, the percent of beneficiaries that must pay a $40–$100 premium has more than doubled. In 1999, only 50,000 Medicare beneficiaries lived in an area where the minimum premium is in the $80 to $100 range; however, in 2000, the number will rise to 207,000. The majority of these individuals (60 percent) are residents of rural counties.

TABLE 9.—PERCENT OF BENEFICIARIES LIVING IN DESIGNATED AREAS HAVING ACCESS TO AN M+C PLAN WITH ASSOCIATED PREMIUM 1999

Premium amount	1999			2000			Total percent change
	Urban (percent)	Rural (percent)	Total (percent)	Urban (percent)	Rural (percent)	Total (percent)	
$0	79	63	78	78	40	75	−3
$0.01–$19.99	1	2	2	3	11	4	2
$20.00–$39.99	5	14	5	9	18	9	4
$40.00–$59.99	4	11	5	6	17	6	2
$60.00–$79.99	1	8	2	1	7	2	0
$80.00–$99.99	0	0	0	0	0	1	1

In addition, access to a zero premium plan for rural beneficiaries will be reduced by almost 50 percent. In 1999, 1.3 million rural beneficiaries (63 percent of those with any plan available) live in an area with at least one zero premium plan; in 2000, only 784,000 rural beneficiaries, (40 percent of those with any plan available), will have such an option. One-half million fewer rural beneficiaries will have access to a zero premium plan.

7. Premiums in Areas With Only One Plan

Medicare beneficiaries who live in areas with only one plan will be particularly affected by premium increases. Approximately 8 percent of M+C beneficiaries (just over three million) live in areas with only one plan. Note also in Table 10 that of the 207,000 beneficiaries who live in areas where the minimum monthly premium available is over $80, 94 percent (over 195,000) live in areas with only one plan available. There will be a nearly six-fold increase from 1.6 percent to 9.3 percent in the percentage of beneficiaries who live in an area where the sole M+C plan available has a monthly premium in the $80 to $100 range.

TABLE 10.—MEDICARE BENEFICIARY POPULATION (TOTAL), ACCESS TO ONLY ONE PLAN

Minimum premium	Year 1999		Year 2000	
	Beneficiaries	Percent	Beneficiaries	Percent
Zero	803,162	31.6	599,553	28.4
$0.01–$19.99	17,614	0.7	0	0.0
$20.00–$39.99	467,284	18.4	410,662	19.5
$40.00–$59.99	716,662	28.2	683,029	32.4
$60.00–$79.99	499,095	19.6	220,237	10.4
$80.00–$99.99	39,742	1.6	195,432	9.3
Total	2,543,559	100	2,108,913	100

Premium increases in areas with only one plan will have the most pronounced impact in rural areas. From 1999 to 2000, roughly the same percentage of beneficiaries who live in rural areas will have only one plan available—28.4 percent and 29.6 percent in each year, respectively. However, Table 11 shows that zero premium plans are becoming less widely available in rural areas. It also shows that there will be a significant increase in the number of rural Medicare beneficiaries whose only M+C option is a relatively high cost plan.

TABLE 11.—MEDICARE BENEFICIARY POPULATION (RURAL ONLY) ACCESS TO ONLY ONE PLAN

Minimum premium	Year 1999		Year 2000	
	Beneficiaries	Percent	Beneficiaries	Percent
Zero	271,833	37.7	174,956	28.1
$0.01–$19.99	17,614	2.4		0.0
$20.00–$39.99	96,131	13.3	104,796	16.8
$40.00–$59.99	135,440	18.8	146,425	23.5
$60.00–$79.99	160,647	22.3	81,774	13.1
$80.00–$99.99	39,742	5.5	115,669	18.5
Total	721,407	100	623,620	100

8. Impact of BBRA

The Balanced Budget Refinement Act (BBRA) made two changes to the payment methodology established by the BBA. First, Section 512 of the BBRA introduced bonus payments for M+C organizations that enter previously unserved counties. These organizations will receive an additional 5 percent payment for the first 12 months and an additional 3 percent for the subsequent 12 months. The second change in section 517 of the BBRA was to lower the reduction in the National per Capita Medicare +Choice Growth percentage

from a 5 percent reduction to a 3 percent reduction in calculating the 2002 payment rates.

The Congressional Budget Office (CBO) estimated that the bonus payments would amount to additional payments of $.1 billion over three years. Our experience to date suggests that this figure may be high, as currently there are only five M+C organizations receiving bonus payments and very few pending applications from prospective M+C organizations that would be eligible for the bonus. However, there is an application on file from a prospective M+C organization that envisions expanding into a large number of previously unserved counties. If this organization is extremely successful in enrolling beneficiaries, the CBO estimate could in fact be a low estimate.

We estimate that lowering the reduction of the National per Capita Medicare+Choice Growth percentage in the year 2002 will provide an additional $80 million in payments to plans in 2002, and an additional $560 million over 5 years. Payments to plans in all subsequent years will be higher because of the effect of lowering the reduction on the baseline.

C. Response to Comments on Interim Final Rule

Since the publication of our June 26, 1998 interim final rule, we have implemented several significant changes aimed at alleviating unnecessary administrative burdens. Examples of these changes include the less expansive provider participation requirements adopted in our February 17, 1999 rule, our December 1998 revisions to the QISMC standards as discussed below, and clarification of the attestation requirements through this final rule. Clearly the cumulative effect of these changes will be to reduce the administrative costs associated with these requirements. Although we continue to solicit quantifiable data that can help us to assess the costs of complying with particular provisions, we have not received any data in this regard. We remain particularly interested in detailed estimates of the administrative costs associated with the QISMC and HEDIS standards. Research of available literature/studies related to these administrative costs is presented below.

1. Quality Standards

The BBA codified many existing quality assurance requirements that had been established through operational policy letters and other guidance issued under the Medicare risk and cost contracting programs.

On September 28, 1998, we issued interim Quality Improvement Systems for Managed Care (QISMC) standards and guidance. QISMC is a system for ensuring that managed care organizations contracting with Medicare and Medicaid protect and improve the health and satisfaction of enrolled beneficiaries. It consists of a set of standards and guidelines developed around four domains—quality assessment and performance improvement, enrollee rights, health services management, and delegation.

QISMC was developed in conjunction with federal and state officials, beneficiary advocates and the managed care industry to develop a coordinated quality oversight system to reduce duplicative or conflicting efforts, emphasize demonstrable and measurable improvement, and avoid reinventing the wheel. QISMC standards represent the evolution of existing quality standards being used by commercial, Medicare and Medicaid health plans or managed care organizations. We believe QISMC incorporates the currently accepted quality assurance elements and provides safeguards for vulnerable Medicare and Medicaid populations enrolled in managed care.

We reviewed NCQA accreditation 1999 standards for their consistency with QISMC standards. This is an appropriate comparison because the National Committee for Quality Assurance has been recognized as a forerunner in assuring quality assurance in health plans through its accreditation processes, and development and implementation of HEDIS performance data reporting. Also, many Medicare+Choice organizations are NCQA accredited.

Our findings are provided in the table below, which was reviewed by NCQA representatives in order to assure the highest level of technical accuracy. In general, almost two-thirds of NCQA accreditation 1999 standards were determined to be either consistent with variation or highly consistent or identical to QISMC standards.

TABLE 12

[In percent]

NCQA 1999	Overall	Domain 1	Domain 2	Domain 3	Domain 4
		Quality assessment and performance improvement	Enrollee rights	Health services management	Delegation
Substantially Greater Than QISMC	12	4	11	17	.....
Consistent with QISMC	62	65	68	53	100
Substantially Fewer Requirements	26	30	21	29	.....

Beneficiaries will benefit significantly from information available to them about the performance of their health plans as well as through improvements in the delivery of care and services that evolve out of on-going quality improvement projects under QISMC. Beneficiaries already have access to health plan performance and consumer satisfaction measures about the M+C organizations available in their area through our beneficiary education campaign and individual plan marketing.

We expect that as consumers become increasingly familiar with health plan performance and consumer satisfaction information, it will become an integral part of their decision-making process, in addition to cost and benefits, for selecting their M+C organization. It is our intent that as consumers become better informed and decide not to select plans of lower quality, such plans will be motivated to initiate improvements in the quality of care they provide.

At the same time, we expect that plan's focus on one national and one plan-specific quality assessment and performance improvement project each year will improve the delivery of services to Medicare beneficiaries, especially beneficiaries suffering from chronic conditions. M+C organizations will need to be proactive in identifying and treating beneficiaries who suffer

from medical conditions which are the focus of their quality assessment and performance improvement projects in addition to their HEDIS measures. This will ultimately lead to improved care and services for Medicare beneficiaries through the institutionalization of these practices.

a. QISMC Compliance. Purchaser demands have driven many managed care organizations to become NCQA accredited, implement quality measurement and performance improvement strategies, and report performance and satisfaction data. This has resulted in many managed care organizations becoming NCQA accredited, especially on the east and west coasts. We estimate that the cost of becoming NCQA accredited ranges between $300,000–$500,000.

We do not believe that QISMC will present significant additional fixed costs for M+C organizations that have already received accreditation from the National Committee for Quality Assurance. While QISMC presents some subtle and significant differences from NCQA accreditation, we do not expect that organizations that have prepared for NCQA accreditation will incur significant additional costs to comply with QISMC. We recognize that there will be incremental costs associated with QISMC, such as costs associated with additional quality assessment and performance improvement projects, internal staff training expenses, and oversight and compliance.

In addition, we expect that some M+C organizations that are not NCQA accredited may incur higher costs to comply with QISMC than organizations in other parts of the country.

b. HEDIS Reporting. Since 1997, we have required M+C organizations to report HEDIS and consumer satisfaction data. Beginning in 1998, we required M+C organizations to begin reporting audited HEDIS data as a result of inconsistencies in HEDIS reporting.

We do not expect that requirements for reporting HEDIS and consumer satisfaction measures are inconsistent with expectations that private purchasers have access to health plan performance data (GAO, June 1998). As a result, we do not expect that organizations will incur significant new fixed costs as a result of requirements to report performance measurement and consumer satisfaction data, since we expect that M+C organizations will use audited HEDIS data. However, we do recognize that there may be incremental costs to reporting audited HEDIS data in terms of additional processes, audit fees, etc.

In addition, requirements for M+C organizations to report audit HEDIS data will likely yield improved processes for collecting and reporting complete, accurate and timely data as a result of an independent third party review of their data collection, warehousing and production/reporting processes.

c. Quality Assessment and Performance Improvement Projects. We recognize that a significant difference between QISMC and NCQA accreditation 1999 is that QISMC is much more prescriptive in defining the type, scope and measurement of quality assessment and performance improvement projects. In response to industry concerns, we have reduced the number and delayed the timeframe for implementing quality assessment and performance improvement projects.

At the same time, specifying beginning and ending dates for QAPIs will ensure that plans do not become mired in projects that do not end. We expect that plans will focus their efforts on achieving results and institutionalizing improvements in the delivery of care, data collection and reporting and information system improvements gained from successful QAPI projects. Even in instances where demonstrable improvements were not obtained, we expect that, in many cases, some improvement will result.

In addition, plans will have added incentives to initiate performance improvement projects that will lead to more cost-effective delivery of health care services, such as influenza immunization. For example, one national managed care organization increased the percentage of Medicare enrollees receiving flu shots from 27 percent to 55 percent in one year. The organization reported a reduction of about 30 percent in hospital admissions for pneumonia, savings of about $700,000, and fewer lives lost. (GAO, May 1996) We expect that investments in QAPI activities will lead to cost-savings over and above the initial investment.

We recognize that some high-performing managed care organizations will have less ability to achieve additional improvements in some areas. Some organizations will respond to incentives to select projects where results may be more easily obtainable. We continue to believe, however, that there are significant gains that remain to be made in the delivery of quality services.

We concur with industry comments that small plans may have difficulty in complying, since they may not have a statistically credible population for producing reliable and/or comparable measures. For example, a small plan with a healthier population than average may not have sufficient instances of myocardial infarction for which beta-blocker treatment would be appropriate. We will work with these organizations to address these and other unique issues that may arise.

We believe that requiring plans to participate in at least one national and one plan-specific QAPI project annually and to demonstrate a 10 percent improvement in their QAPI is in the best interest of beneficiaries. These requirements will improve the quality of care and services delivered to Medicare and other populations served by the M+C organization, as performance improvement practices become routine.

d. Deeming. To avoid duplication of effort and unnecessary administrative burdens with respect to internal quality assurance requirements, we are recognizing accrediting by national, private accrediting organizations that we determine to be consistent with our QA requirements. We believe that this will significantly benefit a significant portion of M+C organizations that are already accredited, reducing costs, capitalizing on efficiencies, and avoiding duplicative processes.

2. Provider Procedures

Much less information is available about other requirements cited by some commenters as entailing significant administrative burdens. For example, we received many public comments regarding provider participation requirements. We responded to many of those comments in our February 17, 1999, final rule (64 FR 7968), under which we narrowed many of the requirements set forth in our June 26, 1998 interim final rule (63 FR 34968). Modifications to the interim final rule included:

- Applying the applicable notice and appeal rights and consultation requirements only to physicians, as defined under section 1861 of the Act;
- Adopting a narrower interpretation of what constitute ''rules regarding participation'' to focus on whether a physician can participate under a given M+C plan;
- Clarifying that an M+C organization need only have reasonable procedures for notifying potential participating physicians of participation rules, which may include providing the information upon request;
- Clarifying that an M+C organization is not required to release information that an organization considers proprietary information;
- Clarifying that in the event that immediate changes are mandated

through Federal law or regulation, an organization should be exempt from the requirement that written notice be provided before the changes are put into effect;

- Clarifying that there is no requirement that an organization obtain signatures acknowledging receipt of a notice of changes;
- Limiting the applicability of the appeals process to appealing adverse participation decisions;
- Clarifying that the availability of the provider appeals process applies only to cases involving suspension or termination of participation privileges, rather than including initial denials of an application to participate; and
- Clarifying that the information to be included in a notification of a decision to suspend or terminate an agreement with a physician is limited to information relevant to the decision.

Since publication of our February 17, 1999 final rule, we have subsequently communicated with several M+C organizations about the costs and benefits associated with the requirements included in this final rule. We believe that the steps taken in our February 17, 1999 final rule significantly reduced the burden on M+C organizations and also ensured that providers and beneficiaries receive the protections intended by Congress under the Act. For example, by narrowing the scope of the requirement for advance notice of changes in participation rules, an M+C organization need not prepare an advance notice for administrative and other changes that do not affect whether a physician can participate in a plan. Notification of most changes made by a M+C organization can be made via usual communication methods, such as regular newsletters, rather than through the preparation of special mailings or other more burdensome methods.

In addition, the M+C organization must consult with the physicians who have agreed to provide services under the M+C plan offered by the organization, regarding the organization's medical policy, quality assurance program, and medical management procedures, and ensure that the following standards are met. We understand that these requirements are consistent with current operational practices by M+C organizations and pose little additional burden, and that the costs associated with incremental changes would be marginal.

We also understand that our requirements concerning credentialing processes and prohibitions on discrimination reflect current practices and similar requirements from other entities (for example, accrediting bodies) and do not impose additional burden.

3. Attestation Requirements

Similarly, commenters objected to attestation requirements as discussed in detail above (See Subpart K). To receive a monthly payment under subpart F, the chief executive officer (CEO) or chief financial officer (CFO) of a M+C organization must request payment under the contract on a document that certifies the accuracy, completeness, and truthfulness of relevant data that we request. Such data include specified enrollment information, encounter data, and other information that we may specify. The CEO or CFO must certify that each enrollee for whom the organization is requesting payment is validly enrolled in an M+C plan offered by the organization, and the information relied upon by us in determining payment is accurate. The CEO or CFO must certify that the encounter data it submits under § 422.257 are accurate, complete, and truthful. If such encounter data are generated by a related entity, contractor, or subcontractor of an M+C organization, such entity, contractor, or subcontractor must similarly certify the accuracy, completeness, and truthfulness of the data. In addition, the M+C organization must certify that the information in its ACR submission is accurate and fully conforms to the requirements in § 422.310 in order to retain payment amounts below the amount of its ACR.

We understand that the collection and dissemination of this information by M+C organizations is undertaken in a manner that reflects an M+C organization's best efforts to ensure its accuracy, completeness, and truthfulness. Accordingly, we do not believe that this requirement imposes significant new burdens on an M+C organization that operates in good faith to comply with requirements under the M+C program. We realize that mistakes and errors may occur even under an organization's best efforts, and these attestation requirements are not intended to penalize an M+C organization that operates in good faith. We believe these requirements are important to safeguard the integrity of the M+C program against those few M+C organizations that do not utilize the kind of business and operational practices of most M+C organizations. We also believe the requirements will provide an important tool for seeking out the few bad actors that could harm the M+C program, beneficiaries, providers, and other M+C organizations. As suggested by many commenters, we have revised the requirements to establish a ''good faith'' compliance standard as opposed to requiring an attestation of 100 percent accuracy for encounters and enrollment (payment related) data. We believe this change should alleviate commenters concerns over the undue financial burdens associated with attestation requirements.

VI. Other Required Information

A. Federalism Summary Impact Statement

On August 4, 1999, the president signed Executive Order 13132 (effective November 2, 1999) establishing certain requirements that an agency must meet when it promulgates regulations that impose substantial direct compliance costs on State and local governments, preempt State law, or otherwise have federalism implications. Any such regulations must include a federalism summary impact statement that describes the agency's consultation with State and local officials and summarizes the nature of their concerns, the extent to which these concerns have been met, and the agency's position supporting the need to issue the regulation.

In this final rule, we are not promulgating any changes to the existing M+C regulations that meet any of the criteria mentioned above that would require the inclusion of a federalism impact statement under Executive Order 13132. However, the M+C interim final rule published on June 26, 1998 (63 FR 34968) did contain provisions that have a federalism impact, and we respond to comments on these provisions from States and other interested parties in this rule. Thus, in keeping with the intent of the Executive Order that we closely examine any policies that have federalism implications or would limit the policy making discretion of the States, we have prepared the following voluntary federalism impact statement.

In establishing the M+C program, the BBA included two provisions that have significant implications for States. First, under section 1855(a)(1) of the Act, an organization that wishes to participate in the M+C program generally is required to be organized and licensed under State law as a risk-bearing entity eligible to offer health benefits coverage in each State in which it offers an M+C plan. This statutory requirement is codified at § 422.400(a) and § 422.501(b)(1) of the M+C regulations, and we do not believe it interferes with State functions or limits their policy making discretion. The requirement does not imposes any significant

additional burdens on States, who for are already carrying out this licensing function. We received no comments from States on this provision.

The other aspect of the M+C statute and regulations that has significant federalism implications involves the Federal preemption provisions set forth under section 1856(b) of the Act and § 422.402. Section 1856(b)(3)(A) provides for Federal preemption of State laws, regulations, and standards affecting any M+C standard if the state provisions are inconsistent with Federal standards. As discussed in the preamble to the interim final rule (63 FR 35012), and in section II.I of this preamble, we are applying this ''general preemption'' in much the same way that we previously applied Executive Order 12612 on Federalism. That is, State laws or standards that are more strict than the M+C standards would not be preempted unless they prevented compliance with the M+C requirements.

In addition to this general preemption, the Congress also provided (under section 1856(b)(3)(B) for a ''specific preemption'' whereby M+C standards supersede any State laws and standards in the following three areas:

- Benefit requirements;
- Requirements relating to the inclusion or treatment of providers; and
- Coverage determinations (including related appeals and grievance processes).

During the development of the June 26, 1998 interim final rule, we consulted with the National Association of Insurance Commissioners (NAIC) regarding the proper interpretation of these provisions. (The NAIC is the organization of the chief insurance regulators from the 50 states, the District of Columbia, and four U.S. territories.) The interim final rule contained an extensive discussion of this subject, including providing examples both of State laws that would be preempted under the M+C statue (such as ''any willing provider laws'' that would mandate the inclusion of specific types of providers or practitioners) and of State requirements that would continue to apply (such as a requirement that all providers and practitioners be licensed by the State and comply with scope of practice laws). We asserted our intention to adopt a narrow interpretation of the applicability of the three areas of specific preemption in order to ensure that any regulatory preemption of State law would be restricted to the minimum level necessary consistent with the BBA. State and local officials then had an opportunity to participate in the rulemaking process through their public comments on the M+C interim final rule.

For the most part, commenters representing State governments supported HCFA's narrow interpretation of the BBA's specific preemption provisions. (See section II.I of this final rule for a full discussion of comments on these provisions.) The most notable exception to this general support was the contention by one State that its mandatory drug benefit laws should not be preempted by the M+C benefit provisions; but we continue to believe that the specific preemption of ''benefit requirements'' under section 1856(b)(3)(B) of the Act clearly contradicts the State's contention. Moreover, we believe that our general approach is fully consistent with the ''Special Requirements for Preemption'' set forth in section 4 of Executive Order 13132. This section directs that an agency take action to preempt State law only where the exercise of State authority directly conflicts with the exercise of Federal authority under Federal law or there is other clear evidence (such as an express statutory preemption provision) to conclude that Congress intended the agency to have the authority to preempt State law. It also provides that any regulatory preemption of State law be restricted to the minimum level necessary to achieve the objectives of the relevant statute. In conclusion, we believe that the concerns of State and local officials have been met to the greatest possible extent, consistent with the BBA's preemption provisions.

B. Waiver of Notice of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to afford a period for public comments before issuing a regulation in final form. However, we may waive that procedure if we find good cause that prior notice and comment are impractical, unnecessary, or contrary to the public interest. In addition, section 1871(b)(2)(B) of the Act provides that a notice of proposed rulemaking is not required if a statute establishes a specific deadline for implementation of a provision that is less than 150 days after the enactment of the statute in which the deadline is contained. Finally, Congress provides in certain cases by statute for the publication of a final rule without prior notice and comment.

For the most part, the changes to the M+C regulations set forth in this final rule with comment period result from our review of the public comments on the June 26, 1998 interim final rule that established the M+C program. Congress expressly authorized the publication of that final rule without prior notice and comment in section 1856(b)(1) of the Act. To the extent the provisions of this final rule respond to comments on that rule, they will have been subjected to prior notice and comment. However, as discussed in detail in section I.C of this preamble, this rule also makes conforming revisions to the regulations that are necessary to reflect changes to the M+C statute resulting from the BBRA (Pub. L. 106–113) which was enacted on November 29, 1999. These changes in requirements and new requirements or provisions were enacted by Congress, and would be in effect without regard to whether they are reflected in conforming changes to the regulations text, since a statute controls over a regulation. In this final rule, we merely have revised the regulations text to reflect these new statutory provisions, as we interpret them. In most cases, the BBRA provisions have merely been incorporated virtually verbatim, with no interpretation necessary. Examples of such provisions include: the earlier availability of alternative Medicare enrollment options and the elimination of the lock-in rules for institutionalized individuals under section 501 of the BBRA, changes in the effective date of elections under section 502, the extension of Medicare cost contracts under section 503, the modification of the 5-year re-entry rule after contract terminations under section 513, flexibility to tailor benefits under an M+C plan under section 515, the delay until July 1 in the deadline for ACR submissions under section 516, the reduction in the adjustment in the national per capita M+C growth percentage under section 517, the new deeming provisions in section 518, the revised quality assurance requirements for PPOs under section 520, and the user fee provisions in section 522. For these types of provisions, we do not believe that publishing a notice a proposed rulemaking is necessary, nor would it be practical given that a number of the provisions have already taken effect consistent with effective dates established under the BBRA. (For example, the changes in the effective date of elections and the new quality assurance requirements for PPOs took effect on January 1, 2000, and several other provisions were effective upon enactment of the BBRA.) In addition, we believe that it would be contrary to the public interest to delay implementation of these provisions until the process of publishing both a proposed and a final

rule could be completed. Finally, we note that the BBRA was enacted on November 29, 1999; thus publication of a notice of proposed rulemaking is not required under section 1871(b) of the Act before implementing any new statutory provisions that took effect upon enactment or on January 1, 2000. Thus, we find good cause to waive proposed rulemaking for these provisions. We are, however, providing a 60-day period for public comment on those provisions.

In the case of two BBRA provisions, we have reflected our interpretation of the provisions in the regulations text. This interpretation is already in effect, and has been applied, as the provisions in question are already in effect. These provisions are section 501(c) of the BBRA, which permits an M+C organization that has reduced a plan service area to offer continued enrollment to current enrollees in all or a portion of the reduced areas, and section 512 that introduces ''bonus payments'' to encourage organizations to offer M+C plans in areas without such plans. Both of these provisions are discussed in detail in section I.C of this preamble, and both required a limited amount of interpretation of the statute in order to implement the provisions on a timely basis. For example, with regard to the continuation of enrollment option (which was effective upon enactment of the BBRA), we have clarified that an M+C organization may offer enrollment in any plan it offers in the affected area, rather than solely the plan in which an individual was previously enrolled. This clarification results in greater flexibility for M+C enrollees and is consistent with our interpretation of a similar statutory provision affecting individuals with ESRD. Similarly, with regard to the bonus payment provisions (which took effect as of January 1, 2000), we have indicated that if an M+C organization or organizations offers two or more new plans simultaneously in a given area, the organization could receive the bonus payments for each new plan. We believe this interpretation of the statute clearly is consistent with legislative intent to promote the availability of more M+C alternatives for Medicare beneficiaries.

Policy clarifications of this limited nature were essential to implement these BBRA provisions in a clear and timely manner. Again, it would have been impractical and contrary to the public interest to proceed with proposed rulemaking before implementing the interpretive policies linked with these provisions, nor is such rulemaking required under section 1871(b) of the Act. Thus, we believe that the ''good cause'' exemption to notice and comment rulemaking is equally applicable for these BBRA provisions as for the others discussed above, and the same 60-day period for public comment applies.

C. Responses to Comments

As discussed above, a limited number of the provisions set forth in this final rule are subject to a 60-day comment period. Because of the large number of items of correspondence we normally receive on a rule, we are not able to acknowledge or respond to them individually. We will, however, consider all comments that we receive by the date specified in the **DATES** section of this preamble and, if we proceed with subsequent rulemaking, we will respond to the comments in that document.

List of Subjects

42 CFR Part 417

Administrative practice and procedure, Grant programs-health, Health care, health facilities, Health insurance, Health maintenance organizations (HMO), Loan programs-health, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 422

Administrative practice and procedure, Health facilities, Health maintenance organizations (HMO), Medicare+Choice, Penalties, Privacy, Provider-sponsored organizations (PSO), Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, HCFA amends 42 CFR chapter IV as set forth below:

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

1. The authority citation for part 417 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), secs. 1301, 1306, and 1310 of the Public Health Service Act (2 U.S.C. 300e, 300e–5, 300e–9), and 31 U.S.C. 9701.

2. Revise § 417.402(b) to read as follows:

§ 417.402 Effective date of initial regulations.

* * * * *

(b) The changes made to section 1876 of the Act by section 4002 of the Balanced Budget Act (BBA) of 1997 are incorporated in section 422 except for 1876 cost contracts. Upon enactment of the BBA (August 5, 1997) no new cost contracts or service area expansions are accepted by HCFA except for current Health Care Prepayment Plans that may convert to 1876 cost contracts. Also, 1876 cost contracts may not be extended or renewed beyond December 31, 2004.

PART 422—MEDICARE+CHOICE PROGRAM

1. The authority citation for part 422 continues to read as follows:

Authority: Secs. 1102, 1851 through 1857, 1859, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395w–21 through 1395w–27, and 1395hh).

2. Section 422.2 is amended by:

A. Revising the definitions of ''Basic benefits,'' ''Benefits,'' ''M+C plan,'' ''Mandatory supplemental benefits,'' ''Optional supplemental benefits,'' ''Religious and fraternal (RFB) society,'' ''RFB plan,'' and ''Service area.''

B. Adding the definition of ''National coverage determination.''

C. Removing the definitions of ''Emergency medical condition,'' ''Emergency services,'' and ''Urgently needed services.''

§ 422.2 Definitions.

* * * * *

Basic benefits means all Medicare-covered benefits (except hospice services) and additional benefits.

Benefits are health care services that are intended to maintain or improve the health status of enrollees, for which the M+C organization incurs a cost or liability under an M+C plan (not solely an administrative processing cost). Benefits are submitted and approved through the ACR process.

* * * * *

M+C plan means health benefits coverage offered under a policy or contract by an M+C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M+C plan (or in individual segments of a service area, under § 422.304(b)(2)).

* * * * *

Mandatory supplemental benefits are health services not covered by Medicare that an M+C enrollee must purchase as part of an M+C plan that are paid for in full, directly by (or on behalf of) Medicare enrollees, in the form of premiums or cost-sharing.

* * * * *

National coverage determination (NCD) means a national policy determination regarding the coverage status of a particular service that HCFA makes under section 1862(a)(1) of the

Act, and publishes as a **Federal Register** notice or HCFA ruling. (The term does not include coverage changes mandated by statute.)

* * * * *

Optional supplemental benefits are health services not covered by Medicare that are purchased at the option of the M+C enrollee and paid for in full, directly by (or on behalf of) the Medicare enrollee, in the form of premiums or cost-sharing. These services may be grouped or offered individually.

* * * * *

Religious and fraternal benefit (RFB) society means an organization that—

(1) Is described in section 501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of that Act; and

(2) Is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches.

RFB plan means an M+C plan that is offered by an RFB society.

Service area means a geographic area approved by HCFA within which an M+C-eligible individual may enroll in a particular M+C plan offered by an M+C organization. Each M+C plan must be available to all M+C-eligible individuals within the plan's service area. In deciding whether to approve an M+C plan's proposed service area, HCFA considers the following criteria:

(1) Whether the area meets the ''county integrity rule'' that a service area generally consists of a full county or counties. However, HCFA may approve a service area that includes a portion of a county if it determines that the ''partial county'' area is necessary, nondiscriminatory, and in the best interests of the beneficiaries.

(2) The extent to which the proposed services area mirrors service areas of existing commercial health care plans or M+C plans offered by the organization.

(3) For M+C coordinated care plans and network M+C MSA plans, whether the contracting provider network meets the access and availability standards set forth in § 422.112. Although not all contracting providers must be located within the plan's service area, HCFA must determine that all services covered under the plan are accessible from the service area.

(4) For non-network M+C MSA plans, HCFA may approve single county non-network M+C MSA plans even if the M+C organization's commercial plans have multiple county service areas.

3. In § 422.4, revise paragraph (a)(1)(iii) and add a new paragraph (a)(1)(iv), to read as follows:

§ 422.4 Types of M+C plans.

(a) * * *

(1) * * *

(iii) Coordinated care plans include plans offered by health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs) as specified in paragraph (a)(1)(iv) of this section, RFBs, and other network plans (except network MSA plans).

(iv) A PPO plan is a plan that has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers; and is offered by an organization that is not licensed or organized under State law as an HMO.

* * * * *

4. Revise § 422.8 to read as follows:

§ 422.8 Evaluation and determination procedures.

(a) *Basis for evaluation and determination.* (1) HCFA evaluates an application for an M+C contract on the basis of information contained in the application itself and any additional information that HCFA obtains through on-site visits, public hearings, and any other appropriate procedures.

(2) If the application is incomplete, HCFA notifies the contract applicant and allows 60 days from the date of the notice for the contract applicant to furnish the missing information.

(3) After evaluating all relevant information, HCFA determines whether the contract applicant's application meets the applicable requirements of § 422.6.

(b) *Use of information from a prior contracting period.* If an M+C organization, HMO, competitive medical plan, or health care prepayment plan has failed to comply with the terms of a previous year's contract with HCFA under title XVIII of the Act, or has failed to complete a corrective action plan during the term of the contract, HCFA may deny an application from a contract applicant based on the contract applicant's failure to comply with that prior contract with HCFA even if the contract applicant meets all of the current requirements.

(c) *Notice of determination.* HCFA notifies each applicant that applies for an M+C contract under this part of its determination and the basis for the determination. The determination may be approval, intent to deny, or denial.

(d) *Approval of application.* If HCFA approves the application, it gives written notice to the contract applicant, indicating that it meets the requirements for an M+C contract.

(e) *Intent to deny.* (1) If HCFA finds that the contract applicant does not appear to meet the requirements for an M+C organization and appears to be able to meet those requirements within 60 days, HCFA gives the contract applicant notice of intent to deny the application for an M+C contract and a summary of the basis for this preliminary finding.

(2) Within 60 days from the date of the notice, the contract applicant may respond in writing to the issues or other matters that were the basis for HCFA's preliminary finding and may revise its application to remedy any defects HCFA identified.

(f) *Denial of application.* If HCFA denies the application, it gives written notice to the contract applicant indicating—

(1) That the contract applicant does not meet the contract requirements under part C of title XVIII of the Act;

(2) The reasons why the contract applicant does not meet the contract requirements; and

(3) The contract applicant's right to request reconsideration in accordance with the procedures specified in subpart N of this part.

(g) *Oversight of continuing compliance.* (1) HCFA oversees an M+C organization's continued compliance with the requirements for an M+C organization.

(2) If an M+C organization no longer meets those requirements, HCFA terminates the contract in accordance with § 422.510.

5. Revise § 422.10 to read as follows:

§ 422.10 Cost-sharing in enrollment-related costs (M+C user fee).

(a) *Basis and scope.* This section implements that portion of section 1857 of the Act that pertains to cost-sharing in enrollment-related costs. It sets forth the procedures that HCFA follows to determine the aggregate annual ''user fee'' to be contributed by M+C organizations and to assess the required user fees for M+C plans offered by M+C organizations.

(b) *Purpose of assessment.* Section 1857(e)(2) of the Act authorizes HCFA to charge and collect from each M+C plan offered by an M+C organization its pro rate share of fees for administering section 1851 of the Act, relating to dissemination of enrollment information; and section 4360 of the Omnibus Budget Reconciliation Act of 1990, relating to the health insurance counseling and assistance program.

(c) *Applicability.* The fee assessment also applies to those demonstrations for which enrollment is effected or coordinated under section 1851 of the Act.

(d) *Collection of fees.* (1) *Timing of collection.* HCFA collects the fees over 9 consecutive months beginning with January of each fiscal year.

(2) *Amount to be collected.* The aggregate amount of fees for a fiscal year is the lesser of—

(i) The estimated costs to be incurred by HCFA in that fiscal year to carry out the activities described in paragraph (b) of this section; or

(ii) For fiscal year 2000, $100 million and for fiscal year 2001 and each succeeding year, the M+C portion (as defined in paragraph (e) of this section) of $100 million.

(e) *M+C portion.* In this section, the term ''M+C portion'' means, for a fiscal year, the ratio, as estimated by the Secretary of the average number of individuals enrolled in M+C plans during the fiscal year to the average number of individuals entitled to benefits under part A, and enrolled under part B, during the fiscal year.

(f) *Assessment methodology.* (1) The amount of the M+C portion of the user fee each M+C organization must pay is assessed as a percentage of the total Medicare payments to each organization. HCFA determines this percentage rate using the following formula:

A times B divided by C where—

A is the total estimated January payments to all organizations subject to the assessment;

B is the 9-month (January through September) assessment period; and

C is the total fiscal year M+C user fee assessment amount determined in accordance with paragraph (d)(2) of this section.

(2) HCFA determines each organization's pro rata share of the annual fee on the basis of the organization's calculated monthly payment amount during the 9 consecutive months beginning with January. HCFA calculates each organization's monthly pro rata share by multiplying the established percentage rate by the total monthly calculated Medicare payment amount to the organization as recorded in HCFA's payment system on the first day of the month.

(3) HCFA deducts the organization's fee from the amount of Federal funds otherwise payable to the organization for that month under the M+C program.

(4) If assessments reach the amount authorized for the year before the end of September, HCFA discontinues assessment.

(5) If there are delays in determining the amount of the annual aggregate fees specified in paragraph (d)(2) of this section, or the fee percentage rate specified in paragraph (f)(2), HCFA may adjust the assessment time period and the fee percentage amount.

6. Revise § 422.50(a) to read as follows:

§ 422.50 Eligibility to elect an M+C plan.

(a) An individual is eligible to elect an M+C plan if he or she—

(1) Is entitled to Medicare under Part A and enrolled in Part B (except that an individual entitled only to Part B and who was enrolled in an HMO or CMP with a risk contract under part 417 of this chapter on December 31, 1998 may continue to be enrolled in the M+C organization as an M+C plan enrollee);

(2) Has not been medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in an M+C plan or in a health plan offered by the M+C organization is eligible to elect an M+C plan offered by that organization;

(3) Meets either of the following residency requirements:

(i) Resides in the service area of the M+C plan.

(ii) Resides outside of the service area of the M+C plan and is enrolled in a health plan offered by the M+C organization during the month immediately preceding the month in which the individual is entitled to both Medicare Part A and Part B, provided that an M+C organization chooses to offer this option and that HCFA determines that all applicable M+C access requirements of § 422.112 are met for that individual through the M+C plan's established provider network. The M+C organization must furnish the same benefits to these enrollees as to enrollees who reside in the service area;

(4) Has been a member of an Employer Group Health Plan (EGHP) that includes the elected M+C plan, even if the individual lives outside of the M+C plan service area, provided that an M+C organization chooses to offer this option and that HCFA determines that all applicable M+C access requirements at § 422.12 are met for that individual through the M+C plan's established provider network. The M+C organization must furnish the same benefits to all enrollees, regardless of whether they reside in the service area;

(5) Completes and signs an election form and gives information required for enrollment; and

(6) Agrees to abide by the rules of the M+C organization after they are disclosed to him or her in connection with the election process.

* * * * *

7. In § 422.54, the heading of paragraph (b) and paragraphs (c)(2), (d)(1), and (d)(3) are revised to read as follows:

§ 422.54 Continuation of enrollment.

* * * * *

(b) *Basic rule.* * * *

(c) * * *

(2) An enrollee who moves out of the service area into the geographic area designated as the continuation area has the choice of continuing enrollment or disenrolling from the plan. The enrollee must make the choice of continuing enrollment in a manner specified by HCFA. If no choice is made, the enrollee must be disenrolled from the plan.

* * * * *

(d) * * *

(1) *Continuation of enrollment benefits.* The M+C organization must, at a minimum, provide or arrange for the Medicare-covered benefits as described in § 422.101(a).

* * * * *

(3) *Reasonable cost-sharing.* For services furnished in the continuation area, an enrollee's cost-sharing liability is limited to the cost-sharing amounts required in the M+C plan's service area (in which the enrollee no longer resides).

* * * * *

8. Section § 422.60 is amended by:

A. Revising paragraph (b)(1).

B. Adding paragraph (b)(3).

C. Revising paragraphs (e)(6), (f)(1), and (f)(3).

§ 422.60 Election process.

* * * * *

(b) *Capacity to accept new enrollees.* (1) M+C organizations may submit information on enrollment capacity of plans they offer by July 1 of each year as provided by § 422.306(a)(1).

* * * * *

(3) HCFA considers enrollment limit requests for an M+C plan service area, other than those submitted with the adjusted community rate proposal, or for a portion of the plan service area, only if the health and safety of beneficiaries is at risk, such as if the provider network is not available to serve the enrollees in all or a portion of the service area.

* * * * *

(e) * * *

(6) Upon receipt of the election form or from the date a vacancy occurs for an individual who was accepted for future enrollment, the M+C organization transmits, within the timeframes

specified by HCFA, the information necessary for HCFA to add the beneficiary to its records as an enrollee of the M+C organization.

(f) * * *

(1) In cases in which an M+C organization has both a Medicare contract and a contract with an employer group health plan, and in which the M+C organization arranges for the employer to process election forms for Medicare-entitled group members, who wish to enroll under the Medicare contract, the effective date of the election may be retroactive. Consistent with § 422.250(b), payment adjustments based on a retroactive effective date may be made for up to a 90-day period.

* * * * *

(3) Upon receipt of the election form from the employer, the M+C organization must submit the enrollment within timeframes specified by HCFA.

9. Section 422.62 is amended by:

A. Removing, in paragraph (a)(3), the phrase ''as provide under'' and adding in its place the phrase ''as provided under''.

B. Revising paragraphs (a)(4)(i) and (a)(5)(i).

C. Adding new paragraph (a)(6).

D. Revising paragraph (b)(1).

§ 422.62 Election of coverage under an M+C plan.

(a) * * *

(4) * * *

(i) Except as provided in paragraphs (a)(4)(ii), (a)(4)(iii), and (a)(6) of this section, an individual who is eligible to elect an M+C plan in 2002 may elect an M+C plan or change his or her election from an M+C plan to original Medicare or to a different M+C plan, or from original Medicare to an M+C plan, but only once during the first 6 months of the year.

* * * * *

(5) * * *

(i) For 2003 and subsequent years, except as provided in paragraphs (a)(5)(ii), (a)(5)(iii), and (a)(6) of this section, an individual who is eligible to elect an M+C plan may elect an M+C plan, change his or her election from an M+C plan to original Medicare or to a different M+C plan, or from original Medicare to an M+C plan, but only once during the first 3 months of the year.

* * * * *

(6) *Open enrollment period for institutionalized individuals.* After 2001, an individual who is eligible to elect an M+C plan and who is institutionalized, as defined by HCFA, is not limited (except as provided for in paragraph (d) of this section for M+C MSA plans) in the number of elections or changes he or she may make. Subject to the M+C plan being open to enrollees as provided under § 422.60(a)(2), an M+C eligible institutionalized individual may at any time elect an M+C plan or change his or her election from an M+C plan to original Medicare, to a different M+C plan, or from original Medicare to an M+C plan.

(b) * * *

(1) HCFA or the organization has terminated the organization's contract for the plan, discontinued the plan in the area in which the individual resides, or the organization has notified the individual of the impending termination of the plan, or the impending discontinuation of the plan in the area in which the individual resides.

* * * * *

10. Section 422.64 is revised to read as follows:

§ 422.64 Information about the M+C program.

Each M+C organization must provide, on an annual basis, and in a format and using standard terminology that may be specified by HCFA, the information necessary to enable HCFA to provide to current and potential beneficiaries the information they need to make informed decisions with respect to the available choices for Medicare coverage.

11. Section § 422.66 is amended by:

A. Republishing the heading of paragraph (b) and the introductory text for paragraph (b)(3).

B. Revising paragraphs (b)(3)(i), (d)(1), (d)(3), the introductory text for paragraph (e), and paragraphs (e)(2), and (f).

§ 422.66 Coordination of enrollment and disenrollment through M+C organizations.

* * * * *

(b) *Disenrollment—*

* * * * *

(3) *Responsibilities of the M+C organization.* The M+C organization must—

(i) Submit a disenrollment notice to HCFA within timeframes specified by HCFA;

* * * * *

(d) * * *

(1) *Basic rule.* An M+C plan offered by an M+C organization must accept any individual (regardless of whether the individual has end-stage renal disease) who is enrolled in a health plan offered by the M+C organization during the month immediately preceding the month in which he or she is entitled to both Part A and Part B, and who meets the eligibility requirements at § 422.50.

* * * * *

(3) *Effective date of conversion.* If an individual chooses to remain enrolled with the M+C organization as an M+C enrollee, the individual's conversion to an M+C enrollee is effective the month in which he or she is entitled to both Part A and Part B in accordance with the requirements in paragraph (d)(5) of this section.

* * * * *

(e) *Maintenance of enrollment.* An individual who has made an election under this section is considered to have continued to have made that election until either of the following, which ever occurs first:

* * * * *

(2) The elected M+C plan is discontinued or no longer serves the area in which the individual resides, the organization does not offer, or the individual does not elect, the option of continuing enrollment, as provided under either § 422.54 or § 422.74(b)(3)(ii).

(f) *Exception for employer group health plans.* (1) In cases when an M+C organization has both a Medicare contract and a contract with an employer group health plan, and in which the M+C organization arranges for the employer to process election forms for Medicare-entitled group members who wish to disenroll from the Medicare contract, the effective date of the election may be retroactive. Consistent with § 422.250(b), payment adjustments based on a retroactive effective date may be made for up to a 90-day period.

(2) Upon receipt of the election form from the employer, the M+C organization must submit a disenrollment notice to HCFA within timeframes specified by HCFA.

12. Revise § 422.68(c) to read as follows:

§ 422.68 Effective dates of coverage and change of coverage.

* * * * *

(c) *Open enrollment periods.* For an election, or change in election, made during an open enrollment period as described in § 422.62(a)(3) through (a)(6), coverage is effective as of the first day of the first calendar month following the month in which the election is made, except that, if the election or change in election is made after the 10th day of any calendar month, then the election shall not take effect until the first day of the second calendar month following the date on which the election is made.

* * * * *

13. Section 422.74 is amended by revising paragraphs (b)(2)(i), (b)(3), (c),

(d)(1), the heading of paragraph (d)(3), (d)(4), and (d)(7) to read as follows:

§ 422.74 Disenrollment by the M+C organization.

* * * * *

(b) * * *

(2) * * *

(i) The individual no longer resides in the M+C plan's service area as specified under paragraph (d)(4) of this section, is no longer eligible under § 422.50(a)(3)(ii), and optional continued enrollment has not been offered or elected under § 422.54.

* * * * *

(3) *Plan termination or reduction of area where plan is available.* (i) *General rule.* An M+C organization that has its contract for an M+C plan terminated, that terminates an M+C plan, or that discontinues offering the plan in any portion of the area where the plan had previously been available, must disenroll affected enrollees in accordance with the procedures for disenrollment set forth at paragraph (d)(7) of this section, unless the exception in paragraph (b)(3)(ii) of this section applies.

(ii) *Exception.* When an M+C organization discontinues offering an M+C plan in a portion of its service area, the M+C organization may elect to offer enrollees residing in all or portions of the affected area the option to continue enrollment in an M+C plan offered by the organization, provided that there is no other M+C plan offered in the affected area at the time of the organization's election. The organization may require an enrollee who chooses to continue enrollment to agree to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively through facilities designated by the organization within the plan service area.

(c) *Notice requirement.* If the disenrollment is for any of the reasons specified in paragraphs (b)(1), (b)(2)(i), or (b)(3) of this section (that is, other than death or loss of entitlement to Part A or Part B) the M+C organization must give the individual a written notice of the disenrollment with an explanation of why the M+C organization is planning to disenroll the individual. Notices for reasons specified in paragraphs (b)(1) through (b)(2)(i) must—

(1) Be mailed to the individual before submission of the disenrollment notice to HCFA; and

(2) Include an explanation of the individual's right to a hearing under the M+C organization's grievance procedures.

(d) * * *

(1) *Monthly basic and supplementary premiums are not paid timely.* An M+C organization may disenroll an individual from the M+C plan for failure to pay any basic and supplementary premiums under the following circumstances:

(i) The M+C organization makes a reasonable effort to collect unpaid premium amounts by sending a written notice of nonpayment to the enrollee within 20 days after the date the delinquent charges were due—

(A) Alerting the individual that the premiums are delinquent;

(B) Providing the individual with an explanation of the disenrollment procedures and any lock-in requirements of the M+C plan; and

(C) Advising that failure to pay the premiums within the 90-day grace period will result in termination of M+C coverage;

(ii) The M+C organization only disenrolls a Medicare enrollee when the organization has not received payment within 90 days after the date it has sent the notice of nonpayment to the enrollee.

(iii) The M+C organization gives the individual a written notice of disenrollment that meets the requirement set forth in paragraph (c) of this section.

(iv) If the enrollee fails to pay the premium for optional supplemental benefits (that is, a package of benefits that an enrollee is not required to accept), but pays the basic premium and any mandatory supplemental premium, the M+C organization has the option to discontinue the optional supplemental benefits and retain the individual as an M+C enrollee.

* * * * *

(3) *Individual commits fraud or permits abuse of enrollment card.* * * *

* * * * *

(4) *Individual no longer resides in the M+C plan's service area.* (i) *Basis for disenrollment.* Unless continuation of enrollment is elected under § 422.54, the M+C organization must disenroll an individual if the M+C organization establishes, on the basis of a written statement from the individual or other evidence acceptable to HCFA, that the individual has permanently moved out of a plan's service area. If the individual has not moved from the M+C plan's service area, but has left the plan's service area for more than 6 months, the M+C organization must disenroll the individual.

(ii) *Special rule.* The M+C organization must disenroll an individual who is enrolled in the M+C plan, under the eligibility requirements at § 422.50(a)(3)(ii) or (a)(4), if the organization establishes, on the basis of a written statement from the individual or other evidence acceptable to HCFA, that the individual has permanently moved from the residence in which she or he resided at the time of enrollment in the M+C plan, to an area outside the M+C plan service area (unless continuation of enrollment is elected under § 422.54). If the individual has not permanently moved from the residence in which she or he resided at the time of enrollment in the M+C plan, but has left the residence for over 6 months, the M+C organization must disenroll the individual.

(iii) *Notice of disenrollment.* The M+C organization must give the individual a written notice of the disenrollment that meets the requirements set forth in paragraph (c) of this section.

* * * * *

(7) *Plan termination or area reduction.* (i) When an M+C organization has its contract for an M+C plan terminated, terminates an M+C plan, or discontinues offering the plan in any portion of the area where the plan had previously been available, the M+C organization must give each affected M+C plan enrollee a written notice of the effective date of the plan termination or area reduction and a description of alternatives for obtaining benefits under the M+C program.

(ii) The notice must be sent before the effective date of the plan termination or area reduction, and in the timeframes specified in § 422.506(a)(2).

* * * * *

14. Section 422.80 is amended by:

A. Republishing the introductory text in paragraph (b)(5).

B. Revising paragraph (b)(5)(v).

C. Republishing the introductory text in paragraph (c).

D. Revising paragraph (c)(4).

E. Adding new paragraphs (e)(1)(vi), (e)(1)(vii), and (e)(1)(viii).

F. Revising paragraph (f).

§ 422.80 Approval of marketing materials and election forms.

* * * * *

(b) * * *

(5) Examples of marketing materials include, but are not limited to:

* * * * *

(v) Membership communication materials such as membership rules, subscriber agreements (evidence of coverage), member handbooks and wallet card instructions to enrollees.

* * * * *

(c) *Guidelines for HCFA review.* In reviewing marketing material or election

forms under paragraph (a) of this section, HCFA determines that the marketing materials:

* * * * *

(4) Are not materially inaccurate or misleading or otherwise make material misrepresentations.

* * * * *

(e) * * *

(1) * * *

(vi) Use providers or provider groups to distribute printed information comparing the benefits of different health plans unless the materials have the concurrence of all M+C organizations involved and have received prior approval by HCFA. Physicians or providers may distribute health plan brochures (exclusive of application forms) at a health fair or in their offices. Physicians may discuss, in response to an individual patient's inquiry, the various benefits in different health plans.

(vii) Accept plan applications in provider offices or other places where health care is delivered.

(viii) Employ M+C plan names that suggest that a plan is not available to all Medicare beneficiaries. This prohibition shall not apply to M+C plan names in effect on July 31, 2000.

* * * * *

(f) *Employer group retiree marketing.* M+C organizations may develop marketing materials designed for members of an employer group who are eligible for employer-sponsored benefits through the M+C organization, and furnish these materials only to the group members. While the materials must be submitted for approval under paragraph (a) of this section, HCFA will not review portions of these materials that relate to employer group benefits.

15. Revise § 422.100 to read as follows:

§ 422.100 General requirements.

(a) *Basic rule.* Subject to the conditions and limitations set forth in this subpart, an M+C organization offering an M+C plan must provide enrollees in that plan with coverage of the basic benefits described in paragraph (c) of this section (and, to the extent applicable, the benefits described in § 422.102) by furnishing the benefits directly or through arrangements, or by paying for the benefits. HCFA reviews these benefits subject to the requirements of § 422.100(g) and the requirements in subpart G of this part.

(b) *Services of noncontracting providers and suppliers.* (1) An M+C organization must make timely and reasonable payment to or on behalf of the plan enrollee for the following services obtained from a provider or supplier that does not contract with the M+C organization to provide services covered by the M+C plan:

(i) Ambulance services dispatched through 911 or its local equivalent as provided in § 422.113.

(ii) Emergency and urgently needed services as provided in § 422.113.

(iii) Maintenance and post-stabilization care services as provided in § 422.113.

(iv) Renal dialysis services provided while the enrollee was temporarily outside the plan's service area.

(v) Services for which coverage has been denied by the M+C organization and found (upon appeal under subpart M of this part) to be services the enrollee was entitled to have furnished, or paid for, by the M+C organization.

(2) An M+C plan (other than an M+C MSA plan) offered by an M+C organization satisfies paragraph (a) of this section with respect to benefits for services furnished by a noncontracting provider if that M+C plan provides payment in an amount the provider would have received under original Medicare (including balance billing permitted under Medicare Part A and Part B).

(c) *Types of benefits.* An M+C plan includes at a minimum basic benefits, and also may include mandatory and optional supplemental benefits.

(1) Basic benefits are all Medicare-covered services, except hospice services, and additional benefits as defined in § 422.2 and meeting all requirements in § 422.312.

(2) Supplemental benefits, which consist of—

(i) Mandatory supplemental benefits are services not covered by Medicare that an M+C enrollee must purchase as part of an M+C plan that are paid for in full, directly by (or on behalf of) Medicare enrollees, in the form of premiums or cost-sharing.

(ii) Optional supplemental benefits are health services not covered by Medicare that are purchased at the option of the M+C enrollee and paid for in full, directly by (or on behalf of) the Medicare enrollee, in the form of premiums or cost-sharing. These services may be grouped or offered individually.

(d) *Availability and structure of plans.* An M+C organization offering an M+C plan must offer it—

(1) To all Medicare beneficiaries residing in the service area of the M+C plan;

(2) At a uniform premium, with uniform benefits and cost-sharing throughout the plan's service area, or segment of service area as provided in § 422.304(b)(2).

(e) *Terms of M+C plans.* Terms of M+C plans described in instructions to beneficiaries, as required by § 422.111, will include basic and supplemental benefits and terms of coverage for those benefits.

(f) *Multiple plans in one service area.* An M+C organization may offer more than one M+C plan in the same service area subject to the conditions and limitations set forth in this subpart for each M+C plan.

(g) *HCFA review and approval of M+C benefits.* HCFA reviews and approves M+C benefits using written policy guidelines and requirements in this part, operational policy letters, and other HCFA instructions to ensure that—

(1) Medicare-covered services meet HCFA fee-for-service guidelines;

(2) M+C organizations are not designing benefits to discriminate against beneficiaries; and

(3) Benefit design meets other M+C program requirements.

(h) *Benefits affecting screening mammography, influenza vaccine, and pneumoccal vaccine.* (1) Enrollees of M+C organizations may directly access (through self-referral) screening mammography and influenza vaccine.

(2) M+C organizations may not impose cost-sharing for influenza vaccine and pneumococcal vaccine on their M+C plan enrollees.

(i) *Requirements relating to Medicare conditions of participation.* Basic benefits must be furnished through providers meeting the requirements in § 422.204(b)(3).

(j) *Provider networks.* The M+C plans offered by an M+C organization may share a provider network as long as each M+C plan independently meets the access and availability standards described at § 422.112, as determined by HCFA.

16. Revise § 422.101 to read as follows:

§ 422.101 Requirements relating to basic benefits.

Except as specified in § 422.264 (for entitlement that begins or ends during a hospital stay) and § 422.266 (with respect to hospice care), each M+C organization must meet the following requirements:

(a) Provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available to beneficiaries residing in the plan's

service area. Services may be provided outside of the service area of the plan if the services are accessible and available to enrollees.

(b) Comply with—

(1) HCFA's national coverage determinations;

(2) General coverage guidelines included in original Medicare manuals and instructions unless superseded by operational policy letters or regulations in this part; and

(3) Written coverage decisions of local carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered under the M+C plan.

17. Revise § 422.102 to read as follows:

§ 422.102 Supplemental benefits.

(a) *Mandatory supplemental benefits.* (1) Subject to HCFA's approval, an M+C organization may require Medicare enrollees of an M+C plan other than an MSA plan to accept and pay for services in addition to Medicare-covered services described in § 422.101 and additional benefits described in § 422.312.

(2) If the M+C organization imposes mandatory supplemental benefits, it must impose them on all Medicare beneficiaries enrolled in the M+C plan.

(3) HCFA approves mandatory supplemental benefits if the benefits are designed in accordance with HCFA's guidelines and requirements as stated in this part and instructions and operational policy letters.

(b) *Optional supplemental benefits.* Except as provided in § 422.104 in the case of MSA plans, each M+C organization may offer (for election by the enrollee and without regard to health status) services that are not included in the basic benefits as described in § 422.100(c) and any mandatory supplemental benefits described in paragraph (a) of this section. Optional supplemental benefits are purchased at the discretion of the enrollee and must be offered to all Medicare beneficiaries enrolled in the M+C plan.

(c) *Payment for supplemental services.* All supplemental benefits are paid for in full, directly by (or on behalf of) the enrollee of the M+C plan.

(d) *Marketing of supplemental benefits.* M+C organizations may offer enrollees a group of services as one optional supplemental benefit, offer services individually, or offer a combination of groups and individual services.

18. Section 422.105 is amended by:

A. Revising the introductory text for paragraph (a).

B. Revising paragraph (f).

§ 422.105 Special rules for point of service option.

(a) *General rule.* A POS benefit is an option that an M+C organization may offer in an M+C coordinated care plan or network M+C MSA plan to provide enrollees with additional choice in obtaining specified health care services. The organization may offer a POS option—

* * * * *

(f) *POS-related data.* An M+C organization that offers a POS benefit through an M+C plan must report enrollee utilization data at the plan level by both plan contracting providers (in-network) and by non-contracting providers (out-of-network) including enrollee use of the POS benefit, in the form and manner prescribed by HCFA.

19. Revise § 422.106 to read as follows:

§ 422.106 Coordination of benefits with employer group health plans and Medicaid.

(a) *General rule.* If an M+C organization contracts with an employer group health plan (EGHP) that covers enrollees in an M+C plan, or contracts with a State Medicaid agency to provide Medicaid benefits to individuals who are eligible for both Medicare and Medicaid, and who are enrolled in an M+C plan, the enrollees must be provided the same benefits as all other enrollees in the M+C plan, with the EGHP or Medicaid benefits supplementing the M+C plan benefits. Jurisdiction regulating benefits under these circumstances is as follows:

(1) All requirements of this part that apply to the M+C program apply to the M+C plan coverage provided to enrollees eligible for benefits under an EGHP or Medicaid contract.

(2) Employer benefits that complement an M+C plan, and the marketing materials associated with the benefits, are not subject to review or approval by HCFA. M+C plan benefits provided to members of the EGHP, and the associated marketing materials, are subject to HCFA review and approval.

(3) Medicaid benefits are not reviewed under this part, but are subject to appropriate HCFA review under the Medicaid program. M+C plan benefits provided to individuals entitled to Medicaid benefits provided by the M+C organization under a contract with the State Medicaid agency are subject to M+C rules and requirements.

(b) *Examples.* Employer/Medicaid benefits, permissible EGHP or Medicaid plan benefits include the following:

(1) Payment of a portion or all of the M+C basic and supplemental premiums.

(2) Payment of a portion or all of other cost-sharing amounts approved for the M+C plan.

(3) Other employer-sponsored benefits that may require additional premium and cost-sharing, or other benefits provided by the organization under a contract with the State Medicaid agency.

20. Section 422.108 is amended by:

A. Republishing the introductory text for paragraph (b).

B. Revising paragraphs (b)(2), (c), the introductory text in paragraph (d), and paragraph (e).

C. Adding a new paragraph (f).

§ 422.108 Medicare secondary payer (MSP) procedures.

* * * * *

(b) Responsibilities of the M+C organization. The M+C organization must, for each M+C plan—

* * * * *

(2) Identify the amounts payable by those payers; and * * * * *

* * * * *

(c) *Collecting from other entities.* The M+C organization may bill, or authorize a provider to bill, other individuals or entities for covered Medicare services for which Medicare is not the primary payer, as specified in paragraphs (d) and (e) of this section.

(d) *Collecting from other insurers or the enrollee.* If a Medicare enrollee receives from an M+C organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the M+C organization may bill, or authorize a provider to bill any of the following—

* * * * *

(e) *Collecting from group health plans (GHPs) and large group health plans (LGHPs).* An M+C organization may bill a GHP or LGHP for services it furnishes to a Medicare enrollee who is also covered under the GHP or LGHP and may bill the Medicare enrollee to the extent that he or she has been paid by the GHP or LGHP.

(f) *MSP rules and State laws.* Consistent with § 422.402 concerning the Federal preemption of State law, the rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to M+C plans only to the extent that those State laws are inconsistent with the standards established under this part. A State cannot take away an M+C organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to

bill, for services for which Medicare is not the primary payer. Section 1852(a)(4) of the Social Security Act does not prohibit a State from limiting the amount of the recovery; thus, State law could modify, but not negate, an M+C organization's rights in this regard.

21. In 422.109, the introductory text for paragraph (b) and paragraph (b)(5) are revised to read as follows:

§ 422.109 Effect of national coverage determinations (NCDs).

* * * * *

(b) The M+C organization must furnish, arrange or pay for an NCD ''significant cost'' service before the adjustment of the annual M+C capitation rate. The following rules apply to these services:

* * * * *

(5) Beneficiaries are liable for any applicable coinsurance amounts, but are not responsible for the Part A deductible.

* * * * *

22. Revise § 422.110(c) to read as follows:

§ 422.110 Discrimination against beneficiaries prohibited.

* * * * *

(c) *Additional requirements.* An M+C organization is required to observe the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, and Americans with Disabilities Act (see § 422.502(h)).

23. Section 422.111 is amended by:

A. Revising the introductory text in paragraph (a).

B. Revising paragraphs (b)(2)(i), (b)(4), and (b)(5)(i).

C. Republishing the introductory text in paragraph (c) and revising paragraph (c)(1).

D. Revising paragraph (e).

E. Adding new paragraph (f).

§ 422.111 Disclosure requirements.

(a) *Detailed description.* An M+C organization must disclose the information specified in paragraph (b) of this section—

* * * * *

(b) * * *

(2) * * *

(i) The benefits offered under original Medicare, including the content specified in paragraph (f)(1) of this section;

* * * * *

(4) Out-of-area coverage provided under the plan, including coverage provided to individuals eligible to enroll in the plan under § 422.50(a)(3)(ii).

(5) * * *

(i) Explanation of what constitutes an emergency, referencing the definitions of emergency services and emergency medical condition at § 422.113;

* * * * *

(c) *Disclosure upon request.* Upon request of an individual eligible to elect an M+C plan, an M+C organization must provide to the individual the following information:

(1) The information required paragraph (f) of this section.

* * * * *

(e) *Changes to provider network.* The M+C organization must make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contracted is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must be notified.

(f) *Disclosable information*—(1) *Benefits under original Medicare.* (i) Covered services.

(ii) Beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts.

(iii) Any beneficiary liability for balance billing.

(2) *Enrollment procedures.* Information and instructions on how to exercise election options under this subpart.

(3) *Rights.* A general description of procedural rights (including grievance and appeals procedures) under original Medicare and the M+C program and the right to be protected against discrimination based on factors related to health status in accordance with § 422.110.

(4) *Medigap and Medicare Select.* A general description of the benefits, enrollment rights, and requirements applicable to Medicare supplemental policies under section 1882 of the Act, and provisions relating to Medicare Select policies under section 1882(t) of the Act.

(5) *Potential for contract termination.* The fact that an M+C organization may terminate or refuse to renew its contract, or reduce the service area included in its contract, and the effect that any of those actions may have on individuals enrolled in that organization's M+C plan.

(6) *Comparative information.* A list of M+C plans that are or will be available to residents of the service area in the following calendar year, and, for each available plan, information on the aspects described in paragraphs (c)(7) through (c)(11) of this section, presented in a manner that facilitates comparison among the plans.

(7) *Benefits.* (i) Covered services beyond those provided under original Medicare.

(ii) Any beneficiary cost-sharing.

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an M+C MSA plan, the amount of the annual MSA deposit and the differences in cost-sharing, enrollee premiums, and balance billing, as compared to M+C plans.

(v) In the case of an M+C private fee-for-service plan, differences in cost-sharing, enrollee premiums, and balance billing, as compared to M+C plans.

(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

(vii) The types of providers that participate in the plan's network and the extent to which an enrollee may select among those providers.

(viii) The coverage of emergency and urgently needed services.

(8) *Premiums.* (i) The M+C monthly basic beneficiary premiums.

(ii) The M+C monthly supplemental beneficiary premium.

(9) *The plan's service area.*

(10) *Quality and performance indicators* for benefits under a plan to the extent they are available as follows (and how they compare with indicators under original Medicare):

(i) Disenrollment rates for Medicare enrollees for the 2 previous years, excluding disenrollment due to death or moving outside the plan's service area, calculated according to HCFA guidelines.

(ii) Medicare enrollee satisfaction.

(iii) Health outcomes.

(iv) Plan-level appeal data.

(v) The recent record of plan compliance with the requirements of this part, as determined by the Secretary.

(vi) Other performance indicators.

(11) *Supplemental benefits.* Whether the plan offers mandatory supplemental benefits or offers optional supplemental benefits and the premiums and other terms and conditions for those benefits.

24. Section 422.112 is amended by:

A. Republishing the introductory text to paragraph (a).

B. Revising paragraphs (a)(2), (a)(3) and (a)(9).

C. Adding new paragraph (a)(10).

D. Removing paragraph (c).

§ 422.112 Access to services.

(a) *Rules for coordinated care plans and network M+C MSA plans.* An M+C

organization that offers an M+C coordinated care plan or network M+C MSA plan may specify the networks of providers from whom enrollees may obtain services if the M+C organization ensures that all covered services, including additional or supplemental services contracted for by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To accomplish this, the M+C organization must meet the following requirements:

* * * * *

(2) *PCP panel.* Establish a panel of PCPs from which the enrollee may select a PCP. If an M+C organization requires its enrollees to obtain a referral in most situations before receiving services from a specialist, the M+C organization must either assign a PCP for purposes of making the needed referral or make other arrangements to ensure access to medically necessary specialty care.

(3) *Specialty care.* Provide or arrange for necessary specialty care, and in particular give women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits (as defined in § 422.2). The M+C organization arranges for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs.

* * * * *

(9) *Cultural considerations.* Ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

(10) *Ambulance services, emergency and urgently needed services, and post-stabilization care services coverage.* Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services in accordance with § 422.113.

* * * * *

25. Add new § 422.113 to read as follows:

§ 422.113 Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services.

(a) *Ambulance services.* The M+C organization is financially responsible for ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health.

(b) *Emergency and urgently needed services.* (1) *Definitions.*

(i) *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—

(A) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(ii) *Emergency services* means covered inpatient and outpatient services that are—

(A) Furnished by a provider qualified to furnish emergency services; and

(B) Needed to evaluate or stabilize an emergency medical condition.

(iii) *Urgently needed services* means covered services that are not emergency services as defined this section, provided when an enrollee is temporarily absent from the M+C plan's service (or, if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area but the organization's provider network is temporarily unavailable or inaccessible) when the services are medically necessary and immediately required—

(A) As a result of an unforeseen illness, injury, or condition; and

(B) It was not reasonable given the circumstances to obtain the services through the organization offering the M+C plan.

(2) *M+C organization financial responsibility.* The M+C organization is financially responsible for emergency and urgently needed services—

(i) Regardless of whether the services are obtained within or outside the M+C organization;

(ii) Regardless of whether there is prior authorization for the services.

(A) Instructions to seek prior authorization for emergency or urgently needed services may not be included in any materials furnished to enrollees (including wallet card instructions), and enrollees must be informed of their right to call 911.

(B) Instruction to seek prior authorization before the enrollee has been stabilized may not be included in any materials furnished to providers (including contracts with providers);

(iii) In accordance with the prudent layperson definition of *emergency medical condition* regardless of final diagnosis;

(iv) For which a plan provider or other M+C organization representative instructs an enrollee to seek emergency services within or outside the plan; and

(v) With a limit on charges to enrollees for emergency services of $50 or what it would charge the enrollee if he or she obtained the services through the M+C organization, whichever is less.

(3) *Stabilized condition.* The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the M+C organization.

(c) *Maintenance care and post-stabilization care services* (hereafter together referred to as ''post-stabilization care services'').

(1) *Definition. Post-stabilization care services* means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (c)(2)(iii) of this section, to improve or resolve the enrollee's condition.

(2) *M+C organization financial responsibility.* The M+C organization—

(i) Is financially responsible (consistent with § 422.214) for post-stabilization care services obtained within or outside the M+C organization that are pre-approved by a plan provider or other M+C organization representative;

(ii) Is financially responsible for post-stabilization care services obtained within or outside the M+C organization that are not pre-approved by a plan provider or other M+C organization representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the M+C organization for pre-approval of further post-stabilization care services;

(iii) Is financially responsible for post-stabilization care services obtained within or outside the M+C organization that are not pre-approved by a plan provider or other M+C organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if—

(A) The M+C organization does not respond to a request for pre-approval within 1 hour;

(B) The M+C organization cannot be contacted; or

(C) The M+C organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the M+C

organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in § 422.113(c)(3) is met; and

(iv) Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the M+C organization.

(3) *End of M+C organization's financial responsibility.* The M+C organization's financial responsibility for post-stabilization care services it has not pre-approved ends when—

(i) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(ii) A plan physician assumes responsibility for the enrollee's care through transfer;

(iii) An M+C organization representative and the treating physician reach an agreement concerning the enrollee's care; or

(iv) The enrollee is discharged.

26. Revise § 422.118 to read as follows:

§ 422.118 Confidentiality and accuracy of enrollee records.

For any medical records or other health and enrollment information it maintains with respect to enrollees, an M+C organization must establish procedures to do the following:

(a) Abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. The M+C organization must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify—

(1) For what purposes the information will be used within the organization; and

(2) To whom and for what purposes it will disclose the information outside the organization.

(b) Ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

(c) Maintain the records and information in an accurate and timely manner.

(d) Ensure timely access by enrollees to the records and information that pertain to them.

27. Section 422.152 is amended by:

A. Revising the heading and introductory text for paragraph (b).

B. Revising the heading and introductory text for paragraph (e).

C. Revising paragraph (e)(1).

D. Republishing the heading of paragraph (f).

E. Adding new paragraph (f)(3).

§ 422.152 Quality assessment and performance improvement program.

* * * * *

(b) *Requirements for network M+C MSA plans and M+C coordinated care plans other than PPO plans.* An organization offering a network M+C MSA plan or M+C coordinated care plan other than a PPO plan must do the following:

* * * * *

(e) *Requirements for M+C PPO plans, non-network MSA plans, and M+C private fee-for-service plans.* An organization offering an M+C plan, non-network MSA plan, or private fee-for-service plan must do the following:

(1) Measure performance under the plan using standard measures required by HCFA and report its performance to HCFA. The standard measures may be specified in uniform data collection and reporting instruments required by HCFA and will relate to—

(i) Clinical areas including effectiveness of care, enrollee perception of care, and use of services; and

(ii) Nonclinical areas including access to and availability of services, appeals and grievances, and organizational characteristics.

* * * * *

(f) *Requirements for all types of plans*—

* * * * *

(3) *Remedial action.* For each plan, the organization must correct all problems that come to its attention through internal surveillance, complaints, or other mechanisms.

28. In § 422.154, the introductory text for paragraph (b) is republished, and paragraph (b)(2) is revised to read as follows:

§ 422.154 External review.

* * * * *

(b) *Terms of the agreement.* The agreement must be consistent with HCFA guidelines and include the following provisions:

* * * * *

(2) Except in the case of complaints about quality, exclude review activities that HCFA determines would duplicate review activities conducted as part of an approved accreditation process or as part of HCFA monitoring.

* * * * *

29. Revise paragraphs (a) and (b) in § 422.156 to read as follows:

§ 422.156 Compliance deemed on the basis of accreditation.

(a) *General rule.* An M+C organization is deemed to meet all of the requirements of any of the areas described in paragraph (b) of this section if—

(1) The M+C organization is fully accredited (and periodically reaccredited) for the standards related to the applicable area under paragraph (b) of this section by a private, national accreditation organization approved by HCFA; and

(2) The accreditation organization used the standards approved by HCFA for the purposes of assessing the M+C organization's compliance with Medicare requirements.

(b) *Deemable requirements.* The requirements relating to the following areas are deemable:

(1) Quality assurance.

(2) Antidiscrimination.

(3) Access to services.

(4) Confidentiality and accuracy of enrollee records.

(5) Information on advance directives.

(6) Provider participation rules.

* * * * *

30. Section 422.157 is amended by republishing the introductory text for paragraph (a) and revising paragraphs (a)(3) and (b)(1) to read as follows:

§ 422.157 Accreditation organizations.

(a) *Conditions for approval.* HCFA may approve an accreditation organization with respect to a given standard under this part if it meets the following conditions:

* * * * *

(3) It ensures that:

(i) Any individual associated with it, who is also associated with an entity it accredits, does not influence the accreditation decision concerning that entity.

(ii) The majority of the membership of its governing body is not comprised of managed care organizations or their representatives.

(iii) Its governing body has a broad and balanced representation of interests and acts without bias.

* * * * *

(b) *Notice and comment*—(1) Proposed notice. HCFA publishes a notice in the **Federal Register** whenever it is considering granting an accreditation organization's application for approval. The notice—

(i) Announces HCFA's receipt of the accreditation organization's application for approval;

(ii) Describes the criteria HCFA will use in evaluating the application; and

(iii) Provides at least a 30-day comment period.

* * * * *

31. Revise the introductory text of § 422.158(e) to read as follows:

§ 422.158 Procedures for approval of accreditation as basis for deeming compliance.

* * * * *

(e) *Notice of determination.* HCFA gives the accreditation organization, within 210 days of receipt of its completed application, a formal notice that—

* * * * *

32. Section 422.202 is amended by:

A. Revising the introductory text of paragraph (b).

B. Adding a heading to paragraph (c).

C. Adding a new paragraph (d)

§ 422.202 Participation procedures.

* * * * *

(b) *Consultation.* The M+C organization must establish a formal mechanism to consult with the physicians who have agreed to provide services under the M+C plan offered by the organization, regarding the organization's medical policy, quality assurance programs and medical management procedures and ensure that the following standards are met:

* * * * *

(c) *Subcontracted groups.* * * *

* * * * *

(d) *Suspension or termination of contract.* An M+C organization that operates a coordinated care plan or network MSA plan providing benefits through contracting providers must meet the following requirements:

(1) *Notice to physician.* An M+C organization that suspends or terminates an agreement under which the physician provides services to M+C plan enrollees must give the affected individual written notice of the following:

(i) The reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by the M+C organization.

(ii) The affected physician's right to appeal the action and the process and timing for requesting a hearing.

(2) *Composition of hearing panel.* The M+C organization must ensure that the majority of the hearing panel members are peers of the affected physician.

(3) *Notice to licensing or disciplinary bodies.* An M+C organization that suspends or terminates a contract with a physician because of deficiencies in the quality of care must give written notice of that action to licensing or disciplinary bodies or to other appropriate authorities.

(4) *Timeframes.* An M+C organization and a contracting provider must provide at least 60 days written notice to each other before terminating the contract without cause.

33. Revise § 422.204 to read as follows:

§ 422.204 Provider selection and credentialing.

(a) *General rule.* An M+C organization must have written policies and procedures for the selection and evaluation of providers. These policies must conform with the credential and recredentialing requirements set forth in paragraph (b) of this section and with the antidiscrimination provisions set forth in § 422.205.

(b) *Basic requirements.* An M+C organization must follow a documented process with respect to providers and suppliers who have signed contracts or participation agreements that—

(1) For providers (other than physicians and other health care professionals) requires determination, and redetermination at specified intervals, that each provider is—

(i) Licensed to operate in the State, and in compliance with any other applicable State or Federal requirements; and

(ii) Reviewed and approved by an accrediting body, or meets the standards established by the organization itself;

(2) For physicians and other health care professionals, including members of physician groups, covers—

(i) Initial credentialing that includes written application, verification of licensure or certification from primary sources, disciplinary status, eligibility for payment under Medicare, and site visits as appropriate. The application must be signed and dated and include an attestation by the applicant of the correctness and completeness of the application and other information submitted in support of the application;

(ii) Recredentialing at least every 2 years that updates information obtained during initial credentialing and considers performance indicators such as those collected through quality assurance programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, and other plan activities, and that includes an attestation of the correctness and completeness of the new information; and

(iii) A process for consulting with contracting health care professionals with respect to criteria for credentialing and recredentialing.

(3) Specifies that basic benefits must be provided through, or payments must be made to, providers and suppliers that meet applicable requirements of title XVIII and part A of title XI of the Act. In the case of providers meeting the definition of ''provider of services'' in section 1861(u) of the Act, basic benefits may only be provided through these providers if they have a provider agreement with HCFA permitting them to provide services under original Medicare.

(4) Ensures compliance with the requirements at § 422.752(a)(8) that prohibit employment or contracts with individuals (or with an entity that employs or contracts with such an individual) excluded from participation under Medicare and with the requirements at § 422.220 regarding physicians and practitioners who opt out of Medicare.

34. Add § 422.205 to read as follows:

§ 422.205 Provider antidiscrimination rules.

(a) *General rule.* Consistent with the requirements of this section, the policies and procedures concerning provider selection and credentialing established under § 422.204, and with the requirement under § 422.100(c) that all Medicare-covered services be available to M+C plan enrollees, an M+C organization may select the practitioners that participate in its plan provider networks. In selecting these practitioners, an M+C organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If an M+C organization declines to include a given provider or group of providers in its network, it must furnish written notice to the effected provider(s) of the reason for the decision.

(b) *Construction.* The prohibition in paragraph (a)(1) of this section does not preclude any of the following by the M+C organization:

(1) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees (except for M+C private-fee-for-service plans, which may not refuse to contract on this basis).

(2) Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty.

(3) Implementation of measures designed to maintain quality and

control costs consistent with its responsibilities.

35. In § 422.206, the heading for paragraph (b) is republished and paragraph (b)(2) is revised to read as follows:

§ 422.206 Interference with health care professionals' advice to enrollees prohibited.

* * * * *

(b) *Conscience protection.* * * *

(2) Through appropriate written means, makes available information on these policies as follows:

(i) To HCFA, with its application for a Medicare contract, within 10 days of submitting its ACR proposal or, for policy changes, in accordance with § 422.80 (concerning approval of marketing materials and election forms) and with § 422.111.

(ii) To prospective enrollees, before or during enrollment.

(iii) With respect to current enrollees, the organization is eligible for the exception provided in paragraph (b)(1) of this section if it provides notice of such change within 90 days after adopting the policy at issue; however, under § 422.111(d), notice of such a change must be given in advance.

* * * * *

36. Section 422.208 is amended by:

A. Republishing the introductory text for paragraph (c).

B. Revising paragraph (c)(2).

C. Adding a heading to paragraph (e).

§ 422.208 Physician incentive plans: requirements and limitations.

* * * * *

(c) *Basic requirements.* Any physician incentive plan operated by an M+C organization must meet the following requirements:

* * * * *

(2) If the physician incentive plan places a physician or physician group at substantial financial risk (as determined under paragraph (d) of this section) for services that the physician or physician group does not furnish itself, the M+C organization must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with paragraph (f) of this section, and conduct periodic surveys in accordance with paragraph (h) of this section.

* * * * *

(e) *Prohibition for private M+C fee-for-service plans.* * * *

* * * * *

37. In § 422.214, the heading for paragraph (a) is republished and paragraphs (a)(1) and (b) are revised to read as follows:

§ 422.214 Special rules for services furnished by noncontract providers.

(a) *Services furnished by non-section 1861(u) providers.* (1) Any provider (other than a provider of services as defined in section 1861(u) of the Act) that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an M+C coordinated care plan or M+C private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

* * * * *

(b) *Services furnished by section 1861(u) providers of service.* Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an M+C coordinated care plan or M+C private fee-for-service plan must accept as payment in full the amounts (less any payments under §§ 412.105(g) and 413.86(d)) of this chapter that it could collect if the beneficiary were enrolled in original Medicare. (Section 412.105(g) concerns indirect medical education payment to hospitals for managed care enrollees. Section 413.86(d) concerns calculating payment for direct graduate medical education costs.)

38. In § 422.216, paragraphs (a)(4), (b)(2), (c)(2), and the introductory text for paragraph (f) are revised to read as follows:

§ 422.216 Special rules for M+C private fee-for-service plans.

(a) * * *

(4) *Service furnished by providers of service.* Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment mounts for services furnished to a beneficiary enrolled in an M+C private fee-for-service plan must accept as payment in full the amounts (less any payments under §§ 412.105(g) and 413.86(d) of this chapter) that it could collect if the beneficiary were enrolled in original Medicare.

(b) * * *

(2) Noncontract providers. A noncontract provider may not collect from an enrollee more than the cost-sharing established by the M+C private fee-for-service plan as specified in § 422.308(b), unless the provider has opted out of Medicare as described in part 405, subpart D of this chapter.

(c) * * *

(2) *Noncontract providers.* An M+C organization that offers an M+C private fee-for-service plan must monitor the amount collected by noncontract providers to ensure that those amounts do not exceed the amounts permitted to be collected under paragraph (b)(2) of this section, unless the provider has opted out of Medicare as described in part 405, subpart D of this chapter. The M+C organization must develop and document violations specified in instructions and must forward documented cases to HCFA.

* * * * *

(f) *Rules describing deemed contract providers.* Any provider furnishing health services, except for emergency services furnished in a hospital pursuant to § 489.24 of this chapter, to an enrollee in an M+C private fee-for-service plan, and who has not previously entered into a contract or agreement to furnish services under the plan, is treated as having a contract in effect and is subject to the limitations of this section that apply to contract providers if the following conditions are met:

* * * * *

39. Section 422.250 is amended by:

A. In paragraph (a)(1), removing the phrase ''in paragraph (a)(2)'' and adding in its place the phrase ''in paragraphs (a)(2) or (f)''.

B. Revising paragraph (a)(2)(i)(B).

C. Adding new paragraph (g).

§ 422.250 General provisions.

(a) * * *

(2) * * *

(i) * * *

(B) HCFA reduces the payment rate for each renal dialysis treatment by the same amount that the Secretary is authorized to reduce the amount of each composite rate payment for each treatment as set forth in section 1881(b)(7) of the Act. These funds are to be used to help pay for the ESRD network program in the same manner as similar reductions are used in original Medicare.

* * * * *

(g) *Bonus payments.* (1) HCFA provides bonus payments to the M+C organization(s) that first offers a plan in a previously unserved county on or after January 1, 2000 and no later than December 31, 2001. The bonus payment amounts equal—

(i) For the first 12 months after a plan is offered in a previously unserved county, 5 percent of the monthly capitation rate otherwise payable under this section; and

(ii) For the subsequent 12 months, 3 percent of the monthly capitation rate otherwise payable under this section.

(2) A previously unserved county is defined as—

(i) A county in which no M+C plan has been offered; or

(ii) A county in which an M+C plan or plans has been offered, but where any M+C organization offering an M+C plan notified HCFA by October 13, 1999, that it will no longer offer plans in the county as of January 1, 2000.

(3) A plan is considered to be offered when—

(i) The M+C organization sponsoring the plan has a contract in effect to serve beneficiaries in the previously unserved area; and

(ii) The M+C plan is open for enrollment.

40. Revise § 422.254(b)(2) to read as follows:

§ 422.254 Calculation and adjustment factors.

* * * * *

(b) * * *

(2) The percentage points that HCFA uses to reduce its estimates are as follows:

(i) For 1998, 0.8 percentage points.

(ii) For years 1999 through 2001, 0.5 percentage points.

(iii) For 2002, 0.3 percentage points.

(iv) For years after 2002, 0 percentage points.

* * * * *

41. In § 422.257, revise paragraph (d) and add paragraph (g) to read as follows:

§ 422.257 Encounter data.

* * * * *

(d) *Other data requirements.* (1) M+C organizations must submit data that conform to the requirements for equivalent data for Medicare fee-for-service when appropriate, and to all relevant national standards.

(2) The data must be submitted electronically to the appropriate HCFA contractor.

(3) M+C organizations must obtain the encounter data required by HCFA from the provider, supplier, physician, or other practitioner that rendered the services.

(4) M+C organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate encounter data as required by HCFA. These provisions may include financial penalties for failure to submit complete data, or for failure to submit data that conform to the requirements for equivalent data for Medicare fee-for-service.

* * * * *

(g) *Deadlines for submission of encounter data.* Risk adjustment factors for each payment year are based on encounter data submitted for services furnished during the 12 month period ending 6 months before to the payment year (for example, risk adjustment factors for CY 2000 are based on data for services furnished during the period July 1, 1998 through June 30, 1999).

(1) The annual deadline for encounter data submission is September 10 for encounter data reflecting services furnished during the 12 month period ending the prior June 30 (for example, the deadline for submission of data for the period July 1, 1998 through June 30, 1999 is September 10, 1999).

(2) HCFA allows a reconciliation process to account for late data submissions. HCFA continues to accept encounter data submitted after the September 10 deadline until June 30 of the payment year (for example, until June 30, 2000 for data from the period July 1, 1998 through June 30, 1999). After the payment year is completed, HCFA recalculates the risk factors for affected individuals to determine if adjustments to payments are necessary.

42. Revise § 422.300(b)(2) to read as follows:

§ 422.300 Basis and scope.

* * * * *

(b) * * *

(2) For contracts beginning on a date other than January 1 (according to § 422.504(d)), M+C organizations may submit ACRs on a date other than July 1 approved by HCFA.

43. Revise § 422.304(b) to read as follows:

§ 422.304 Rules governing premiums and cost-sharing.

* * * * *

(b) *Uniformity.* (1) *General rule.* The M+C monthly basic beneficiary premium, the M+C monthly supplemental beneficiary premiums, and the M+C monthly MSA premium of an M+C organization may not vary among individuals enrolled in an M+C plan (or segment of the plan as provided under paragraph (b)(2) of this section). In addition, the M+C organization may not vary the level of cost-sharing charged for basic benefits or supplemental benefits (if any), among individuals enrolled in an M+C plan (or segment of the plan as provided under paragraph (b)(2) of this section).

(2) *Segmented service area option.* An M+C organization may apply the uniformity requirements in paragraph (b)(1) of this section to segments of an M+C plan service area (rather than to the entire service area) as long as any such segment is composed of one or more M+C payment areas, and the information specified under § 422.306 is submitted separately, as provided in that section, for each such segment.

* * * * *

44. Revise the introductory text in § 422.306(a)(1) to read as follows:

§ 422.306 Submission of proposed premiums and related information.

(a) *General rule.* (1) Not later than July 1 of each year, each M+C organization and any organization intending to contract as an M+C organization in the subsequent year must submit to HCFA, in the manner and form prescribed by HCFA, for each M+C plan (or service area segment, under § 422.304(b)(2)) it intends to offer in the following year—

* * * * *

45. Section 422.310 is amended by:

A. In the introductory text for paragraph (d), removing the phrase ''paragraphs (a)(1) and (a)(2) of this section'' and adding in its place the phrase ''paragraphs (d)(1) and (d)(2) of this section''.

B. Revising paragraph (c)(3).

§ 422.310 Adjusted community rate (ACR) approval process.

* * * * *

(c) * * *

(3) *Additional revenues.* The relative cost ratio for total revenues for an M+C plan is determined by comparing the total revenues charged on an accrual basis during the most recently ended calendar year prior to submission of the ACR for Medicare enrollees (including payments from HCFA without any needed offsets or reductions, such as, those required by § 422.250(a)(2)(i)(B) for ESRD enrollees) that elected the M+C plan to the total revenues charged for non-Medicare enrollees over the same period. The non-Medicare enrollees included in this computation must be consistent with the non-Medicare enrollees included in the initial rate computation. When the relative cost ratio for total revenues is applied to the total initial rate, the value of additional revenues is the remaining value after removing the value of direct medical costs (as adjusted by paragraph (c)(1) of this section) and the value of Administration (as adjusted by paragraph (c)(2) of this section).

46. In § 422.312, the introductory text for paragraph (b) is republished and paragraph (b)(1) is revised to read as follows:

§ 422.312 Requirement for additional benefits.

* * * * *

(b) *Requirement for additional benefits.* If there is an adjusted excess amount for the plan it offers, the M+C organization must—

(1) Provide additional benefits with an actuarial value (less the actuarial value of any cost-sharing associated with the benefit) which HCFA determines is at least equal to the adjusted excess amount; and

* * * * *

47–50. In § 422.352, the introductory text for paragraph (a) is republished and paragraph (a)(1) is revised to read as follows:

§ 422.352 Basic requirements.

(a) *General rule.* An organization is considered a PSO for purposes of an M+C contract if the organization—

(1) Has obtained a waiver of State licensure as provided for under § 422.370;

* * * * *

51. Section 422.500 is amended by:

A. Revising the definition of ''clean claim.''

B. Adding definitions for ''downstream entity'' and ''first tier entity.''

§ 422.500 Definitions.

* * * * *

Clean claim means—

(1) A claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with § 422.257(d)) or particular circumstance requiring special treatment that prevents timely payment; and

(2) A claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Downstream entity means any party that enters into an acceptable written arrangement below the level of the arrangement between an M+C organization (or contract applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

First tier entity means any party that enters into an acceptable written arrangement with an M+C organization or contract applicant to provide administrative services or health care services for a Medicare eligible individual.

* * * * *

52. Section 422.501 is amended by:

A. Republishing the introductory text in paragraphs (b), (b)(3), and (b)(3)(vi).

B. Revising paragraphs (b)(3)(vi)(G) and (b)(5).

C. Removing paragraph (b)(3)(vi)(H).

D. Republishing the introductory text in (d)(2) and (d)(2)(iii).

E. Revising paragraph (d)(2)(iii)(A).

§ 422.501 General provisions.

* * * * *

(b) *Conditions necessary to contract as an M+C organization.* Any entity seeking to contract as an M+C organization must:

* * * * *

(3) Have administrative and management arrangements satisfactory to HCFA, as demonstrated by at least the following:

* * * * *

(vi) A compliance plan that consists of the following:

* * * * *

(G) Procedures for ensuring prompt response to detected offenses and development of corrective action initiatives relating to the organization's M+C contract.

* * * * *

(5) The M+C organization's contract must not have been terminated by HCFA under § 422.510 within the past 2 years unless—

(i) During the 6-month period beginning on the date the organization notified HCFA of the intention to terminate the most recent previous contract, there was a change in the statute or regulations that had the effect of increasing M+C payments in the payment area or areas at issue; or

(ii) HCFA has otherwise determined that circumstances warrant special consideration.

* * * * *

(d) * * *

(2) Each contract under this section must provide that HCFA, or any person or organization designated by HCFA has the right to:

* * * * *

(iii) Audit and inspect any books, contracts, and records of the M+C organization that pertain to—

(A) The ability of the organization or its first tier or downstream providers to bear the risk of potential financial losses; or

* * * * *

53. Section 422.502 is amended by:

A. In paragraph (a)(12), removing the phrase ''To comply will all requirements'' and adding in its place the phrase ''To comply with all requirements''.

B. Republishing the introductory text for paragraph (g).

C. Revising the introductory text for paragraph (g)(1) and the introductory text for paragraph (g)(3).

D. Revising paragraph (i)(3).

E. Revising paragraph (l).

§ 422.502 Contract provisions.

* * * * *

(g) *Beneficiary financial protections.* The M+C organization agrees to comply with the following requirements:

(1) Each M+C organization must adopt and maintain arrangements satisfactory to HCFA to protect its enrollees from incurring liability (for example, as a result of an organization's insolvency or other financial difficulties) for payment of any fees that are the legal obligation of the M+C organization. To meet this requirement, the M+C organization must—

* * * * *

(3) In meeting the requirements of this paragraph, other than the provider contract requirements specified in paragraph (g)(1)(i) of this section, the M+C organization may use—

* * * * *

(i) * * *

(3) All contracts or written arrangements between M+C organizations and providers, related entities, contractors, subcontractors, first tier and downstream entities must contain the following:

(i) Enrollee protection provisions that provide, consistent with paragraph (g)(1) of this section, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the obligation of the M+C organization.

(ii) Accountability provisions that indicate that—

(A) The M+C organization oversees and is accountable to HCFA for any functions or responsibilities that are described in these standards; and

(B) The M+C organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph (i)(4) of this section.

(iii) A provision requiring that any services or other activity performed by a related entity, contractor, subcontractor, or first-tier or downstream entity in accordance with a contract or written agreement are consistent and comply with the M+C organization's contractual obligations.

* * * * *

(l) *Certification of data that determine payment.* As a condition for receiving a monthly payment under subpart F of this part, the M+C organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on a document that certifies (based on best knowledge, information, and belief) the accuracy,

completeness, and truthfulness of relevant data that HCFA requests. Such data include specified enrollment information, encounter data, and other information that HCFA may specify.

(1) The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify that each enrollee for whom the organization is requesting payment is validly enrolled in an M+C plan offered by the organization and the information relied upon by HCFA in determining payment (based on best knowledge, information, and belief) is accurate, complete, and truthful.

(2) The CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify (based on best knowledge, information, and belief) that the encounter data it submits under § 422.257 are accurate, complete, and truthful.

(3) If such encounter data are generated by a related entity, contractor, or subcontractor of an M+C organization, such entity, contractor, or subcontractor must similarly certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

(4) The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify (based on best knowledge, information, and belief) that the information in its ACR submission is accurate, complete, and truthful and fully conforms to the requirements in § 422.310.

54. In § 422.504, revise paragraph (b) and remove paragraph (d) to read as follows:

§ 422.504 Effective date and term of contract.

* * * * *

(b) *Term of contract.* Each contract is for a period of at least 12 months.

* * * * *

55. Section 422.506 is amended by:

A. Republishing the introductory text of paragraph (a)(2).

B. Revising paragraph (a)(2)(i) and the introductory text of paragraph (a)(3).

C. Removing paragraph (b)(1)(ii).

D. Redesignating paragraphs (b)(1)(iii) and (b)(1)(iv) as (b)(1)(ii) and (b)(1)(iii), respectively.

§ 422.506 Nonrenewal of contract.

(a) * * *

(2) If an M+C organization does not intend to renew its contract, it must notify—

(i) HCFA in writing, by July 1 of the year in which the contract would end;

* * * * *

(3) HCFA may accept a nonrenewal notice submitted after July 1 if—

* * * * *

56. Section 422.510 is amended by adding paragraph (a)(12) and revising paragraph (c)(1) to read as follows:

§ 422.510 Termination of contract by HCFA.

(a) * * *

(12) The M+C organization substantially fails to comply with the marketing requirements in § 422.80.

* * * * *

(c) * * *

(1) *General.* Before terminating a contract for reasons other than the grounds specified in paragraph (a)(5) of this section, HCFA provides the M+C organization with reasonable opportunity to develop and receive HCFA approval of a corrective action plan to correct the deficiencies that are the basis of the proposed termination.

57. Revise § 422.514(b)(1) to read as follows:

§ 422.514 Minimum enrollment requirements.

* * * * *

(b) * * *

(1) For a contract applicant or M+C organization that does not meet the applicable requirement of paragraph (a) of this section at application for an M+C contract or during the first 3 years of the contract, HCFA may waive the minimum enrollment requirement as provided for below. To receive a waiver, a contract applicant or M+C organization must demonstrate to HCFA's satisfaction that it is capable of administering and managing an M+C contract and is able to manage the level of risk required under the contract. Factors that HCFA takes into consideration in making this evaluation include the extent to which—

(i) The contract applicant or M+C organization's management and providers have previous experience in managing and providing health care services under a risk-based payment arrangement to at least as many individuals as the applicable minimum enrollment for the entity as described in paragraph (a) of this section, or

(ii) The contract applicant or M+C organization has the financial ability to bear financial risk under an M+C contract. In determining whether an organization is capable of bearing risk, HCFA considers factors such as the organization's management experience as described in paragraph (b)(1)(i) of this section and stop-loss insurance that is adequate and acceptable to HCFA; and

(iii) The contract applicant or M+C organization is able to establish a marketing and enrollment process that allows it to meet the applicable enrollment requirement specified in paragraph (a) of this section before completion of the third contract year.

* * * * *

58. Revise § 422.520(a)(3) to read as follows:

§ 422.520 Prompt payment by M+C organization.

* * * * *

(a) * * *

(3) All other claims must be paid or denied within 60 calendar days from the date of the request.

* * * * *

§ 422.550 [Amended]

59. In § 422.550(a)(2), the heading ''Unincorporated sole proprietor'' is removed and the heading ''Asset Sale'' is added in its place.

60. In § 422.561, the introductory text is republished and the definitions of ''Appeal'' and ''Authorized representative'' are revised to read as follows:

§ 422.561 Definitions.

As used in this subpart, unless the context indicates otherwise—

Appeal means any of the procedures that deal with the review of adverse organization determinations on the health care services the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service, as defined under § 422.566(b). These procedures include reconsiderations by the M+C organization, and if necessary, an independent review entity, hearings before ALJs, review by the Departmental Appeals Board (DAB), and judicial review.

Authorized representative means an individual authorized by an enrollee, or under State law, to act on his or her behalf in obtaining an organization determination or in dealing with any of the levels of the appeal process, subject to the rules described in 20 CFR part 404, subpart R, unless otherwise stated in this subpart.

* * * * *

61. Section 422.562 is amended by republishing the introductory text for paragraphs (a) and (a)(1) and revising paragraph (a)(1)(ii).

§ 422.562 General provisions.

(a) *Responsibilities of the M+C organization.* (1) An M+C organization, with respect to each M+C plan that it offers, must establish and maintain—

* * * * *

(ii) A procedure for making timely organization determinations;

* * * * *

62. Revise § 422.566(b) to read as follows:

§ 422.566 Organization determinations.

* * * * *

(b) *Actions that are organization determinations.* An organization determination is any determination made by an M+C organization with respect to any of the following:

(1) Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.

(2) Payment for any other health services furnished by a provider other than the M+C organization that the enrollee believes—

(i) Are covered under Medicare; or

(ii) If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the M+C organization.

(3) The M+C organization's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the M+C organization.

(4) Discontinuation of a service if the enrollee believes that continuation of the services is medically necessary.

(5) Failure of the M+C organization to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

* * * * *

63. Section 422.568 is revised to read as follows:

§ 422.568 Standard timeframes and notice requirements for organization determinations.

(a) *Timeframe for requests for service.* When a party has made a request for a service, the M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination. The M+C organization may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). When the M+C organization extends the timeframe, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision to grant an extension. The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

(b) *Timeframe for requests for payment.* The M+C organization must process requests for payment according to the ''prompt payment'' provisions set forth in § 422.520.

(c) *Written notification by practitioners.* At each patient encounter with an M+C enrollee, a practitioner must notify the enrollee of his or her right to receive, upon request, a detailed written notice from the M+C organization regarding the enrollee's services, consistent with paragraph (d) of this section. The practitioner's notification must—

(1) Provide the enrollee with the information necessary to contact the M+C organization; and

(2) Comply with any other requirements specified by HCFA.

(d) *Written notice for M+C organization denials.* If an enrollee requests an M+C organization to provide a detailed notice of a practitioner's decision to deny a service in whole or in part, or if an M+C organization decides to deny service or payment in whole or in part, it must give the enrollee written notice of the determination.

(e) *Form and content of the M+C organization notice.* The notice of any denial under paragraph (d) of this section must—

(1) Use approved notice language in a readable and understandable form;

(2) State the specific reasons for the denial;

(3) Inform the enrollee of his or her right to a reconsideration;

(4)(i) For service denials, describe both the standard and expedited reconsideration processes, including the enrollee's right to, and conditions for, obtaining an expedited reconsideration and the rest of the appeal process; and

(ii) For payment denials, describe the standard reconsideration process and the rest of the appeal process; and

(5) Comply with any other notice requirements specified by HCFA.

(f) *Effect of failure to provide timely notice.* If the M+C organization fails to provide the enrollee with timely notice of an organization determination as specified in this section, this failure itself constitutes an adverse organization determination and may be appealed.

64. Section 422.570 is amended by:

A. Revising paragraph (a).

B. Republishing the introductory text for paragraph (d).

C. Revising the introductory text to paragraph (d)(2) and revising paragraph (d)(2)(iii).

D. Adding a new paragraph (d)(2)(iv).

§ 422.570 Expediting certain organization determinations.

(a) *Request for expedited determination.* An enrollee or a physician (regardless of whether the physician is affiliated with the M+C organization) may request that an M+C organization expedite an organization determination involving the issues described in § 422.566(b)(3) and (b)(4). (This does not include requests for payment of services already furnished.)

* * * * *

(d) *Actions following denial.* If an M+C organization denies a request for expedited determination, it must take the following actions:

* * * * *

(2) Give the enrollee prompt oral notice of the denial and subsequently deliver, within 3 calendar days, a written letter that—

* * * * *

(iii) Informs the enrollee of the right to resubmit a request for an expedited determination with any physician's support; and

(iv) Provides instructions about the grievance process and its timeframes.

* * * * *

65. In § 422.572, revise paragraphs (b), (c), and (d) to read as follows:

§ 422.572 Timeframes and notice requirements for expedited organization determinations.

* * * * *

(b) *Extensions.* The M+C organization may extend the 72-hour deadline by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). When the M+C organization extends the deadline, it must notify the enrollee in writing of the reasons for the delay and

inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision to grant an extension. The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

(c) *Confirmation of oral notice.* If the M+C organization first notifies an enrollee of its expedited determination orally, it must mail written confirmation to the enrollee within 3 calendar days of the oral notification.

(d) *How the M+C organization must request information from noncontract providers.* If the M+C organization must receive medical information from noncontract providers, the M+C organization must request the necessary information from the noncontract provider within 24 hours of the initial request for an expedited organization determination. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the M+C organization in meeting the required timeframe. Regardless of whether the M+C organization must request information from noncontract providers, the M+C organization is responsible for meeting the timeframe and notice requirements of this section.

* * * * *

66. Section 422.584 is amended by:

A. Revising paragraph (a).

B. Republishing the introductory text to paragraph (d).

C. Revising paragraph (d)(2).

§ 422.584 Expediting certain reconsiderations.

(a) *Who may request an expedited reconsideration.* An enrollee or a physician (regardless of whether he or she is affiliated with the M+C organization) may request that an M+C organization expedite a reconsideration of a determination that involves the issues described in § 422.566(b)(3) and (b)(4). (This does not include requests for payment of services already furnished.)

* * * * *

(d) *Actions following denial.* If an M+C organization denies a request for expedited reconsideration, it must take the following actions:

* * * * *

(2) Give the enrollee prompt oral notice, and subsequently deliver, within 3 calendar days, a written letter that—

(i) Explains that the M+C organization will process the enrollee's request using the 30-day timeframe for standard reconsiderations;

(ii) Informs the enrollee of the right to file a grievance if he or she disagrees with the organization's decision not to expedite;

(iii) Informs the enrollee of the right to resubmit a request for an expedited reconsideration with any physician's support; and

(iv) Provides instructions about the grievance process and its timeframes.

* * * * *

67. Section 422.590 is amended by:

A. Republishing the heading for paragraph (a) and revising paragraph (a)(1).

B. Republishing the heading for paragraph (d) and revising paragraphs (d)(2), (d)(3), and (d)(4).

C. Republishing the heading for paragraph (g) and revising paragraph (g)(2).

§ 422.590 Timeframes and responsibility for reconsiderations.

(a) *Standard reconsideration: Request for services.* (1) If the M+C organization makes a reconsidered determination that is completely favorable to the enrollee, the M+C organization must issue the determination (and effectuate it in accordance with § 422.618(a)) as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days from the date it receives the request for a standard reconsideration. The M+C organization may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). When the M+C organization extends the timeframe, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision to grant an extension. For extensions, the M+C organization must issue and effectuate its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

* * * * *

(d) *Expedited reconsideration*—* * *

(2) *Extensions.* The M+C organization may extend the 72-hour deadline by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). When the M+C organization extends the timeframe, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision to grant an extension. The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires but no later than upon expiration of the extension.

(3) *Confirmation of oral notice.* If the M+C organization first notifies an enrollee of a completely favorable expedited reconsideration, it must mail written confirmation to the enrollee within 3 calendar days.

(4) *How the M+C organization must request information from noncontract providers.* If the M+C organization must receive medical information from noncontract providers, the M+C organization must request the necessary information from the noncontract provider within 24 hours of the initial request for an expedited reconsideration. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the M+C organization in meeting the required timeframe. Regardless of whether the M+C organization must request information from noncontract providers, the M+C organization is responsible for meeting the timeframe and notice requirements.

* * * * *

(g) *Who must reconsider an adverse organization determination.* * * *

(2) When the issue is the M+C organization's denial of coverage based on a lack of medical necessity (or any substantively equivalent term used to describe the concept of medical necessity), the reconsidered determination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue. The physician making the reconsidered determination need not, in all cases, be of the same specialty or subspecialty as the treating physician.

68. In § 422.594, the introductory text for paragraph (b) is republished, and paragraph (b)(1) is revised to read as follows:

§ 422.594 Notice of reconsidered determination by the independent entity.

* * * * *

(b) *Content of the notice.* The notice must—

(1) State the specific reasons for the entity's decisions in understandable language;

* * * * *

69. Revise § 422.596 to read as follows:

§ 422.596 Effect of a reconsidered determination.

A reconsidered determination is final and binding on all parties unless a party other than the M+C organization files a request for a hearing under the provisions of § 422.602, or unless the reconsidered determination is revised under § 422.616.

70. Revise § 422.612(b) to read as follows:

§ 422.612 Judicial review.

* * * * *

(b) *Review of Board decision.* Any party, including the M+C organization, may request judicial review (upon notifying the other parties) of the Board decision if it is the final decision of HCFA and the amount in controversy is $ 1,000 or more.

* * * * *

71. Section 422.618 is amended by:

A. Revising the section heading.

B. Redesignating paragraph (b) as paragraph (c).

C. Adding a new paragraph (b).

D. Revising newly designated paragraph (c).

§ 422.618 How an M+C organization must effectuate standard reconsidered determinations or decisions.

* * * * *

(b) *Reversals by the independent outside entity.* (1) *Requests for service.* If, on reconsideration of a request for service, the M+C organization's determination is reversed in whole or in part by the independent outside entity, the M+C organization must authorize the service under dispute within 72 hours from the date it receives notice reversing the determination, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days from that date. The M+C organization must inform the independent outside entity that the organization has effectuated the decision.

(2) *Requests for payment.* If, on reconsideration of a request for payment, the M+C organization's determination is reversed in whole or in part by the independent outside entity, the M+C organization must pay for the service no later than 30 calendar days from the date it receives notice reversing the organization determination. The M+C organization must inform the independent outside entity that the organization has effectuated the decision.

(c) *Reversals other than by the M+C organization or the independent outside entity.* If the independent outside entity's determination is reversed in whole or in part by the ALJ, or at a higher level of appeal, the M+C organization must pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days from the date it receives notice reversing the determination. The M+C organization must inform the independent outside entity that the organization has effectuated the decision.

72. Add new § 422.619 to read as follows:

§ 422.619 How an M+C organization must effectuate expedited reconsidered determinations.

(a) *Reversals by the M+C organization.* If on reconsideration of an expedited request for service, the M+C organization completely reverses its organization determination, the M+C organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 72 hours after the date the M+C organization receives the request for reconsideration (or no later than upon expiration of an extension described in § 422.590(d)(2)).

(b) *Reversals by the independent outside entity.* If the M+C organization's determination is reversed in whole or in part by the independent outside entity, the M+C organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. The M+C organization must inform the independent outside entity that the organization has effectuated the decision.

(c) *Reversals other than by the M+C organization or the independent outside entity.* If the independent review entity's expedited determination is reversed in whole or in part by the ALJ, or at a higher level of appeal, the M+C organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 days from the date it receives notice reversing the determination. The M+C organization must inform the independent outside entity that the organization has effectuated the decision.

73. Section 422.620 is revised to read as follows:

§ 422.620 How enrollees of M+C organizations must be notified of noncoverage of inpatient hospital care.

(a) *Enrollee's entitlement.* Where an M+C organization has authorized coverage of the inpatient admission of an enrollee, either directly or by delegation (or the admission constitutes emergency or urgently needed care, as described in §§ 422.2 and 422.113), written notice of noncoverage under paragraph (c) of this section must be provided to each enrollee. An enrollee is entitled to coverage until at least noon the day after such notice is provided. If PRO review is requested under § 422.622, coverage is extended as provided in that section.

(b) *Physician concurrence required.* Before notice of noncoverage is provided as described in paragraph (c) of this section, the entity that makes the noncoverage/discharge determination (that is, the hospital by delegation or the M+C organization) must obtain the concurrence of the physician who is responsible for the enrollee's hospital care.

(c) *Notice to the enrollee.* In all cases in which a determination is made that inpatient hospital care is no longer necessary, no later than the day before hospital coverage ends, written notice must be provided to the enrollee that includes the following elements:

(1) The reason why inpatient hospital care is no longer needed.

(2) The effective date and time of the enrollee's liability for continued inpatient care.

(3) The enrollee's appeal rights.

(4) Additional information specified by HCFA.

74. Revise § 422.648(b) to read as follows:

§ 422.648 Reconsideration: Applicability.

* * * * *

(b) HCFA reconsiders the specified determinations if the contract applicant or the M+C organization files a written request in accordance with § 422.650.

75. In § 422.650, paragraphs (c) and (d) are revised to read as follows:

§ 422.650 Request for reconsideration.

* * * * *

(c) *Proper party to file a request.* Only an authorized official of the contract applicant or M+C organization that was the subject of a contract determination may file the request for reconsideration.

(d) *Withdrawal of a request.* The M+C organization or contract applicant who filed the request for a reconsideration may withdraw it at any time before the notice of the reconsidered determination is mailed. The request for

withdrawal must be in writing and filed with HCFA.

76. Revise § 422.652 to read as follows:

§ 422.652 Opportunity to submit evidence.

HCFA provides the M+C organization or contract applicant and the HCFA official or officials who made the contract determination reasonable opportunity, not to exceed the timeframe in which an M+C organization could choose to request a hearing as described at § 422.662, to present as evidence any documents or written statements that are relevant and material to the matters at issue.

77. Revise § 422.656 to read as follows:

§ 422.656 Notice of reconsidered determination.

(a) HCFA gives the M+C organization or contract applicant written notice of the reconsidered determination.

(b) The notice—

(1) Contains findings with respect to the contract applicant's qualifications to enter into, or the M+C organization's qualifications to remain under, a contract with HCFA under Part C of title XVIII of the Act;

(2) States the specific reasons for the reconsidered determination; and

(3) Informs the M+C organization or contract applicant of its right to a hearing if it is dissatisfied with the determination.

78. In § 422.660, the introductory text is republished and paragraph (a) is revised to read as follows:

§ 422.660 Right to a hearing.

The following parties are entitled to a hearing:

(a) A contract applicant that has been determined in a reconsidered determination to be unqualified to enter into a contract with HCFA under Part C of title XVIII of the Act.

* * * * *

79. In § 422.662, paragraphs (a) and (b) are revised to read as follows:

§ 422.662 Request for hearing.

(a) *Method and place for filing a request.* A request for a hearing must be made in writing and filed by an authorized official of the contract applicant or M+C organization that was the party to the determination under appeal. The request for a hearing must be filed with any HCFA office.

(b) *Time for filing a request.* A request for a hearing must be filed within 15 days after the date of the reconsidered determination.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 15, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Approved: June 16, 2000.

Donna E. Shalala,

Secretary.

[FR Doc. 00–15648 Filed 6–19–00; 12:00 pm]

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June 29, 2000

Part III

Securities and Exchange Commission

17 CFR Part 248
Privacy of Consumer Financial Information (Regulation S–P); Rules

SECURITIES AND EXCHANGE COMMISSION

17 CFR Part 248

[Release Nos. 34–42974, IC–24543, IA–1883; File No. S7–6–00]

RIN 3235–AH90

Privacy of Consumer Financial Information (Regulation S–P)

AGENCY: Securities and Exchange Commission.

ACTION: Final rule.

SUMMARY: The Securities and Exchange Commission is adopting Regulation S–P, privacy rules promulgated under section 504 of the Gramm-Leach-Bliley Act. Section 504 requires the Commission and other federal agencies to adopt rules implementing notice requirements and restrictions on a financial institution's ability to disclose nonpublic personal information about consumers. Under the Gramm-Leach-Bliley Act, a financial institution must provide its customers with a notice of its privacy policies and practices, and must not disclose nonpublic personal information about a consumer to nonaffiliated third parties unless the institution provides certain information to the consumer and the consumer has not elected to opt out of the disclosure. The Act also requires the Commission to establish for financial institutions appropriate standards to protect customer information. The final rules implement these requirements of the Gramm-Leach-Bliley Act with respect to investment advisers registered with the Commission, brokers, dealers, and investment companies, which are the financial institutions subject to the Commission's jurisdiction under that Act.

DATES: *Effective Date:* This regulation is effective November 13, 2000.

Compliance Dates: Compliance will be mandatory as of July 1, 2001. Joint marketing and service agreements in effect as of July 1, 2000 must be brought into compliance with § section 248.13 of Regulation S–P by July 1, 2002.

FOR FURTHER INFORMATION CONTACT: For information regarding the rules as they relate to brokers or dealers, contact George Lavdas or Jerome Roche, Office of Chief Counsel, Division of Market Regulation, (202) 942–0073, or regarding the rules as they relate to investment companies or registered investment advisers, Penelope W. Saltzman or Hugh P. Lutz, Office of Regulatory Policy, (202) 942–0690, Division of Investment Management, Securities and Exchange Commission, 450 5th Street, NW., Washington, DC 20549.

SUPPLEMENTARY INFORMATION: The Securities and Exchange Commission (the ''Commission'') today is adopting new Regulation S–P, 17 CFR 248.1–248.30, under Title V of the Gramm-Leach-Bliley Act [Pub. L. No. 106–102, 113 Stat. 1338 (1999), to be codified at 15 U.S.C. 6801–6831], the Securities Exchange Act of 1934 [15 U.S.C. 78] (''Exchange Act''), the Investment Company Act of 1940 [15 U.S.C. 80a] (''Investment Company Act''), and the Investment Advisers Act of 1940 [15 U.S.C. 80b] (''Investment Advisers Act'').

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I. Background

Subtitle A of Title V of the Gramm-Leach-Bliley Act (''G–L–B Act'' or the ''Act''), captioned Disclosure of Nonpublic Personal Information (''Title V''), limits the instances in which a financial institution may disclose nonpublic personal information about a consumer to nonaffiliated third parties, and requires a financial institution to disclose to all of its customers the institution's privacy policies and practices with respect to information sharing with both affiliates and nonaffiliated third parties. Title V also requires the Office of the Comptroller of the Currency, Board of Governors of the Federal Reserve System, Federal Deposit Insurance Corporation, Office of Thrift Supervision (collectively, the ''Banking Agencies''), Secretary of the Treasury, National Credit Union Administration, Federal Trade Commission (collectively with the Banking Agencies, the ''Agencies''), and the Commission, after consulting with representatives of State insurance authorities designated by the National Association of Insurance Commissioners, to prescribe regulations necessary to carry out the purposes of Title V.[1]

Commission representatives participated with representatives from the Agencies in drafting rules to implement Title V. As required by the G–L–B Act, the rules we are adopting today are, to the extent possible, consistent with and comparable to the rules adopted by the Agencies.[2] Regulation S–P contains rules of general applicability that are substantially similar to the rules adopted by the Agencies. The rules also contain examples that illustrate the application of the general rules. These examples differ from those used by the Agencies in order to provide more meaningful guidance to the financial institutions subject to the Commission's jurisdiction.

Title V also requires the Commission (and each of the Agencies) to establish appropriate standards for financial institutions subject to their jurisdiction to safeguard customer information and records. Regulation S–P includes requirements for investment advisers registered with the Commission (''registered advisers''), brokers, dealers (collectively, ''broker-dealers''), and investment companies (''funds'') to adopt appropriate policies and procedures that address safeguards to protect this information.[3]

II. Overview of Comments Received

On March 2, 2000, the Commission issued a notice of proposed rulemaking (the ''proposal'' or ''proposed rules'').[4] The Commission received a total of 115 comments in response to the proposal.[5] Of these, approximately 14 were from individuals, virtually all of whom encouraged the Commission to provide greater protection of individuals' financial privacy. Many individuals noted their concerns generally about the

[1] G–L–B Act § 504(a)(1).

[2] *See* G–L–B Act § 504(a). The Banking Agencies published a joint release adopting rules to implement Title V earlier this month. Privacy of Consumer Financial Information, 65 FR 35162 (June 1, 2000) (''Banking Agencies' Release''). The National Credit Union Administration approved its final rules on May 8, 2000 [Privacy of Consumer Financial Information; Requirements for Insurance, 65 FR 31722 (May 18, 2000)]. The Federal Trade Commission adopted its privacy rules on May 12, 2000 [Privacy of Consumer Financial Information, 65 FR 33646 (May 24, 2000)].

[3] Under the G–L–B Act, investment advisers registered with the States are regulated by the Federal Trade Commission. *See* G–L–B Act § 505(a)(7).

[4] Privacy of Consumer Financial Information (Regulation S–P), Exchange Act Release No. 42484 (Mar. 2, 2000) [65 FR 12354 (Mar. 8, 2000)] (''Proposing Release'').

[5] The Banking Agencies, FTC, and NCUA received a total of 8,126, 640, and 99 comments, respectively, in response to their proposed rules.

loss of privacy and the receipt of unwanted solicitations by marketers.[6]

Other commenters advocated that we extend privacy protections in a number of ways. These suggestions included requiring (i) financial institutions to provide consumers with access to information about them maintained by the institutions and the opportunity to correct errors, (ii) more detailed disclosures of the information collected and disclosed, and (iii) disclosures of a financial institution's privacy policies and practices earlier in the process of establishing a customer relationship.

The National Association of Insurance Commissioners (''NAIC'') submitted a comment on behalf of the State insurance authorities that generally supported the Commission's proposed rules. The NAIC also proposed various measures to provide certain protections for consumers, such as specifying means to exercise the right to opt out of the disclosure of information. The NAIC further advised the Commission to clarify the boundary of federal and State jurisdiction over privacy regulations and ensure that the financial privacy rules under the Act are compatible with the privacy rules relating to medical information that are to be issued by the Secretary of the Department of Health and Human Services (''HHS'') under the Health Insurance Portability and Accountability Act (''HIPAA'') of 1996.[7]

We received approximately 20 letters from broker-dealers, funds, registered advisers, insured depository institutions, bank holding companies, and their representatives.[8] These commenters suggested many changes to the proposed rules. The most common suggestions included: (i) Extending the effective date of the rules; (ii) amending the definition of ''nonpublic personal information'' to focus more clearly on what they believe is ''financial'' information; (iii) streamlining information required in the initial and annual disclosures; (iv) clarifying how one or more of the statutory exceptions operate; (v) revising or clarifying the definitions of ''consumer'' and ''customer''; and (vi) adding flexibility to provide initial notices at some point other than ''prior to'' the time a customer relationship is established.

We have modified the proposed rules in light of the comments received.[9] These comments, and our responses to them, are discussed in the following section-by-section analysis.

III. Section-by-Section Analysis

The final Regulation presents the various sections in five subparts that consist of related sections. Related concepts are grouped together to make the rules easier to follow. A comparison table is included in section V to assist readers in locating provisions that appeared in the proposal. We also have added an Appendix to the final rules, setting out sample disclosures for broker-dealers, funds, and registered advisers to consider.

Section 248.1 Purpose and Scope

We are revising section 248.1, which identifies the purposes and scope of the rules. As stated in the proposal, the rule is intended to require a broker-dealer, fund, or registered adviser to provide notice to customers about its privacy policies and practices; to describe the conditions under which the institution may disclose nonpublic personal information about consumers to nonaffiliated third parties; and to provide a method for consumers to prevent the financial institution from disclosing that information to certain nonaffiliated third parties by ''opting out'' of that disclosure, subject to various exceptions as stated in the rules.

Most of the comments received on this section focused on the scope of the rules. Several commenters suggested that the Commission clarify how the rules apply to insurance companies. Section 505 of the G–L–B Act sets out the Commission's enforcement authority with respect to broker-dealers, funds, and registered advisers. The section explicitly excludes ''persons providing insurance'' from the Commission's (and the Agencies') enforcement authority (and, by operation of section 504(a)(1) of the G–L–B Act, from the Commission's and the Agencies' rulemaking authority). We believe that the G–L–B Act relies on the States to enforce Title V with respect to any insurance activities conducted by broker-dealers, funds, or registered advisers. Consistent with this reading of the statute, the final rule excludes the provision of insurance by a broker-dealer, fund, or registered adviser from the scope of Regulation S–P. If the insurance product also is a security, however, any broker-dealer or fund that provides that security, or registered adviser that provides advice with respect to that security is subject to Regulation S–P.[10] In addition, insurance company separate accounts that are ''investment companies'' under the Investment Company Act are subject to this part.[11]

Several commenters stated that Regulation S–P should apply to foreign financial institutions that solicit business from individuals in the United States. As adopted, the requirements of Regulation S–P apply to any broker-dealer, fund, or investment adviser that is registered with the Commission, regardless of whether its consumers are U.S. persons or non-U.S. persons, and regardless of whether it conducts its activities through U.S. or non-U.S. offices or branches.[12] We also have decided not to apply Regulation S–P to any foreign (or ''non-resident'') broker-dealer or fund that is not registered with the Commission. Despite the broad reach of the U.S. federal securities laws,[13] we believe it would be impractical to apply Regulation S–P to those foreign unregistered entities. If a foreign broker-dealer or fund conducts activities through U.S. interstate commerce in a manner that subjects it to the registration requirements of the U.S. securities laws, it is subject to those requirements and any other applicable protections to investors, such as anti-fraud protections. We do not believe that subjecting these unregistered entities to the obligation to provide the privacy and opt out notices under Regulation S–P would add to the protections provided to investors under the G–L–B Act. As noted above,

[6] Commenters also requested that the Commission support legislation that the commenters believe would provide additional protections. In addition, the Commission received a comment letter from the Congressional Privacy Caucus, which encouraged the Commission to exercise its rulemaking authority to provide more protections than were proposed. The Chairman of the Commission also received two letters signed by several members of Congress, and a third letter from other commenters, which urged the Commission not to delay the compliance date of the final rules until July 1, 2001.

[7] *See* Standards for Individually Identifiable Health Information, 64 FR 59918 (Nov. 3, 1999) (as amended by 65 FR 427 (Jan. 5, 2000)).

[8] Representatives of a wide variety of other interests, including the health care industry, retail merchants, insurance companies, credit bureaus, and higher education, also submitted comment letters.

[9] We also have included a guide to assist broker-dealers, funds, and registered advisers in their efforts to comply with the privacy rules. *See infra* section VI.

[10] *See infra* discussion of sections 248.3(j), (k) (noting that variable annuities and variable life insurance contracts are insurance products and securities).

[11] *See infra* section 248.3(r).

[12] The Regulation also applies to any unregistered broker, dealer or fund in the United States. *See* section 248.1. In accordance with the G–L–B Act, however, Regulation S–P does not apply to any investment adviser that is not registered with the Commission. *See* G–L–B Act §§ 505(a)(5) (Commission has jurisdiction over broker-dealers, funds, and registered advisers); 505(a)(7) (Federal Trade Commission has jurisdiction over financial institutions not subject to the specific jurisdiction of the federal functional regulators). We also note that the privacy rules of Banking Agencies do not apply to foreign offices of financial institutions. *See, e.g.*, Banking Agencies' Release, sections 40.1, 216.1, 332.1, 573.1.

[13] *See, e.g.*, *Alfadda* v. *Fenn*, 935 F.2d 475 (2d Cir.), *cert. denied*, 502 U.S. 1005 (1991); *see also Steele* v. *Bulova Watch Co.*, 344 U.S. 280 (1952).

however, if a foreign broker-dealer, fund, or investment adviser decides to register with the Commission, it would be required to comply fully with Regulation S–P.[14]

Several commenters suggested that the rule should not apply to entities that must comply with regulations proposed by HHS to implement the HIPAA.[15] We do not believe that broker-dealers, funds, or registered advisers would be subject to any rules HHS has proposed under HIPAA regarding protected health information. We recognize, however, that there could be areas of overlap between the rules adopted by HHS under HIPAA and the privacy rules. After HHS publishes its final rules, we will consult with HHS to avoid the imposition of duplicative or inconsistent requirements.

Section 248.2 Rule of Construction

We are revising section 248.2, which sets out a rule of construction intended to clarify the effect of the examples used in the rules, to include the sample clauses in the Appendix to the rules. As noted in the Proposing Release, the examples (and the sample clauses) are not intended to be exhaustive; rather, they are intended to provide guidance about how the rules would apply in specific situations.[16]

Commenters generally agreed that examples are helpful in clarifying how the rules will work in specific circumstances. Some commenters also suggested that we include more examples, and provide examples of model disclosures. A few commenters suggested that the regulation state that a financial institution is not obligated to comply with an example but has the latitude to comply with the general rules in other ways. Other commenters also requested that we treat the examples as safe harbors or establish a presumption that compliance with the examples constitutes compliance with the rules. Others stated that the examples ought to be identical in each privacy regulation adopted by the Commission and the Agencies.

We agree that more examples would be helpful, and have included additional examples in appropriate places throughout the rules. We also have provided sample clauses in the Appendix to assist broker-dealers, funds, and registered advisers in drafting privacy notices. The sample clauses are provided to illustrate the level of detail we believe is appropriate. We caution financial institutions against relying on the sample disclosures without determining the relevance or appropriateness of the disclosure for their operations. We have used statutory terms, such as ''nonpublic personal information'' and ''nonaffiliated third parties,'' in the sample clauses to convey generally the subject of the clauses. However, a financial institution that uses these terms must provide sufficient information to enable consumers to understand what these terms mean in the context of the institution's notices.[17]

We have not added a statement in the final rule regarding a financial institution's ability to comply with the rules in ways other than as suggested in the examples. The rule states that the facts and circumstances of each individual situation will determine whether compliance with an example constitutes compliance with the applicable rule.[18] The examples and the sample clauses do not provide a safe harbor.[19] Nevertheless, we believe that, when read together, the rule of construction, examples, and sample clauses provide broker-dealers, funds, and registered advisers sufficient guidance on ways to comply with the rules as well as sufficient flexibility to comply with the regulation in ways appropriate for the institution.

Section 248.3 Definitions

(a) *Affiliate.* We are adopting the definition of ''affiliate'' as proposed. The rule incorporates the definition of ''affiliate'' in the G–L–B Act.[20] An affiliation exists when one company ''controls'' (as defined in section 248.3(g) below), is controlled by, or is under common control with another company. The definition includes both financial institutions and entities that are not financial institutions. The proposed rule also provided that a broker-dealer, fund, or registered adviser would be considered an affiliate of another company if the other company is regulated under Title V by one of the Agencies, and under that Agency's rules, the other entity would be affiliated with the broker-dealer, fund, or registered adviser. Few commenters addressed this definition, and none disagreed with it.

(b) *Broker.* We are adopting the definition of ''broker'' as proposed. The definition incorporates the meaning of ''broker'' in the Exchange Act. One commenter suggested that the definition exclude foreign banks and savings institutions because they will be subject to the privacy rules of the Banking Agencies.[21] We disagree, and the rule does not include this exception.[22] Brokers registered with the Commission include foreign entities that may not be subject to the Banking Agencies' privacy rules, which do not extend to foreign entities that do not have offices within the United States.[23]

(c) *Clear and conspicuous.* We are revising the definition of ''clear and conspicuous'' in response to issues raised by commenters. The proposed rules required various notices to be ''clear and conspicuous,'' and defined the term to mean that the notice must be reasonably understandable and designed to call attention to the nature and significance of the information contained in the notice. The proposal did not mandate the use of any particular technique for making the notices clear and conspicuous, but provided examples of how a notice may be made clear and conspicuous. As noted in the Proposing Release, each financial institution would retain the flexibility to decide for itself how best to comply with this requirement.[24]

We received a large number of comments on the proposed definition. Several commenters favored adopting the definition as proposed, with some advocating that the final rule include a requirement that disclosures be on a separate piece of paper in order to ensure that they will be conspicuous. Others stated that the definition was unnecessary, given the experience financial institutions have in complying

[14] We note that a foreign broker-dealer, fund, or investment adviser that registers with the Commission also must comply with regulatory requirements concerning service of process in the United States. *See* Exchange Act rule 15b1–5(a) [17 CFR 240.15b1–5(a)] (requiring foreign broker-dealer that registers with the Commission to consent to service of process in the United States). *See also* Investment Company Act rule 7d–1(b)(7) [17 CFR 7d–1(b)(7)]; Investment Advisers Act rule 0–2 [17 CFR 275.0–2].

[15] *See supra* note 7.

[16] *See* Proposing Release, *supra* note 4, at discussion of section 248.2.

[17] The sample disclosures address solely the level of detail required and do not attempt to provide guidance on issues such as type size, margin width, or other characteristics that affect whether a notice is clear and conspicuous.

[18] *Cf.* Banking Agencies' Release, *supra* note 2, at sections 40.2, 216.2, 332.2, 573.2 (''Compliance with an example or use of a sample clause, to the extent applicable, constitutes compliance with this part.'').

[19] *Compare* Banking Agencies' Release, *supra* note 2, sections 40.2, 216.2, 332.2, 573.2.

[20] G–L–B Act § 509(6).

[21] *See supra* discussion of section 248.2. We are unaware of any savings institution that is registered as a broker and would be subject to Regulation S–P.

[22] *See also supra* discussion of section 248.1 (privacy rules apply to the foreign offices of registered broker-dealers, funds, and advisers, in addition to the U.S. offices of all broker-dealers, funds, and registered advisers).

[23] Banking Agencies' Release, *supra* note 2, sections 40.1(b), 216.1(b), 332.1(b), 573.1(b).

[24] *See* Proposing Release, *supra* note 4, at discussion of proposed section 248.3(c).

with requirements that disclosures mandated by other laws be clear and conspicuous. Several commenters stated that the definition is inconsistent with requirements in other consumer protection regulations such as Regulation Z[25] and the Truth in Savings regulation,[26] which require only that a disclosure be reasonably understandable.[27] A few commenters questioned how the requirement would work in a document that contains several disclosures that are required to be clear and conspicuous, while others raised questions about how a disclosure may be clear and conspicuous on an Internet web site.

New standard for ''clear and conspicuous.'' The proposed definition developed the concept of ''clear and conspicuous.'' The phrase ''designed to call attention to the nature and significance of the information contained'' was intended to provide meaning to the term ''conspicuous.'' We believe that this standard will result in notices to consumers that communicate effectively the information consumers need in order to make an informed choice about the privacy of their information, including whether to open a brokerage account, purchase fund shares, or enter into an advisory contract with an adviser.

Examples of ''clear and conspicuous.'' We recognize that many of the examples are imprecise. We believe, however, that more prescriptive examples, while perhaps easier to conform to, likely would result in requirements that would be inappropriate in a given circumstance. To avoid this result, the examples provide generally applicable guidance about ways in which a broker-dealer, fund, or registered adviser may make a disclosure clear and conspicuous. We note that the examples do not mandate how to make a disclosure clear and conspicuous. A financial institution must decide for itself how best to comply with the general rule, and may use techniques not listed in the examples. To address concerns about the imprecision of the examples, we have incorporated several of the commenters' suggestions in the final rule for ways to make the guidance more helpful.[28]

Combination of several notices. Commenters stated that a document may combine different types of disclosures that are subject to specific disclosure requirements under different regulations. For example, a fund that includes a privacy notice in its prospectus would have to make the privacy notice clear and conspicuous, and would have to prepare the prospectus according to certain standards under the Securities Act of 1933.[29] The final rule provides an example of how a financial institution may make privacy disclosures conspicuous, including privacy disclosures that are combined in a document with other information.[30] In order to avoid the potential conflicts between two different rules requiring different sets of disclosures that are subject to different standards, the final rule does not mandate precise specifications for presenting various disclosures.

Disclosures on Internet web pages. Several commenters requested guidance on how they may clearly and conspicuously disclose privacy-related information on their Internet sites. Disclosures over the Internet may present some issues that will not arise in paper-based disclosures. Consumers may view various web pages within a financial institution's web site in a different order each time they access the site, aided by hypertext links. Depending on the hardware and software used to access the Internet, some web pages may require consumers to scroll down to view the entire page. To address these issues, the example concerning Internet disclosures states that broker-dealers, funds, and registered advisers may comply with the rule if they use text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the web site (such as text, graphics, hypertext links, or sound) do not distract attention from the notice.[31] The examples also note that the institution should place a notice or a conspicuous link on a screen that consumers frequently access, such as a page on which consumers conduct transactions.

There is a range of approaches a broker-dealer, fund, or registered adviser could use based on current technology. For example, a broker-dealer could use a dialog box that pops up to provide the disclosure before a consumer provides information to a financial institution. Another approach would be a simple, clearly labeled graphic located near the top of the page or in close proximity to the financial institution's logo, directing the customer, through a hypertext link or hotlink, to the privacy disclosures on a separate web page.

(d) *Collect.* We are revising the definition of ''collect'' to clarify the scope of the term.[32] The G–L–B Act requires a financial institution to disclose in its initial and annual notices the categories of nonpublic personal information that the institution collects. The proposal defined ''collect'' to mean obtaining any information that is organized or retrievable on a personally identifiable basis, irrespective of the source of the underlying information. This definition was included to provide guidance about the information that a broker-dealer, fund, or registered adviser must include in its notices and to clarify that the obligations arise regardless of whether the institution obtains the information from a consumer or from some other source.

Commenters suggested that the final rule treat information that is not organized and retrievable in an automated fashion as not ''collected.'' We disagree that information should not be deemed to be collected simply because it is not retrievable in an automated fashion. We believe that the method of retrieval is irrelevant to whether information should be protected under the rule. We agree, however, that the scope of the regulation should be refined, and have changed the definition of ''collect'' by using language from the Privacy Act of 1974.[33]

Other commenters requested that the rule clarify that information that a broker-dealer, fund, or registered adviser receives but then immediately passes along without retaining a copy, is not ''collected.'' We believe that merely receiving information without retaining it would not be ''collecting'' the information. The final rule reflects this by stating that the information must be organized or retrievable by the financial institution.

(f) *Company.* We received no substantive comments on the proposed definition of ''company'' and are adopting it as proposed.[34]

(g) *Consumer.* We are adopting as proposed the definition of ''consumer,''

[25] 12 CFR part 226.

[26] Regulation DD, 12 CFR part 230.

[27] Many of these commenters expressed concern that the examples would invite litigation because of ambiguities inherent in terms used in the examples in the proposed rule such as ''ample line spacing,'' ''wide margins,'' and ''explanations * * * subject to different interpretations.''

[28] *See* section 248.3(c)(2).

[29] *See* 17 CFR 230.421(b).

[30] *See* section 248.3(c)(2)(ii)(E). Because we believe that privacy disclosures may be clear and conspicuous when combined with other disclosures, the rule does not mandate that privacy disclosures be provided on a separate piece of paper. The requirement is not necessary and would significantly increase the burden on financial institutions.

[31] Section 248.3(c)(2)(iii).

[32] *See* section 248.3(d).

[33] 5 U.S.C. 552a.

[34] See section 248.3(f).

and are revising the examples under the definition in response to issues raised by commenters. The G–L–B Act distinguishes ''consumers'' from ''customers'' for purposes of the statute's notice requirements. A broker-dealer, fund, or registered adviser is required to give a ''consumer'' the notices required under Title V only if the institution intends to disclose nonpublic personal information about the consumer to a nonaffiliated third party for purposes other than as permitted by section 502(e) of the statute.[35] We received a large number of comments on this proposed definition that raised questions about how the definition would apply in a variety of situations.

Evaluation of a request for a financial product or service. The proposal defined ''consumer'' to mean an individual (and his or her legal representative) who obtains, from a financial institution, financial products or services that are to be used primarily for personal, family, or household purposes.[36] Because ''financial product or service'' includes a financial institution's evaluation of an application or request to obtain a financial product or service, a person becomes a consumer even if the application or request is denied or withdrawn.[37] The examples for the definition of ''consumer'' clarify that a consumer includes an individual who provides nonpublic personal information when seeking to obtain brokerage or investment advisory services. For example, an investor who provides nonpublic personal information to several registered advisers (whether orally or in writing) in seeking financial advisory services would be a consumer of each registered adviser, even if the investor does not enter into an advisory contract with any of the advisers.

Many commenters disagreed that someone should be deemed a consumer of a financial institution by virtue of the institution evaluating nonpublic personal information provided by the individual in an application or otherwise. These commenters maintained that the individual has not obtained a financial product or service, as is required by the G–L–B Act. We believe, however, that a ''financial product or service'' includes the evaluation of information an individual provides to the financial institution in order to obtain some other financial product or service. Broker-dealers, funds, and registered advisers frequently provide a range of services in connection with the delivery of a financial product, including the evaluation of information provided by an individual. The evaluation may be the sole financial product or service delivered, or one of several services provided in connection with establishing a customer relationship. For example, an investor who seeks to invest in certain investment products, such as stock options, must provide a broker-dealer or registered adviser with nonpublic personal information in connection with the request. Based on this nonpublic personal information, the broker-dealer or registered adviser may open an account for the investor, but deny his or her request to invest in options. Whether the evaluation is the sole product or service or one of several, the institution's evaluation of the individual's information is a separate financial product or service.

The proposed definition of ''consumer'' also is consistent with one of the primary purposes of Title V: To enable an individual to restrict a financial institution from sharing nonpublic personal information about the individual with a nonaffiliated third party. The information an individual provides to a financial institution before a customer relationship is established is likely to contain precisely the types of information that the statute is designed to protect. This information is no less deserving of protection simply because an application is denied or withdrawn. For these reasons, we have retained in the examples in the definition of ''consumer'' an individual who provides nonpublic personal information to a broker-dealer or investment adviser in connection with obtaining brokerage or investment advisory services.[38]

Loan sales. Several commenters requested clarification of circumstances in which a borrower becomes a consumer. The final rule provides that a person will be a consumer of any entity that holds ownership or servicing rights to an individual's loan.[39] We believe that financial institutions that own or service a loan provide a financial product or service to the individual borrower in question. In some cases, the product or service is the funding of the loan, directly or indirectly. In other cases, the product or service is the processing of payments, sending account-related notices, responding to consumer questions, and complaints about the handling of the account. The final rule defines ''consumer'' in a way that covers individuals receiving financial products or services in each of these situations.

Agents of financial institutions. Several commenters maintained that an individual should not be considered to be a consumer of an entity that is acting as agent for a financial institution.[40] These commenters noted that the financial institution that hires the agent is responsible for that agent's conduct in carrying out the agency responsibilities. We agree and continue to believe that the broker-dealer, fund, or registered adviser has a consumer relationship, even if the institution uses agents to help it deliver its products or services. For example, fund consumers would not become consumers of the fund's transfer agent that services the fund's customer accounts. The final rule retains the examples addressing clearing agents and provides a more general example to illustrate this principle.[41]

Legal representative. We also agree with the suggestion by several commenters that the definition of ''consumer'' should clarify that a financial institution may satisfy the obligations stemming from a consumer relationship by dealing either with the individual who obtains a financial product or service from a financial institution or that individual's legal representative. We do not intend that the rule require a financial institution to send opt out and initial notices to *both* the individual and his or her legal representatives, and have amended the final rule accordingly.[42]

Trusts. We received several comments concerning whether an individual who obtains financial services in connection with trusts is a consumer or customer of a financial institution. Several commenters urged the Commission generally to exempt a financial institution from the requirements of the rules when it acts as a fiduciary or, in the alternative, to clarify the categories of individuals who are considered to be customers. Commenters proposed, for example, that individuals who are beneficiaries with current interests should be identified as customers, whereas individuals who are only

[35] *See* G–L–B Act § 502(a). *See also* sections 248.14 and 248.15. By contrast, the broker-dealer, fund, or registered adviser must give all ''customers'' a notice of the institution's privacy policy at the time of establishing a customer relationship and annually thereafter during the continuation of the customer relationship. G–L–B Act § 503(a).

[36] *See* proposed section 248.3(g)(1).

[37] *See* discussion of section 248.3(o) below.

[38] *See* section 248.3(g)(2)(i).

[39] Those consumers may not be customers, however. *See infra* discussion of section 248.3 (explaining how the definition of ''customer'' will be applied in the loan context). *See* section 248.4(c)(2).

[40] *See* proposed section 248.3(g)(2)(iii).

[41] *See* section 248.3(g)(2)(iii), (v).

[42] Section 248.3(g)(1).

contingent beneficiaries should not be customers. Other commenters stated that when the financial institution serves as trustee of a trust, neither the grantor nor beneficiary is a consumer or customer under the rules. In these commenters' view, the trust itself is the institution's ''customer,'' and therefore the rules should not apply to a financial institution when it acts as trustee. These commenters also stated that when a financial institution is a trustee, it serves as a fiduciary and is subject to other obligations to protect the confidentiality of the beneficiaries' information that are more stringent than those under the provisions in the G–L–B Act. Similarly, these and other commenters claimed that an individual who is a participant in an employee benefit plan administered or advised by a financial institution does not qualify as a consumer or customer. They contended that plan participants have no direct relationship with the financial institution and, in any event, the financial institution is authorized to use information that would be covered under the G–L–B Act only in accordance with the directions of the plan sponsor. The commenters concluded, therefore, that the regulations should specifically exclude individuals who are participants in an employee benefit plan from the definition of customer.

We believe that the definition of ''consumer'' in the G–L–B Act does not squarely resolve whether the beneficiary of a trust is a consumer of the financial institution that is the trustee. We agree with the commenters who concluded that, when the financial institution serves as trustee of a trust, neither the grantor nor beneficiary is a consumer or customer under the rules. Instead, the trust itself is the entity that obtains the financial services, and the rules do not apply because the trust is not an individual.[43] We note that a financial institution that is a trustee assumes obligations as a fiduciary, including the duty to protect the confidentiality of the beneficiaries' information, that are consistent with the purposes of the G–L–B Act and enforceable under State law. Accordingly, we have excluded an individual who is a beneficiary of a trust or a plan participant in an employee benefit plan, from the definitions of ''consumer'' and ''customer.'' Nevertheless, we believe that an individual who selects a financial institution to be a custodian of securities or assets in an individual retirement account or individual retirement arrangement (''IRA'') is a ''consumer'' under the G–L–B Act. We have included examples in the rule that appropriately illustrate this interpretation of the G–L–B Act.[43]

Requirements arising from consumer relationship. While the proposed and final rules define ''consumer'' broadly, we note that this definition will not result in any additional burden to a broker-dealer, fund, or registered adviser if (i) no customer relationship is established and (ii) the institution does not intend to disclose nonpublic personal information about the consumer to nonaffiliated third parties. Under the approach taken in the final rule, a broker-dealer, fund, or registered adviser is under no obligation to provide a consumer who is not a customer with any privacy disclosures unless it intends to disclose the consumer's nonpublic personal information to nonaffiliated third parties outside the exceptions in sections 248.14 and 248.15. The institution may disclose a consumer's nonpublic personal information to nonaffiliated third parties under the final rule, if it delivers the requisite notices and the consumer does not opt out. Thus, the rule allows a financial institution to avoid all of the rule's requirements for consumers who are not customers if the institution chooses not to share information about the consumers with nonaffiliated third parties. Conversely, if a broker-dealer, fund, or registered adviser chooses to share consumers' nonpublic personal information with nonaffiliated third parties, the financial institution is free to do so, provided it notifies consumers about the sharing and affords them a reasonable opportunity to opt out. In this way, the rule attempts to strike a balance between protecting an individual's nonpublic personal information and minimizing the burden on a financial institution.

(h) *Consumer reporting agency.* We received no comments on the proposed definition of ''consumer reporting agency,'' and we are adopting it as proposed.[45] The definition incorporates the definition of ''consumer reporting agency'' in the Fair Credit Reporting Act.[46]

(i) *Control.* We are adopting the definition of ''control'' as proposed. ''Control'' means the power to exercise a controlling influence over the management or policies of a company whether through ownership of securities, by contract, or otherwise. In addition, ownership of more than 25 percent of a company's voting securities creates a presumption of control of the company. This definition is used to determine when companies are affiliated.[47] Under the definition, companies are considered to be affiliates regardless of whether the control is by a company or individual.

Some commenters suggested that the rule adopt the definition of control used in Form BD to determine when an entity is a ''control affiliate.''[48] Another commenter suggested a test that focuses solely on percent of stock owned in a company in order to avoid the uncertainties from a ''control-in-fact'' test. One commenter suggested alternative definitions based on (i) the ability to control the use of information in a company in which an ownership interest exists or (ii) a bright line 10 percent ownership test that also provided for aggregating the interests of credit unions and their wholly owned subsidiaries.

We believe that a test based only on stock ownership is unlikely to be flexible enough to address all situations in which companies should be considered to be affiliated. In addition, the proposed definition of control is consistent with the definition in Form BD, except that the definition in Form BD creates a presumption of control in

[43] Similarly, a trust, partnership, or personal corporation that has an account with a broker-dealer, fund, or registered adviser would not be a customer for purposes of the privacy rules because these entities are not individuals.

[44] *See* section 248.3(g)(2)(vii)–(viii), 248.3(k)(2)(i)(D). Three commenters also requested clarification in the examples on whether an individual who uses a financial tool that a financial institution makes available on the Internet is the institution's consumer. The commenters noted that individuals generally use these tools on a one-time or sporadic basis, and the tool typically does not require the user to enter his or her name or address. Thus, the information provided through the Internet tool is not personally identifiable. We agree that under these circumstances the individual would not be the institution's ''consumer'' and that these circumstances are covered in the examples under the definition of ''consumer'' and personally identifiable financial information. *See* section 248.3(g)(2)(ii), 248.3(u)(2)(ii)(B).

[45] *See* section 248.3(h). The definition is used in sections 248.6(c)(1)(iv), 248.12(a), and 248.15(a)(5) of the final rules.

[46] 15 U.S.C. 1681a(f).

[47] *See* discussion of section 248.3(a) above.

[48] *See* Form BD, Uniform Application for Broker-Dealer Registration, Explanation of Terms, ¶ 1. Form BD defines ''control'' to mean the power, directly or indirectly, to direct the management or policies of a company, whether through ownership of securities, by contract, or otherwise. In addition, there is a presumption of control for any person that (i) is a director, general partner, or officer exercising executive responsibility (or having similar status or functions); (ii) has the right to vote 25 percent or more of a class of voting securities or the power to sell or direct the sale of 25 percent or more of a class of voting securities; or (iii) in the case of a partnership, has the right to receive upon dissolution, or has contributed, 25 percent or more of the capital.

broader circumstances.[49] The rule limits the presumption of control to ownership of more than 25 percent of the voting securities, consistent with the definition of control in the Investment Company Act.[50] This definition does not prevent a finding of control-in-fact in the circumstances that create a presumption of control under the definition in Form BD.

(j), (k) *Customer, Customer relationship.* We received a large number of comments on the definition of ''customer'' and ''customer relationship.'' A ''customer'' is a consumer who has a ''customer relationship'' with a financial institution, and a ''customer relationship'' is a continuing relationship between a consumer and a broker-dealer, fund, or registered adviser under which the institution provides a financial product or service that is to be used by the consumer primarily for personal, family, or household purposes. As noted in the proposal, a one-time transaction may be sufficient to establish a customer relationship, depending on the nature of the transaction. A consumer would not become a customer simply by engaging in an isolated transaction that by itself would be insufficient to establish a customer relationship, such as when an individual opens a brokerage account solely for the purpose of liquidating or purchasing securities as an accommodation, *i.e.,* on a one-time basis, without the expectation of engaging in other transactions.

Point at which a consumer becomes a customer. Commenters criticized the vagueness of the standard for differentiating consumers from customers. Several suggested that the distinction should be based on when a consumer and financial institution enter into a written contract for a financial product or service.

We recognize that the distinction between consumers and customers will, in some instances, require a financial institution to make a judgment about whether a customer relationship is established. When an individual engages in a transaction and is not likely to expect further communication about that transaction from the financial institution (such as brokerage services as an accommodation to buy or liquidate securities), the individual will not have established a customer relationship as a result of that transaction. In other situations when a consumer typically would receive some measure of continued service following, or in connection with, a transaction (such as when a consumer opens a brokerage account, is the record owner of fund shares, or obtains investment advice), a customer relationship is established. We believe that the distinction set out in the proposed rule, as further clarified by the examples in the final rule of when a customer relationship is and is not established, provides a sufficiently clear line while retaining flexibility to address less clear-cut situations on a case-by-case basis.

Use of ''isolated transaction'' test. The final rule does not define the distinction between consumer and customer based solely on whether the transaction is an isolated event. We used this concept in an example in the proposed rule to illustrate one of the factors that may determine whether a relationship is of a continuing nature. Several commenters suggested that this approach was insufficiently precise to serve as a workable distinction between consumers and customers. We agree that the test may not be useful in all situations, but believe that it will help clarify the status of relationships in certain circumstances. Accordingly, the final rule retains the following example of an ''isolated transaction'': providing brokerage services as an accommodation to buy or liquidate securities without the expectation of engaging in further transactions does not establish a customer relationship.[51]

Purchase of insurance. Some commenters suggested that, in the context of financial institutions that engage in the sale of insurance and that are regulated by the Commission, the customer should be the policyholder and not the beneficiary. As discussed above, Regulation S–P does not apply to the provision of insurance by broker-dealers, funds, or registered advisers. A variable annuity or variable life insurance contract, however, is both an insurance product and a security.[52] We agree with the commenters, and the final rule includes an example of purchasing a variable annuity as one situation in which a customer relationship is formed.[53] In this case, the person obtaining a financial product or service from the financial institution is the person purchasing the annuity.[54]

Sales of loans. As noted above, several commenters raised questions about loan sales. They stated that when a financial institution sells the servicing rights for a loan to another financial institution, the borrower should not be considered a customer of both institutions. Commenters suggested that the entity with which the borrower communicates about the loan (*i.e.,* the servicer) could have the *customer* relationship with the borrower, and that the other institutions could have a *consumer* relationship with the borrower.

We believe that it is appropriate to consider that a loan transaction gives rise to only one customer relationship and that this customer relationship may be transferred in connection with a sale of part or all of the loan. In this way, the borrower will not be inundated by privacy notices, many of which might be from secondary market purchasers that the borrower did not know had any connection to his or her loan. We note, however, that a borrower will remain a consumer of the institution that transfers the servicing rights, as well as a consumer of any other institution that holds an interest in the loan.

Under the final rules, therefore, a financial institution will be considered to have established a customer relationship with any individual to whom it makes a loan.[55] If the institution transfers the servicing rights of that loan to another institution, the second institution will establish a customer relationship with the individual, and the first institution's customer relationship will end (if the relationship is based solely on the loan).[56] If the originating lender sells the loan but continues to service the loan, it will continue to have a customer relationship with the borrower, and the purchaser will have a consumer relationship with the borrower.[57] For example, a broker-dealer who purchases a loan, but not the servicing rights to the loan, will have a *consumer* relationship, but not a *customer* relationship, with the borrower.[58]

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[49] *Id. See also* section 248.3(i).

[50] *See* 15 U.S.C. 80a–2(a)(9).

[51] *See* section 248.3(k)(2)(ii).

[52] *See e.g., SEC* v. *Variable Annuity Life Ins. Co.,* 359 U.S. 65 (1959) (variable annuities); Exemption of Certain Variable Life Insurance Contracts and Their Issuers from Federal Securities Laws, Investment Company Act Release No. 7644 (Jan. 31, 1973) [38 FR 4315 (Feb. 13, 1973)] (variable life contracts).

[53] *See* section 248.3(k)(2)(i)(E).

[54] These individuals could include a contract owner and could also include any other individual who has the rights of a contract owner, such as the ability to direct underlying investments.

[55] *See* section 248.3(k)(2)(i)(A) (consumer who has a brokerage account (including a margin account) has a continuing relationship with a broker-dealer).

[56] The originating lender will then have a *consumer* relationship with the borrower.

[57] In those circumstances, the borrower will be entitled to receive initial and annual notices from the loan servicer.

[58] A broker-dealer who purchases loans for securitization would have to provide notice and opt out to borrowers before sharing nonpublic personal information about the borrowers with nonaffiliated third parties, unless the sharing was necessary to effect or administer the securitization. *See* section 248.14(a)(3).

Fund shares purchased through an intermediary. Several commenters suggested that an individual who is the record owner of fund shares should not be a fund's ''customer'' if the fund is limited, under its contract with the intermediary who sold the shares, to servicing the investor's account. The commenters argue that these investors would be confused by receiving privacy notices from the fund. We proposed a ''bright line'' example of record ownership to establish the customer relationship because the fund clearly has nonpublic personal information about its record owners that is personally identifiable. We do not believe that an investor who receives account statements and other information from a fund that services the investor's account will be confused by receiving notices regarding the fund's privacy policies and practices. Moreover, an investor is unlikely to know whether a fund is contractually limited in its use of the investor's nonpublic personal information or whether those contract terms may change. For these reasons, we are adopting the proposed example that record owners of fund shares are the fund's customers.[59]

Fund complex. One commenter suggested that a customer of a fund should be considered a customer of the fund complex, which may include the fund's primary investment adviser, or that a fund customer, at least in some cases, should also be considered a customer of the fund's primary investment adviser. We noted in the Proposing Release that the record owner of fund shares has a customer relationship with both the fund and the principal underwriter (which is a broker-dealer) that sells the shares.[60] The customer relationship with the broker-dealer arises because the investor has an account with the broker-dealer, who provides financial services directly to the investor. By contrast, an investment adviser to a fund does not generally have an ongoing account relationship with each fund shareholder. Instead, it serves the fund shareholders indirectly through the portfolio management services it provides to the fund.

We recognize that the definition of ''customer'' may have disparate effects on the ability of some investment advisers to receive nonpublic personal information about fund investors. For example, if the underwriter of a fund is affiliated with the fund's investment adviser, the underwriter can share nonpublic personal information about its customers with the adviser. By contrast, if the underwriter is not affiliated with the fund's investment adviser, the underwriter can share this type of information only under an exception in section 248.13, 248.14, or 248.15, and the adviser's ability to reuse the information would be limited to the purpose for which it received the information. These limitations result from the language of the G–L–B Act, which defines affiliation in terms of ''control,'' and we are unwilling to modify the definition of ''customer relationship'' to alter the effect of that definition.[61] For these reasons, we believe that, in the absence of an advisory contract with the investor, a fund's primary investment adviser does not have a customer relationship with the fund's customers.[62]

Transferred accounts. One commenter requested clarification about whether an investor becomes a consumer of a broker-dealer when the consumer's account is transferred to the broker-dealer. An individual who has an account with a broker-dealer or a contract with a registered adviser has established a customer relationship with that broker-dealer or adviser. Thus, the investor is a customer of that broker-dealer or registered adviser, regardless of whether the account was transferred at the customer's request or as the result of a merger, acquisition, or assignment. Accordingly, the final rule includes an example that an individual is a customer of a broker-dealer or registered adviser if the individual's account is transferred to the broker-dealer or adviser.[63]

Trusts. The final rule adds an example to clarify that an individual will be deemed to establish a customer relationship when a broker-dealer, fund, or registered adviser acts as a custodian for securities or assets in an IRA.[64] This example is consistent with the explanation set out above in the discussion of ''consumer'' concerning trusts.[65]

(l) *Dealer.* We received no comments on the proposed definition of ''dealer'' and are adopting it as proposed. The definition incorporates the definition of dealer in the Exchange Act.[66]

(m) *Federal functional regulator.* We are defining the term ''federal functional regulator'' in place of ''government regulator.'' The proposal sought comment on a definition of ''government regulator'' which included each of the Agencies, the Commission, and State insurance authorities under the circumstances identified in the definition. This term was used in the exception in proposed section 248.15(a)(4) for disclosures to law enforcement agencies, ''including government regulators.''

For purposes of the privacy rules, this term is relevant in determining when an entity is an affiliate and when a broker-dealer, fund, or registered adviser may disclose information to a law enforcement agency.[67] The exception for disclosure as stated in the G–L–B Act uses the term ''Federal functional regulator,''[68] which is defined in the statute at section 509(2) and includes the Secretary of the Treasury for purposes of the exception permitting disclosures to law enforcement agencies. We have decided that it is appropriate to use the term ''federal functional regulator'' instead of ''government regulator.''

(n) *Financial institution.* We are adopting the definition of ''financial institution'' as proposed. The proposal defined ''financial institution'' as any institution the business of which is engaging in activities that are financial in nature, or incidental to such financial activities, as described in section 4(k) of the Bank Holding Company Act of 1956.[69] The G–L–B Act also defines ''financial institution,'' and the proposal excepted from the definition those entities the G–L–B Act also excepts.[70]

[59] One commenter also requested that the Commission except from the notice requirements closed-end funds whose information about record owners is limited to name, address, and number of shares held and who neither have affiliates nor share nonpublic personal information with third parties. The G–L–B Act does not exempt closed-end funds from privacy provisions of Title V. Although closed-end funds may bear the costs of mailing initial privacy notices to new customers, they can reduce the burden of annual notices by including them with a shareholder report. *See* discussion of section 248.3(c) (definition of ''clear and conspicuous'').

[60] *See* Proposing Release, *supra* note 4, at text following n.37.

[61] *See* G–L–B Act § 509(6).

[62] The investment adviser may receive nonpublic personal information about the fund's shareholders in connection with performing services on behalf of the fund or servicing the shareholders' accounts. The G–L–B Act permits a fund to share this information with the adviser if the adviser is an affiliate or if the adviser is a nonaffiliated third party. *See* G–L–B Act §§ 502(b)(2), (e). *See also* sections 248.13, 248.14.

[63] Section 248.3(k)(2)(i)(A).

[64] Section 248.3(k)(2)(i)(D).

[65] See supra discussion of section 248.3(g).

[66] 15 U.S.C. 78c(a)(5).

[67] The term also is used in the definition of ''affiliate.'' *See* section 248.3(a).

[68] *See* G–L–B Act § 502(e)(5).

[69] 69 12 U.S.C. 1843(k).

[70] G–L–B Act § 509(3); proposed section 248.3(m)(2). Two commenters requested that the rule clarify that an independent contractor registered representative of a broker-dealer is not a separate financial institution when acting in the capacity of a registered representative. We believe that the rules address this situation and need no further revision. An independent contractor

Continued

Commenters suggested that the final rule include additional exceptions from the definition, such as for securitization trusts, debt buyers, and credit bureaus. We have not included these exceptions in the final rule. We believe it is inappropriate to exclude many of the activities suggested by commenters because the objective of the suggested exclusions can be achieved in other ways. Even if an entity is a financial institution as that term is used in the G–L–B Act, it will not have any disclosure responsibilities under the Act or this rule if it does not provide a financial product or service to a consumer. In most of the situations posited by the commenters, the entity in question will not meet that test and therefore will fall outside the scope of the rules with respect to privacy disclosures.[71]

(o) *Financial product or service.* We are adopting the definition of ''financial product or service'' as proposed. The proposal defined the term as a product or service that a broker-dealer, fund, or registered adviser could offer by engaging in an activity that is financial in nature, or incidental to such a financial activity, under section 4(k) of the Bank Holding Company Act. An activity that is complementary to a financial activity, as described in section 4(k), was not included in the proposed definition of ''financial product or service.'' The proposal's definition included the broker-dealer, fund, or registered adviser's evaluation of nonpublic personal information collected in connection with a request by a consumer for a financial product or service even if the request ultimately is rejected or withdrawn.[72] It also included the distribution of information about a consumer for the purpose of assisting the consumer in obtaining a financial product or service.

Several commenters criticized the proposed definition and suggested that the evaluation of application information should not be considered a financial product or service. For the reasons discussed above regarding the definition of ''consumer,'' we continue to believe that it is appropriate to retain evaluation or brokerage of information as within the scope of financial products or services covered by the rules.

(q) *Investment adviser.* We received no comments on the proposed definition of ''investment adviser'' and are adopting it as proposed. The definition incorporates the definition of ''investment adviser'' under the Investment Advisers Act.[73]

(r) *Investment company.* We received no substantive comments on the proposed definition of ''investment company'' and are adopting it as proposed. The definition incorporates the definition of ''investment company'' under the Investment Company Act, whether or not the company is registered with the Commission.[74]

(s) *Nonaffiliated third party.* We are adopting the definition of nonaffiliated third party as proposed. The proposal defined the term as any ''person'' (including natural persons as well as corporate entities) except (i) an affiliate of a financial institution and (ii) a joint employee of a financial institution and a third party. The proposal clarified the circumstances under which a company that is controlled by a broker-dealer, fund, or registered adviser through that institution's merchant banking activities or insurance company activities would be a ''nonaffiliated third party'' of the broker-dealer, fund, or registered adviser.

We received very few comments in response to the proposed definition. One commenter requested that the final rule state that a disclosure of information to someone who is serving as a joint employee of two financial institutions should be deemed to have been disclosed to both financial institutions. We disagree with this result. Instead, we believe it is appropriate to deem the information to have been given to the financial institution that is providing the financial product or service in question. Thus, for example, if an employee of a bank is also an employee of a brokerage firm, information that employee receives in connection with a securities transaction conducted with the brokerage firm would be considered as received by the brokerage firm.

(t) *Nonpublic personal information.* We are revising the definition of ''nonpublic personal information.'' Section 509(4) of the G–L–B Act defines the term to mean ''personally identifiable financial information'' that is provided by a consumer to a financial institution, results from any transaction with the consumer or any service performed for the consumer, or is otherwise obtained by the financial institution. The term also includes any ''list, description, or other grouping of consumers (and publicly available information pertaining to them) that is derived using any nonpublic personal information that is not publicly available information.'' The G–L–B Act excludes publicly available information (unless provided as part of the list, description, or other grouping described above), as well as any list, description, or other grouping of consumers (and publicly available information pertaining to them) that is derived without using nonpublic personal information. The statute does not define either ''personally identifiable financial information'' or ''publicly available information.''

The proposed rules implemented the definition of ''nonpublic personal information'' under the G–L–B Act by restating the categories of information described above. The proposed rules treated information as publicly available if a broker-dealer, fund, or registered adviser *could* obtain it from a public source. We also asked for comment on an approach that would have deemed information as ''publicly available'' only if a financial institution *actually* obtained it from a public source (''alternative approach'').[75] Most commenters supported the proposed approach to publicly available

registered representative is considered an ''associated person'' of a broker-dealer under the Exchange Act if the representative's activities are subject to control by the broker-dealer, such as when there is a principal and agent relationship. *See* Letter to Gordon S. Macklin, President, National Association of Securities Dealers, Inc. from Douglas Scarff, Director, Division of Market Regulation, Commission (June 18, 1982) (on file with the Commission). As discussed above, a broker-dealer's consumer is not considered a consumer of the broker-dealer's agent. *See* section 248.3(g)(2)(v). An independent contractor, however, also may be a registered adviser who as such, acts in a different capacity than as agent for the broker-dealer. In these circumstances, the registered representative is a different financial institution. Therefore, an investor who obtains investment advisory services from that registered representative acting as an investment adviser would be a consumer of the investment adviser.

[71] These entities will, however, be subject to the limits on reuse and redisclosure under section 248.11 with respect to any nonpublic personal information they receive from a nonaffiliated financial institution that has disclosure obligations under these rules.

[72] *But see* section 248.3(g)(2)(ii) (an individual is not a consumer of a broker-dealer, fund, or registered adviser if the individual provides the institution only with name, address, and general areas of interest in connection with a request for a prospectus, investment adviser brochure, or other information about financial products or services).

[73] 15 U.S.C. 80b–2(a)(11).

[74] 15 U.S.C. 80a–3. As noted in the Proposing Release, a business development company, which is an investment company but is not required to register with the Commission, is subject to Regulation S–P. *See* Proposing Release, *supra* note 4, at n.30. *See also* 15 U.S.C. 80a–2(a)(48). An entity that is not an ''investment company'' under the Investment Company Act, is not subject to Regulation S–P. *See* 15 U.S.C. 80a–3(c).

[75] The Banking Agencies (other than the Board of Governors of the Federal Reserve) and the Federal Trade Commission proposed alternative rule text for this approach. *See* Privacy of Consumer Financial Information, 65 FR 8770, 8790–91, 8804–05, 8811–12 (Feb. 22, 2000); Privacy of Consumer Financial Information, 65 FR 11174, 11189–90 (Mar. 1, 2000) (Federal Trade Commission proposal).

information. They noted that the proposed rule was consistent with the Act and would be far less burdensome on financial institutions. They also stated that any requirement that the information actually be obtained from a public source would impose a needless burden on financial institutions (by requiring, for instance, that a financial institution ''tag'' information it obtained from public records) and is not required by the Act. Other commenters advocated the alternative approach. They argued that the alternative approach would provide the greatest protection for consumers by treating any information the consumer gives to a financial institution to obtain a financial product or service as nonpublic personal information. This protection would be lost only if a financial institution actually obtained the information from a public source. These commenters also preferred the bright-line distinction drawn by the alternative approach.

The final rule adopts an approach that we believe incorporates the benefits of both alternatives. As under the proposed rule, in the final rule information will be deemed to be ''publicly available'' and therefore excluded from the definition of ''nonpublic personal information'' if a broker-dealer, fund, or registered adviser reasonably believes that the information is lawfully made available to the general public from one of the three categories of sources listed in the rule.[76] The examples provided in the rule clarify when a broker-dealer, fund, or registered adviser has a reasonable belief that information is lawfully made available to the general public. For example, an institution would have a reasonable belief if (i) the institution has confirmed, or the consumer has represented, that the information is publicly available from a public source, or (ii) the institution has taken steps to submit the information, in accordance with its internal procedures and policies and with applicable law, to a keeper of federal, State, or local government records who is required by law to make the information publicly available.[77] The examples also state that a broker-dealer, fund, or registered adviser would have a reasonable belief that a telephone number is publicly available if the institution located the number in a telephone book or if the consumer told the institution that the number is not unlisted.[78] Moreover, the examples make clear that an institution may not assume information about a particular consumer is publicly available simply because that type of information is normally provided to a government record keeper and made available to the public by the record keeper, because the consumer may have the ability to keep that information non public or to screen his or her identity.

The approach of the final rule is based on the underlying principle that a consumer in many circumstances can control the public availability or identification of his or her information and that a financial institution therefore should not assume that the information about that customer is in fact publicly available. Thus, even though a lender typically enters a mortgage in public records in order to protect its security interest, when a borrower can maintain the privacy of his or her personal information by owning the property and obtaining the loan through a separate legal entity, the customer's name would not appear in the public record. In the case of a telephone number, a person may request that his or her number be unlisted. Thus, in evaluating whether it is reasonable to believe that information is publicly available, a financial institution must determine whether the consumer has kept the information or his or her identity from being a matter of public record.[79]

To implement the complex definition of ''nonpublic personal information'' that is provided in the statute, the final rule adopts a definition that consists, generally speaking, of (i) personally identifiable financial information, plus (ii) a consumer list or description or grouping of consumers (and publicly available information pertaining to the consumers) that is derived using any personally identifiable financial information that is *not* publicly available information. From that body of information, the final rule excludes publicly available information (except as noted above or if the information is disclosed in a manner that indicates that the individual is the institution's consumer) and any consumer list that is derived without using personally identifiable financial information that is not publicly available information.[80] Examples illustrate how this definition applies in the context of consumer lists.[81]

(u) *Personally identifiable financial information.* We are adopting the definition of ''personally identifiable financial information'' substantially as proposed. The proposed rule defined the term to include (i) information that a consumer provides a broker-dealer, fund, or registered adviser in order to obtain a financial product or service, (ii) information resulting from any transaction between the consumer and a broker-dealer, fund, or registered adviser involving a financial product or service, and (iii) information about a consumer that a broker-dealer, fund, or registered adviser otherwise obtains in connection with providing a financial product or service to the consumer. The proposed rule also treated the fact that someone is a consumer of a broker-dealer, fund, or registered adviser as personally identifiable financial information. In essence, the proposed rules treated any personally identifiable information as ''financial'' if a broker-dealer, fund, or registered adviser obtained the information in connection with providing a financial product or service to a consumer. We noted in the Proposing Release that this interpretation may result in certain information being covered by the rules that may not commonly be considered intrinsically financial, such as health status.[82]

We received a large number of comments in response to the definition of ''personally identifiable financial information.'' Many commenters objected to including in the term certain identifying information that they did not view as ''financial,'' such as name, address, and telephone number. Many commenters argued that ''personally identifiable financial information'' should not include the fact that someone is a customer of a financial institution. These commenters noted that many customer relationships are matters of public record (such as would be the case, for instance, any time a transaction results in the recording of a security interest) while other customer relationships are matters of public knowledge (because consumers frequently disclose the relationships by writing checks, using credit cards, and so on). Many commenters stated that aggregate data about a financial institution's customers that lack personal identifiers should not be considered personally identifiable financial information.

Treatment of identifying information as financial. We continue to believe that it is appropriate to treat any information as ''financial'' information if a financial institution obtains it in order to provide

[76] *See* section 248.3(v)(1). *See also* 17 CFR 230.144A(d)(1), .903(b)(1)(i).

[77] Section 248.3(v)(2).

[78] *See* section 248.3(v)(3)(iii)(2).

[79] *Compare* Banking Agencies' Release, *supra* note 2, sections 40.3(p), 216.3(p), 332.3(p), 573.3(p) (definition of ''publicly available information'').

[80] *See* sections 248.3(t)(2).

[81] *See* section 248.3(t)(3).

[82] *See* Proposing Release, *supra* note 4, at discussion of proposed section 248.3(v).

a financial product or service. We also believe this approach is consistent with the G–L–B Act. Although the statute does not define the term ''financial,'' it does include a broad definition of ''financial institution'' used in the G–L–B Act, which encompasses a large number of entities (such as travel agencies, insurance companies, and data processors) that engage in activities not traditionally considered financial. As a consequence of that definition, the range of information that has a bearing on the terms and availability of a financial product or service or that a financial institution uses in connection with providing a financial product or service is extremely broad and may include, for instance, medical information and other types of information that might not commonly be thought of as financial. It includes information a broker-dealer, fund, or registered adviser requests from the consumer, obtains from a transaction involving a financial product or service with the consumer, or otherwise obtains in connection with providing a financial product or service to a consumer. Thus, the information included in the definition of ''financial'' is information the broker-dealer, fund, or registered adviser has determined is relevant to providing a financial product or service.

We are sensitive to the concern expressed by several commenters about the need for ready access to identifying information to locate individuals who are attempting to evade their financial obligations. These commenters suggested that names, addresses, and telephone numbers should not be treated as financial information. We believe, however, that this information is financial, and is covered by the G–L–B Act. Broker-dealers, funds, and registered advisers rely on a broad range of information, including information such as addresses and telephone numbers, when providing financial products or services. Broker-dealers, funds, and registered advisers use location information to provide a wide variety of financial services, such as sending account statements and disbursing funds to a consumer. We concluded that it would be inappropriate to exclude certain items of information from the definition of personally identifiable financial information simply because a particular broker-dealer, fund, or registered adviser might not rely on those items when providing a particular financial product or service.[83]

Customer relationship as ''personally identifiable financial information.'' We disagree with those commenters who maintain that customer relationships should not be considered to be personally identifiable financial information. This information is ''personally identifiable'' because it identifies the individual as a customer of the institution. The information is financial because it reveals a financial relationship with the institution and the receipt of financial products or services from the institution.

Changes made to the definition. We have revised the definition of ''personally identifiable financial information'' to make it easier to read and understand. In addition, the final rule adds to the examples of information covered by the rule any information that the institution collects through an information-collecting device from a web server, often referred to as a ''cookie.'' [84] This example illustrates one of the many ways that a financial institution may obtain information about a consumer in connection with providing a financial product or service to that consumer.

In addition, in response to many comments from the securities industry, the final rule also includes an example that clarifies that aggregate information (or ''blind data'') lacking personal identifiers is not covered by the definition of ''personally identifiable financial information.'' [85] We agree with the commenters who argued that this type of data does not ''identify'' any individual.

(v) *Publicly available information.* We are adopting the definition of ''publicly available information'' substantially as proposed. The proposal defined the term to include information that is lawfully available to the general public from official public records (such as real estate recordations or security interest filings), information from widely distributed media (such as a telephone book, television or radio program, or newspaper), and information that is required to be disclosed to the general public by federal, State, or local law (such as prospectuses and periodic shareholder reports). The proposed rule stated that publicly available information from widely distributed media would include information from an Internet site that is available to the general public without requiring a password or similar restriction. As previously explained in the discussion of ''nonpublic personal information,'' we have adopted the proposed approach in the final rule, but with additional clarifying provisions.

Many commenters questioned the appropriateness of excluding from the definition of ''publicly available information'' information that a person obtains over the Internet by using a password or complying with a similar restriction. These commenters noted that many Internet sites are available to a large number of people, each of whom needs a user name and identification number to access the sites. Several of these commenters suggested that it would be more appropriate to focus on whether the information was lawfully placed on the Internet.

We agree with these comments, and have revised the final rule to remove the reference to passwords or similar restrictions from the example of the Internet as a ''widely distributed'' medium of communication. In its place, we have substituted a standard that requires the information, whether from the Internet or otherwise, to be available on an unrestricted basis. Information that an individual specifically requests be compiled, such as information that a locator or ''look up'' service provides with respect to a particular individual that may combine confidential information in addition to publicly available information, will not be considered available to the general public on an unrestricted basis, regardless of whether the information is provided over the Internet or otherwise. The rule also states that an Internet site is not restricted merely because an Internet service provider or a site operator requires a fee or password, as long as access is otherwise available to the general public. One common use of passwords is to confine the access of web site users to specific, individual information. However, web site operators also may require user identifications and passwords as a method of tracking access rather than restricting access to the information available through the website. Internet service providers may charge fees to users to access the site rather than to restrict access to particular information. Other sites available to the general public, such as daily newspapers, also may charge a fee to access archived

[83] We note that names, addresses, and telephone numbers, if publicly available, will not be subject to the opt out provisions of the statute unless that information is ''derivative information'' (*i.e.*, information that is part of a list, description, or other grouping of consumers that is derived from personally identifiable financial information that is not publicly available information). An investment adviser's client list is an example of this type of information, even if the list includes clients' names, addresses, and telephone numbers that are otherwise publicly available. In circumstances in which a consumer does not opt out, a financial institution may disclose nonpublic personal information about a consumer to a nonaffiliated third party if the disclosure is consistent with the institution's opt out and privacy notices.

[84] *See* section 248.3(u)(2)(i)(F).

[85] *See* section 248.3(u)(2)(ii)(B).

information. Therefore, we believe that the definition of ''widely distributed media'' should properly focus on whether the information is lawfully available to the general public, rather than on the type of medium from which information is obtained.

We note that the concept of information being lawfully obtained was included in the proposal, and is retained in the final rule.[86] Thus, information unlawfully obtained will not be deemed to be publicly available notwithstanding that it may be available to the general public through widely distributed media.

(w) *You.* We are adopting the definition of ''you'' largely as proposed. The proposed definition of ''you'' referred to broker-dealers, funds, and registered advisers, which are the entities within the Commission's jurisdiction under Title V. We are, however, revising the definition to clarify that the provision of insurance by financial institutions under the Commission's primary jurisdiction is not covered under these rules.[87]

A. Subpart A—Privacy and Opt Out Notices

Sections 248.4 through 248.9 of Regulation S–P include requirements concerning the delivery of initial and annual notices about the privacy policies and practices of a financial institution, and about the opportunity and methods for consumers to opt out of their institution's sharing of their nonpublic personal information with nonaffiliated third parties.

Section 248.4 Initial Privacy Notice to Consumers Required

We are revising the requirements relating to initial privacy notices to consumers, in response to issues raised by commenters. The G-L-B Act requires a financial institution to provide an initial notice of its privacy policies and practices in two circumstances. For customers, the notice must be provided at the time of establishing a customer relationship.[88] For consumers who are not customers, the notice must be provided before disclosing nonpublic personal information about the consumer to a nonaffiliated third party.[89]

The proposed rules implemented these requirements by mandating that a financial institution provide the initial notice to an individual prior to the time a customer relationship is established and the opt out notice prior to disclosing nonpublic personal information to nonaffiliated third parties. The rule required these disclosures to be clear and conspicuous and to accurately reflect the institution's privacy policies and practices. The proposal also set out rules governing when a customer relationship is established and how a financial institution is to provide notice.[90]

We received many comments raising concerns about proposed section 248.4. Most commenters from the securities industry raised questions about the time when initial notices must be provided, the point at which a customer relationship is established, and how initial notices may be provided.

Providing initial notices ''prior to'' time customer relationship is established. Almost all the commenters from the securities industry stated that, because the statute requires only that the initial notice be provided ''at the time of establishing a customer relationship,'' the regulation should not require that the notice be provided ''prior to'' the point when a customer relationship is established. Some of these commenters were concerned that the rule could be interpreted as requiring a financial institution to provide disclosures at a point different from when they must provide other federally mandated consumer disclosures during the process of establishing a customer relationship.

Although we believe many commenters misinterpreted the proposed language concerning the timing for providing initial notices, we have revised the rule to clarify the requirement. The final rule states that, as a general rule, the initial notice must be given not later than the time when a financial institution establishes a customer relationship.[91] As stated in the Proposing Release, the initial notices may be provided at the same time a broker-dealer, fund, or registered adviser is required to give other notices, such as the requirement that credit terms in margin transactions be disclosed,[92] or that a registered adviser provide each client with a written disclosure statement (''brochure'') not later than the time of entering an investment advisory contract with the client.[93] This approach, like the approach taken in the proposed rule, strikes a balance between (i) ensuring that consumers will receive privacy notices at a meaningful point during the process of ''establishing a customer relationship'' and (ii) minimizing unnecessary burden on broker-dealers, funds, and registered advisers that may otherwise result if the final rule were to require financial institutions to provide consumers with a series of notices at various times in a transaction.

Providing notices after customer relationship is established. Several commenters stated that the rule should provide financial institutions with the flexibility to deliver the initial notice *after* the customer relationship is established under certain circumstances. These commenters offered several situations in which a customer relationship is established without direct contact between the consumer and the financial institution. The commenters stated that delivery of the initial notice *before* the customer relationship is established in these situations would be impractical. Commenters also indicated that in many circumstances requiring delivery at this time would have a significant adverse effect on the ability to provide a financial product or service to a consumer as quickly as the consumer desires.

To accommodate the wide range of situations presented by the commenters, we have modified the examples of when subsequent delivery of the initial notice is appropriate, so that they now are more broadly applicable. As stated in the final rule in section 248.4(e), a broker-dealer, fund, or registered adviser may satisfy the delivery requirement by providing the initial notice within a reasonable time after establishing a customer relationship, in three instances. First, the institution may provide notice after the fact if the customer has not elected to establish the customer relationship.[94] This might occur, for example, when a brokerage account is transferred to another broker by a trustee selected by the Securities Investor Protection Corporation (''SIPC'') and appointed by a United States Court.[95] Second, a broker-dealer, fund, or registered adviser may send a notice after establishing a customer relationship when to do otherwise

[86] *See* section 248.3(v)(1).

[87] As noted above, however, broker-dealers and funds that provide insurance products that also are securities and registered advisers who provide advice with respect to those products will be subject to this part with respect to their provision of those securities and advice about those securities. *See supra* discussion of section 248.1.

[88] G–L–B Act § 503(a).

[89] G–L–B Act § 502(a).

[90] *See* proposed section 248.4.

[91] Section 248.4(a)(1).

[92] 17 CFR 240.10b–16. *See* Proposing Release, *supra* note 4, at text accompanying n.35.

[93] 17 CFR 275.204–3(b) (requiring delivery of the brochure (i) not less than 48 hours before entering into an investment advisory contract with the client or (ii) at the time of entering into the contract as long as the client has at least 5 business days to cancel the contract without penalty).

[94] *See* section 248.4(e)(1)(i).

[95] *See* 15 U.S.C. 78eee–78fff–1.

would substantially delay the consumer's transaction and the consumer agrees to receive the notice at a later time.[96] An example of this is when an investor requests over the telephone that a broker-dealer execute a securities trade. The final example states that delayed delivery is permissible when a nonaffiliated broker-dealer or registered adviser purchases fund shares or establishes a brokerage account on behalf of a customer.[97]

We note that in most situations, a broker-dealer, fund, or registered adviser should give the initial notice at a point when the consumer still has a meaningful choice about whether to enter into the customer relationship.[98] The exceptions listed in the examples, while not exhaustive, are intended to illustrate the less frequent situations when delivery either would pose a significant impediment to the conduct of a routine business practice or the consumer agrees to receive the notice later in order to obtain a financial product or service immediately.

In circumstances when it is appropriate to deliver an initial notice after the customer relationship is established, a broker-dealer, fund, or registered adviser should deliver the notice within a reasonable time thereafter. Several commenters requested that the final rule specify how many days a financial institution has in which to deliver the notice under these circumstances. However, we believe that a rule prescribing the maximum number of days would be inappropriate because (i) the circumstances of when an after-the-fact notice is appropriate are likely to vary significantly, and (ii) a rule that attempts to accommodate every circumstance is likely to provide more time than is appropriate in many instances. Therefore, we have retained the more general rule as set out in the proposal.[99]

As we noted in the Proposing Release, nothing in the rule is intended to discourage a financial institution from providing an individual with a privacy notice at an earlier point in the relationship in order to make it easier for the individual to compare its privacy policies and practices with those of other institutions in advance of conducting transactions.[100]

New notices not required for each new financial product or service. Several commenters asked whether a new initial notice is required every time a consumer obtains a financial product or service from that broker-dealer, fund, or registered adviser. These commenters suggested that a consumer would not materially benefit from repeated disclosures of the same information, and that requiring additional initial notices to be provided to the same consumer would be burdensome on financial institutions.

We agree that it would be burdensome, with little corresponding benefit to the consumer, to require a financial institution to provide the same consumer with additional copies of its initial notice every time the consumer obtains a financial product or service. Accordingly, the final rule states that a broker-dealer, fund, or registered adviser will satisfy the notice requirements when an existing customer obtains a new financial product or service if the institution's initial, revised, or annual notice (as appropriate) is accurate with respect to the new financial product or service.[101]

Joint accountholders. We agreed with several commenters who recommended that the final rule state that a financial institution is not obligated to provide more than one notice to joint accountholders.[102] Accordingly, the final rule clarifies that one notice may be sent in connection with a joint account.[103] A broker-dealer, fund, or registered adviser may, in its discretion, provide notices to each party to the account. This situation might arise, for example, when a financial institution does not want one opt out election to apply automatically to all joint accountholders.[104]

Mergers. A few commenters requested guidance on what notices are required in the event of a merger of two financial institutions or an acquisition of one financial institution by another. In such a situation, the need to provide new initial (and opt out) notices to the customers of the entity that ceases to exist will depend on whether the notices previously given to those customers accurately reflect the policies and practices of the surviving entity. If they do, the surviving entity will not be required under the rule to provide new notices.[105]

As was stated in the Proposing Release, a financial institution may not fail to maintain the protections that it represents in the notice that it will provide.[106] We expect that broker-dealers, funds, and registered advisers will take appropriate measures to adhere to their stated policies and practices.

Section 248.5 Annual Privacy Notice to Customers Required

We are adopting largely as proposed the requirements relating to annual privacy notices to consumers. Section 503 of the G–L–B Act requires a financial institution to provide notices of its privacy policies and practices at least annually to its customers ''during the continuation'' of a customer relationship. The proposed rules implemented this requirement by requiring a clear and conspicuous notice that accurately reflects the privacy policies and practices then in effect to be provided at least once during any period of twelve consecutive months.[107] The proposed rule noted that the rule governing how to provide an initial notice also would apply to annual notices, and stated that a financial institution would not be required to provide annual notices to a customer with whom it no longer has a continuing relationship.[108]

Many commenters from the securities industry requested that the final rule permit annual notices to be given each calendar year, instead of every 12 months. A few commenters recommended that the rule require notices each calendar year, with no more than 15 months elapsing between mailings. To clarify the extent of financial institutions' flexibility, the final rule retains the general rule requiring annual notices but then provides an example, stating that a broker-dealer, fund, or registered adviser may select a calendar year as the

[96] *See* section 248.4(e)(1)(ii).

[97] *See* section 248.4(e)(1)(iii).

[98] *See, e.g,* section 248.9(b)(1)(iii) (example of reasonable expectation that consumer will receive actual notice of initial privacy notice on Internet web site provides that consumer acknowledges receipt of notice as a necessary step to obtaining a particular financial product or service).

[99] *See* section 248.4(e)(1).

[100] *See* Proposing Release, supra note 4, at discussion of proposed section 248.4.

[101] *See* section 248.4(d).

[102] A few commenters noted that disclosure obligations arising from joint accounts are well settled under other rules, such as the regulations implementing the Equal Credit Opportunity Act, *see* 12 CFR part 202, and the Truth in Lending Act, 15 U.S.C. 1601. Commenters noted that under both Regulation B and Regulation Z, a financial institution is permitted to give one notice. The authorities cited include requirements that the financial institution give disclosures as appropriate to the ''primary applicant'' if readily apparent, *see* 12 CFR 202.9(f), or to a person ''primarily liable on the account.'' *See* 12 CFR 226.5(b).

[103] *See* section 248.9(g).

[104] *See* discussion of section 248.9 below on how to provide opt out notices.

[105] If the surviving or acquiring institution does not deliver new notices, it must honor any opt outs the predecessor or acquired institution received from consumers.

[106] Proposing Release, *supra* note 4, at section discussing proposed section 248.4.

[107] *See* section 248.5(a).

[108] Proposed section 248.5(c)(1).

12-month period within which notices will be provided, and deliver the first annual notice at any point in the calendar year following the year in which the customer relationship was established.[109] The final rule also requires that a broker-dealer, fund, or registered adviser apply the 12-consecutive-month period to its customers consistently.

Several commenters suggested that a financial institution be permitted to make the annual notice available upon request only, particularly if there have been no material changes to the notice since it was last delivered. These commenters argued that little value is added by providing customers with additional copies each year of the same information. Some suggested that financial institutions be permitted to provide a ''short-form'' annual notice, in which the institution informs its customers that there has been no change to its privacy policies and practices and that the customers may obtain a copy upon request.

We have not amended the final rule to permit this approach, for two reasons. First, we believe that the G–L–B Act requires a full set of disclosures to each customer once a year.[110] Second, the revisions to the disclosure provisions reflected in the final rule clarify that a broker-dealer, fund, or registered adviser is not required to provide a lengthy and detailed privacy notice. Small institutions that do not share information with third parties beyond the statutory exceptions should be able to provide a short, streamlined notice. The rule also permits a broker-dealer, fund, or registered adviser to provide annual notices to customers over the institution's web site if the customer conducts transactions electronically and agrees to the electronic disclosures.[111] As a result, the final rule achieves much of the burden reduction sought by those requesting a short-form annual notice option.[112]

[109] *See* section 248.5(a)(2).

[110] The G–L–B Act states that ''not less than annually during the continuation of [a customer] relationship, a financial institution shall provide a clear and conspicuous disclosure to such consumer [i.e., one with whom a customer relationship has been formed], * * * of such financial institution's policies and practices with respect to'' the information enumerated in the Act. G–L–B Act § 503.

[111] *See also* discussion of section 248.9 below.

[112] Members of the banking industry also commented on the paragraph in this section regarding termination of a customer relationship and examples set forth in the Banking Agencies' proposing release. *See* section 248.5(b). We have made a technical revision to one of the examples in response to the only comment that specifically addressed the Commission's proposed examples. *See* section 248.5(b)(2)(iii).

Section 248.6 Information To Be Included in Initial and Annual Privacy Notices

We are revising the requirements for information to be included in initial and annual privacy notices. The revisions clarify the level of detail required in these notices, and permit a ''short-form'' initial notice in certain circumstances.

Section 503 of the G–L–B Act identifies the items of information that a broker-dealer, fund, or registered adviser must include in its initial and annual notices. Section 503(a) of the G-L-B Act sets out the general requirement that a financial institution must provide customers with a notice describing the institution's policies and practices with respect to, among other things, disclosing nonpublic personal information to affiliates and nonaffiliated third parties. Section 503(b) of the Act identifies certain elements that must be addressed in that notice.

The proposed rule implemented section 503 by requiring a financial institution to provide information concerning:

- The categories of nonpublic personal information that a broker-dealer, fund, or registered adviser may collect;
- The categories of nonpublic personal information that a broker-dealer, fund, or registered adviser may disclose;
- The categories of affiliates and nonaffiliated third parties to whom a broker-dealer, fund, or registered adviser discloses nonpublic personal information, other than those to whom information is disclosed under an exception in section 502(e) of the G–L–B Act;
- The broker-dealer, fund, or registered adviser's policies with respect to sharing information about former customers;
- The categories of information that are disclosed under agreements with third party service providers and joint marketers and the categories of third parties providing the services;
- A consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties;
- Any disclosures regarding affiliate information sharing opt outs a financial institution is providing under the Fair Credit Reporting Act; and
- The institution's policies and practices with respect to protecting the confidentiality, security, and integrity of nonpublic personal information.

We received a large number of comments concerning these requirements, and most made the points summarized below.

Level of detail required. Many commenters observed that the level of detail required by the proposed rule would result in lengthy, complicated, and confusing disclosures. These comments have led us to revise the rule to clarify the level of detail required in a financial institution's initial and annual disclosures.

We do not intend to require a broker-dealer, fund, or registered adviser to publish lengthy disclosures that precisely identify every type of information collected or shared, the name of every entity with which the institution shares information, and a complete description of the technical specifications of how the institution protects its customers' records or the identity of each employee who has access to those records. Instead, the rule is intended to require notices that provide consumers with the types of third parties with which a financial institution shares nonpublic personal information, the types of information it shares, and the other information about the institution's privacy policies and practices listed above. The final rule, like the proposal, permits a broker-dealer, fund, or registered adviser to comply with these notice requirements by describing its privacy policies and practices.[113] We believe that in most cases the initial and annual disclosure requirements can be satisfied by disclosures contained in a tri-fold brochure.

In response to commenters' concerns that consumers will not read long, detailed disclosures, we have revised the examples of the disclosures to clarify the level of detail that we think is appropriate. We have provided sample clauses in the Appendix to the rules, and have set out a compliance guide below in this release. Because the examples are not exclusive, the final rule permits a financial institution to use different categories than those provided in the examples, thereby providing additional flexibility for financial institutions in complying with the disclosure requirements. In addition, we have revised the language that precedes the items of information to be addressed in the initial notice, to clarify that a broker-dealer, fund, or registered adviser is required only to address those items that apply to the institution. Thus, for instance, if an investment adviser does not disclose nonpublic personal information to third parties, it may simply omit any reference to the categories of affiliates

[113] *See* section 248.6(e).

and nonaffiliated third parties to whom the institution discloses nonpublic personal information.

As noted in the Proposing Release, the required content is the same for both the initial and annual notices of privacy policies and practices.[114] While the information contained in the notices must be accurate as of the time the notices are provided, a financial institution may prepare its notices based on current and anticipated policies and practices.

Short-form initial notice. We have reconsidered the need to give consumers a copy of a financial institution's complete initial notice when there is no customer relationship. In these circumstances, we believe that the objectives of the statute can be accomplished in a less burdensome way than was proposed. Accordingly, we have exercised our exemptive authority under section 504(b) to create an exception to the general rule that a financial institution must provide both the initial and opt out notices to a consumer before disclosing nonpublic personal information about that consumer to nonaffiliated third parties.

Section 248.6(d) provides that a financial institution may provide a ''short-form'' initial privacy policy notice along with the opt out notice to a consumer with whom the institution does not have a customer relationship. The short-form notice must clearly and conspicuously state that the disclosure containing information about the institution's privacy policies and practices is available on request, and must provide one or more reasonable means by which the consumer may obtain a copy of the notice. We believe that the short-form is appropriate because a consumer who does not become a customer of a broker-dealer, fund, or registered adviser may have less interest in certain elements of the institution's privacy policies. Thus, the consumer may receive greater benefit from obtaining a short-form notice with the opt out notice, which informs the consumer about the categories of his or her information the institution may share and the categories of nonaffiliated third parties that may receive the information. The rule also requires a broker-dealer, fund, or registered adviser to provide a consumer who is interested in the more complete privacy disclosures with a reasonable means to obtain them.

Information about affiliate sharing. Several commenters suggested that the rule should not require that initial and annual notices include categories of affiliates with whom a financial institution shares information. These commenters noted that the Act specifically requires disclosures of categories of nonaffiliated third parties only, and that the only statutorily mandated disclosures concerning affiliate sharing are disclosures required, if any, concerning affiliate sharing under the Fair Credit Reporting Act (''FCRA'').[115] These commenters concluded that the Commission and the Agencies, by expanding the disclosure requirements in the manner prescribed in the proposed rule, would be exceeding their rulemaking authority and imposing an unnecessary burden on financial institutions.

We believe that the language and legislative history of section 503 support requiring disclosures of affiliate sharing beyond what may be required by the FCRA. First, section 503(b) does not state that the items listed in the section are to be the only items set out in a financial institution's initial and annual disclosures. Instead, it uses the nonrestrictive phrase ''shall include'' when discussing the contents of the disclosures, thereby preserving flexibility for the Commission (which was expressly granted authority under section 503(a) to prescribe rules governing these notices) to require that additional items be addressed in the disclosures consistent with those specifically enumerated.

Second, section 503(a) states that the financial institution shall provide in its initial and annual notices ''a clear and conspicuous disclosure * * * of such financial institution's policies and practices with respect to—(1) disclosing nonpublic personal information to affiliates and nonaffiliated third parties, consistent with section 502, including the categories of information that may be disclosed; * * *'' While the FCRA disclosures would be a subset of the disclosures required by section 503(a)(1), they may not be sufficient to fully satisfy that requirement.

Third, the legislative history of the G–L–B Act suggests that Congress intended the disclosures to provide more information about affiliate sharing than what may be required under the FCRA.[116] That history underscores the Congressional intent of ensuring that individuals are given the opportunity to make informed decisions about the privacy policies and practices of financial institutions. We believe that limiting the disclosures about affiliate sharing just to those disclosures that may be required under the FCRA would frustrate that purpose.[117]

[114] Proposing Release, *supra* note 4, at discussion of proposed section 248.6.

[115] *See* 15 U.S.C. 1681a(d)(2)(A)(iii). Section 603(d)(2)(A)(iii) of the FCRA excludes from the definition of ''consumer report'' the communication of certain consumer information among affiliated entities if the consumer is notified about the disclosure of such information and given an opportunity to opt out of the disclosure of that information. The information that can be disclosed to affiliates under this provision includes, for instance, information from consumer reports and applications for financial products or services. In general, this information includes personal information provided directly by the consumer to the institution, such as income and assets, in addition to information contained within consumer reports.

[116] *See, e.g.,* remarks of Sen. Gramm (noting that the privacy bill contains ''for the first time a full disclosure requirement. It requires every bank in America, when you open your account to tell you precisely what their policy is: Do they share personal financial information within the bank? Do they share it outside the bank?''), 145 Cong. Rec. S13786 (daily ed. Nov. 3, 1999); remarks of Sen. Hagel, *id.* at S13876 (''Financial institutions would be required to disclose their privacy policies to their customers on a timely basis. If customers do not believe adequate protections exist at their institution, they can take their business elsewhere.'').

[117] Commenters from other industries who addressed the issue argued that a financial institution should not be required to include FCRA disclosures in its annual notices. To the extent that broker-dealers share information about margin loans, they may be subject to the FCRA. As previously discussed, section 503(b)(4) of the G–L–B Act requires a financial institution's initial and annual notice to include the disclosures required, if any, under section 603(d)(2)(A)(iii) of the FCRA. The proposed rules implemented section 503(b)(4) of the G–L–B Act by requiring that a broker-dealer, fund, or registered adviser's initial and annual notice include any disclosures a financial institution makes under section 603(d)(2)(A)(iii) of the FCRA. Proposed section 248.6(a)(7). Several commenters noted that the FCRA requires disclosures of a consumer's right to opt out of affiliate sharing only once, and that the G–L–B Act states, in section 506(c), that nothing in the G–L–B Act is to be construed to modify, limit, or supersede the operation of the FCRA. These commenters maintain that the ''if any'' language of section 503(b)(4), read in the context of section 506, suggests that, because at most only one notice must be provided under the FCRA, section 503 should require only one FCRA disclosure under the privacy rules.

As discussed above, we believe that in order to comply with the requirement that it disclose its policies and practices with respect to sharing information with affiliated and nonaffiliated third parties, a financial institution must describe the circumstances under which it will share information with affiliates. The ability of consumers to opt out of affiliate information sharing under the FCRA affects a financial institution's policies and practices with respect to disclosing information to its affiliates. Failing to include this information and an explanation of how the opt out right may be exercised would make the disclosures incomplete.

In addition, section 503 does not distinguish between the disclosures to be provided in the initial notice from those to be provided in the annual notice. Thus, section 503 suggests that any disclosures that are required under the FCRA must be included in both the initial and annual notices.

We interpret the ''if any'' language as an acknowledgment that not all institutions provide FCRA notices because not all institutions engage in the type of affiliate sharing covered by the FCRA. We do not believe that requiring the FCRA notice to appear as part of the annual notice under the privacy rules, modifies, limits, or supersedes the

Disclosures of the right to opt out. Other commenters suggested that the final rule eliminate the requirement that the initial and annual notices contain disclosures about a consumer's right to opt out. These commenters pointed out that the statute does not specifically require these disclosures.

As previously discussed, section 503(a) of the statute requires a financial institution to disclose its policies and practices with respect to sharing information, both with affiliated and nonaffiliated third parties. Given that a financial institution's practices with respect to sharing nonpublic personal information with nonaffiliated third parties will be affected by the opt out rights created by the statute, an institution will need to describe these opt out rights in order to provide a complete disclosure that satisfies the statute.

Other comments. We received many comments expressing support for a number of the provisions in proposed section 248.6. For example, several commenters agreed with the approach of permitting a financial institution to state generally that it makes disclosures to nonaffiliated third parties ''as permitted by law'' to describe disclosures made under one of the exceptions. Others agreed with the proposed flexibility to allow a disclosure to be based on current and contemplated information sharing. In light of these comments, we have adopted proposed section 248.6 with changes as discussed above. The final rule makes several other stylistic changes to the material in section 248.6 that are intended to make the rule easier to read.

Section 248.7 Form of Opt Out Notice to Consumers; Opt Out Methods

We are adopting as proposed the requirement that any opt out notice provided by a broker-dealer, fund, or registered adviser be clear and conspicuous and accurately explain the right to opt out.[118] The final rule also requires, as proposed, that a financial institution provide the consumer with a reasonable means by which to opt out, and honor an opt out election as soon as reasonably practicable. The rule also states that an opt out election survives until revoked by the consumer. In addition, we have adopted provisions to address the application of these rules to joint accounts, the means by which an opt out right may be exercised, duration of an opt out, the level of detail required in the opt out notice, and the time by which an opt out election must be honored. The final rule also includes stylistic changes to make it easier to read.

Joint accounts. We agree with the commenters who stated that a financial institution should have the option of providing one notice per account, regardless of the number of persons on the account, and the final rule includes a new section to address this issue.[119] Under the final rule, a financial institution may provide one initial, annual, and opt out notice per account. However, each of the accountholders must have the right to opt out. The final rule also requires a broker-dealer, fund, and registered adviser to state in the opt out notice provided to a joint accountholder whether the institution will consider an opt out by a joint accountholder as an opt out by all of the accountholders or whether each accountholder is permitted to opt out separately.

Means of opting out. At the suggestion of many commenters, the final rule includes a provision that permits a broker-dealer, fund, or registered adviser to require that a consumer opt out through a specific means, if the means is reasonable for the consumer.[120] We recognize that a financial institution may not have systems in place or trained personnel to handle opt out elections at each point of contact between a consumer and financial institution and therefore may choose not to honor opt out elections communicated to the institution through means other than those specified for the consumer.

As was proposed, the examples provide that a broker-dealer, fund, or registered adviser may not require a consumer to write his or her own letter in order to opt out.[121] The final rule adds an example of a toll-free telephone number as another way by which financial institutions may allow consumers to opt out.[122]

Duration of opt out. Several commenters requested changes to the proposed provision concerning duration of an opt out.[123] They noted that a financial institution would be required to keep track of opt out elections if, for example, a person opts out during the course of establishing a customer relationship with a financial institution, terminates that relationship, and then establishes another customer relationship several years later, perhaps under a different name or with someone on a joint account. The commenters suggested that it would be more appropriate in these circumstances to treat the opt out election made in connection with the first relationship as applying solely to that relationship.

We agree with the commenters' suggestions. Under the final rule, a broker-dealer, fund, or registered adviser is to treat an opt out election made by a customer in connection with a prior customer relationship as applying solely to the nonpublic personal information that the institution collected during, or related to, that relationship. That opt out will continue until the customer revokes it.[124] However, if the customer relationship terminates and a new one is established at a later point, the institution must then provide a new opt out notice to the customer in connection with the new relationship, and any prior opt out election does not apply to the new relationship.[125]

Level of detail required in opt out notice. We are adopting as proposed the rule requirements for the form of the opt out notice.[126] A few commenters interpreted the proposal as requiring a more detailed disclosure of categories of nonpublic personal information and nonaffiliated third parties in the opt out notice than is required in the initial and annual notices.[127] We did not intend this result, and specifically referred to section 248.6 in the proposed opt out provision to address precisely this concern. The disclosures in the initial and annual notices of the categories of nonpublic personal information being disclosed and the categories of nonaffiliated third parties to whom the information is disclosed will suffice for the opt out notices as well. If the opt out notice is a part of the same document that contains the disclosures that must be included in the initial notice, then the financial institution is not required to restate those disclosures in the opt out notice. In these circumstances, the rule requires only that when the opt out

operation of the FCRA; financial institutions will have exactly the same FCRA obligations following the effective date of the privacy rules as they had before. The only difference will be that, as required by the G–L–B Act, a financial institution's initial and annual disclosures about its privacy policy and practices will need to reflect how the institution complies with the affiliate sharing provisions of the FCRA.

[118] *See* section 248.8(a).

[119] *See* section 248.7(d).

[120] *See* section 248.7(a)(2)(iv).

[121] *See* section 248.7(a)(2)(iii)(A).

[122] *See* section 248.7(a)(2)(ii)(D).

[123] *See* proposed section 248.8(e).

[124] *See* section 248.7(g)(1).

[125] *See* section 248.7(g)(2).

[126] *See* section 248.7(a)(1).

[127] *See* proposed section 248.8(a)(2)(i) (a financial institution ''provides adequate notice * * * if [the institution] identifies all of the categories of nonpublic personal information that [the institution] discloses or reserves the right to disclose to nonaffiliated third parties as described in [section 248.6]'').

and privacy notices are read together, they clearly disclose the categories of nonpublic personal information the institution intends to share and the categories of nonaffiliated third parties with whom it will share.

One commenter suggested that, while a broker-dealer, fund, or registered adviser should have the option of providing an opt out notice that is sufficiently broad to cover anticipated disclosures, the institution also should be permitted to provide a customer who already has opted out with a new opt out notice in connection with a new financial product or service. If the consumer does not opt out a second time, the institution would be free to disclose nonpublic personal information obtained in connection with that financial product or service.

We agree that a broker-dealer, fund, or registered adviser should have the flexibility to provide opt out notices that are either narrowly tailored to specific types of nonpublic personal information and types of nonaffiliated third parties or that are more broadly worded to anticipate future disclosure plans. We note, however, that when a consumer has elected to opt out of sharing certain nonpublic personal information, the opt out remains in effect until the consumer affirmatively revokes the opt out. Similarly, when a consumer opts out after receiving an opt out notice that is broad enough to cover the new type of information the institution intends to share, the consumer does not have to opt out again.

Time by which opt out must be honored. We are adopting in the final rule the proposed requirement that a financial institution comply with an opt out election ''as soon as reasonably practicable.'' [128] Many commenters asked us to clarify in the final rule when a financial institution must stop disclosing nonpublic personal information to nonaffiliated third parties after it receives an opt out. Suggestions for a more precise standard ranged from immediate to several months after receiving the opt out. We believe that a more general rule is appropriate in light of the wide range of practices among financial institutions. A broker-dealer, fund, or registered adviser might view a specific standard as a safe harbor in all circumstances and thus fail to implement an opt out as early as it could. In addition, a standard that reflects existing industry practices and capabilities is likely to become outmoded quickly as advances in technology increase efficiency. We therefore decline to adopt a more rigid standard.

Section 248.8 Revised Privacy Notices

We are adopting as proposed the rule regarding revised privacy notices.[129] The rule prohibits a financial institution, directly or through its affiliates, from disclosing nonpublic personal information about its consumers to nonaffiliated third parties unless the institution first provided a copy of its privacy notice and opt out notice. The rule also requires that these notices be accurate when given.[130] Thus, if a broker-dealer, fund, or registered adviser wants to disclose nonpublic personal information in a way that is not accurately described in its notices, the institution must provide new notices before disclosing that information. The rule also provides examples of when a new notice is required.[131]

Section 248.9 Delivering Privacy and Opt Out Notices

The requirements for delivery of initial, annual, and opt out notices were set out in three different sections of the proposed rules.[132] The final rules combine in one section the requirements for delivery of each type of notice.[133] The general provision requires that an institution provide a notice to a consumer in a manner such that the consumer can reasonably be expected to receive actual notice in writing, or, if the consumer agrees, electronically.[134]

Posting initial notices on an Internet web site. The final rule retains the proposed example of posting a notice on an Internet web site and requiring a consumer to acknowledge receipt of the notice as a step in the process of obtaining a financial product or service, as one way to comply with the rule.[135] A few commenters suggested that a financial institution be allowed to deliver initial notices simply by posting the institution's notice on its Internet web site. We believe that posting the notice on a web site alone would not be sufficient in all cases for a broker-dealer, fund, or registered adviser reasonably to expect that its consumers will receive the notice.[136] Accordingly, we have not expanded the rule beyond the circumstances described in the proposed example.

Posting annual notices on an Internet web site. At the suggestion of several commenters, the final rule clarifies that a broker-dealer, fund, or registered adviser may reasonably expect a customer who uses the institution's Internet web site to obtain financial products or services will receive actual notice if the customer has agreed to accept notices at the institution's web site, and if the institution continuously posts a current notice of its privacy policies and practices in a clear and conspicuous manner on the web site.[137] We agree that it is appropriate to provide annual notices in this way for customers who conduct transactions electronically and agree to accept notices on a web site. We also believe that this revision will reduce the burden on broker-dealers, funds, and registered advisers while ensuring that customers who transact business electronically will have continuous access to institutions' privacy policies and practices.

Householding. Two commenters requested that the Commission permit broker-dealers and funds to deliver a single privacy notice to consumers who share the same address (''householding''). The Commission currently permits householding of prospectuses and fund shareholder reports, and the commenters argue that the same justifications that support the existing householding rules, such as reducing the number of duplicate documents investors receive, would apply with respect to privacy notices.[138] We agree that householding is appropriate in certain circumstances, and the final rule adds an example that allows a broker-dealer or fund to consider that customers have actually received an annual privacy notice if the institution includes the notice with or in a prospectus or shareholder report delivered under conditions set forth in rules permitting householding of those documents.[139]

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[128] *See* section 248.7(e).

[129] *See* section 248.8. The final rule is in a separate section for emphasis.

[130] *See* section 248.8(a)(1).

[131] *See* section 248.8(b).

[132] *See* proposed sections 248.4(d) (initial notice), 248.5(b) (annual notice), and 248.8(b) (opt out notice).

[133] *See* section 248.9.

[134] Section 248.9(a).

[135] *See* section 248.9(b)(1)(iii).

[136] Nevertheless, there may be circumstances in which an Internet web site notice might be delivered in a way that will enable the broker-dealer, fund, or registered adviser to reasonably expect that the consumer will receive it.

[137] *See* section 248.9(c)(i).

[138] *See* Delivery of Disclosure Documents to Households, Investment Company Act Release No. 24123 (Nov. 4, 1999) [64 FR 62540 (Nov. 16, 1999)]. The Commission also has proposed rule amendments to permit householding of proxy or information statements. *See* Delivery of Proxy and Information Statements to Households, Investment Company Act Release No. 24124 (Nov. 4, 1999) [64 FR 62548 (Nov. 16, 1999)]. The comment period on this proposal ended January 18, 2000.

[139] *See* section 248.9(c)(2).

The example requires that the annual privacy notice be delivered with or in a prospectus or shareholder report that is householded because we believe that customers whose disclosure documents are householded also would consent to having their annual privacy notices householded. We cannot assume that the same would be true for other customers. The example also limits householding to annual privacy notices because we believe that any reduction in the number of initial notices consumers might receive due to householding would be minimal. Individuals who share the same address may not become consumers of a broker-dealer, fund, or registered adviser at the same time.

Disclosures to customers requesting no communication. We received comment that the final rule clarify that a financial institution may honor a customer's request not to receive information from the institution about his or her relationship with the institution. The final rule clarifies that a broker-dealer, fund, or registered adviser need not send an *annual* privacy notice to a customer who affirmatively requests no communication from the institution, provided that the notice is available upon request.[140]

Reaccessing a notice. The final rule provides an example that permits a broker-dealer, fund, or registered adviser to provide only the current privacy notice on a web site to someone seeking to obtain the privacy notice after having received the initial notice.[141] This example responds to a request for clarification in the rule concerning potential confusion and burden that might result if the rule required a financial institution to make available every version of its privacy policies.

Joint notices. The final rule affirms that two or more financial institutions may provide a joint notice as long as the notice is accurate with respect to each institution.[142] This provision reflects requests by many commenters from the securities industry that the rule permit this flexibility. We believe that broker-dealers, funds, and registered advisers should be able to combine initial, annual, or revised disclosures in one document and to give, on a collective basis, a consumer only one copy of the notice. For example, a clearing broker could provide a joint notice with an introducing broker for which it clears transactions on a fully disclosed basis, or a fund complex could provide a joint notice for all the funds in the complex. We emphasize that the notice must be accurate for each institution that uses the notice, and must identify each institution by name.[143]

B. Subpart B—Limits on Disclosure

Sections 248.10 through 248.12 of Regulation S–P contain limitations concerning (i) disclosure of nonpublic personal information to nonaffiliated third parties, (ii) redisclosure or reuse of information that a financial institution discloses to other parties, and (iii) sharing of account number information for marketing purposes.

Section 248.10 Limits on Disclosure of Nonpublic Personal Information to Nonaffiliated Third Parties

We are adopting the limits on disclosure of nonpublic personal information to nonaffiliated third parties, substantially as proposed.[144] Section 502(a) of the G–L–B Act generally prohibits a financial institution, directly or through its affiliates, from sharing nonpublic personal information about a consumer with a nonaffiliated third party unless the institution (i) provides the consumer with a notice of the institution's privacy policies and practices, (ii) provides the consumer with a clear and conspicuous notice that the consumer's nonpublic personal information may be disclosed to nonaffiliated third parties, (iii) gives the consumer an opportunity to opt out of that disclosure, and (iv) informs the consumer how to opt out.[145]

Most commenters on this section focused on the question of what is a reasonable opportunity to opt out. Some suggested that the rule permit a financial institution to begin sharing information immediately after it provides the opt out and initial notice in connection with an electronic transaction, such as an ATM transaction. Others advocated a mandatory delay of 120 days after the notices are provided.

We believe that the wide variety of suggestions underscores the appropriateness of a more general test rather than a mandatory waiting period in all cases. If a broker-dealer intends to disclose nonpublic personal information that it obtains through an isolated transaction and the consumer is provided a convenient means of opting out as part of the transaction, it would be reasonable not to force the broker-dealer to wait before sharing the information.[146] For notices that are provided by mail, however, we believe the consumer should have additional time. In these latter circumstances, we consider it reasonable to permit the consumer to opt out by mailing back a form, by calling a toll-free number, or by any other reasonable means within 30 days after the date the opt out notice was mailed.[147] The final rule also provides an example of a reasonable opportunity for opting out in connection with accounts opened electronically.[148] However, we have not tried to anticipate every scenario and establish a specific period for each. Instead, the rule provides that the consumer must be given a reasonable opportunity to opt out and then includes some illustrative examples of what would be reasonable in different contexts.[149]

Section 248.11 Limits on Redisclosure and Reuse of Information

We are revising the limits on redisclosure and reuse to clarify their scope. The limits on redisclosure and reuse that apply to recipients of nonpublic personal information and their affiliates will depend on whether the information was provided under an exception in section 502(e) of the G–L–B Act.

Section 502(c) of the G–L–B Act provides that a nonaffiliated third party that receives nonpublic personal information from a financial institution must not, directly or indirectly through an affiliate, disclose that information to

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[140] *See* section 248.9(c)(1)(ii). A customer may request no communication or that the institution refrain from sending the annual notices. We note, however, that broker-dealers, funds, and registered advisers must provide customers with any communications (such as shareholder reports or confirmation statements) required under the federal securities laws. *See, e.g.,* 15 U.S.C. 80a–29(e). These institutions also must provide customers with initial, opt out, and revised privacy notices. *See* sections 248.4, 248.7, 248.8.

[141] *See* section 248.9(e)(2)(iii).

[142] *See* section 248.9(f). *See also* Proposing Release, *supra* note 4, at paragraph following n.34 (''[t]he proposed rules do not prohibit two or more institutions from providing a joint initial, annual, or opt out notice * * *'').

[143] Records concerning privacy notices delivered to consumers and consumer opt outs must be maintained in accordance with the recordkeeping requirements of 17 CFR 240.17a–4 (broker-dealers); 270.31a–2 (funds); 275.204–2 (registered advisers). *See also* section 248.30 (requiring broker-dealers, funds, and registered advisers to establish procedures and policies to safeguard customer information and records).

[144] Section 248.10.

[145] Proposed section 248.7 implemented these provisions by requiring a broker-dealer, fund, or registered adviser to give the consumer the initial notice required by section 248.4, the opt out notice required by section 248.8, and a reasonable opportunity to opt out.

[146] *See* section 248.10(a)(3)(iii).

[147] *See* section 248.10(a)(3)(i).

[148] *See* section 248.10(a)(3)(ii).

[149] Some commenters stated that the proposal inappropriately implied that the opportunity to opt out by mail is available only when a consumer has a customer relationship with the financial institution. *See* proposed section 248.7(a)(3)(i). The final rule deletes the reference to a customer relationship in that section to avoid creating that implication. *See* section 248.10(a)(3)(i).

any person that is not affiliated with the financial institution or the third party, unless the disclosure would be lawful if made directly by the financial institution. A broker-dealer, fund, or registered adviser generally may disclose nonpublic personal information to a nonaffiliated third party (i) for any purpose if the consumer has received a privacy and opt out notice and has not exercised the right to opt out, (ii) under section 502(b), and (iii) in accordance with specific enumerated exceptions under section 502(e).

The limits on redisclosure and reuse in the proposed rule reflected our belief that implicit in the joint marketing and enumerated exceptions is the idea that information may be used only for the purposes for which the third party received it.[150] The proposed rules implemented section 502(c) by imposing limits on redisclosure for a broker-dealer, fund, or registered adviser that receives information from a nonaffiliated financial institution, and for any nonaffiliated third party that receives nonpublic personal information from a broker-dealer, fund, or registered adviser.[151] The proposed rules also implemented the implicit limitations on reuse by imposing limits on the ability of broker-dealers, funds, and registered advisers and nonaffiliated third parties to reuse nonpublic personal information they receive.[152]

We sought comment on the correct interpretation of ''lawful'' in the context of section 502(c), and whether a recipient of nonpublic personal information could ''lawfully'' disclose information if the disclosure complied with a notice provided by the institution that initially made the disclosure. Finally, we invited comment on whether the rules should require a financial institution that discloses nonpublic personal information to a nonaffiliated third party to develop policies and procedures to ensure that the third party complies with the limits on redisclosure of that information.

Limits on reuse and redisclosure. Commenters who disagreed with the proposal to impose limits on reuse argued that Congress, by addressing limits on redisclosures in section 502(c), provided the only limits that may be imposed on what a recipient of nonpublic personal information can do with that information. We disagree. Although section 502(c) does not expressly address reuse, reuse limitations are, as indicated, implicit in the provisions authorizing or permitting disclosures. For example, it would be inconsistent with the purposes of the Act to permit information disclosed in accordance with section 502(e)(1) (which permits disclosures as necessary to effect, administer, or enforce a transaction with a consumer or in connection with certain routine activities related to such a transaction) to be used for the third party recipient's marketing purposes. Moreover, permitting reuse without limits would undermine the protections afforded to a consumer who does not establish a customer relationship. Such a person does not receive notice that the disclosures under section 502(e) are even made because these disclosures do not entitle the consumer to any privacy or opt out notice. Thus, the limits on reuse are the only protection under the statute for a consumer who is not a customer. Accordingly, consistent with the purposes of the G–L–B Act, the rule limits the reuse of information received under an exception of the Act.[153]

By contrast, when a consumer decides not to opt out after receiving adequate notices and the opportunity to do so, that consumer has decided to permit the broker-dealer, fund, or registered adviser to share his or her nonpublic personal information with the categories of entities identified in the institution's notices. The consumer's primary protection in the case of a disclosure falling outside the section 502(e) exceptions comes from receiving the mandatory disclosures and the right to opt out. The G–L–B Act provides additional protection in section 502(c) by restricting a recipient's ability to redisclose information to entities not affiliated with either the recipient or the financial institution making the initial disclosure. Thus, if a consumer permits a broker-dealer, fund, or registered adviser to disclose nonpublic personal information to the categories of nonaffiliated third parties that are described in the institution's notices, recipients of that nonpublic personal information appear authorized under the statute to make disclosures consistent with those notices.

Limits on redisclosure and reuse when information is received under section 502(e). If a broker-dealer, fund, or registered adviser *receives* nonpublic personal information provided under section 502(e), it may disclose the information to its affiliates or to the affiliates of the financial institution from which it received the information. The broker-dealer, fund, or registered adviser also may disclose and use the information under the same type of exceptions in the ordinary course of business to carry out the activity covered by the exception under which the institution received the information.[154] The affiliates of the broker-dealer, fund, or registered adviser may disclose and use the information, but only to the extent permissible for the broker-dealer, fund, or registered adviser.[155]

These same general rules apply to a third party other than a broker-dealer, fund, or registered adviser that receives nonpublic personal information from a broker-dealer, fund, or registered adviser. Thus, the third party receiving the information under one of the section 502(e) exceptions may disclose the information to its affiliates or to the affiliates of the broker-dealer, fund, or registered adviser that made the disclosure. The third party also may disclose and use the information under one of the section 502(e) exceptions as noted in the rule. The affiliates of the third party may disclose and use the information only to the extent permissible for the third party.

Limits on redisclosure and reuse when information is not received under section 502(e). If a broker-dealer, fund, or registered adviser receives nonpublic personal information *outside* one of the section 502(e) exceptions, it may disclose the information to (i) its affiliates, (ii) the affiliates of the financial institution that made the initial disclosure, or (iii) any other person if the disclosure would be lawful if made directly by the financial institution from which the information was received.[156] Thus, the receiving broker-dealer, fund, or registered adviser may disclose under one of the section 502(e) exceptions.

If a third party receives information from a broker-dealer, fund, or registered adviser outside one of the section 502(e) exceptions, the third party may disclose to its affiliates or to the affiliates of the broker-dealer, fund, or registered adviser. The third party also may disclose to any other person if the disclosure would be lawful if made by the broker-dealer, fund, or registered

[150] For example, as discussed further below in this section, permitted use for an enumerated exception would not include use for marketing purposes.

[151] *See* proposed section 248.12(a)(1), 248.12(b)(1).

[152] *See* proposed section 248.12(a)(2), 248.12(b)(2).

[153] *See* G–L–B Act § 504(a)(1) (authorizing the Commission to prescribe regulations necessary to carry out the purposes of Title V).

[154] *See* sections 248.14, 248.15.

[155] *See* section 248.11(a).

[156] The examples also provide that a broker-dealer, fund, or registered adviser may redisclose information according to the privacy notices of the institution making the initial disclosures, as limited by any opt out elections received by that institution. Section 248.11(b)(2).

adviser. The third party's affiliates may disclose and use the information to the same extent permissible for the third party.

If an entity receives information outside of one of the section 502(e) exceptions, that entity will in essence ''step into the shoes'' of the broker-dealer, fund, or registered adviser that made the initial disclosures. Thus, if the broker-dealer, fund, or registered adviser made the initial disclosures after representing to its consumers that it had carefully screened the entities to whom it intended to disclose the information, the receiving entity must comply with those representations. Otherwise, the subsequent disclosure by the receiving entity would not comply with the notices given to consumers and would not, therefore, be lawful. Even if these representations do not prevent the recipient from redisclosing the information, the recipient's ability to redisclose will be limited by whatever opt out instructions the consumer gave to the broker-dealer, fund, or registered adviser making the initial disclosures and by any new opt out instructions the consumer gives after the initial disclosure. The receiving entity, therefore, must have procedures in place to monitor continually the status of who opts out and to what extent. Given these practical limitations on the ability of a recipient to disclose under another institution's privacy and opt out notices, entities are most likely to redisclose under one of the section 502(e) exceptions (as implemented by sections 248.14 and 248.15 of the final rule).

Monitoring third parties. Most commenters stated that financial institutions should not have to monitor compliance with the redisclosure and reuse provisions of the rule, and we have decided not to revise the rule to impose a specific duty on broker-dealers, funds, and registered advisers to monitor third parties' use of nonpublic personal information they provide. The rule does not, however, address whether obligations to monitor reuse and redisclosure may arise in other contexts. Most of the commenters who requested that we not impose such a duty stated that they have contracts in place that limit the recipient's use of the information. In addition, the limits on reuse as stated in the final rule provide a basis for an enforcement action to be brought against an entity that violates those limits.[157]

Section 248.12 Limits on Sharing Account Number Information for Marketing Purposes

We are revising the proposed rule regarding limits on sharing account number information for marketing purposes[158] by (i) adding two exceptions that we believe are necessary to enable broker-dealers, funds, and registered advisers to engage in legitimate, routine business practices and that are unlikely to pose a significant potential for abuse, and (ii) clarifying that the prohibition does not apply in two circumstances frequently mentioned in the comments.[159] Section 502(d) of the G–L–B Act prohibits a financial institution from disclosing, ''other than to a consumer reporting agency, an account number or similar form of access number or access code for a credit card account, deposit account, or transaction account of a consumer to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.'' The proposal applied this statutory prohibition to disclosures made directly or indirectly by a broker-dealer, fund, or registered adviser, and sought comment on whether the rule should include any exceptions to the prohibition. Some commenters suggested various exceptions while other commenters supported a flat prohibition in order to protect consumers from unscrupulous practices.

Disclosures to a financial institution's agent or service provider. Several financial institutions stated that they use agents or service providers to conduct marketing on the institution's behalf. This might occur, for example, when a broker-dealer instructs a service provider that assists in the delivery of required regulatory notices to include a ''statement stuffer'' about the broker-dealer's products and services. We recognize the need to disclose account numbers in this instance, and believe that this kind of disclosure poses little risk to the consumer.

Several commenters argued that the final rule should exclude disclosures to agents because they effectively act as the financial institution in marketing the financial products and services of the broker-dealer, fund, or registered adviser. We are concerned, however, that the agent of these financial institutions may engage in practices contrary to the institution's instructions. While a broker-dealer, fund, or registered adviser frequently will use agents to assist it in marketing its products, providing agents access to a consumer's account number may erode a consumer's protections. Accordingly, we have added an exception to permit a broker-dealer, fund, or registered adviser to disclose account numbers to an agent for the purpose of marketing the institution's financial product or services as long as the agent has no authority to initiate charges to the account.[160]

Encrypted numbers. Many commenters urged us to exercise our exemptive authority to permit the transmission of account numbers in encrypted form or to clarify that the prohibition applies only to disclosure to nonaffiliated third parties who are not subject to one of the exceptions under sections 248.13, 248.14, or 148.15. Several commenters noted that financial institutions frequently use encrypted account numbers and other internal identifiers of an account to ensure that a consumer's instructions are properly executed. The inability to continue using these internal identifiers would increase the likelihood of errors in processing a consumer's instructions. These commenters also noted that if internal identifiers are not used, a consumer would have to provide an account number in order to ensure proper handling of a request. This procedure could expose the consumer to a greater risk than would the use of an internal tracking system that preserves the confidentiality of a number that may be used to access the account. One commenter also noted that customer account numbers are protected by strict contractual confidentiality provisions.

We believe an encrypted account number without the key is not the same as the number itself and thus falls outside the prohibition in section 502(d). The G–L–B Act focuses on numbers that provide *access* to an account. The encrypted number, however, operates as an identifier attached to an account for internal tracking purposes only, and without the key does not permit someone to access an account. For this reason the final rule clarifies that an account number, or similar form of access number or access code, does not include a number or code in an encrypted number form, as long as the financial institution does not provide the recipient with the means to decrypt the number.[161]

C. Subpart C—Exceptions

Sections 248.13 through 248.15 of Regulation S–P include exceptions from

[157] *See* section 248.11(c).

[158] *See* proposed section 248.13.

[159] *See* section 248.12.

[160] *See* section 248.12(b)(1).

[161] *See* section 248.12(c).

the provisions requiring financial institutions to provide privacy notices and opt out notices to consumers. These exceptions permit broker-dealers, funds, and registered advisers to disclose information to nonaffiliated third parties in circumstances such as maintaining or servicing a customer's account, or complying with federal, State, or local laws.

Section 248.13 Exception to Opt Out Requirements for Service Providers and Joint Marketing

We are adopting substantially as proposed an exception to the opt out requirements for service providers and joint marketing, with revisions to clarify the rule's scope.[162] Section 502(b) of the G–L–B Act permits financial institutions to share information with a nonaffiliated third party without providing the consumer a right to opt out if the third party is to perform services for (or functions on behalf of) the financial institution, including marketing the institution's own products or services, or financial products or services offered under a joint agreement between two or more financial institutions. Section 502(b)(2) requires the financial institution to ''fully disclose'' to the consumer that it will provide this information to the nonaffiliated third party before sharing the information and to enter into a contract with the third party that requires the third party to maintain the confidentiality of the information. As noted in the proposed rule, this contract should be designed to ensure that the third party (i) will maintain the confidentiality of the information at least to the same extent as is required for the financial institution that discloses it, and (ii) will use the information solely for the purposes for which the information is disclosed or as otherwise permitted under the proposed rules.[163]

Commenters expressed concern that routine servicing agreements between a financial institution and, for instance, a customer account servicer would be subject to the requirements of the proposed rules.[164] These commenters noted that section 502(e) of the G–L–B Act contains several exceptions that permit broker-dealers, funds, and registered advisers to share information necessary to allow a third party to perform services for the institution. The commenters requested clarification that sharing information with a service provider under one of the section 502(e) exceptions is not subject to the requirements imposed under section 502(b)(2) of the G–L–B Act. We agree that when a broker-dealer, fund, or registered adviser is permitted to share nonpublic personal information with a nonaffiliated third party under section 502(e), the institution does not have to comply first with the requirements imposed by section 502(b)(2).

A few commenters also argued that it is illogical to impose requirements on service providers that receive information under section 502(b)(2) when no requirements are imposed on service providers that receive information under section 502(e). We believe, however, that a plain reading of section 502(b)(2) leads to that result.[165] We read the phrase ''if the financial institution fully discloses * * *'' as used in section 502(b)(2) to modify the phrase ''This subsection shall not prevent a financial institution from providing nonpublic personal information to a nonaffiliated third party to perform services for or functions on behalf of the financial institution, * * *.'' We therefore conclude that any disclosure to a service provider not covered by section 502(e) must satisfy the disclosure and written contract requirements of section 502(b)(2).

The Proposing Release requested comment on whether the rule should include safeguards beyond those provided by the G–L–B Act to protect a financial institution from the risks that can arise from agreements with third parties. The majority of commenters who addressed the issue argued that the rule should not. We agree that the protections set out in the statute, as implemented by section 248.13(a)(1), are adequate for purposes of the privacy rules. Those protections require a financial institution to provide the initial notice required by section 248.4 as well as to enter into a contractual agreement with a third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the institution disclosed the information, including use under an exception in sections 248.14 or 248.15 in the ordinary course of business to carry out those purposes. These limitations will preclude recipients from sharing a consumer's nonpublic personal information through a chain of third party joint marketing agreements.

Many commenters recommended that the Commission permit broker-dealers, funds, and registered advisers to grandfather prior joint marketing and servicing agreements, or permit institutions to comply with the requirements by notifying existing service providers about the privacy rules' requirements. One commenter stated that without a grandfather provision, institutions would need more than six months to review prior agreements and negotiate amendments with third parties. We believe that a balance must be struck that minimizes interference with existing contracts while preventing evasions of the regulation. To achieve these goals, the final rule provides that contracts entered into on or before July 1, 2000 must be brought into compliance with the provisions of section 248.13 by July 1, 2002.[166]

Section 248.14 Exceptions to Notice and Opt Out Requirements for Processing and Servicing Transactions

We have revised the proposed exceptions to notice and opt out requirements for processing and servicing transactions[167] to include disclosures made in connection with (i) servicing or processing financial products or services requested by the consumer or (ii) maintaining or servicing a customer account.[168] As previously discussed, section 502(e) of the G–L–B Act creates exceptions to the requirements that apply to the disclosure of nonpublic personal information to nonaffiliated third parties. Paragraph (1) of that section sets out certain exceptions for disclosures made in connection with the administration, processing, servicing, and sale of a consumer's account. Proposed section 248.10 implemented those exceptions by restating them with only stylistic changes that were intended to make the exceptions easier to read. The Proposing Release noted that the exceptions set out in proposed sections 248.10 and 248.11 do not affect a financial institution's obligation to provide initial and annual notices of its privacy policies and practices.

We received many comments from broker-dealers, funds, and registered

[162] *See* proposed section 248.9, section 248.13.

[163] *See* proposed section 248.9, (a)(2). The exceptions were set forth in proposed sections 248.10 and 248.11.

[164] *See* section 248.13.

[165] The statute states, in relevant part, that section 502(b)— shall not prevent a financial institution from providing nonpublic personal information to a nonaffiliated third party to perform services for or functions on behalf of the financial institution, including the marketing of the financial institution's own products or services, or financial products or services offered pursuant to joint agreements between two or more financial institutions that comply with the requirements imposed by the regulations prescribed under section 504, if the financial institution fully discloses the providing of such information and enters into a contractual agreement with the third party that requires the third party to maintain the confidentiality of such information.

[166] Section 248.18(c).

[167] *See* proposed section 248.10.

[168] Section 248.14.

advisers noting that, by deleting the statutory phrase ''in connection with'' from the exceptions for information shared (i) to service or process a financial product or service requested by the consumer or (ii) to maintain or service a customer account, we narrowed the application of the exception. We did not intend this result, and have changed the final rule accordingly.[169]

Several other commenters requested that the final rule provide specific examples of situations that would fall within the exception for processing and servicing customer accounts (such as transfers from a broker-dealer to its registered representatives, or as necessary to arbitrate a dispute, with the consent of the consumer's fiduciary or representative). Others stated that certain services, such as those provided by attorneys, are ''necessary'' to effect, administer, or enforce a transaction. We believe that disclosures to these types of professionals and under the circumstances posited by the commenters may be necessary to effect, administer, or enforce a transaction in a given situation. However, we have not listed specific types of disclosures in the regulation as necessarily falling within the scope of the exception because we are concerned that a general statement could be applied inappropriately to shelter disclosures that, in fact, are not necessary to effect, administer, or enforce a transaction.

Other commenters suggested that the final rule clarify, in situations in which a financial institution uses an agent to provide services to a consumer, that the consumer does not have to request directly or authorize the service provider to provide the financial product or service but may request it from the financial institution instead. For example, a consumer may ask the fund or its transfer agent for additional account information that the transfer agent provides as a service for the fund. We agree that the communication may be between the consumer and the service provider, and note that the rule governing agents as set out in the definition of ''consumer'' above provides the flexibility sought by the commenters. An individual will not be a consumer of an entity that is acting as agent for a broker-dealer, fund, or registered adviser in connection with that institution's providing a financial product or service to the consumer.

Section 248.15 Other Exceptions to Notice and Opt Out Requirements

We are adopting as proposed the section that includes ''other'' exceptions to the notice and opt out requirements. As noted above, section 502(e) of the G–L–B Act contains several exceptions to the requirements that otherwise would apply to the disclosures of nonpublic personal information to nonaffiliated third parties. The proposed rule set out those exceptions for disclosures that are not made in connection with the administration, processing, servicing, or sale of a consumer's account, and made stylistic changes to the statutory language that were intended to clarify the exceptions.[170] The proposal also provided an example of the consent exception in the context of a consumer who consents to having a broker or investment adviser confirm the amount of assets in the customer's account to a nonaffiliated mortgage lender so that the lender can evaluate the customer's application for a loan. We invited comment on whether we should add safeguards to the exception for consent in order to minimize the potential for consumer confusion.

Several commenters responded to the request for comment on whether the consent exception should include consumer safeguards, such as a requirement that the consent be written, be indicated by a signature on a separate line, or automatically terminate after a certain period of time. Some commenters favored the additional safeguards discussed in the proposal, while others maintained that safeguards are unnecessary. Several suggested that the consent exception include a provision noting that participation in a program where a consumer receives ''bundled'' products and services necessarily implies consent to the disclosure of information between the entities that provide the bundled products or services. Others suggested that certain terms and conditions be imposed on any consent agreement, such as a time by which the financial institution must stop disclosing nonpublic personal information once a consent is revoked.

We have declined to elaborate on the requirements for obtaining consent or the consumer safeguards that should be in place when a consumer consents. We believe that the resolution of this issue is appropriately left to the particular circumstances of a given transaction. We note that any broker-dealer, fund, or registered adviser that obtains the consent of a consumer to disclose nonpublic personal information should take steps to ensure that the limits of the consent are well understood by both the institution and the consumer. We also note that a consumer may always revoke his or her consent. In light of the safeguards already in place, we have decided not to adopt additional safeguards in the consent exception.

Many commenters offered specific suggestions for additional exceptions or revisions to the proposed exceptions. In some cases, the suggestions are accommodated elsewhere in the regulation (such as exceptions to permit disclosures to independent contractor registered representatives or attorneys to effect a transaction).[171] In other cases, the suggestions are inconsistent with the statute.[172] Accordingly, we have retained the statement of the exceptions as proposed.[173]

D. Subpart D—Relation to Other Laws; Effective Date

Sections 248.16 through 248.18 of Regulation S–P include provisions that explain the interaction between the regulation and certain other laws, and that provide an effective date and compliance date for the regulation.

Section 248.16 Protection of Fair Credit Reporting Act

We are adopting as proposed the section that explains the interaction between Regulation S–P and the Fair Credit Reporting Act.[174] Section 506 of the G–L–B Act makes several amendments to the FCRA to vest rulemaking authority in various agencies and to restore the Banking Agencies' regular examination authority. Paragraph (c) of section 506 states that, except for these amendments to the FCRA, nothing in Title V of the G–L–B Act is to be construed to modify, limit, or supersede the operation of the FCRA, and no inference is to be drawn on the basis of the provisions of Title V whether information is transaction or experience information under section 603 of the FCRA. Proposed section 248.14 implemented section 506(c) of the G–L–B Act by restating the statute,

[169] *See* section 248.14(a).

[170] Proposed section 248.11.

[171] *See* section 248.14(a) (excepting from initial and opt out notice requirements disclosures to nonaffiliated third parties as necessary to effect a transaction that a consumer requests or in connection with servicing or processing a financial product that a consumer requests or authorizes).

[172] One commenter, for example, suggested that the rule completely exempt a financial institution from all of the requirements under Title V if the institution makes no disclosures other than those permitted by section 502(e).

[173] *See* section 248.15.

[174] Section 248.16.

making only minor stylistic changes intended to make the rule clearer.

Comments about this provision focused on whether the Commission, by requiring annual notice of a consumer's right to opt out under the FCRA, was modifying, limiting, or superseding the operation of the FCRA. For the reasons explained in the discussion of section 248.6, above, we do not believe that the annual disclosure mandated by the G–L–B Act affects in any way the obligations imposed by the FCRA.

Section 248.17 Relation to State laws.

We are adopting as proposed the section that explains the interaction between Regulation S–P and State laws.[175] Section 507 of the G–L–B Act provides that Title V does not preempt any State law that provides greater protections than are provided by Title V. Determinations of whether a State law or Title V provides greater protections are to be made by the Federal Trade Commission (''FTC'') after consultation with the agency that regulates either the party filing a complaint or the financial institution about whom the complaint was filed, and may be initiated by any interested party or on the FTC's own motion. The proposed rule essentially restated section 507, stating that the proposed rules (as opposed to the statute) do not preempt State laws that provide greater protection for consumers than do the rules.

Commenters on this section expressed concern about the potential differences between federal and State privacy laws. Several supported coordination and cooperation among federal and State regulators to ensure consistency in privacy policies. Some commenters requested clarification of whether a particular State law would be considered more restrictive, while others suggested that the final rules establish a choice of law principle for financial institutions operating in more than one State. These and other suggestions made by the commenters appear to exceed the scope of this rulemaking.

Section 248.18 Effective Date; Transition Rule

We are adopting as proposed the effective date for Regulation S–P of November 13, 2000, and are providing a compliance date of July 1, 2001.[176] We also are adding a provision that clarifies the requirement that financial institutions provide initial privacy and opt out notices to customers by July 1, 2001, and a provision that phases in compliance with respect to existing service agreements.[177]

Section 510 of the G–L–B Act states that, as a general rule, the relevant provisions of Title V take effect six months after the date on which rules are required to be adopted, *i.e.,* November 12, 2000. However, section 510(1) authorizes us to prescribe a later date in the rules adopted under section 504. The Proposing Release sought comment on the effective date prescribed by the statute.[178] It also would have required that financial institutions provide initial notices, within 30 days of the effective date of the final rule, to people who were customers as of the effective date. The Proposing Release noted that a financial institution would have to provide opt out notices before the rule's effective date if the institution wanted to continue sharing nonpublic personal information with nonaffiliated third parties without interruption.[179]

The Congressional Privacy Caucus, several members of Congress, and other commenters have urged the Commission and the Agencies not to delay the effective date past the date set forth in the G–L–B Act.[180] By contrast, the overwhelming majority of commenters from the securities industry who addressed this provision requested additional time to comply with the final rule. Commenters stated that six months would not be sufficient to take the steps needed to comply with the regulation, including preparing new disclosure forms, developing software needed to track opt outs, training employees, and creating management oversight systems. Several commenters suggested that it would be less effective and potentially more confusing for consumers to receive several notices around the end of the year 2000 than it would be for the notices to be delivered during a ''rolling phase-in.'' Others noted that the proposed effective date would place a severe strain on financial institutions at a time when other year-end notices need to be prepared and delivered. Several commenters noted that financial institutions have not budgeted for the expenses in the current year that likely will be incurred. Requests for extensions of the effective date typically ranged from six to 24 months from the proposed effective date of the rule (*i.e.,* from November 13, 2000).

Many commenters also stated that a 30-day phase-in for initial notices to existing customers is not feasible, given the large number of notices, the short period of time allowed, and the competing demands on financial institutions at the time when the initial notices must be sent. A few suggested that the rule require initial notices to be sent only to people who establish customer relationships after the effective date of the rule, and allow a financial institution to send annual notices to existing customers at some point during the next 12 months and annually thereafter.

We agree that six months may be insufficient in certain instances for a financial institution to have ensured that its forms, systems, and procedures comply with the rule. In order to accommodate situations requiring additional time, we will give financial institutions until July 1, 2001 to be in full compliance with the regulation. Financial institutions are expected, however, to begin compliance efforts promptly, to use the period prior to June 30, 2001 to implement and test their systems, and to be in full compliance by July 1, 2001. Given that this provides financial institutions more than 12 months in which to comply with the rules, we have determined that there no longer is any need for a separate phase-in for providing initial notices. Thus, a financial institution will need to deliver all required opt out notices and initial notices before July 1, 2001. We believe that this extension represents a fair balance between those seeking prompt implementation of the protections afforded by the statute and those concerned about the reliability of the systems that are put in place.

We encourage financial institutions to provide disclosures as soon as practicable. Broker-dealers, funds, and registered agents that do not disclose nonpublic personal information to third parties have fewer burdens under the regulation (both in terms of the notice requirements and opt out mechanism) and should therefore be able to provide privacy notices to their consumers sooner. Depending on the readiness of an institution to process opt out elections, institutions might wish to consider including the privacy and opt out notices in the same mailing as is used to provide tax information or account statements to consumers in the first quarter of 2001 to increase the likelihood that a consumer will not mistake the notices for an unwanted solicitation.

[175] Section 248.17.

[176] Section 248.18(a).

[177] Section 248.18(b), (c).

[178] Because Nobvember 12, 2000 is a Sunday, the proposed rule provided an effective date of Monday, November 13, 2000. *See* proposed rule 248.16(a).

[179] *See* Proposing Release, *supra* note 4, at discussion of proposed section 248.16.

[180] *See supra* note 6.

The extension of the compliance date should provide much of the relief sought by those who suggested that initial notices should not be required for existing customers. By allowing financial institutions to deliver notices over a significantly longer period of time than was proposed, the concentrated burden that would have been imposed by the proposed rules is avoided. Accordingly, we have not adopted the suggestion that initial notices be required only for new customers after the effective date of the rule.

Broker-dealers, funds, and registered advisers need not give initial notices to customers whose relationships have terminated before the date by which institutions must be in compliance with the rules. Thus, if an account is inactive according to a financial institution's policies before July 1, 2001, then no initial notice would be required in connection with that account. However, because these former customers would remain consumers, a broker-dealer, fund, or registered adviser would have to provide a privacy and opt out notice to them if the institution intended to disclose their nonpublic personal information to nonaffiliated third parties beyond the exceptions in sections 248.14 and 248.15.

Full compliance with the rules' restrictions on disclosures is required on July 1, 2001. To be in full compliance, broker-dealers, funds, and registered advisers must have provided their existing customers with a privacy notice, an opt out notice, and a reasonable amount of time to opt out before that date. If these have not been provided, the disclosure restrictions will apply. This means that a broker-dealer, fund, or registered adviser would have to cease sharing customers' nonpublic personal information with nonaffiliated third parties on that date, unless it may share the information under an exception under sections 248.14 or 248.15. Broker-dealers, funds, and registered advisers that both provide the required notices and allow a reasonable period of time to opt out before July 1, 2001, may continue to share nonpublic personal information after that date for customers who do not opt out.

E. Subpart E—Safeguard Procedures

Section 248.30 Procedures To Safeguard Customer Information and Records

Commenters on this section supported the proposal, and we are adopting this section as proposed. Section 501 of the G–L–B Act directs the Commission (and the Agencies) to establish appropriate standards for financial institutions relating to administrative, technical, and physical safeguards to protect customer records and information. The rules implement this section by requiring every broker-dealer, fund, and registered adviser to adopt policies and procedures to address the safeguards described above. Consistent with the Act, the proposed rule further requires that the policies and procedures be reasonably designed to: (i) insure the security and confidentiality of customer records and information; (ii) protect against any anticipated threats or hazards to the security or integrity of customer records and information; and (iii) protect against unauthorized access to or use of customer records or information that could result in substantial harm or inconvenience to any customer.

Some commenters recommended that the Commission add an example to clarify that various financial institutions in a fund complex could satisfy the rule by adopting a single set of policies and procedures for the fund complex. We believe that a single set of policies and procedures for a fund complex could satisfy the rule's requirements, as long as those policies and procedures have been determined to be appropriate for each institution to which they apply.

IV. Appendix—Sample Clauses

In order to provide additional guidance to broker-dealers, funds, and registered advisers concerning the level of detail we believe is appropriate under the Act, we have prepared a variety of sample clauses for institutions to consider. We urge broker-dealers, funds, and registered advisers to carefully review whether these clauses accurately reflect a given institution's policies and practices before using the clauses. Broker-dealers, funds, and registered advisers are free to use different language and to include additional detail as they think is appropriate in their notices.

V. Comparison Chart

Below is a chart showing the comparison of the sections in the final privacy rules and the proposal. Only changes are noted.

Proposal	Content of provision	Final rule
4(d)	How to provide initial notice.	9(a)
N/A	New product for existing customer.	4(d)
4(d)(3) ..	Oral delivery	9(d)
4(d)(4) ..	Retainable notice	9(e)
N/A	Joint relationships (privacy notice).	9(g)
5(b)	How to provide annual notice.	9(a)
5(b)	Actual notice of annual notice.	9(c)
5(c)	Terminated customer relationships.	5(b)
N/A	Delivering short-form initial notices.	6(d)
7	Main operative provision.	10
8(a)	Opt out methods and opt out notice content.	7(a)
8(b)(1) ..	How to deliver opt out notices.	9(a)
8(b)(2) ..	Oral delivery	9(d)
8(b)(3) ..	Same form as initial notice.	7(b)
8(b)(4) ..	Initial notice must accompany opt out notice.	7(c)
N/A	Joint relationships (opt out notice).	7(d)
8(d)	Time to comply with opt out; continuing right to opt out.	7(e) & (f)
8(e)	Duration of opt out	7(g)
8(c)(1) ..	Revised notices	8(a)
8(c)(2) ..	How to deliver revised notice.	8(c)
8(c)(3) ..	Examples of when revised notice is required.	8(b)
9	Exception for service providers and joint marketers.	13
10	Exceptions for processing and servicing transactions.	14
11	Other exceptions	15
12	Redisclosure and reuse	11
13	Sharing account number information.	12
14	FCRA	16
15	State law	17
16	Effective date	18

VI. Guidance for Certain Institutions

To minimize the burden and costs to a broker-dealer, fund, or registered adviser (''you'') and generally clarify the operation of the final rules, we have included this guidance that you may use in conjunction with the sample clauses in the Appendix. This guidance specifically applies to you if you:

(1) do not have any affiliates;

(2) only disclose nonpublic personal information to nonaffiliated third parties in accordance with an exception under sections 248.14 or 248.15, such as in connection with servicing or processing a financial product or service that a consumer requests or authorizes; and

(3) do not reserve the right to disclose nonpublic personal information to

nonaffiliated third parties, except under sections 248.14 and 248.15.[181]

In addition, if you disclose nonpublic personal information in accordance with the exception in section 248.13 (for service providers and joint marketers) you also must include an accurate description of that information, as illustrated by the sample clause in section (K) below.

In general, if you disclose nonpublic personal information to nonaffiliated third parties only as authorized under an exception, then your only responsibilities under the regulation are to provide initial and annual privacy notices to each of your customers. You do not need to provide an opt out notice or opt out rights to your customers.

A. *Initial notice to customers.* You must provide an initial notice to each of your customers. A customer is a natural person who has a continuing relationship with you, as described in section 248.4(c). In general, an individual who opens a brokerage account or enters into an investment advisory contract (whether written or oral) with you is your customer. By contrast, an individual who establishes an account solely for the purpose of liquidating or purchasing securities as an accommodation, *i.e.,* on a one-time basis, without the expectation of engaging in other transactions, is not your customer. In other words, you must provide initial and annual notices to each of your customers, but not to others.

B. *Time to provide initial notice.* You must provide an initial privacy notice to each of your customers not later than when you establish a customer relationship (section 248.4(a)(1)). For example, you must provide a privacy notice to an individual not later than when that individual opens a brokerage account or purchases fund shares in his or her own name. Thus, you can provide the notice to a brokerage account customer together with the account agreement or to a fund shareholder with the application to purchase shares.

If one of your existing customers obtains a new financial product or service from you, then you need not provide another initial notice to that customer (section 248.4(d)) if the earlier notice covered the subsequent product.

For instance, if Alison Individual walks into Broker-Dealer for the first time on July 2, 2001, to open a cash account, then Broker-Dealer complies with section 248.4(a)(1) of the rules if it provides an initial notice to Alison together with the account agreement. When Alison opens her cash account, she becomes a customer of Broker-Dealer. Alison maintains her cash account and, six months later, returns to the Broker-Dealer to open a margin account. If the initial notice that the Broker-Dealer provided to Alison was accurate with respect to the margin account, then the Broker-Dealer need not provide another initial notice to her when she opens the margin account because it has provided a notice to Alison that covered the margin account when she opened her cash account.

C. *Method of providing the initial notice.* You must provide your initial notice so that each customer can reasonably be expected to receive it (section 248.9(a)). For example, you may provide the initial notice by mailing a printed copy of it together with a prospectus. Similarly, you may provide the initial notice by hand-delivering a printed copy of it to the customer together with a brokerage account application or an investment advisory contract.

D. *Compliance with initial notice requirement for existing customers by compliance date.* You must provide an initial notice to each of your current customers not later than July 1, 2001 (section 248.18(b)). You may do so by mailing a printed copy of the notice to the customer's last known address.

E. *Annual notice.* During the continuation of the customer relationship, you must provide an annual notice to the customer, as described in section 248.5(a). You must provide an annual notice to each customer at least once in any period of 12 consecutive months during which the customer relationship exists. You may define the 12-consecutive-month period, but must consistently apply that period to the customer. You may define the 12-consecutive-month period as a calendar year and provide the annual notice to the customer once in each calendar year following the calendar year in which you provided the initial notice. You do not need to provide an annual notice in addition to an initial notice in the same 12-month period.

For example, assume that Broker-Dealer defines the 12-consecutive-month period as a calendar year and provides annual notices to all of its customers on October 1 of each year. If Alison Individual opens a cash account with Broker-Dealer on July 2, 2001, thereby becoming a customer, then Broker-Dealer must provide an initial notice to Alison together with the account agreement or earlier. Broker-Dealer must provide an annual notice to Alison by December 31, 2002. If Broker-Dealer provides an annual notice to Alison on October 1, 2002, as it does for other customers, then it must provide the next annual notice to Alison not later than October 1, 2003.

F. *Method of providing the annual notice.* Like the initial notice, you must provide the annual notice so that each customer can reasonably be expected to receive actual notice of it, in writing (section 248.9(a)). You may do so by mailing a printed copy of the notice to the customer's last known address.

G. *Joint accounts.* If two or more customers jointly obtain a financial product or service, then you may provide one initial notice to those customers jointly. Similarly, you may provide one annual notice to those customers jointly (section 248.9(g)).

H. *Information described in the initial and annual notices.* The initial and annual notices must include an accurate description of the following items of information:

- The categories of nonpublic personal information that you collect (section 248.6(a)(1));
- The fact that you do not disclose nonpublic personal information about your current and former customers to affiliates or nonaffiliated third parties, except as authorized by sections 248.14 and 248.15 (section 248.6(a)(2)–(4)). When describing the categories with respect to those parties, you are required to state only that you make disclosures to other nonaffiliated third parties as permitted by law (section 248.6(c));
- Your policies and practices with respect to protecting the confidentiality and security of nonpublic personal information (section 248.6(a)(8)).

For each of these items of information above, you may use a sample clause from the Appendix.

Note: You may use a sample clause only if that clause accurately describes your actual policies and practices.

I. *Example of notice.* If Broker-Dealer (i) does not have any affiliates and (ii) only discloses nonpublic personal information to nonaffiliated third parties as authorized under sections 248.14 and 248.15, Broker-Dealer may comply with the requirements of section 248.6 of the rules by using the following notice, if applicable.

Broker-Dealer collects nonpublic personal information about you from the following sources:

- *Information we receive from you on applications or other forms;*
- *Information about your transactions with us or others; and*

[181] If you disclose or reserve the right to disclose nonpublic personal information to a nonaffiliated third party under other circumstances, you must comply with other provisions in the rules, notably sections 248.7, 248.8, and 248.13, if applicable. If you disclose or reserve the right to disclose nonpublic personal information to an affiliate you must comply with other provisions in the rules, notably section 248.6(a)(7), as applicable.

• *Information we receive from a consumer reporting agency.*[182]

We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.

If you decide to close your account(s) or become an inactive customer, we will adhere to the privacy policies and practices as described in this notice.

Broker-Dealer restricts access to your personal and account information to those employees who need to know that information to provide products or services to you. Broker-Dealer maintains physical, electronic, and procedural safeguards to guard your nonpublic personal information.

J. *Initial and annual notices must be clear and conspicuous.* We emphasize that you must ensure that both the initial and annual notices are clear and conspicuous, as defined in section 248.3(c).

K. *Example of notice for disclosure to service providers and joint marketers.* If you disclose nonpublic personal information in accordance with the exception in section 248.13, for service providers and joint marketers, you also must include an accurate description of that information. You may comply with the requirements of section 248.13 of the rules by including the following sample clause, if applicable, in the example of notice described in section (I) above:

We may disclose all of the information we collect, as described [describe location in the notice, such as ''above'' or ''below''] to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

L. *Internal controls/supervision.* The Commission expects brokers-dealers, funds, and registered advisers to create appropriate internal control systems and exercise appropriate supervision over compliance with this rule. Compliance systems could include the maintenance of copies of the notices provided to consumers and customers, documentation in customer files showing compliance, and procedures for handling and monitoring opt out requests.

VII. Cost-Benefit Analysis

The Commission is sensitive to the costs and benefits that result from its rules and understands that the rules may impose costs on broker-dealers, funds, and registered advisers. Nevertheless, the rules implement the privacy provisions of Title V and, we believe, impose no costs in addition to those that would result from compliance with the G–L–B Act.

We believe that the requirements to provide opt out notices and to protect customer information will benefit consumers and customers by protecting the privacy of their nonpublic personal information. In addition, the requirements to provide initial and annual privacy notices will allow customers to compare the privacy policies of financial institutions.

We also believe that the rules provide greater certainty to the private sector on how to comply with the G–L–B Act because they are consistent with and comparable to the rules adopted by the Agencies. The examples in the rules and the sample clauses in the Appendix also should provide guidance on how the rules will be enforced with respect to broker-dealers, funds, and registered advisers. Finally, in order to reduce compliance burdens, the rules allow broker-dealers, funds, and registered advisers flexibility to distribute notices and to adopt policies and procedures to protect customer information that are best suited to the institution's business and needs. These benefits are difficult to quantify, and we received no data from commenters.

We estimate that approximately 5500 broker-dealers, 4300 funds, and 8100 registered advisers will be required to comply with the rules. In the first year after the rules are adopted, these institutions must comply with the following requirements: (i) Prepare notices describing the institution's privacy policies; (ii) provide an initial privacy notice and opt out notice to each consumer; (iii) provide an initial privacy notice to each new customer (who did not receive a notice when he or she was a consumer); (iv) provide an annual privacy notice to each existing customer; (v) adopt policies and procedures that address the protection of customer information and records. After the first year, broker-dealers, funds, and registered advisers would be required to revise notices only to reflect changes in their privacy policies. Similarly, these institutions would have to revise their policies and procedures on safeguarding customer information as appropriate to ensure the protection of the information.

In the Proposing Release, we estimated certain costs of complying with the proposed rules.[183] We estimated that a registered adviser would spend on average $615 to draft a privacy notice,[184] and a broker-dealer or fund would spend on average $4920 to draft a privacy notice.[185] Therefore, we estimated a one-time cost to the industry of approximately $53.2 million to draft privacy notices.[186] For mailing the notices, we estimated that it would cost broker-dealers, funds, and registered advisers $2.6 million to provide to their customers initial notices in the first year after adoption, and the same amount to provide annual notices to customers each year after that.[187] In addition, we assumed that most broker-dealers, funds, and

[182] You need to describe only those general categories that apply to your policies and practices. Accordingly, if you do not collect information from a ''consumer reporting agency,'' for instance, then you need not describe that category in your notices.

[183] *See* Proposing Release, *supra* note 4, at section IV.

[184] For purposes of the Paperwork Reduction Act, Commission staff has estimated that an investment adviser would require 4 hours of professional time (at $150 per hour) and 1 hour of clerical or administrative time (at $15 per hour) to prepare (or revise) its privacy notice, for a total of $615 ((4 × $150) + (1 × $15) = $615).

[185] For purposes of the Paperwork Reduction Act, Commission staff has estimated that a broker-dealer or investment company would require 32 hours of professional time and 8 hours of clerical or administrative time to prepare (or revise) its privacy notice, for a total of $4920 ((32 × $150) + (8 × $15) = $4920).

[186] This amount equals the sum of the costs for broker-dealers, funds, and registered advisers ((5500 + 4300) × $4920) + (8,100 × $615) = $53.2 million. The amount of time required for each institution to prepare (or revise) its privacy notices will vary depending on the extent to which (i) the institution shares information and (ii) the institution's sharing policy differs for certain consumers or customers. An institution that does not share information with affiliates or nonaffiliated third parties may provide a simplified notice. *See* section 248.6(c)(5). An institution that has many affiliates and has different policies on sharing based on the affiliate or the customer is likely to require much more time to draft its notices. Our estimate was based on the assumption that most broker-dealers and funds share nonpublic personal information about consumers or customers with their affiliates (or as permitted under one of the exceptions discussed above), but many fewer share information with nonaffiliated third parties, and that registered advisers generally do not share with affiliates or nonaffiliated third parties. For purposes of the Paperwork Reduction Act, Commission staff has estimated that a registered adviser would require, on average, about 5 hours, and a broker-dealer or fund would require from 5 to over 100 hours, with an average of about 40 hours, to prepare (or revise) its privacy notice.

[187] We assumed that broker-dealers, funds, and registered advisers generally would include the initial privacy notices to customers with disclosure documents or account statements that customers currently receive, and that the statements generally would be assembled and sent by organizations that specialize in mailing and distribution. The individual cost per institution would vary significantly depending on the number of the institution's customers. The estimate was based on an average additional cost per mailing of $0.02 for 130.7 million investor accounts. We assumed there are 53 million brokerage accounts, 77.3 million individual fund shareholders (*see* Investment Company Institute, 1999 Mutual Fund Fact Book 41 (May 1999)), and 400,000 customers of registered advisers. We noted that the estimated number of accounts may be significantly higher than the actual number because we were unable to estimate the number of individual accounts used for personal, family, or household purposes.

registered advisers currently have in place procedures to protect customer information. Thus, we estimated that each institution would on average require approximately 30 hours to review and revise its policies and procedures, with a one-time cost to the industry to comply with the rules of approximately $80.6 million.[188]

We received two comments on the cost-benefit analysis, both of which opined that we underestimated the costs and burdens of complying with Regulation S–P. One commenter suggested that we increase our estimate of the cost to mail annual notices to reflect the cost of providing revised privacy notices.[189] This commenter suggested that the cost for privacy notices would increase annual mailing costs by approximately $1.3 million per year.[190]

These commenters further noted that our estimates did not address other costs of compliance, including: Modifying existing systems and databases, developing new systems to track delivery of privacy notices and (if necessary) opt out elections, and training personnel. One commenter estimated that the overall cost of implementing the rules for a large firm would be at least $1 million. The other commenter provided no estimates for these additional costs. Neither commenter provided any specific data to explain the amount of time or the costs associated with the time they believe will be required to implement the rules.

[188] The estimate represented the costs of 30 hours of professional time (at $150 per hour) ((5500 + 4300 + 8100) × 30 × $150 = $80.6 million). Our estimates were based on staff conversations with representatives from the industry. We understand that many large institutions currently have comprehensive policies and procedures for protecting customer information and records. Although the policies of those institutions may need little revision, there may be many departments or other divisions that will participate in the review. Smaller institutions that need less comprehensive policies may devote more time to implementation or revision of their policies and procedures.

[189] *See* section 248.8.

[190] This estimate was based on a cost of $0.02 per mailing to 130.7 million accounts every other year ($0.02 × 130.7 × 5 = $1.3 million). One commenter stated that it would cost $0.40 per piece to mail the privacy notices, the same cost as mailing a confirmation statement. We believe that this commenter assumed that it would have to provide a privacy notice to its existing customers in a separate mailing (as a confirmation must be sent). The extended compliance date should permit broker-dealers, funds, and registered advisers to mail privacy notices to existing customers together with another mailing, such as an account statement or shareholder report, so that the costs will be significantly reduced. The other commenter used our estimate of $0.02 in its estimate of mailing costs, and we have continued to use that estimate in our final cost-benefit analysis.

The cost of developing and maintaining records of delivery of privacy notices and opt out elections, and costs for personnel training will vary greatly depending upon the size of the financial institution, its customer base, number of affiliates, and the extent to which the institution intends to share information. We have been unable to obtain any reliable information with which to quantify the amount of these costs. We recognize that the costs for a large institution that shares information with affiliates and nonaffiliated third parties and that has many customers may exceed $1 million, and that this could increase the compliance costs of the rules. We also believe that the costs for a small institution, such as a registered adviser, that has far fewer customers and does not share with affiliates or nonaffiliated third parties will be significantly less.

As discussed above, the privacy notices will allow customers of broker-dealers, funds, and registered advisers to compare the privacy policies of different institutions. This information is likely to result in some customers moving their accounts or relationships from one institution to another whose policies are better suited to the customers' needs. We are unable to estimate the number of customers who may make this transfer or the resulting economic impact on the industry. We do not believe, however, that customers would move their accounts from broker-dealers, funds, or investment advisers to a different type of financial institution (such as a bank), because we have no basis for assuming that the privacy policies adopted by 17,900 broker-dealers, investment companies, and registered investment advisers would not be sufficiently varied to address the needs of any customer.

VIII. Paperwork Reduction Act

Certain provisions of the rules contain ''collection of information'' requirements within the meaning of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). The Commission published notice soliciting comments on the collection of information requirements in the Proposing Release,[191] and submitted these requirements to the Office of Management and Budget (''OMB'') for review in accordance with 44 U.S.C. 3507(d) and 5 CFR 1320.11. OMB approved the regulation's information collection requirements.[192] An agency may not conduct or sponsor, and a person is not required to respond to, an information collection unless it displays a currently valid OMB control number.[193]

[191] *See* Proposing Release, *supra* note 4, at section V.

[192] The title for the collections of information is: ''Regulation S–P.'' The OMB control number for Regulation S–P is 3235–0537 (expiration date April 30, 2003).

[193] 44 U.S.C. 3506(c)(1)(B)(v).

IX. Summary of Final Regulatory Flexibility Analysis

The Commission has prepared a Final Regulatory Flexibility Analysis (''FRFA'' or ''analysis'') for Regulation S–P in accordance with 5 U.S.C. 604. The following summarizes the FRFA. A copy of the FRFA may be obtained by contacting Penelope W. Saltzman, Securities and Exchange Commission, 450 5th Street, NW., Washington, DC 20549–0506.

The analysis explains that Regulation S–P implements provisions of Title V and that, in general, Title V requires financial institutions to provide notice to consumers about the institution's privacy policies and practices. The statute also restricts the ability of a financial institution to share nonpublic personal information about consumers with nonaffiliated third parties, and allows consumers to prevent the institution from sharing nonpublic personal information about them with certain nonaffiliated third parties by ''opting out'' of the information sharing. In addition, Title V requires the Commission to establish appropriate standards for financial institutions subject to their jurisdiction to safeguard customer information and records.

Section 504 of the G–L–B Act authorizes the Commission and the Agencies to prescribe ''such regulations as may be necessary'' to carry out the purposes of Title V. As discussed in the analysis, we believe that by adopting rules implementing Title V that are consistent with and comparable to those of the Agencies, we will provide the private sector greater certainty on how to comply with the statute and clearer guidance on how the rules will be enforced with respect to the financial institutions subject to Title V that are under the Commission's jurisdiction.

The analysis states that the Proposing Release solicited comments on the IRFA, but we received none. Several commenters who addressed the proposed rules, however, suggested that the Commission reduce compliance burdens by, among other things, providing model forms, providing additional examples, adding additional flexibility for providing the initial notice, and extending the effective date. In response to these comments, we have

provided a guide to assist broker-dealers, funds, and registered advisers in complying with the rules. The rules also include an Appendix with sample clauses that could be used in privacy notices under appropriate circumstances, and should be of particular help to small entities. Other revisions to the rules include: (i) A compliance date of July 1, 2001 (to allow more time to comply and more opportunity to include initial notices with other mailings); (ii) an example that permits householding annual privacy notices with prospectuses or investor reports delivered under the Commission's householding rules;[194] and (iii) permitting delivery of an initial notice within a reasonable time after establishing the customer relationship in two additional circumstances.[195]

As explained in the analysis, the rules will affect all broker-dealers, funds, and registered advisers, including small entities.[196] We estimate that approximately 1000 out of 5500 broker-dealers, 227 out of 4300 funds, and 1500 out of 8100 registered advisers are small entities.

The analysis explains that subject to certain exceptions, the rules generally require that a financial institution provide all of its *customers* the following notices: (i) An initial privacy notice (not later than when the customer relationship is established or, by July 1, 2001 for individuals who are your customers on that date); (ii) an opt out notice (before sharing the customer's nonpublic personal information with nonaffiliated third parties); and (iii) an annual privacy notice for the duration of the customer relationship.

The rules also require a financial institution to provide its *consumers* an initial privacy notice and an opt out notice prior to disclosing the individual's nonpublic personal information with nonaffiliated third parties. If the institution does not intend to share that information about its consumers, then it need not provide them with a privacy or opt out notice.

The many exceptions to the general rules stated above are set forth in sections 248.13, 248.14, and 248.15. The analysis notes that in cases in which a financial institution enters into a contract with a nonaffiliated third party to undertake joint marketing or to have the third party perform certain functions on behalf of the institution, no opt out notice need be given. In those cases, the institution must disclose to the consumer that it is providing the information and enter into a contract with the third party that restricts the third party's use of the information and requires the third party to maintain confidentiality of the information.

As discussed in the analysis, compliance requirements will vary depending, for example, on an institution's information sharing practices, whether the institution already has or discloses a privacy policy, and whether the institution already has established an opt out mechanism. A financial institution would have to summarize its practices regarding its collection, sharing, and safeguarding of certain nonpublic personal information in its initial and annual notices. However, if the institution does not share that information (or shares only to the extent permitted under the exceptions), its privacy notice may be brief. We believe that many financial institutions already have privacy policies in place as part of usual and customary business practices, and that many broker-dealers, funds, and investment advisers currently do not share nonpublic personal information about consumers with nonaffiliated third parties except as would be consistent with one of the many exceptions in the rules.[197] In the Proposing Release, we estimated that a registered adviser would spend an average of 5 hours to prepare a privacy notice, and a broker-dealer or fund would spend approximately 40 hours on average to prepare a privacy notice. We further understand that those institutions that do share information under one of the permitted exceptions generally have contract provisions that prohibit the third party's use of the information for purposes other than the purpose for which the information was shared. Thus we believe that, as a result of the rules, many financial institutions will not have to provide opt out notices to consumers, will have brief annual privacy notices for customers, and will not need to revise their contracts with nonaffiliated third parties to restrict those parties' use of information.

To minimize the burden and costs of distributing privacy policies, the rules do not specify the method for distributing required notices. As discussed more fully in the analysis, a financial institution may include an initial privacy statement with other required disclosure statements, and may include an annual notice with periodic account statements. We estimate that the costs of distributing the notices will be minimal because an institution will include the notices in mailings or distributions that it already sends to consumers and customers.

The analysis explains that the rules require every broker-dealer, fund, and registered adviser to adopt policies and procedures reasonably designed to safeguard customer records and information. The IRFA noted, and we continue to believe, that most if not all financial institutions already have policies and procedures to address the safety and confidentiality of consumer records and information. Nevertheless, financial institutions may review and revise their policies after the rules are adopted. The amount of time an institution will spend reviewing and revising its policies will depend, among other things, on the institution's current policies and its sharing practices. The rules do not specify the means by which institutions must ensure the safety of customer information and records in order to allow each institution to tailor its policies and procedures to its own systems of information gathering and transfer, and the needs of its customers. As noted in the IRFA, Commission staff estimated that in the first year after the rules are adopted, a financial institution would spend an average of 30 hours to adopt or revise its policies.

Two commenters argued that we underestimated the costs of implementing Regulation S–P. As explained in the analysis, the commenters did not provide estimates of the amount of time or the costs to implement the rules. We have been unable to obtain reliable information regarding these costs. Therefore, we have not provided an estimate of the cost of implementing the rules for

[194] *See* section 248.9(c)(2).

[195] *See* section 248.4(e)(1)(ii) and (iii).

[196] For purposes of the Regulatory Flexibility Act, under the Exchange Act a small entity is a broker or dealer that (i) had total capital of less than $500,000 on the date in its prior fiscal year as of which its audited financial statements were prepared or, if not required to file audited financial statements, on the last business day of its prior fiscal year, and (ii) is not affiliated with any person that is not a small entity and is not affiliated with any person that is not a small entity. 17 CFR 240.0–10. Under the Investment Company Act a ''small entity'' is an investment company that, together with other investment companies in the same group of related investment companies, has net assets of $50 million or less as of the end of its most recent fiscal year. 17 CFR 270.0–10. Under the Investment Advisers Act, a small entity is an investment adviser that ''(i) manages less than $25 million in assets, (ii) has total assets of less than $5 million on the last day of its most recent fiscal year, and (iii) does not control, is not controlled by, and is not under common control with another investment adviser that manages $25 million or more in assets, or any person that had total assets of $5 million or more on the last day of the most recent fiscal year. 17 CFR 275.0–7.

[197] For example, as noted in the Proposing Release, investment advisers have fiduciary duties under state law that limit their ability to share information with third parties. *See* Proposing Release, *supra* note 4, at n.4. This and other assumptions discussed in this section also are based on staff conversations with representatives from the securities industry.

individual institutions or for the industry as a whole. Although we recognize that the cost of implementing the rules may be $1 million or more for a large institution that shares information with affiliates and nonaffiliated third parties, we believe the costs for small institutions that do not share nonpublic personal information about consumers will be substantially less.

The analysis explains that the Regulatory Flexibility Act directs the Commission to consider significant alternatives that would accomplish the stated objective, while minimizing any significant adverse impact on small entities. As noted above, we believe that a number of revisions made to the final rules will benefit small entities. Finally, the analysis notes that the rules contain performance rather than design standards. The rules do not specify the (i) form of privacy notices, (ii) method of delivery of the notices to customers and consumers, or (iii) policies and procedures that broker-dealers, funds, and registered advisers must adopt to ensure the privacy of the financial information and records of their customers and consumers. Therefore, the rules provide these entities substantial flexibility that allows them to meet the requirements of Regulation S–P in a way that best suits the institution's individual needs.

X. Analysis of Effects on Efficiency, Competition, and Capital Formation

Section 23(a)(2) of the Exchange Act [198] requires the Commission, in adopting rules under the Exchange Act, to consider the anti-competitive effects of any rules it adopts. The rules, which implement Title V, apply to all broker-dealers, funds, and registered advisers. Each of these institutions must provide initial and annual privacy notices to customers as well as initial notices and opt out forms to consumers before the institution shares nonpublic personal information about consumers with nonaffiliated third parties. These institutions also must establish standards for protecting customer information and records.

Other financial institutions will be subject to substantially similar privacy notice and opt out requirements under rules adopted by the Agencies.[199] Under the G–L–B Act, these agencies also are required to adopt rules addressing policies and procedures for protecting customer information.[200] Therefore, all financial institutions will have to bear the costs of implementing the rules or substantially similar rules.

The rules do not dictate the privacy policies of any financial institution. Some customers may move their accounts from one institution to another based on the institution's privacy policies. Thus, the rules may promote competition among financial institutions based on customers' preferences regarding privacy policies.

Section 3(f) of the Exchange Act [201] and section 2(c) of the Investment Company Act [202] require the Commission, when engaging in rulemaking that requires it to consider or determine whether an action is necessary or appropriate in the public interest, to consider whether the action will promote efficiency, competition, and capital formation. We solicited comment on these matters in connection with the proposed rules but received no comment.[203] Our analysis on competition is discussed above. The rules will result in additional costs for financial institutions, which may affect the efficiency of these institutions. On the other hand, the rules will allow customers of financial institutions to compare privacy policies, which may result in customers choosing to do business with a financial institution based on its policies. We are not aware of any effect the rules will have on capital formation.

XI. Statutory Authority

The Commission is adopting Regulation S–P under the authority set forth in section 504 of the G–L–B Act [15 U.S.C. 6804], sections 17 and 23 of the Exchange Act [15 U.S.C. 78q, 78w], sections 31 and 38 of the Investment Company Act [15 U.S.C. 80a–30(a), 80a–37], and sections 204 and 211 of the Investment Advisers Act [15 U.S.C. 80b–4, 80b–11].

Text of Rules

List of Subjects in 17 CFR Part 248

Brokers, Dealers, Investment advisers, Investment companies, Privacy, Reporting and recordkeeping requirements.

For the reasons set out in the preamble, the Commission amends Title 17, Chapter II of the Code of Federal Regulations by adding a new part 248 to read as follows:

PART 248—REGULATION S–P: PRIVACY OF CONSUMER FINANCIAL INFORMATION

Sec.

248.1 Purpose and scope.
248.2 Rule of construction.
248.3 Definitions.

Subpart A—Privacy and Opt Out Notices

248.4 Initial privacy notice to consumers required.
248.5 Annual privacy notice to customers required.
248.6 Information to be included in privacy notices.
248.7 Form of opt out notice to consumers; opt out methods.
248.8 Revised privacy notices.
248.9 Delivering privacy and opt out notices.

Subpart B—Limits on Disclosures

248.10 Limits on disclosure of nonpublic personal information to nonaffiliated third parties.
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Subpart C—Exceptions

248.13 Exception to opt out requirements for service providers and joint marketing.
248.14 Exceptions to notice and opt out requirements for processing and servicing transactions.
248.15 Other exceptions to notice and opt out requirements.

Subpart D—Relation to Other Laws; Effective Date

248.16 Protection of Fair Credit Reporting Act.
248.17 Relation to State laws.
248.18 Effective date; transition rule.
248.19–248.29 [Reserved]
248.30 Procedures to safeguard customer records and information.

Appendix A to Part 248—Sample Clauses

Authority: 15 U.S.C. 6801–6809; 15 U.S.C. 78q, 78w, 80a–30(a), 80a–37, 80b–4, and 80b–11.

§ 248.1 Purpose and scope.

(a) *Purpose.* This part governs the treatment of nonpublic personal information about consumers by the financial institutions listed in paragraph (b) of this section. This part:

(1) Requires a financial institution to provide notice to customers about its privacy policies and practices;

(2) Describes the conditions under which a financial institution may disclose nonpublic personal information about consumers to nonaffiliated third parties; and

(3) Provides a method for consumers to prevent a financial institution from disclosing that information to most nonaffiliated third parties by ''opting

[198] 15 U.S.C. 78w(a)(2).

[199] *See, e.g.*, Banking Agencies' Release, *supra* note 2.

[200] G–L–B Act § 501(b).

[201] 15 U.S.C. 78c(f).

[202] 15 U.S.C. 80a–2(c).

[203] *See* Proposing Release, *supra* note 4, at section VII.

out'' of that disclosure, subject to the exceptions in §§ 248.13, 248.14, and 248.15.

(b) *Scope.* This part applies only to nonpublic personal information about individuals who obtain financial products or services primarily for personal, family, or household purposes from the institutions listed below. This part does not apply to information about companies or about individuals who obtain financial products or services primarily for business, commercial, or agricultural purposes. This part applies to brokers, dealers, and investment companies, as well as to investment advisers that are registered with the Commission. It also applies to foreign (non-resident) brokers, dealers, investment companies and investment advisers that are registered with the Commission. These entities are referred to in this part as ''you.'' This part does not apply to foreign (non-resident) brokers, dealers, investment companies and investment advisers that are not registered with the Commission. Nothing in this part modifies, limits, or supersedes the standards governing individually identifiable health information promulgated by the Secretary of Health and Human Services under the authority of sections 262 and 264 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–1320d–8).

§ 248.2 Rule of construction.

The examples in this part and the sample clauses in appendix A of this part provide guidance concerning the rule's application in ordinary circumstances. The facts and circumstances of each individual situation, however, will determine whether compliance with an example or use of a sample clause, to the extent applicable, constitutes compliance with this part.

§ 248.3 Definitions.

As used in this part, unless the context requires otherwise:

(a) *Affiliate* of a broker, dealer, or investment company, or an investment adviser registered with the Commission means any company that controls, is controlled by, or is under common control with the broker, dealer, or investment company, or investment adviser registered with the Commission. In addition, a broker, dealer, or investment company, or an investment adviser registered with the Commission will be deemed an affiliate of a company for purposes of this part if:

(1) That company is regulated under Title V of the G–L–B Act by the Federal Trade Commission or by a Federal functional regulator other than the Commission; and

(2) Rules adopted by the Federal Trade Commission or another federal functional regulator under Title V of the G–L–B Act treat the broker, dealer, or investment company, or investment adviser registered with the Commission as an affiliate of that company.

(b) *Broker* has the same meaning as in section 3(a)(4) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a)(4)).

(c)(1) *Clear and conspicuous* means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice.

(2) *Examples.* (i) *Reasonably understandable.* You make your notice reasonably understandable if you:

(A) Present the information in the notice in clear, concise sentences, paragraphs, and sections;

(B) Use short explanatory sentences or bullet lists whenever possible;

(C) Use definite, concrete, everyday words and active voice whenever possible;

(D) Avoid multiple negatives;

(E) Avoid legal and highly technical business terminology whenever possible; and

(F) Avoid explanations that are imprecise and readily subject to different interpretations.

(ii) *Designed to call attention.* You design your notice to call attention to the nature and significance of the information in it if you:

(A) Use a plain-language heading to call attention to the notice;

(B) Use a typeface and type size that are easy to read;

(C) Provide wide margins and ample line spacing;

(D) Use boldface or italics for key words; and

(E) Use distinctive type size, style, and graphic devices, such as shading or sidebars when you combine your notice with other information.

(iii) *Notices on web sites.* If you provide a notice on a web page, you design your notice to call attention to the nature and significance of the information in it if you use text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the web site (such as text, graphics, hyperlinks, or sound) do not distract attention from the notice, and you either:

(A) Place the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

(B) Place a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature, and relevance of the notice.

(d) *Collect* means to obtain information that you organize or can retrieve by the name of an individual or by identifying number, symbol, or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

(e) *Commission* means the Securities and Exchange Commission.

(f) *Company* means any corporation, limited liability company, business trust, general or limited partnership, association, or similar organization.

(g)(1) *Consumer* means an individual who obtains or has obtained a financial product or service from you that is to be used primarily for personal, family, or household purposes, or that individual's legal representative.

(2) *Examples.* (i) An individual is your consumer if he or she provides nonpublic personal information to you in connection with obtaining or seeking to obtain brokerage services or investment advisory services, whether or not you provide brokerage services to the individual or establish a continuing relationship with the individual.

(ii) An individual is not your consumer if he or she provides you only with his or her name, address, and general areas of investment interest in connection with a request for a prospectus, an investment adviser brochure, or other information about financial products or services.

(iii) An individual is not your consumer if he or she has an account with another broker or dealer (the introducing broker-dealer) that carries securities for the individual in a special omnibus account with you (the clearing broker-dealer) in the name of the introducing broker-dealer, and when you receive only the account numbers and transaction information of the introducing broker-dealer's consumers in order to clear transactions.

(iv) If you are an investment company, an individual is not your consumer when the individual purchases an interest in shares you have issued only through a broker or dealer or investment adviser who is the record owner of those shares.

(v) An individual who is a consumer of another financial institution is not your consumer solely because you act as agent for, or provide processing or other services to, that financial institution.

(vi) An individual is not your consumer solely because he or she has designated you as trustee for a trust.

(vii) An individual is not your consumer solely because he or she is a beneficiary of a trust for which you are a trustee.

(viii) An individual is not your consumer solely because he or she is a participant or a beneficiary of an employee benefit plan that you sponsor or for which you act as a trustee or fiduciary.

(h) *Consumer reporting agency* has the same meaning as in section 603(f) of the Fair Credit Reporting Act (15 U.S.C. 1681a(f)).

(i) *Control* of a company means the power to exercise a controlling influence over the management or policies of a company whether through ownership of securities, by contract, or otherwise. Any person who owns beneficially, either directly or through one or more controlled companies, more than 25 percent of the voting securities of any company is presumed to control the company. Any person who does not own more than 25 percent of the voting securities of any company will be presumed not to control the company. Any presumption regarding control may be rebutted by evidence, but, in the case of an investment company, will continue until the Commission makes a decision to the contrary according to the procedures described in section 2(a)(9) of the Investment Company Act of 1940 (15 U.S.C. 80a–2(a)(9)).

(j) *Customer* means a consumer who has a customer relationship with you.

(k)(1) *Customer relationship* means a continuing relationship between a consumer and you under which you provide one or more financial products or services to the consumer that are to be used primarily for personal, family, or household purposes.

(2) *Examples.* (i) *Continuing relationship.* A consumer has a continuing relationship with you if:

(A) The consumer has a brokerage account with you, or if a consumer's account is transferred to you from another broker-dealer;

(B) The consumer has an investment advisory contract with you (whether written or oral);

(C) The consumer is the record owner of securities you have issued if you are an investment company;

(D) The consumer holds an investment product through you, such as when you act as a custodian for securities or for assets in an Individual Retirement Arrangement;

(E) The consumer purchases a variable annuity from you;

(F) The consumer has an account with an introducing broker or dealer that clears transactions with and for its customers through you on a fully disclosed basis;

(G) You hold securities or other assets as collateral for a loan made to the consumer, even if you did not make the loan or do not effect any transactions on behalf of the consumer; or

(H) You regularly effect or engage in securities transactions with or for a consumer even if you do not hold any assets of the consumer.

(ii) *No continuing relationship.* A consumer does not, however, have a continuing relationship with you if you open an account for the consumer solely for the purpose of liquidating or purchasing securities as an accommodation, *i.e.*, on a one time basis, without the expectation of engaging in other transactions.

(l) *Dealer* has the same meaning as in section 3(a)(5) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a)(5)).

(m) *Federal functional regulator* means:

(1) The Board of Governors of the Federal Reserve System;

(2) The Office of the Comptroller of the Currency;

(3) The Board of Directors of the Federal Deposit Insurance Corporation;

(4) The Director of the Office of Thrift Supervision;

(5) The National Credit Union Administration Board; and

(6) The Securities and Exchange Commission.

(n)(1) *Financial institution* means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

(2) *Financial institution* does not include:

(i) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act (7 U.S.C. 1 *et seq.*);

(ii) The Federal Agricultural Mortgage Corporation or any entity chartered and operating under the Farm Credit Act of 1971 (12 U.S.C. 2001 *et seq.*); or

(iii) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales (including sales of servicing rights), or similar transactions related to a transaction of a consumer, as long as such institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

(o)(1) *Financial product or service* means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

(2) *Financial service* includes your evaluation or brokerage of information that you collect in connection with a request or an application from a consumer for a financial product or service.

(p) *G–L–B Act* means the Gramm-Leach-Bliley Act (Pub. L. No. 106–102, 113 Stat. 1338 (1999)).

(q) *Investment adviser* has the same meaning as in section 202(a)(11) of the Investment Advisers Act of 1940 (15 U.S.C. 80b–2(a)(11)).

(r) *Investment company* has the same meaning as in section 3 of the Investment Company Act of 1940 (15 U.S.C. 80a–3), and includes a separate series of the investment company.

(s)(1) *Nonaffiliated third party* means any person except:

(i) Your affiliate; or

(ii) A person employed jointly by you and any company that is not your affiliate (but *nonaffiliated third party* includes the other company that jointly employs the person).

(2) *Nonaffiliated third party* includes any company that is an affiliate solely by virtue of your or your affiliate's direct or indirect ownership or control of the company in conducting merchant banking or investment banking activities of the type described in section 4(k)(4)(H) or insurance company investment activities of the type described in section 4(k)(4)(I) of the Bank Holding Company Act (12 U.S.C. §§ 1843(k)(4)(H) and (I)).

(t)(1) *Nonpublic personal information* means:

(i) Personally identifiable financial information; and

(ii) Any list, description, or other grouping of consumers (and publicly available information pertaining to them) that is derived using any personally identifiable financial information that is not publicly available information.

(2) *Nonpublic personal information* does not include:

(i) Publicly available information, except as included on a list described in paragraph (t)(1)(ii) of this section or when the publicly available information is disclosed in a manner that indicates the individual is or has been your consumer; or

(ii) Any list, description, or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any personally identifiable financial

information that is not publicly available information.

(3) *Examples of lists.* (i) Nonpublic personal information includes any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available information, such as account numbers.

(ii) Nonpublic personal information does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available information, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

(u)(1) *Personally identifiable financial information* means any information:

(i) A consumer provides to you to obtain a financial product or service from you;

(ii) About a consumer resulting from any transaction involving a financial product or service between you and a consumer; or

(iii) You otherwise obtain about a consumer in connection with providing a financial product or service to that consumer.

(2) *Examples.* (i) *Information included.* Personally identifiable financial information includes:

(A) Information a consumer provides to you on an application to obtain a loan, credit card, or other financial product or service;

(B) Account balance information, payment history, overdraft history, and credit or debit card purchase information;

(C) The fact that an individual is or has been one of your customers or has obtained a financial product or service from you;

(D) Any information about your consumer if it is disclosed in a manner that indicates that the individual is or has been your consumer;

(E) Any information that a consumer provides to you or that you or your agent otherwise obtain in connection with collecting on a loan or servicing a loan;

(F) Any information you collect through an Internet ''cookie'' (an information collecting device from a web server); and

(G) Information from a consumer report.

(ii) *Information not included.* Personally identifiable financial information does not include:

(A) A list of names and addresses of customers of an entity that is not a financial institution; or

(B) Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names, or addresses.

(v)(1) *Publicly available information* means any information that you reasonably believe is lawfully made available to the general public from:

(i) Federal, State, or local government records;

(ii) Widely distributed media; or

(iii) Disclosures to the general public that are required to be made by federal, State, or local law.

(2) *Examples.* (i) *Reasonable belief.* (A) You have a reasonable belief that information about your consumer is made available to the general public if you have confirmed, or your consumer has represented to you, that the information is publicly available from a source described in paragraphs (v)(1)(i)–(iii) of this section;

(B) You have a reasonable belief that information about your consumer is made available to the general public if you have taken steps to submit the information, in accordance with your internal procedures and policies and with applicable law, to a keeper of federal, State, or local government records that is required by law to make the information publicly available.

(C) You have a reasonable belief that an individual's telephone number is lawfully made available to the general public if you have located the telephone number in the telephone book or the consumer has informed you that the telephone number is not unlisted.

(D) You do not have a reasonable belief that information about a consumer is publicly available solely because that information would normally be recorded with a keeper of federal, State, or local government records that is required by law to make the information publicly available, if the consumer has the ability in accordance with applicable law to keep that information nonpublic, such as where a consumer may record a deed in the name of a blind trust.

(ii) *Government records.* Publicly available information in government records includes information in government real estate records and security interest filings.

(iii) *Widely distributed media.* Publicly available information from widely distributed media includes information from a telephone book, a television or radio program, a newspaper, or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an Internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

(w) *You* means:

(1) Any broker or dealer;

(2) Any investment company; and

(3) Any investment adviser registered with the Commission under the Investment Advisers Act of 1940.

Subpart A—Privacy and Opt Out Notices

§ 248.4 Initial privacy notice to consumers required.

(a) *Initial notice requirement.* You must provide a clear and conspicuous notice that accurately reflects your privacy policies and practices to:

(1) *Customer.* An individual who becomes your customer, not later than when you establish a customer relationship, except as provided in paragraph (e) of this section; and

(2) *Consumer.* A consumer, before you disclose any nonpublic personal information about the consumer to any nonaffiliated third party, if you make such a disclosure other than as authorized by §§ 248.14 and 248.15.

(b) *When initial notice to a consumer is not required.* You are not required to provide an initial notice to a consumer under paragraph (a) of this section if:

(1) You do not disclose any nonpublic personal information about the consumer to any nonaffiliated third party, other than as authorized by §§ 248.14 and 248.15; and

(2) You do not have a customer relationship with the consumer.

(c) *When you establish a customer relationship.* (1) *General rule.* You establish a customer relationship when you and the consumer enter into a continuing relationship.

(2) *Special rule for loans.* You do not have a customer relationship with a consumer if you buy a loan made to the consumer but do not have the servicing rights for that loan.

(3) *Examples of establishing customer relationship.* You establish a customer relationship when the consumer:

(i) Effects a securities transaction with you or opens a brokerage account with you under your procedures;

(ii) Opens a brokerage account with an introducing broker or dealer that clears transactions with and for its customers through you on a fully disclosed basis;

(iii) Enters into an advisory contract with you (whether in writing or orally); or

(iv) Purchases shares you have issued (and the consumer is the record owner of the shares), if you are an investment company.

(d) *Existing customers.* When an existing customer obtains a new

financial product or service from you that is to be used primarily for personal, family, or household purposes, you satisfy the initial notice requirements of paragraph (a) of this section as follows:

(1) You may provide a revised privacy notice, under § 248.8, that covers the customer's new financial product or service; or

(2) If the initial, revised, or annual notice that you most recently provided to that customer was accurate with respect to the new financial product or service, you do not need to provide a new privacy notice under paragraph (a) of this section.

(e) *Exceptions to allow subsequent delivery of notice.* (1) You may provide the initial notice required by paragraph (a)(1) of this section within a reasonable time after you establish a customer relationship if:

(i) Establishing the customer relationship is not at the customer's election;

(ii) Providing notice not later than when you establish a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time; or

(iii) A nonaffiliated broker or dealer or investment adviser establishes a customer relationship between you and a consumer without your prior knowledge.

(2) *Examples of exceptions.* (i) *Not at customer's election.* Establishing a customer relationship is not at the customer's election if the customer's account is transferred to you by a trustee selected by the Securities Investor Protection Corporation (''SIPC'') and appointed by a United States Court.

(ii) *Substantial delay of customer's transaction.* Providing notice not later than when you establish a customer relationship would substantially delay the customer's transaction when you and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the financial product or service.

(iii) *No substantial delay of customer's transaction.* Providing notice not later than when you establish a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at your office or through other means by which the customer may view the notice, such as on a web site.

(f) *Delivery.* When you are required to deliver an initial privacy notice by this section, you must deliver it according to § 248.9. If you use a short-form initial notice for non-customers according to § 248.6(d), you may deliver your privacy notice according to § 248.6(d)(3).

§ 248.5 Annual privacy notice to customers required.

(a)(1) *General rule.* You must provide a clear and conspicuous notice to customers that accurately reflects your privacy policies and practices not less than annually during the continuation of the customer relationship. *Annually* means at least once in any period of 12 consecutive months during which that relationship exists. You may define the 12-consecutive-month period, but you must apply it to the customer on a consistent basis.

(2) *Example.* You provide a notice annually if you define the 12-consecutive-month period as a calendar year and provide the annual notice to the customer once in each calendar year following the calendar year in which you provided the initial notice. For example, if a customer opens an account on any day of year 1, you must provide an annual notice to that customer by December 31 of year 2.

(b)(1) *Termination of customer relationship.* You are not required to provide an annual notice to a former customer.

(2) *Examples.* Your customer becomes a former customer when:

(i) The individual's brokerage account is closed;

(ii) The individual's investment advisory contract is terminated;

(iii) You are an investment company and the individual is no longer the record owner of securities you have issued; or

(iv) You are an investment company and your customer has been determined to be a lost securityholder as defined in 17 CFR 240.17a–24(b).

(c) *Special rule for loans.* If you do not have a customer relationship with a consumer under the special provision for loans in § 248.4(c)(2), then you need not provide an annual notice to that consumer under this section.

(d) *Delivery.* When you are required to deliver an annual privacy notice by this section, you must deliver it according to § 248.9.

§ 248.6 Information to be included in privacy notices.

(a) *General rule.* The initial, annual, and revised privacy notices that you provide under §§ 248.4, 248.5, and 248.8 must include each of the following items of information that applies to you or to the consumers to whom you send your privacy notice, in addition to any other information you wish to provide:

(1) The categories of nonpublic personal information that you collect;

(2) The categories of nonpublic personal information that you disclose;

(3) The categories of affiliates and nonaffiliated third parties to whom you disclose nonpublic personal information, other than those parties to whom you disclose information under §§ 248.14 and 248.15;

(4) The categories of nonpublic personal information about your former customers that you disclose and the categories of affiliates and nonaffiliated third parties to whom you disclose nonpublic personal information about your former customers, other than those parties to whom you disclose information under §§ 248.14 and 248.15;

(5) If you disclose nonpublic personal information to a nonaffiliated third party under § 248.13 (and no other exception applies to that disclosure), a separate statement of the categories of information you disclose and the categories of third parties with whom you have contracted;

(6) An explanation of the consumer's right under § 248.10(a) to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right at that time;

(7) Any disclosures that you make under section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii)) (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

(8) Your policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

(9) Any disclosure that you make under paragraph (b) of this section.

(b) *Description of nonaffiliated third parties subject to exceptions.* If you disclose nonpublic personal information to third parties as authorized under §§ 248.14 and 248.15, you are not required to list those exceptions in the initial or annual privacy notices required by §§ 248.4 and 248.5. When describing the categories with respect to those parties, you are required to state only that you make disclosures to other nonaffiliated third parties as permitted by law.

(c) *Examples.* (1) *Categories of nonpublic personal information that you collect.* You satisfy the requirement to categorize the nonpublic personal information that you collect if you list the following categories, as applicable:

(i) Information from the consumer;

(ii) Information about the consumer's transactions with you or your affiliates;

(iii) Information about the consumer's transactions with nonaffiliated third parties; and

(iv) Information from a consumer-reporting agency.

(2) *Categories of nonpublic personal information you disclose.* (i) You satisfy the requirement to categorize the nonpublic personal information that you disclose if you list the categories described in paragraph (e)(1) of this section, as applicable, and a few examples to illustrate the types of information in each category.

(ii) If you reserve the right to disclose all of the nonpublic personal information about consumers that you collect, you may simply state that fact without describing the categories or examples of the nonpublic personal information you disclose.

(3) *Categories of affiliates and nonaffiliated third parties to whom you disclose.* You satisfy the requirement to categorize the affiliates and nonaffiliated third parties to whom you disclose nonpublic personal information if you list the following categories, as applicable, and a few examples to illustrate the types of third parties in each category:

(i) Financial service providers;

(ii) Non-financial companies; and

(iii) Others.

(4) *Disclosures under exception for service providers and joint marketers.* If you disclose nonpublic personal information under the exception in § 248.13 to a nonaffiliated third party to market products or services that you offer alone or jointly with another financial institution, you satisfy the disclosure requirement of paragraph (a)(5) of this section if you:

(i) List the categories of nonpublic personal information you disclose, using the same categories and examples you used to meet the requirements of paragraph (a)(2) of this section, as applicable; and

(ii) State whether the third party is:

(A) A service provider that performs marketing services on your behalf or on behalf of you and another financial institution; or

(B) A financial institution with which you have a joint marketing agreement.

(5) *Simplified notices.* If you do not disclose, and do not wish to reserve the right to disclose, nonpublic personal information to affiliates or nonaffiliated third parties except as authorized under §§ 248.14 and 248.15, you may simply state that fact, in addition to the information you must provide under paragraphs (a)(1), (a)(8), (a)(9), and (b) of this section.

(6) *Confidentiality and security.* You describe your policies and practices with respect to protecting the confidentiality and security of nonpublic personal information if you do both of the following:

(i) Describe in general terms who is authorized to have access to the information; and

(ii) State whether you have security practices and procedures in place to ensure the confidentiality of the information in accordance with your policy. You are not required to describe technical information about the safeguards you use.

(d) *Short-form initial notice with opt out notice for non-customers.* (1) You may satisfy the initial notice requirements in §§ 248.4(a)(2), 248.7(b), and 248.7(c) for a consumer who is not a customer by providing a short-form initial notice at the same time as you deliver an opt out notice as required in § 248.7.

(2) A short-form initial notice must:

(i) Be clear and conspicuous;

(ii) State that your privacy notice is available upon request; and

(iii) Explain a reasonable means by which the consumer may obtain the privacy notice.

(3) You must deliver your short-form initial notice according to § 248.9. You are not required to deliver your privacy notice with your short-form initial notice. You instead may simply provide the consumer a reasonable means to obtain your privacy notice. If a consumer who receives your short-form notice requests your privacy notice, you must deliver your privacy notice according to § 248.9.

(4) *Examples of obtaining privacy notice.* You provide a reasonable means by which a consumer may obtain a copy of your privacy notice if you:

(i) Provide a toll-free telephone number that the consumer may call to request the notice; or

(ii) For a consumer who conducts business in person at your office, maintain copies of the notice on hand that you provide to the consumer immediately upon request.

(e) *Future disclosures.* Your notice may include:

(1) Categories of nonpublic personal information that you reserve the right to disclose in the future, but do not currently disclose; and

(2) Categories of affiliates or nonaffiliated third parties to whom you reserve the right in the future to disclose, but to whom you do not currently disclose, nonpublic personal information.

(f) *Sample clauses.* Sample clauses illustrating some of the notice content required by this section are included in Appendix A of this part.

§ 248.7 Form of opt out notice to consumers; opt out methods.

(a)(1) *Form of opt out notice.* If you are required to provide an opt out notice under § 248.10(a), you must provide a clear and conspicuous notice to each of your consumers that accurately explains the right to opt out under that section. The notice must state:

(i) That you disclose or reserve the right to disclose nonpublic personal information about your consumer to a nonaffiliated third party;

(ii) That the consumer has the right to opt out of that disclosure; and

(iii) A reasonable means by which the consumer may exercise the opt out right.

(2) *Examples.* (i) *Adequate opt out notice.* You provide adequate notice that the consumer can opt out of the disclosure of nonpublic personal information to a nonaffiliated third party if you:

(A) Identify all of the categories of nonpublic personal information that you disclose or reserve the right to disclose, and all of the categories of nonaffiliated third parties to which you disclose the information, as described in § 248.6(a)(2) and (3) and state that the consumer can opt out of the disclosure of that information; and

(B) Identify the financial products or services that the consumer obtains from you, either singly or jointly, to which the opt out direction would apply.

(ii) *Reasonable opt out means.* You provide a reasonable means to exercise an opt out right if you:

(A) Designate check-off boxes in a prominent position on the relevant forms with the opt out notice;

(B) Include a reply form together with the opt out notice;

(C) Provide an electronic means to opt out, such as a form that can be sent via electronic mail or a process at your web site, if the consumer agrees to the electronic delivery of information; or

(D) Provide a toll-free telephone number that consumers may call to opt out.

(iii) *Unreasonable opt out means.* You *do not* provide a reasonable means of opting out if:

(A) The only means of opting out is for the consumer to write his or her own letter to exercise that opt out right; or

(B) The only means of opting out as described in any notice subsequent to the initial notice is to use a check-off box that you provided with the initial notice but did not include with the subsequent notice.

(iv) *Specific opt out means.* You may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

(b) *Same form as initial notice permitted.* You may provide the opt out notice together with or on the same written or electronic form as the initial notice you provide in accordance with § 248.4.

(c) *Initial notice required when opt out notice delivered subsequent to initial notice.* If you provide the opt out notice after the initial notice in accordance with § 248.4, you must also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

(d) *Joint relationships.* (1) If two or more consumers jointly obtain a financial product or service from you, you may provide a single opt out notice. Your opt out notice must explain how you will treat an opt out direction by a joint consumer.

(2) Any of the joint consumers may exercise the right to opt out. You may either:

(i) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(ii) Permit each joint consumer to opt out separately.

(3) If you permit each joint consumer to opt out separately, you must permit one of the joint consumers to opt out on behalf of all of the joint consumers.

(4) You may not require *all* joint consumers to opt out before you implement *any* opt out direction.

(5) *Example.* If John and Mary have a joint brokerage account with you and arrange for you to send statements to John's address, you may do any of the following, but you must explain in your opt out notice which opt out policy you will follow:

(i) Send a single opt out notice to John's address, but you must accept an opt out direction from either John or Mary;

(ii) Treat an opt out direction by either John or Mary as applying to the entire account. If you do so, and John opts out, you may not require Mary to opt out as well before implementing John's opt out direction; or

(iii) Permit John and Mary to make different opt out directions. If you do so:

(A) You must permit John and Mary to opt out for each other.

(B) If both opt out, you must permit both to notify you in a single response (such as on a form or through a telephone call).

(C) If John opts out and Mary does not, you may only disclose nonpublic personal information about Mary, but not about John and not about John and Mary jointly.

(e) *Time to comply with opt out.* You must comply with a consumer's opt out direction as soon as reasonably practicable after you receive it.

(f) *Continuing right to opt out.* A consumer may exercise the right to opt out at any time.

(g) *Duration of consumer's opt out direction.* (1) A consumer's direction to opt out under this section is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

(2) When a customer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal information that you collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with you, the opt out direction that applied to the former relationship does not apply to the new relationship.

(h) *Delivery.* When you are required to deliver an opt out notice by this section, you must deliver it according to § 248.9.

§ 248.8 Revised privacy notices.

(a) *General rule.* Except as otherwise authorized in this part, you must not, directly or through any affiliate, disclose any nonpublic personal information about a consumer to a nonaffiliated third party other than as described in the initial notice that you provided to that consumer under § 248.4, unless:

(1) You have provided to the consumer a clear and conspicuous revised notice that accurately describes your policies and practices;

(2) You have provided to the consumer a new opt out notice;

(3) You have given the consumer a reasonable opportunity, before you disclose the information to the nonaffiliated third party, to opt out of the disclosure; and

(4) The consumer does not opt out.

(b) *Examples.* (1) Except as otherwise permitted by §§ 248.13, 248.14, and 248.15, you must provide a revised notice before you:

(i) Disclose a new category of nonpublic personal information to any nonaffiliated third party;

(ii) Disclose nonpublic personal information to a new category of nonaffiliated third party; or

(iii) Disclose nonpublic personal information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to exercise an opt out right regarding that disclosure.

(2) A revised notice is not required if you disclose nonpublic personal information to a new nonaffiliated third party that you adequately described in your prior notice.

(c) *Delivery.* When you are required to deliver a revised privacy notice by this section, you must deliver it according to § 248.9.

§ 248.9 Delivering privacy and opt out notices.

(a) *How to provide notices.* You must provide any privacy notices and opt out notices, including short-form initial notices that this part requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

(b)(1) *Examples of reasonable expectation of actual notice.* You may reasonably expect that a consumer will receive actual notice if you:

(i) Hand-deliver a printed copy of the notice to the consumer;

(ii) Mail a printed copy of the notice to the last known address of the consumer;

(iii) For the consumer who conducts transactions electronically, post the notice on the electronic site and require the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular financial product or service; or

(iv) For an isolated transaction with the consumer, such as an ATM transaction, post the notice on the ATM screen and require the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular financial product or service.

(2) *Examples of unreasonable expectation of actual notice.* You may not, however, reasonably expect that a consumer will receive actual notice of your privacy policies and practices if you:

(i) Only post a sign in your branch or office or generally publish advertisements of your privacy policies and practices; or

(ii) Send the notice via electronic mail to a consumer who does not obtain a financial product or service from you electronically.

(c) *Annual notices only.* (1) You may reasonably expect that a customer will receive actual notice of your annual privacy notice if:

(i) The customer uses your web site to access financial products and services electronically and agrees to receive notices at the web site and you post your current privacy notice continuously in a clear and conspicuous manner on the web site; or

(ii) The customer has requested that you refrain from sending any information regarding the customer relationship, and your current privacy notice remains available to the customer upon request.

(2) *Example of reasonable expectation of receipt of annual privacy notice.* You

may reasonably expect that consumers who share an address will receive actual notice of your annual privacy notice if you deliver the notice with or in a stockholder or shareholder report under the conditions in 17 CFR 270.30d–1(f) or 17 CFR 270.30d–2(b), or with or in a prospectus under the conditions in 17 CFR 230.154.

(d) *Oral description of notice insufficient.* You may not provide any notice required by this part solely by orally explaining the notice, either in person or over the telephone.

(e) *Retention or accessibility of notices for customers.* (1) For customers only, you must provide the initial notice required by § 248.4(a)(1), the annual notice required by § 248.5(a), and the revised notice required by § 248.8, so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

(2) *Examples of retention or accessibility.* You provide a privacy notice to the customer so that the customer can retain it or obtain it later if you:

(i) Hand-deliver a printed copy of the notice to the customer;

(ii) Mail a printed copy of the notice to the last known address of the customer; or

(iii) Make your current privacy notice available on a web site (or a link to another web site) for the customer who obtains a financial product or service electronically and agrees to receive the notice at the web site.

(f) *Joint notice with other financial institutions.* You may provide a joint notice from you and one or more of your affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to you and the other institutions.

(g) *Joint relationships.* If two or more consumers jointly obtain a financial product or service from you, you may satisfy the initial, annual, and revised notice requirements of paragraph (a) of this section by providing one notice to those consumers jointly.

Subpart B—Limits on Disclosures

§ 248.10 Limits on disclosure of nonpublic personal information to nonaffiliated third parties.

(a)(1) *Conditions for disclosure.* Except as otherwise authorized in this part, you may not, directly or through any affiliate, disclose any nonpublic personal information about a consumer to a nonaffiliated third party unless:

(i) You have provided to the consumer an initial notice as required under § 248.4;

(ii) You have provided to the consumer an opt out notice as required in § 248.7;

(iii) You have given the consumer a reasonable opportunity, before you disclose the information to the nonaffiliated third party, to opt out of the disclosure; and

(iv) The consumer does not opt out.

(2) *Opt out definition.* Opt out means a direction by the consumer that you not disclose nonpublic personal information about that consumer to a nonaffiliated third party, other than as permitted by §§ 248.13, 248.14, and 248.15.

(3) *Examples of reasonable opportunity to opt out.* You provide a consumer with a reasonable opportunity to opt out if:

(i) *By mail.* You mail the notices required in paragraph (a)(1) of this section to the consumer and allow the consumer to opt out by mailing a form, calling a toll-free telephone number, or any other reasonable means within 30 days after the date you mailed the notices.

(ii) *By electronic means.* A customer opens an on-line account with you and agrees to receive the notices required in paragraph (a)(1) of this section electronically, and you allow the customer to opt out by any reasonable means within 30 days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account.

(iii) *Isolated transaction with consumer.* For an isolated transaction, such as the provision of brokerage services to a consumer as an accommodation, you provide the consumer with a reasonable opportunity to opt out if you provide the notices required in paragraph (a)(1) of this section at the time of the transaction and request that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

(b) *Application of opt out to all consumers and all nonpublic personal information.* (1) You must comply with this section, regardless of whether you and the consumer have established a customer relationship.

(2) Unless you comply with this section, you may not, directly or through any affiliate, disclose any nonpublic personal information about a consumer that you have collected, regardless of whether you collected it before or after receiving the direction to opt out from the consumer.

(c) *Partial opt out.* You may allow a consumer to select certain nonpublic personal information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

§ 248.11 Limits on redisclosure and reuse of information.

(a)(1) *Information you receive under an exception.* If you receive nonpublic personal information from a nonaffiliated financial institution under an exception in § 248.14 or 248.15, your disclosure and use of that information is limited as follows:

(i) You may disclose the information to the affiliates of the financial institution from which you received the information;

(ii) You may disclose the information to your affiliates, but your affiliates may, in turn, disclose and use the information only to the extent that you may disclose and use the information; and

(iii) You may disclose and use the information pursuant to an exception in §§ 248.14 or 248.15 in the ordinary course of business to carry out the activity covered by the exception under which you received the information.

(2) *Example.* If you receive a customer list from a nonaffiliated financial institution in order to provide account-processing services under the exception in §§ 248.14(a), you may disclose that information under any exception in § 248.14 or 248.15 in the ordinary course of business in order to provide those services. You could also disclose that information in response to a properly authorized subpoena or in the ordinary course of business to your attorneys, accountants, and auditors. You could not disclose that information to a third party for marketing purposes or use that information for your own marketing purposes.

(b)(1) *Information you receive outside of an exception.* If you receive nonpublic personal information from a nonaffiliated financial institution other than under an exception in §§ 248.14 or 248.15, you may disclose the information only:

(i) To the affiliates of the financial institution from which you received the information;

(ii) To your affiliates, but your affiliates may, in turn, disclose the information only to the extent that you can disclose the information; and

(iii) To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which you received the information.

(2) *Example.* If you obtain a customer list from a nonaffiliated financial institution outside of the exceptions in §§ 248.14 and 248.15:

(i) You may use that list for your own purposes;

(ii) You may disclose that list to another nonaffiliated third party only if the financial institution from which you purchased the list could have lawfully disclosed the list to that third party. That is, you may disclose the list in accordance with the privacy policy of the financial institution from which you received the list, as limited by the opt out direction of each consumer whose nonpublic personal information you intend to disclose, and you may disclose the list in accordance with an exception in §§ 248.14 or 248.15, such as in the ordinary course of business to your attorneys, accountants, or auditors.

(c) *Information you disclose under an exception.* If you disclose nonpublic personal information to a nonaffiliated third party under an exception in §§ 248.14 or 248.15, the third party may disclose and use that information only as follows:

(1) The third party may disclose the information to your affiliates;

(2) The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information; and

(3) The third party may disclose and use the information pursuant to an exception in §§ 248.14 or 248.15 in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

(d) *Information you disclose outside of an exception.* If you disclose nonpublic personal information to a nonaffiliated third party other than under an exception in §§ 248.14 or 248.15, the third party may disclose the information only:

(1) To your affiliates;

(2) To its affiliates, but its affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

(3) To any other person, if the disclosure would be lawful if you made it directly to that person.

§ 248.12 Limits on sharing account number information for marketing purposes.

(a) *General prohibition on disclosure of account numbers.* You must not, directly or through an affiliate, disclose, other than to a consumer reporting agency, an account number or similar form of access number or access code for a consumer's credit card account, deposit account, or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

(b) *Exceptions.* Paragraph (a) of this section does not apply if you disclose an account number or similar form of access number or access code:

(1) To your agent or service provider solely in order to perform marketing for your own products or services, as long as the agent or service provider is not authorized to directly initiate charges to the account; or

(2) To a participant in a private label credit card program or an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

(c) *Example—Account number.* An account number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as you do not provide the recipient with a means to decode the number or code.

Subpart C—Exceptions

§ 248.13 Exception to opt out requirements for service providers and joint marketing.

(a) *General rule.* (1) The opt out requirements in §§ 248.7 and 248.10 do not apply when you provide nonpublic personal information to a nonaffiliated third party to perform services for you or functions on your behalf, if you:

(i) Provide the initial notice in accordance with § 248.4; and

(ii) Enter into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which you disclosed the information, including use under an exception in §§ 248.14 or 248.15 in the ordinary course of business to carry out those purposes.

(2) *Example.* If you disclose nonpublic personal information under this section to a financial institution with which you perform joint marketing, your contractual agreement with that institution meets the requirements of paragraph (a)(1)(ii) of this section if it prohibits the institution from disclosing or using the nonpublic personal information except as necessary to carry out the joint marketing or under an exception in §§ 248.14 or 248.15 in the ordinary course of business to carry out that joint marketing.

(b) *Service may include joint marketing.* The services a nonaffiliated third party performs for you under paragraph (a) of this section may include marketing of your own products or services or marketing of financial products or services offered pursuant to joint agreements between you and one or more financial institutions.

(c) *Definition of joint agreement.* For purposes of this section, *joint agreement* means a written contract pursuant to which you and one or more financial institutions jointly offer, endorse, or sponsor a financial product or service.

§ 248.14 Exceptions to notice and opt out requirements for processing and servicing transactions.

(a) *Exceptions for processing and servicing transactions at consumer's request.* The requirements for initial notice in § 248.4(a)(2), for the opt out in §§ 248.7 and 248.10, and for initial notice in § 248.13 in connection with service providers and joint marketing, do not apply if you disclose nonpublic personal information as necessary to effect, administer, or enforce a transaction that a consumer requests or authorizes, or in connection with:

(1) Processing or servicing a financial product or service that a consumer requests or authorizes;

(2) Maintaining or servicing the consumer's account with you, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity; or

(3) A proposed or actual securitization, secondary market sale (including sales of servicing rights), or similar transaction related to a transaction of the consumer.

(b) *Necessary to effect, administer, or enforce a transaction* means that the disclosure is:

(1) Required, or is one of the lawful or appropriate methods, to enforce your rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

(2) Required, or is a usual, appropriate, or acceptable method:

(i) To carry out the transaction or the product or service business of which the transaction is a part, and record, service, or maintain the consumer's account in the ordinary course of providing the financial service or financial product;

(ii) To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

(iii) To provide a confirmation, statement, or other record of the transaction, or information on the status or value of the financial service or financial product to the consumer or the consumer's agent or broker;

(iv) To accrue or recognize incentives or bonuses associated with the transaction that are provided by you or any other party;

(v) To underwrite insurance at the consumer's request or for reinsurance purposes, or for any of the following purposes as they relate to a consumer's insurance: Account administration, reporting, investigating, or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits (including utilization review activities), participating in research projects, or as otherwise required or specifically permitted by federal or State law; or

(vi) In connection with:

(A) The authorization, settlement, billing, processing, clearing, transferring, reconciling or collection of amounts charged, debited, or otherwise paid using a debit, credit, or other payment card, check, or account number, or by other payment means;

(B) The transfer of receivables, accounts, or interests therein; or

(C) The audit of debit, credit, or other payment information.

§ 248.15 Other exceptions to notice and opt out requirements.

(a) *Exceptions to notice and opt out requirements.* The requirements for initial notice in § 248.4(a)(2), for the opt out in §§ 248.7 and 248.10, and for initial notice in § 248.13 in connection with service providers and joint marketing do not apply when you disclose nonpublic personal information:

(1) With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

(2)(i) To protect the confidentiality or security of your records pertaining to the consumer, service, product, or transaction;

(ii) To protect against or prevent actual or potential fraud, unauthorized transactions, claims, or other liability;

(iii) For required institutional risk control or for resolving consumer disputes or inquiries;

(iv) To persons holding a legal or beneficial interest relating to the consumer; or

(v) To persons acting in a fiduciary or representative capacity on behalf of the consumer;

(3) To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating you, persons that are assessing your compliance with industry standards, and your attorneys, accountants, and auditors;

(4) To the extent specifically permitted or required under other provisions of law and in accordance with the Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 *et seq.*), to law enforcement agencies (including a federal functional regulator, the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 U.S.C. Chapter 21 (Financial Recordkeeping), a State insurance authority, with respect to any person domiciled in that insurance authority's State that is engaged in providing insurance, and the Federal Trade Commission), self-regulatory organizations, or for an investigation on a matter related to public safety;

(5)(i) To a consumer reporting agency in accordance with the Fair Credit Reporting Act (15 U.S.C. 1681 *et seq.*), or

(ii) From a consumer report reported by a consumer reporting agency;

(6) In connection with a proposed or actual sale, merger, transfer, or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal information concerns solely consumers of such business or unit; or

(7)(i) To comply with federal, State, or local laws, rules and other applicable legal requirements;

(ii) To comply with a properly authorized civil, criminal, or regulatory investigation, or subpoena or summons by federal, State, or local authorities; or

(iii) To respond to judicial process or government regulatory authorities having jurisdiction over you for examination, compliance, or other purposes as authorized by law.

(b) *Examples of consent and revocation of consent.* (1) A consumer may specifically consent to your disclosure to a nonaffiliated mortgage lender of the value of the assets in the consumer's brokerage or investment advisory account so that the lender can evaluate the consumer's application for a mortgage loan.

(2) A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal information as permitted under § 248.7(f).

Subpart D—Relation to Other Laws; Effective Date

§ 248.16 Protection of Fair Credit Reporting Act.

Nothing in this part shall be construed to modify, limit, or supersede the operation of the Fair Credit Reporting Act (15 U.S.C. 1681 *et seq.*), and no inference shall be drawn on the basis of the provisions of this part regarding whether information is transaction or experience information under section 603 of that Act.

§ 248.17 Relation to State laws.

(a) *In general.* This part shall not be construed as superseding, altering, or affecting any statute, regulation, order, or interpretation in effect in any State, except to the extent that such State statute, regulation, order, or interpretation is inconsistent with the provisions of this part, and then only to the extent of the inconsistency.

(b) *Greater protection under State law.* For purposes of this section, a State statute, regulation, order, or interpretation is not inconsistent with the provisions of this part if the protection such statute, regulation, order, or interpretation affords any consumer is greater than the protection provided under this part, as determined by the Federal Trade Commission, after consultation with the Commission, on the Federal Trade Commission's own motion, or upon the petition of any interested party.

§ 248.18 Effective date; transition rule.

(a) *Effective date.* This part is effective November 13, 2000. In order to provide sufficient time for you to establish policies and systems to comply with the requirements of this part, the compliance date for this part is July 1, 2001.

(b)(1) *Notice requirement for consumers who are your customers on the compliance date.* By July 1, 2001, you must have provided an initial notice, as required by § 248.4, to consumers who are your customers on July 1, 2001.

(2) *Example.* You provide an initial notice to consumers who are your customers on July 1, 2001, if, by that date, you have established a system for providing an initial notice to all new customers and have mailed the initial notice to all your existing customers.

(c) *Two-year grandfathering of service agreements.* Until July 1, 2002, a contract that you have entered into with a nonaffiliated third party to perform services for you or functions on your behalf satisfies the provisions of § 248.13(a)(2), even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal information, as long as you entered into the agreement on or before July 1, 2000.

§§ 248.19–248.29 [Reserved]

§ 248.30 Procedures to safeguard customer records and information.

Every broker, dealer, and investment company, and every investment adviser registered with the Commission must adopt policies and procedures that address administrative, technical, and

physical safeguards for the protection of customer records and information. These policies and procedures must be reasonably designed to:

(a) Insure the security and confidentiality of customer records and information;

(b) Protect against any anticipated threats or hazards to the security or integrity of customer records and information; and

(c) Protect against unauthorized access to or use of customer records or information that could result in substantial harm or inconvenience to any customer.

Appendix A to Part 248—Sample Clauses

Financial institutions, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income, and information from a consumer reporting agency, may give rise to obligations under the Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

A–1—Categories of Information You Collect (All Institutions)

You may use this clause, as applicable, to meet the requirement of § 248.6(a)(1) to describe the categories of nonpublic personal information you collect.

Sample Clause A–1:

We collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates, or others; and
- Information we receive from a consumer reporting agency.

A–2—Categories of Information You Disclose (Institutions That Disclose Outside of the Exceptions)

You may use one of these clauses, as applicable, to meet the requirement of § 248.6(a)(2) to describe the categories of nonpublic personal information you disclose. You may use these clauses if you disclose nonpublic personal information other than as permitted by the exceptions in §§ 248.13, 248.14, and 248.15.

Sample Clause A–2, Alternative 1:

We may disclose the following kinds of nonpublic personal information about you:

- Information we receive from you on applications or other forms, such as [*provide illustrative examples, such as ''your name, address, social security number, assets, and income''*];
- Information about your transactions with us, our affiliates, or others, such as [*provide illustrative examples, such as ''your account balance, payment history, parties to transactions, and credit card usage''*]; and
- Information we receive from a consumer reporting agency, such as [*provide illustrative examples, such as ''your creditworthiness and credit history''*].

Sample Clause A–2, Alternative 2:

We may disclose all of the information that we collect, as described [*describe location in the notice, such as ''above'' or ''below''*].

A–3—Categories of Information You Disclose and Parties to Whom You Disclose (Institutions That Do Not Disclose Outside of the Exceptions)

You may use this clause, as applicable, to meet the requirements of §§ 248.6(a)(2), (3), and (4) to describe the categories of nonpublic personal information about customers and former customers that you disclose and the categories of affiliates and nonaffiliated third parties to whom you disclose. You may use this clause if you do not disclose nonpublic personal information to any party, other than as permitted by the exceptions in §§ 248.14 and 248.15.

Sample Clause A–3:

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

A–4—Categories of Parties to Whom You Disclose (Institutions That Disclose Outside of the Exceptions)

You may use this clause, as applicable, to meet the requirement of § 248.6(a)(3) to describe the categories of affiliates and nonaffiliated third parties to whom you disclose nonpublic personal information. You may use this clause if you disclose nonpublic personal information other than as permitted by the exceptions in §§ 248.13, 248.14, and 248.15, as well as when permitted by the exceptions in §§ 248.14 and 248.15.

Sample Clause A–4:

We may disclose nonpublic personal information about you to the following types of third parties:

- Financial service providers, such as [*provide illustrative examples, such as ''mortgage bankers, securities broker-dealers, and insurance agents''*];
- Non-financial companies, such as [*provide illustrative examples, such as ''retailers, direct marketers, airlines, and publishers''*]; and
- Others, such as [*provide illustrative examples, such as ''non-profit organizations''*].

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

A–5—Service Provider/Joint Marketing Exception

You may use one of these clauses, as applicable, to meet the requirements of § 248.6(a)(5) related to the exception for service providers and joint marketers in § 248.13. If you disclose nonpublic personal information under this exception, you must describe the categories of nonpublic personal information you disclose and the categories of third parties with whom you have contracted.

Sample Clause A–5, Alternative 1:

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:

- Information we receive from you on applications or other forms, such as [*provide illustrative examples, such as ''your name, address, social security number, assets, and income''*];
- Information about your transactions with us, our affiliates, or others, such as [*provide illustrative examples, such as ''your account balance, payment history, parties to transactions, and credit card usage''*]; and
- Information we receive from a consumer reporting agency, such as [*provide illustrative examples, such as ''your creditworthiness and credit history''*].

Sample Clause A–5, Alternative 2:

We may disclose all of the information we collect, as described [*describe location in the notice, such as ''above'' or ''below''*] to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

A–6—Explanation of Opt Out Right (Institutions That Disclose Outside of the Exceptions)

You may use this clause, as applicable, to meet the requirement of § 248.6(a)(6) to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. You may use this clause if you disclose nonpublic personal information other than as permitted by the exceptions in §§ 248.13, 248.14, and 248.15.

Sample Clause A–6:

If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may [*describe a reasonable means of opting out, such as ''call the following toll-free number: (insert number)''*].

A–7—Confidentiality and Security (All Institutions)

You may use this clause, as applicable, to meet the requirement of § 248.6(a)(8) to describe your policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

Sample Clause A–7:

We restrict access to nonpublic personal information about you to [*provide an appropriate description, such as ''those employees who need to know that information to provide products or services to you''*]. We maintain physical, electronic, and procedural safeguards that comply with federal standards to guard your nonpublic personal information.

By the Commission.

Dated: June 22, 2000.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 00–16269 Filed 6–28–00; 8:45 am]

BILLING CODE 8010–01–P

Federal Register

Thursday,
June 29, 2000

Part IV

Federal Emergency Management Agency

Compendium of Flood Map Changes; Notice

FEDERAL EMERGENCY MANAGEMENT AGENCY

Compendium of Flood Map Changes

AGENCY: Federal Emergency Management Agency (FEMA).

ACTION: Notice.

SUMMARY: This Notice provides listings of changes made to National Flood Insurance Program (NFIP) maps produced by FEMA effective during the last 6 months of 1999.

DATES: The listings include changes to NFIP maps that became effective July 1, 1999, through December 31, 1999.

FOR FURTHER INFORMATION CONTACT: Michael K. Buckley, P.E., Director, Technical Services Division, Mitigation Directorate, Federal Emergency Management Agency, Washington, DC 20472, (202)646-2756.

SUPPLEMENTARY INFORMATION: In accordance with Section 1360(i) of the National Flood Insurance Reform Act of 1994, this Notice is provided to inform interested parties of changes made by FEMA to NFIP maps. The two listings provided show communities affected by map changes made by letter and communities affected by physical map changes. For each Letter of Map Change, the first listing provides the map panel(s) affected, effective (determination) date of the change, case number, and determination type. For each physical map change, the Map Revision listing provides the map panel(s) affected and the effective date of the change. The listing also identifies: (1) those panels on which the Special Flood Hazard Areas have not been changed or have been changed only to incorporate the Letters of Map Change issued before the effective date; and (2) those panels for which a Flood Insurance Rate Map is produced for the first time, resulting only in changes to flood insurance and floodplain management requirements in the affected community. Future notices of changes to NFIP maps will be published approximately every 6 months.

Dated: June 8, 2000.

Michael J. Armstrong,

Associate Director for Mitigation.

Two listings are provided below. The first listing includes all Letters of Map Change issued by FEMA from July 1 through December 31, 1999. The following types of letters are included in the listing:

Type	Description
01	Letter of Map Revision Based on Fill (218-65)
02	Letter of Map Amendment (218-70)
05	Letter of Map Revision With Base Flood Elevation Changes
06	Letter of Map Revision Without Base Flood Elevation Changes
08	Denial
12	Floodway Revision
17	Letter of Map Revision-inadvertent inclusion in floodway (218-65)
18	Letter of Map Revision-inadvertent inclusion in V zone (218-65)
19	Letter of Map Change Revalidation.

The second listing includes map panels that FEMA physically revised and republished from July 1 through December 31, 1999. For those map panels on which the Special Flood Hazard Areas have not been changed or have been changed only to incorporate Letters of Map Change issued before the effective date, two asterisks(**) are shown to the right of the map panel number. For those map panels for which a Flood Insurance Rate Map is produced for the first time, resulting only in changes to flood insurance and floodplain management requirements in the affected community, three asterisks(***) are shown to the right of the map panel number.

Region	State	Community	Map panel	Determination date	Case No.	Type
01	CT	BARKHAMSTED, TOWN OF	0901340010B	20-OCT-1999	99-01-1004A	02
01	CT	BERLIN, TOWN OF	0900220010D	04-AUG-1999	99-01-1056A	02
01	CT	BERLIN, TOWN OF	0900220010D	13-DEC-1999	98-01-067P	05
01	CT	CANTERBURY, TOWN OF	0901830015A	14-JUL-1999	99-01-496A	02
01	CT	DARIEN, TOWN OF	0900050005E	18-OCT-1999	99-01-686P	05
01	CT	FAIRFIELD, TOWN OF	0900070004C	29-SEP-1999	99-01-1192A	02
01	CT	FAIRFIELD, TOWN OF	0900070006C	30-JUL-1999	99-01-1000A	17
01	CT	FAIRFIELD, TOWN OF	0900070009C	27-AUG-1999	99-01-1006A	02
01	CT	FARMINGTON, TOWN OF	0900290005C	04-AUG-1999	99-01-1016A	01
01	CT	GLASTONBURY, TOWN OF	0901240010B	20-AUG-1999	99-01-1174A	02
01	CT	GLASTONBURY, TOWN OF	0901240010B	17-AUG-1999	99-01-1014A	02
01	CT	GREENWICH, TOWN OF	0900080005C	18-AUG-1999	99-01-1038A	02
01	CT	GREENWICH, TOWN OF	0900080018C	20-AUG-1999	99-01-1064A	02
01	CT	GREENWICH, TOWN OF	0900080019C	21-JUL-1999	99-01-1018A	17
01	CT	GREENWICH, TOWN OF	0900080021C	06-AUG-1999	99-01-808A	02
01	CT	GREENWICH, TOWN OF	0900080022C	24-SEP-1999	99-01-019P	05
01	CT	GREENWICH, TOWN OF	0900080024C	20-AUG-1999	99-01-1160A	02
01	CT	GREENWICH, TOWN OF	0900080024C	25-AUG-1999	99-01-1084A	02
01	CT	GREENWICH, TOWN OF	0900080024C	29-SEP-1999	99-01-830A	02
01	CT	GROTON, TOWN OF	0900970010C	01-DEC-1999	00-01-0108A	02
01	CT	GUILFORD, TOWN OF	0900770010B	19-NOV-1999	99-01-1344A	02
01	CT	HAMDEN, TOWN OF	0900780005B	16-JUL-1999	99-01-1012A	02
01	CT	MADISON, TOWN OF	0900790012D	03-SEP-1999	99-01-956A	02
01	CT	MADISON, TOWN OF	0900790012D	30-JUL-1999	99-01-560A	02
01	CT	MANCHESTER, TOWN OF	0900310004D	24-SEP-1999	99-01-1138A	02
01	CT	MERIDEN, CITY OF	0900810004B	09-JUL-1999	99-01-826A	02
01	CT	NEW BRITAIN, CITY OF	0900320001C	14-JUL-1999	99-01-676A	02
01	CT	NEW CANAAN, TOWN OF	0900100002B	16-JUL-1999	99-01-828A	02
01	CT	NEW HARTFORD, TOWN OF	0900480006B	17-SEP-1999	99-01-1204A	02
01	CT	NORTH CANAAN, TOWN OF	0901490002B	23-JUL-1999	99-01-646A	02
01	CT	NORWALK, CITY OF	0900120005C	20-AUG-1999	99-01-796A	02
01	CT	PLAINVILLE, TOWN OF	0900340005C	20-AUG-1999	99-01-1172A	02
01	CT	PUTNAM, TOWN OF	0901940002B	29-DEC-1999	00-01-0074A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
01	CT	RIDGEFIELD, TOWN OF	0900130003B	22-SEP-1999	99-01-906A	02
01	CT	ROCKY HILL, TOWN OF	0901420010B	22-SEP-1999	99-01-878A	01
01	CT	SOMERS, TOWN OF	0901120004B	20-AUG-1999	99-01-768A	02
01	CT	STAMFORD, CITY OF	0900150006C	10-NOV-1999	99-01-1338A	02
01	CT	STAMFORD, CITY OF	0900150007D	29-SEP-1999	98-01-049P	05
01	CT	STONINGTON, TOWN OF	0901060017F	15-OCT-1999	99-01-1304A	02
01	CT	VERNON, TOWN OF	0901310005C	15-OCT-1999	99-01-1208A	02
01	CT	VERNON, TOWN OF	0901310005C	10-AUG-1999	99-01-1220V	19
01	CT	WALLINGFORD, TOWN OF	0900900006C	22-DEC-1999	00-01-0162A	02
01	CT	WALLINGFORD, TOWN OF	0900900009B	22-DEC-1999	00-01-0100A	02
01	CT	WATERTOWN, TOWN OF	0900580006B	19-NOV-1999	99-01-1362A	02
01	CT	WEST HARTFORD, TOWN OF	0950820002D	13-OCT-1999	99-01-962A	02
01	CT	WEST HARTFORD, TOWN OF	0950820003C	28-DEC-1999	99-01-055P	05
01	CT	WEST HARTFORD, TOWN OF	0950820003C	16-NOV-1999	99-01-009P	05
01	CT	WEST HARTFORD, TOWN OF	0950820003C	17-SEP-1999	98-01-069P	05
01	CT	WESTPORT, TOWN OF	0900190003C	15-DEC-1999	00-01-0156A	02
01	CT	WETHERSFIELD, TOWN OF	0900400003B	08-OCT-1999	99-01-003P	05
01	CT	WILTON, TOWN OF	0900200007C	22-SEP-1999	98-01-031P	06
01	MA	ANDOVER, TOWN OF	2500760005B	13-OCT-1999	99-01-1270A	02
01	MA	ANDOVER, TOWN OF	2500760007B	17-NOV-1999	99-01-1042A	02
01	MA	BARNSTABLE, TOWN OF	2500010006D	29-OCT-1999	99-01-1194A	02
01	MA	BEDFORD, TOWN OF	2552090003C	29-OCT-1999	99-01-1384A	02
01	MA	BILLERICA, TOWN OF	2501830010C	15-AUG-1999	98-01-017P	05
01	MA	BOURNE, TOWN OF	2552100001E	10-AUG-1999	99-01-1282V	19
01	MA	BRIDGEWATER, TOWN OF	2502600002C	10-SEP-1999	99-01-1347V	19
01	MA	BRIDGEWATER, TOWN OF	2502600015B	02-JUL-1999	99-01-944A	02
01	MA	BROCKTON, CITY OF	2502610005C	10-NOV-1999	99-01-1110A	02
01	MA	COHASSET, TOWN OF	2502360004C	27-OCT-1999	99-01-1146A	02
01	MA	COHASSET, TOWN OF	2502360004C	24-AUG-1999	99-01-1134A	02
01	MA	CONCORD, TOWN OF	2501890010B	19-NOV-1999	00-01-0094A	02
01	MA	DEDHAM, TOWN OF	2502370005C	27-AUG-1999	99-01-740A	02
01	MA	DUNSTABLE, TOWN OF	2501910005B	08-NOV-1999	99-01-041P	06
01	MA	DUXBURY, TOWN OF	2502630005B	30-JUL-1999	99-01-756A	02
01	MA	DUXBURY, TOWN OF	2502630012C	10-NOV-1999	99-01-930A	02
01	MA	EASTON, TOWN OF	2500530010D	12-NOV-1999	99-01-1388A	02
01	MA	EASTON, TOWN OF	2500530010D	06-OCT-1999	99-01-510A	02
01	MA	FALMOUTH, TOWN OF	2552110004H	18-AUG-1999	99-01-882A	02
01	MA	FRAMINGHAM, TOWN OF	2501930008C	12-NOV-1999	99-01-1366A	02
01	MA	HADLEY, TOWN OF	2501630002B	05-NOV-1999	99-01-1404A	02
01	MA	HINGHAM, TOWN OF	2502680001B	23-JUL-1999	99-01-896A	02
01	MA	HOLBROOK, TOWN OF	2552120005C	24-NOV-1999	99-01-1298A	02
01	MA	HOLLISTON, TOWN OF	2501950003C	15-JUL-1999	99-01-752A	02
01	MA	IPSWICH, TOWN OF	2500860007D	10-SEP-1999	99-01-1156A	02
01	MA	LAKEVILLE, TOWN OF	2502710015C	25-AUG-1999	99-01-1150A	02
01	MA	MARION, TOWN OF	2552130002D	09-JUL-1999	99-01-844A	02
01	MA	MARSHFIELD, TOWN OF	2502730003D	08-OCT-1999	99-01-1104A	02
01	MA	MEDFIELD, TOWN OF	2502420005B	23-JUL-1999	99-01-918A	02
01	MA	METHUEN, TOWN OF	2500930010C	11-AUG-1999	99-01-1092A	02
01	MA	MIDDLEBOROUGH, TOWN OF	2502750030B	29-SEP-1999	99-01-1132A	02
01	MA	MILLBURY, TOWN OF	2503180005B	09-NOV-1999	00-01-0062V	19
01	MA	MILLIS, TOWN OF	2502440002C	29-SEP-1999	99-01-1218A	02
01	MA	NATICK, TOWN OF	2502070006B	04-AUG-1999	99-01-910A	02
01	MA	NEEDHAM, TOWN OF	2552150002C	03-DEC-1999	99-01-1216A	02
01	MA	NEWTON, CITY OF	2502080004D	17-SEP-1999	99-01-818A	02
01	MA	NORTH ANDOVER, TOWN OF	2500980003C	10-NOV-1999	99-01-1390A	02
01	MA	NORTH ANDOVER, TOWN OF	2500980009C	14-JUL-1999	99-01-840A	02
01	MA	NORTON, TOWN OF	2500600006C	03-SEP-1999	99-01-1144A	02
01	MA	ORLEANS, CITY OF	2500100002D	13-AUG-1999	99-01-1010A	02
01	MA	QUINCY, CITY OF	2552190016B	18-AUG-1999	99-01-1050A	02
01	MA	RANDOLPH, TOWN OF	2502510002C	15-SEP-1999	99-01-862A	02
01	MA	ROCKLAND, TOWN OF	2502810001B	06-AUG-1999	99-01-702A	02
01	MA	ROCKPORT, TOWN OF	2501000001B	04-AUG-1999	99-01-1032A	02
01	MA	SALISBURY, TOWN OF	2501030003C	13-AUG-1999	99-01-502A	02
01	MA	SHREWSBURY, TOWN OF	2503320004B	20-OCT-1999	99-01-774A	02
01	MA	SOUTH HADLEY, TOWN OF	2501700010A	18-AUG-1999	99-01-916A	02
01	MA	STOUGHTON, TOWN OF	2502530001B	03-DEC-1999	99-01-1254A	02
01	MA	STOW, TOWN OF	2502160005B	29-DEC-1999	00-01-0216A	02
01	MA	SWANSEA, TOWN OF	2552210007C	17-SEP-1999	99-01-958A	02
01	MA	TEWKSBURY, TOWN OF	2502180006B	01-SEP-1999	99-01-680A	02
01	MA	TOPSFIELD, TOWN OF	2501060001D	08-OCT-1999	99-01-1082A	02
01	MA	TOPSFIELD, TOWN OF	2501060001D	08-JUL-1999	99-01-602A	02
01	MA	WAYLAND, CITY OF	2502240002C	22-DEC-1999	99-01-1332A	02
01	MA	WELLFLEET, TOWN OF	2500140008B	22-DEC-1999	00-01-0168A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
01	MA	WEST NEWBURY, TOWN OF	2501080005A	28-JUL-1999	99-01-974A	02
01	MA	WILMINGTON, TOWN OF	2502270003C	03-DEC-1999	99-01-1396A	02
01	MA	WORTHINGTON, TOWN OF	2501750016B	27-OCT-1999	99-01-1096A	02
01	ME	ALEXANDER, TOWN OF	230303B	27-AUG-1999	99-01-998A	02
01	ME	ALEXANDER, TOWN OF	230303B	27-AUG-1999	99-01-996A	02
01	ME	BELGRADE, TOWN OF	2302320010B	15-OCT-1999	99-01-954A	01
01	ME	BETHEL, TOWN OF	2300880005C	10-DEC-1999	00-01-0080A	02
01	ME	BLUE HILL, TOWN OF	2302740015A	29-SEP-1999	99-01-1214A	02
01	ME	BLUE HILL, TOWN OF	2302740020A	01-DEC-1999	00-01-0068A	18
01	ME	BLUE HILL, TOWN OF	2302740020A	18-AUG-1999	99-01-900A	18
01	ME	BOOTHBAY HARBOR, TOWN OF	2302130002B	28-SEP-1999	98-01-061P	05
01	ME	BOOTHBAY, TOWN OF	2302120011B	28-JUL-1999	99-01-968A	02
01	ME	BRIDGTON, TOWN OF	2300410010B	03-NOV-1999	99-01-1228A	02
01	ME	BRIDGTON, TOWN OF	2300410010B	27-OCT-1999	99-01-1166A	02
01	ME	BRISTOL, TOWN OF	2302150015B	12-NOV-1999	99-01-1234A	02
01	ME	CARIBOU, CITY OF	2300140010C	04-AUG-1999	99-01-498A	02
01	ME	CUSHING, TOWN OF	2302240005B	14-JUL-1999	99-01-986A	02
01	ME	DEER ISLE, TOWN OF	2302800015B	02-JUL-1999	99-01-948A	18
01	ME	ELIOT, TOWN OF	2301490010B	05-NOV-1999	99-01-1238A	02
01	ME	ELLSWORTH, CITY OF	2300660020B	22-SEP-1999	99-01-1252A	02
01	ME	ENFIELD, TOWN OF	2303840005A	14-JUL-1999	99-01-946A	02
01	ME	GOULDSBORO,TOWN OF	2302830020B	08-SEP-1999	99-01-1002A	01
01	ME	GRAY, TOWN OF	2300480010A	27-OCT-1999	00-01-0032A	02
01	ME	GREENWOOD, TOWN OF	230332A	10-SEP-1999	99-01-1126A	02
01	ME	HARMONY, TOWN OF	230360B	04-OCT-1999	99-01-007P	06
01	ME	HARPSWELL, TOWN OF	2301690011B	26-OCT-1999	99-01-1184A	02
01	ME	HARRISON, TOWN OF	2300490010B	11-AUG-1999	99-01-980A	02
01	ME	HARTLAND, TOWN OF	2303619999A	15-SEP-1999	99-01-864A	02
01	ME	KENNEBUNKPORT, TOWN OF	2301700004B	24-NOV-1999	99-01-994A	02
01	ME	KENNEBUNKPORT, TOWN OF	2301700007B	13-OCT-1999	99-01-1292A	01
01	ME	LAMOINE, TOWN OF	2302850010A	19-NOV-1999	99-01-1322A	02
01	ME	LAMOINE, TOWN OF	2302850010A	18-AUG-1999	99-01-1088A	02
01	ME	LAMOINE, TOWN OF	2302850010A	16-JUL-1999	99-01-970A	02
01	ME	LEBANON, TOWN OF	230193	08-JUL-1999	99-01-904A	02
01	ME	LOVELL, TOWN OF	2303360015B	29-DEC-1999	00-01-0114A	02
01	ME	LOVELL, TOWN OF	2303360015B	06-AUG-1999	99-01-1048A	02
01	ME	LYMAN, TOWN OF	2301950005A	27-OCT-1999	99-01-1336A	02
01	ME	MARIAVILLE, TOWN OF	230286	17-NOV-1999	00-01-0070A	02
01	ME	MATTAWAMAKEAG, TOWN OF	2301740010A	20-AUG-1999	99-01-876A	02
01	ME	MEXICO, TOWN OF	2300950004B	25-AUG-1999	99-01-1170A	02
01	ME	MONMOUTH, TOWN OF	2302400010A	17-DEC-1999	00-01-0106A	02
01	ME	MT. VERNON, TOWN OF	230241A	08-OCT-1999	99-01-1300A	02
01	ME	NAPLES, TOWN OF	2300500021B	13-OCT-1999	99-01-1272A	02
01	ME	NEWPORT, TOWN OF	230398B	01-SEP-1999	99-01-834A	02
01	ME	NORTH BERWICK, TOWN OF	2301970007C	23-JUL-1999	99-01-1026A	02
01	ME	ORLAND,TOWN OF	230288A	01-OCT-1999	99-01-732A	02
01	ME	OXFORD, TOWN OF	2308690006A	04-AUG-1999	99-01-700A	02
01	ME	OXFORD, TOWN OF	2308690015A	10-NOV-1999	00-01-0046A	02
01	ME	PALMYRA, TOWN OF	230366B	29-OCT-1999	99-01-1122A	02
01	ME	PITTSFIELD, TOWN OF	2301270005C	09-JUL-1999	99-01-858A	02
01	ME	PORTLAND, CITY OF	2300510007C	17-DEC-1999	00-01-0140A	02
01	ME	PORTLAND, CITY OF	2300510007C	10-SEP-1999	99-01-1154A	02
01	ME	PORTLAND, CITY OF	2300510007C	22-SEP-1999	99-01-1106A	02
01	ME	RANGELEY, TOWN OF	2303520001B	10-SEP-1999	99-01-1348V	19
01	ME	RANGELEY, TOWN OF	2303520004B	27-OCT-1999	99-01-1140A	02
01	ME	ROME, TOWN OF	2302460010B	23-JUL-1999	99-01-1046A	02
01	ME	SABATTUS, TOWN OF	2300110005B	08-DEC-1999	00-01-0178X	02
01	ME	SABATTUS, TOWN OF	2300110005B	22-SEP-1999	99-01-1256A	02
01	ME	SACO, CITY OF	2301550029C	14-JUL-1999	99-01-934A	02
01	ME	SANFORD, TOWN OF	2301560017E	08-OCT-1999	99-01-1202A	02
01	ME	SCARBOROUGH, TOWN OF	2300520023D	17-DEC-1999	00-01-0174A	02
01	ME	SORRENTO, TOWN OF	230292A	12-NOV-1999	99-01-1262A	02
01	ME	ST. ALBANS, TOWN OF	230369A	27-OCT-1999	99-01-1386A	02
01	ME	ST. ALBANS, TOWN OF	230369A	27-OCT-1999	99-01-1380A	02
01	ME	ST. ALBANS, TOWN OF	230369A	27-OCT-1999	99-01-1378A	02
01	ME	ST. ALBANS, TOWN OF	230369A	06-OCT-1999	99-01-1232A	02
01	ME	ST. GEORGE, TOWN OF	2302290015C	08-SEP-1999	99-01-1054A	02
01	ME	STANDISH, TOWN OF	2302070010B	06-OCT-1999	99-01-952A	02
01	ME	STANDISH, TOWN OF	2302070040B	24-NOV-1999	00-01-0104A	02
01	ME	SURRY, TOWN OF	2302960010B	10-DEC-1999	00-01-0076A	01
01	ME	SURRY, TOWN OF	2302960010B	04-AUG-1999	99-01-1060A	18
01	ME	SURRY, TOWN OF	2302960015B	02-JUL-1999	99-01-846A	18
01	ME	SWANVILLE,TOWN OF	230267A	22-DEC-1999	00-01-0172A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
01	ME	TOPSHAM, TOWN OF	2301220008B	18-AUG-1999	99-01-866A	02
01	ME	TRENTON, TOWN OF	2302990010A	23-JUL-1999	99-01-600A	01
01	ME	TURNER, TOWN OF	2300100010B	11-AUG-1999	99-01-988A	02
01	ME	VINALHAVEN, TOWN OF	230230A	27-OCT-1999	99-01-1198A	02
01	ME	WARREN, TOWN OF	2300810005B	18-AUG-1999	99-01-1080A	02
01	ME	WATERBORO, TOWN OF	2301990003C	01-DEC-1999	00-01-0102A	02
01	ME	WELD, TOWN OF	230353A	30-JUL-1999	99-01-776A	02
01	ME	WINDHAM, TOWN OF	2301890015B	18-AUG-1999	99-01-1020A	02
01	ME	WINTERVILLE PLANTATION	230450A	03-NOV-1999	99-01-1326A	02
01	ME	WINTHROP, TOWN OF	2300720020B	19-NOV-1999	99-01-1196A	02
01	ME	YORK, TOWN OF	2301590022B	02-NOV-1999	99-01-1034A	02
01	ME	YORK, TOWN OF	2301590024B	03-AUG-1999	99-01-940A	02
01	ME	YORK, TOWN OF	2301590024B	28-SEP-1999	99-01-190A	02
01	NH	ALLENSTOWN, TOWN OF	3301030010B	01-NOV-1999	98-01-027P	05
01	NH	BEDFORD, TOWN OF	3300830005C	15-JUL-1999	99-01-029P	05
01	NH	CONCORD, CITY OF	3301100020A	28-JUL-1999	99-01-936A	01
01	NH	EPSOM, TOWN OF	3301120010B	01-NOV-1999	98-01-027P	05
01	NH	FREMONT, TOWN OF	3301310005C	22-DEC-1999	99-01-1180A	02
01	NH	FREMONT, TOWN OF	3301310005C	22-SEP-1999	99-01-742A	02
01	NH	GORHAM, TOWN OF	3300320010C	29-DEC-1999	99-01-1288A	02
01	NH	GORHAM, TOWN OF	3300320015C	01-DEC-1999	99-01-017P	05
01	NH	HAMPSTEAD, TOWN OF	3302110005A	01-DEC-1999	99-01-1364A	02
01	NH	JACKSON, TOWN OF	3300140025B	18-AUG-1999	99-01-1078A	02
01	NH	MANCHESTER, CITY OF	3301690020B	01-DEC-1999	00-01-0110A	02
01	NH	MIDDLETON, TOWN OF	3302220001B	11-AUG-1999	99-01-1100A	02
01	NH	NEW DURHAM, TOWN OF	3302270010B	29-SEP-1999	99-01-1152A	02
01	NH	PELHAM, TOWN OF	3301000001B	09-DEC-1999	99-01-1278A	02
01	NH	PORTSMOUTH, CITY OF	3301390015B	06-OCT-1999	99-01-033P	05
01	NH	RAYMOND, TOWN OF	3301400005D	01-DEC-1999	99-01-1374A	02
01	NH	RAYMOND, TOWN OF	3301400005D	17-SEP-1999	99-01-992A	02
01	NH	SALEM, TOWN OF	3301420005C	07-JUL-1999	99-01-880A	02
01	NH	SALEM, TOWN OF	3301420010C	15-SEP-1999	99-01-045P	05
01	NH	WOLFEBORO, TOWN OF	3302390015A	18-AUG-1999	99-01-1066A	02
01	RI	BARRINGTON, TOWN OF	44001C0007F	27-OCT-1999	99-01-1314A	02
01	RI	COVENTRY, TOWN OF	4400040015A	03-NOV-1999	99-01-1258A	02
01	RI	COVENTRY, TOWN OF	4400040015A	22-SEP-1999	99-01-1178A	02
01	RI	CRANSTON, CITY OF	4453960009B	10-NOV-1999	00-01-0038A	02
01	RI	CRANSTON, CITY OF	4453960009B	20-AUG-1999	99-01-1136A	02
01	RI	HOPKINTON, TOWN OF	4400280009B	03-NOV-1999	99-01-1276A	02
01	RI	NEW SHOREHAM, TOWN OF	4400360004D	16-JUL-1999	99-01-894A	02
01	RI	NEWPORT, CITY OF	4454030002F	14-JUL-1999	99-01-976A	02
01	RI	NORTH KINGSTOWN, TOWN OF	4454040008B	03-NOV-1999	99-01-1406A	02
01	RI	NORTH PROVIDENCE, TOWN OF	4400200001B	07-DEC-1999	00-01-0200V	19
01	RI	PORTSMOUTH, TOWN OF	4454050004D	01-OCT-1999	99-01-1118A	02
01	RI	PROVIDENCE, CITY OF	4454060002E	22-SEP-1999	99-01-950A	02
01	RI	SOUTH KINGSTOWN, TOWN OF	4454070003D	24-NOV-1999	00-01-0078A	02
01	RI	SOUTH KINGSTOWN, TOWN OF	4454070028F	07-JUL-1999	99-01-606A	02
01	RI	WARWICK, CITY OF	4454090006E	24-SEP-1999	99-01-1074A	02
01	RI	WARWICK, CITY OF	4454090009D	16-JUL-1999	99-01-688A	02
01	VT	CAMBRIDGE, TOWN OF	5000610025B	27-AUG-1999	99-01-990A	02
01	VT	CANAAN, TOWN OF	5000460005B	13-AUG-1999	99-01-924A	02
01	VT	FERRISBURG, TOWN OF	5000020020B	20-OCT-1999	99-01-1328A	02
01	VT	FERRISBURG, TOWN OF	5000020020B	24-SEP-1999	99-01-1230A	02
01	VT	GRAFTON, TOWN OF	5001290015D	03-SEP-1999	99-01-1070A	02
01	VT	GROTON, TOWN OF	5000260010B	27-OCT-1999	99-01-1376A	02
01	VT	HARTFORD, TOWN OF	5001480007B	17-DEC-1999	99-01-1040A	01
01	VT	LONDONDERRY, TOWN OF	5001320005C	05-NOV-1999	00-01-0042A	02
01	VT	LUDLOW, TOWN OF	5001500015B	22-SEP-1999	99-01-1200A	02
01	VT	LUDLOW, VILLAGE OF	5002940001B	08-OCT-1999	99-01-1212A	02
01	VT	LUDLOW, VILLAGE OF	5002940001B	21-JUL-1999	99-01-1030A	02
01	VT	NEWBURY, TOWN OF	5002370005C	22-JUL-1999	99-01-1128V	19
01	VT	NEWFANE, TOWN AND VILLAGE OF	5001330020B	05-NOV-1999	00-01-0066A	02
01	VT	NEWFANE, TOWN AND VILLAGE OF	5001330020B	17-SEP-1999	99-01-1090A	02
01	VT	PITTSFORD, TOWN OF	5000980015B	03-NOV-1999	99-01-1356A	02
01	VT	STAMFORD, TOWN OF	5000200020B	29-OCT-1999	99-01-1368A	02
01	VT	THETFORD, TOWN OF	5000750010B	21-DEC-1999	00-01-0202V	19
01	VT	WALLINGFORD, TOWN OF	5001030005B	01-DEC-1999	00-01-0116A	02
01	VT	WELLS, TOWNSHIP OF	5002710001B	22-DEC-1999	00-01-0176A	02
01	VT	WINDSOR, TOWN OF	5001590004C	20-AUG-1999	99-01-1116A	02
02	NJ	ABSECON, CITY OF	3400010001C	24-AUG-1999	99-02-1320V	19
02	NJ	BERNARDSVILLE, BOROUGH OF	3404290001B	27-OCT-1999	99-02-1068A	01
02	NJ	BOONTON, TOWNSHIP OF	3403360010C	24-NOV-1999	00-02-0122A	02
02	NJ	BOUND BROOK, BOROUGH OF	3404300001C	03-NOV-1999	99-02-1242A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
02	NJ	BRICK, TOWNSHIP OF	3452850005D	13-OCT-1999	99-02-1262A	02
02	NJ	CARLSTADT, BOROUGH OF	34003C0254F	24-NOV-1999	99-02-1350A	02
02	NJ	COLTS NECK, TOWNSHIP OF	3402910002C	22-DEC-1999	99-02-888A	02
02	NJ	CRANFORD, TOWNSHIP OF	3452910001B	10-NOV-1999	00-02-0038A	02
02	NJ	CRANFORD, TOWNSHIP OF	3452910001B	17-DEC-1999	00-02-0032A	02
02	NJ	DENVILLE, TOWNSHIP OF	3452920005B	27-AUG-1999	99-02-1052A	02
02	NJ	EVESHAM, TOWNSHIP OF	3400970003C	22-SEP-1999	99-02-1028A	02
02	NJ	FAIR LAWN, BOROUGH OF	34003C0167F	27-OCT-1999	99-02-1356A	02
02	NJ	FAIR LAWN, BOROUGH OF	34003C0167F	01-SEP-1999	99-02-1136A	02
02	NJ	FAIR LAWN, BOROUGH OF	34003C0186F	02-JUL-1999	99-02-884A	02
02	NJ	FRANKLIN LAKES, BOROUGH OF	34003C0064F	03-NOV-1999	99-02-1326A	02
02	NJ	FRANKLIN LAKES, BOROUGH OF	34003C0066F	05-NOV-1999	99-02-1366A	02
02	NJ	FRANKLIN LAKES, BOROUGH OF	34003C0066F	21-JUL-1999	99-02-878A	02
02	NJ	FRANKLIN LAKES, BOROUGH OF	34003C0151F	22-SEP-1999	99-02-896A	02
02	NJ	GLEN ROCK, BOROUGH OF	34003C0159G	06-OCT-1999	99-02-1018A	02
02	NJ	GLEN ROCK, BOROUGH OF	34003C0159G	17-SEP-1999	99-02-940A	02
02	NJ	GREENWICH, TOWNSHIP OF	3402040004C	01-SEP-1999	99-02-1062A	02
02	NJ	HAMILTON, TOWNSHIP OF	3400090005A	08-OCT-1999	99-02-942A	02
02	NJ	HAMILTON, TOWNSHIP OF	3402460015C	17-NOV-1999	00-02-0068A	02
02	NJ	HAMILTON, TOWNSHIP OF	3402460015C	29-DEC-1999	99-02-1334A	02
02	NJ	HAMILTON, TOWNSHIP OF	3402460015C	11-AUG-1999	99-02-914A	02
02	NJ	HIGHLANDS, BOROUGH OF	3452970001B	03-SEP-1999	99-02-978A	02
02	NJ	HIGHLANDS, BOROUGH OF	3452970001B	27-AUG-1999	99-02-1066A	02
02	NJ	HOBOKEN, CITY OF	3402220001B	28-DEC-1999	00-02-0006A	01
02	NJ	HOBOKEN, CITY OF	3402220001B	06-OCT-1999	99-02-1114A	02
02	NJ	HO-HO-KUS, BOROUGH OF	34003C0176F	10-SEP-1999	99-02-1286A	02
02	NJ	HOWELL, TOWNSHIP OF	3403010016B	13-OCT-1999	99-02-934A	02
02	NJ	LINCOLN PARK, BOROUGH OF	3453000001B	16-JUL-1999	99-02-988A	01
02	NJ	LINDEN, CITY OF	3404670002B	10-AUG-1999	99-02-003P	05
02	NJ	LINDEN, CITY OF	3404670002B	10-AUG-1999	99-02-005P	05
02	NJ	LITTLE EGG HARBOR, TOWNSHIP OF	3403800027B	13-OCT-1999	99-02-1168A	02
02	NJ	LIVINGSTON, TOWNSHIP OF	3401850002D	17-SEP-1999	99-02-962A	02
02	NJ	LOWER ALLOWAYS CREEK, TOWNSHIP OF	3404160013B	29-DEC-1999	00-02-0132A	02
02	NJ	LOWER ALLOWAYS CREEK, TOWNSHIP OF	3404160013B	16-JUL-1999	99-02-916A	02
02	NJ	MAHWAH, TOWNSHIP OF	34003C0057F	29-DEC-1999	00-02-0160A	02
02	NJ	MAHWAH, TOWNSHIP OF	34003C0059F	23-JUL-1999	99-02-910A	01
02	NJ	MANALAPAN, TOWNSHIP OF	3403080002A	01-NOV-1999	99-02-063P	05
02	NJ	MANASQUAN, BOROUGH OF	3453030001C	20-AUG-1999	99-02-1026A	02
02	NJ	MANTUA, TOWNSHIP OF	3402070015B	01-SEP-1999	99-02-1100A	02
02	NJ	MIDDLESEX, BOROUGH OF	3453050001B	01-JUL-1999	99-02-874A	02
02	NJ	MIDDLETOWN, TOWNSHIP OF	3403130002B	10-SEP-1999	99-02-1158A	02
02	NJ	MONROE, TOWNSHIP OF	3402690003C	22-JUL-1999	99-02-1002A	02
02	NJ	MONTGOMERY, TOWNSHIP OF	3404390005B	20-OCT-1999	99-02-930A	02
02	NJ	MONTVALE, BOROUGH OF	34003C0091F	22-OCT-1999	99-02-1352A	02
02	NJ	MONTVALE, BOROUGH OF	34003C0091F	01-SEP-1999	99-02-1090A	02
02	NJ	MONTVALE, BOROUGH OF	34003C0091F	03-NOV-1999	99-02-1086A	17
02	NJ	NEPTUNE, TOWNSHIP OF	3403170003C	03-DEC-1999	00-02-0110A	02
02	NJ	NEPTUNE, TOWNSHIP OF	3403170003C	12-NOV-1999	00-02-0036A	02
02	NJ	NEWARK, CITY OF	3401890004B	22-DEC-1999	00-02-0288A	01
02	NJ	OCEAN, TOWNSHIP OF	3403190005D	16-JUL-1999	99-02-534A	02
02	NJ	OLD BRIDGE, TOWN OF	3402650004D	15-SEP-1999	99-02-690A	02
02	NJ	PALMYRA, BOROUGH OF	3401100001C	08-DEC-1999	00-02-0222X	01
02	NJ	PALMYRA, BOROUGH OF	3401100001C	20-OCT-1999	99-02-1250A	01
02	NJ	PALMYRA, BOROUGH OF	3401100001C	20-AUG-1999	99-02-1150A	02
02	NJ	PARSIPPANY-TROY HILLS, TOWNSHIP OF	3403550009B	01-OCT-1999	99-02-1008A	01
02	NJ	PARSIPPANY-TROY HILLS, TOWNSHIP OF	3403550009B	01-SEP-1999	99-02-982A	02
02	NJ	PASSAIC, TOWNSHIP OF	340356A	01-SEP-1999	99-02-1048A	02
02	NJ	PASSAIC, TOWNSHIP OF	340356A	20-AUG-1999	99-02-708A	02
02	NJ	PATERSON, CITY OF	3404040001A	15-SEP-1999	99-02-055P	05
02	NJ	PENNSVILLE, TOWNSHIP OF	3405120005B	17-DEC-1999	00-02-0258A	02
02	NJ	PENNSVILLE, TOWNSHIP OF	3405120005B	12-NOV-1999	99-02-1404A	02
02	NJ	PEQUANNOCK, VILLAGE OF	3453110001C	29-DEC-1999	00-02-0204A	02
02	NJ	PEQUANNOCK, VILLAGE OF	3453110001C	19-NOV-1999	00-02-0096A	02
02	NJ	PEQUANNOCK, VILLAGE OF	3453110001C	17-SEP-1999	99-02-1198A	02
02	NJ	PEQUANNOCK, VILLAGE OF	3453110001C	12-NOV-1999	99-02-1078A	02
02	NJ	PEQUANNOCK, VILLAGE OF	3453110001C	04-AUG-1999	99-02-902A	02
02	NJ	PLAINSBORO, TOWN OF	3402750003B	13-OCT-1999	99-02-846A	01
02	NJ	POINT PLEASANT, BOROUGH OF	3453130001B	27-OCT-1999	99-02-1396A	02
02	NJ	PRINCETON, TOWNSHIP OF	3402520003B	12-NOV-1999	99-02-1238A	02
02	NJ	ROSELLE, BOROUGH OF	3404720001A	10-AUG-1999	99-02-005P	05
02	NJ	ROSELLE, BOROUGH OF	3404720001A	10-AUG-1999	99-02-003P	05
02	NJ	ROXBURY, TOWNSHIP OF	3403620006B	24-SEP-1999	99-02-932A	01
02	NJ	SCOTCH PLAINS, TOWNSHIP OF	3404740005B	01-OCT-1999	99-02-1274A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
02	NJ	SOUTH BRUNSWICK, TOWNSHIP OF	3402780006B	03-DEC-1999	99-02-016A	01
02	NJ	SUMMIT, CITY OF	3404760001A	13-OCT-1999	99-02-706A	02
02	NJ	UPPER SADDLE RIVER, BOROUGH OF	34003C0086G	06-OCT-1999	99-02-644A	01
02	NJ	WASHINGTON, TOWNSHIP OF	3402130003B	08-SEP-1999	99-02-1014A	02
02	NJ	WEST MILFORD, TOWNSHIP OF	3404110004B	24-SEP-1999	99-02-960A	02
02	NJ	WINSLOW, TOWNSHIP OF	3401480013B	18-AUG-1999	99-02-970A	02
02	NJ	WINSLOW, TOWNSHIP OF	3401480026B	06-AUG-1999	99-02-530A	02
02	NY	AMENIA, TOWN OF	3613320015D	30-JUL-1999	99-02-974A	02
02	NY	AMHERST, TOWN OF	3602260004D	12-NOV-1999	99-02-1390A	02
02	NY	AMHERST, TOWN OF	3602260004D	25-AUG-1999	99-02-1044A	02
02	NY	ANGOLA, VILLAGE OF	360982B	01-SEP-1999	99-02-1034A	02
02	NY	ARCADE, VILLAGE OF	3615550005D	21-JUL-1999	99-02-968A	01
02	NY	BARNEVELD, VILLAGE OF	3615690001C	04-AUG-1999	99-02-1000A	02
02	NY	BEACON, CITY OF	3602170001B	22-DEC-1999	99-02-027P	06
02	NY	BEEKMANTOWN, TOWN OF	3601660005B	22-SEP-1999	99-02-1288A	02
02	NY	BELLMONT, TOWN OF	361392A	19-NOV-1999	00-02-0080A	02
02	NY	BELLMONT, TOWN OF	361392A	20-OCT-1999	99-02-646A	02
02	NY	BETHLEHEM, TOWN OF	3615400010B	28-JUL-1999	99-02-882A	02
02	NY	BOONVILLE, TOWN OF	3605190010B	29-SEP-1999	99-02-992A	02
02	NY	BRIGHTON, TOWN OF	3604100005B	08-NOV-1999	99-02-007P	05
02	NY	BRUNSWICK, TOWN OF	3611300005B	10-OCT-1999	99-02-1302A	02
02	NY	BUFFALO, CITY OF	3602300010B	02-JUL-1999	99-02-892A	02
02	NY	BUFFALO, CITY OF	3602300010C	29-DEC-1999	00-02-0118A	02
02	NY	BUFFALO, CITY OF	3602300010C	03-DEC-1999	00-02-0108A	02
02	NY	BUFFALO, CITY OF	3602300010C	01-DEC-1999	00-02-0104A	02
02	NY	BUFFALO, CITY OF	3602300010C	10-DEC-1999	00-02-0090A	02
02	NY	BUFFALO, CITY OF	3602300010C	03-DEC-1999	00-02-0092A	02
02	NY	BUFFALO, CITY OF	3602300010C	22-DEC-1999	00-02-0098A	02
02	NY	BUFFALO, CITY OF	3602300010C	10-SEP-1999	99-02-1294A	02
02	NY	BUFFALO, CITY OF	3602300010C	29-SEP-1999	99-02-1296A	02
02	NY	BUFFALO, CITY OF	3602300010C	22-DEC-1999	99-02-1300A	02
02	NY	BUFFALO, CITY OF	3602300010C	24-AUG-1999	99-02-1012A	02
02	NY	BUFFALO, CITY OF	3602300010C	24-AUG-1999	99-02-1370V	19
02	NY	CAMILLUS, TOWN OF	3605700004D	17-SEP-1999	99-02-1116A	02
02	NY	CAMILLUS, TOWN OF	3605700006D	13-OCT-1999	99-02-1260A	02
02	NY	CAMPBELL, TOWN OF	3607680010C	23-JUL-1999	99-02-918A	02
02	NY	CAPE VINCENT, TOWN OF	361062C	08-OCT-1999	99-02-1178A	02
02	NY	CARMEL,TOWN OF	3606690003C	19-NOV-1999	99-02-1064A	02
02	NY	CHEEKTOWAGA, TOWN OF	3602310010F	06-OCT-1999	99-02-1166A	02
02	NY	CHESTER, TOWN OF	3608700005B	10-NOV-1999	99-02-1400A	02
02	NY	CHESTER, TOWN OF	3608700010B	18-AUG-1999	99-02-1080A	01
02	NY	CICERO, TOWN OF	3605720004D	22-DEC-1999	00-02-0196A	02
02	NY	CICERO, TOWN OF	3605720004D	04-AUG-1999	99-02-954A	02
02	NY	CLARENCE, TOWN OF	3602320005C	22-OCT-1999	99-02-1394A	02
02	NY	CLARENCE, TOWN OF	3602320005C	18-AUG-1999	99-02-1006A	02
02	NY	CLARENCE, TOWN OF	3602320011C	29-DEC-1999	00-02-0234A	17
02	NY	CLARENCE, TOWN OF	3602320011C	24-NOV-1999	00-02-0078A	02
02	NY	CLARENCE, TOWN OF	3602320011C	20-OCT-1999	99-02-1412A	02
02	NY	CLARENCE, TOWN OF	3602320011C	10-NOV-1999	99-02-1406A	02
02	NY	CLARENCE, TOWN OF	3602320011C	12-NOV-1999	99-02-1266A	02
02	NY	CLARENCE, TOWN OF	3602320013C	12-NOV-1999	99-02-1312A	02
02	NY	CLARENCE, TOWN OF	3602320013C	17-SEP-1999	99-02-1252A	02
02	NY	CLARENCE, TOWN OF	3602320013C	20-AUG-1999	99-02-1092A	02
02	NY	CLARENCE, TOWN OF	3602320013C	13-OCT-1999	99-02-1094A	02
02	NY	CLARENCE, TOWN OF	3602320014C	18-AUG-1999	99-02-990A	02
02	NY	CORTLAND, CITY OF	3601780001C	22-OCT-1999	99-02-1402A	02
02	NY	CROWN POINT,TOWN OF	3611480020B	08-DEC-1999	99-02-1342A	02
02	NY	DEER PARK, TOWN OF	3606120005C	21-OCT-1999	99-02-1386V	19
02	NY	DRESDEN, TOWN OF	3614100015B	22-OCT-1999	99-02-1060A	02
02	NY	EAST AURORA, VILLAGE OF	3653350005B	08-DEC-1999	99-02-976A	02
02	NY	EAST FISHKILL, TOWN OF	3613360013B	01-SEP-1999	99-02-1098A	02
02	NY	EAST ROCKAWAY, VILLAGE OF	36059C0218F	28-JUL-1999	99-02-522A	02
02	NY	EASTON, TOWN OF	3612240010B	01-DEC-1999	00-02-0062A	02
02	NY	ELLENBURG, TOWN OF	361382A	08-OCT-1999	99-02-1276A	02
02	NY	ELLENBURG, TOWN OF	361382A	08-OCT-1999	99-02-1278A	02
02	NY	ELMIRA, CITY OF	3601500005C	28-DEC-1999	99-02-248P	05
02	NY	FINE, TOWN OF	361177B	21-JUL-1999	99-02-814A	02
02	NY	GORHAM, TOWN OF	3606010001C	12-NOV-1999	99-02-1182A	02
02	NY	GORHAM, TOWN OF	3606010003C	06-OCT-1999	99-02-1176A	02
02	NY	GORHAM, TOWN OF	3606010003C	24-SEP-1999	99-02-1118A	02
02	NY	GOSHEN, VILLAGE OF	3615710004B	17-SEP-1999	99-02-736A	02
02	NY	GRAFTON, TOWN OF	3611500003B	03-DEC-1999	99-02-1362A	02
02	NY	GREECE, TOWN OF	3604170004E	03-NOV-1999	00-02-0040A	01

Region	State	Community	Map panel	Determination date	Case No.	Type
02	NY	GREECE, TOWN OF	3604170004E	29-OCT-1999	99-02-1184A	01
02	NY	GREECE, TOWN OF	3604170006E	20-OCT-1999	99-02-1360A	02
02	NY	HAMBURG, TOWN OF	3602440005B	17-DEC-1999	99-02-041P	05
02	NY	HEMPSTEAD, TOWN OF	36059C0214G	24-SEP-1999	99-02-1324A	02
02	NY	HEMPSTEAD, TOWN OF	36059C0261F	03-NOV-1999	99-02-1322A	02
02	NY	HENRIETTA, TOWN OF	3604190005E	16-DEC-1999	00-02-0170A	01
02	NY	HENRIETTA, TOWN OF	3604190005E	08-DEC-1999	99-02-1128A	02
02	NY	ILION, VILLAGE OF	3603080001C	17-DEC-1999	00-02-0100A	02
02	NY	ILION, VILLAGE OF	3603080001C	10-SEP-1999	99-02-1380V	19
02	NY	JERUSALEM, TOWN OF	360959C	13-JUL-1999	99-02-1010A	02
02	NY	LAGRANGE, TOWN OF	3610110005D	10-SEP-1999	99-02-1378V	19
02	NY	LAGRANGE, TOWN OF	3610110015C	18-AUG-1999	99-02-952A	02
02	NY	LANCASTER, TOWN OF	3602490002B	22-OCT-1999	99-02-1280A	02
02	NY	LANCASTER, TOWN OF	3602490010B	10-AUG-1999	99-02-045P	06
02	NY	LANCASTER, TOWN OF	3602490010B	09-AUG-1999	98-02-011P	05
02	NY	LANSING, TOWN OF	3608520037C	02-JUL-1999	99-02-558A	02
02	NY	LEWISTON, TOWN OF	3605020010B	25-AUG-1999	99-02-1040A	02
02	NY	LONG BEACH, CITY OF	36059C0309F	23-JUL-1999	99-02-958A	02
02	NY	LYSANDER, TOWN OF	3605830015B	28-JUL-1999	99-02-870A	02
02	NY	MAMARONECK, VILLAGE OF	3609160002D	12-NOV-1999	99-02-1282A	02
02	NY	MILO, TOWN OF	360961C	03-DEC-1999	99-02-1408A	02
02	NY	MOUNT KISCO, VILLAGE OF	3609180001B	08-JUL-1999	99-02-760A	02
02	NY	NEW YORK, CITY OF	3604970076C	17-SEP-1999	99-02-1310A	02
02	NY	NEW YORK, CITY OF	3604970082C	17-DEC-1999	00-02-0232A	02
02	NY	NEW YORK, CITY OF	3604970082C	03-DEC-1999	99-02-1164A	02
02	NY	NEW YORK, CITY OF	3604970082C	08-OCT-1999	99-02-1004A	02
02	NY	NEW YORK, CITY OF	3604970082C	21-JUL-1999	99-02-904A	02
02	NY	NEW YORK, CITY OF	3604970092C	10-SEP-1999	99-02-1112A	02
02	NY	NEW YORK, CITY OF	3604970092C	20-JUL-1999	99-02-754A	02
02	NY	NEW YORK, CITY OF	3604970092C	08-SEP-1999	99-02-716A	02
02	NY	NEW YORK, CITY OF	3604970092C	13-AUG-1999	99-02-714A	02
02	NY	NEW YORK, CITY OF	3604970107B	30-JUL-1999	99-02-620A	02
02	NY	NEW YORK, CITY OF	3604970114D	22-SEP-1999	99-02-1020A	02
02	NY	NEW YORK, CITY OF	3604970114D	08-JUL-1999	99-02-818A	02
02	NY	NEW YORK, CITY OF	3604970114D	05-NOV-1999	99-02-752A	02
02	NY	NEW YORK, CITY OF	3604970115B	13-OCT-1999	99-02-1240A	02
02	NY	NEW YORK, CITY OF	3604970115B	30-JUL-1999	99-02-926A	02
02	NY	NEW YORK, CITY OF	3604970125D	29-SEP-1999	99-02-1124A	02
02	NY	NEW YORK, CITY OF	3604970125D	27-AUG-1999	99-02-1038A	02
02	NY	NEW YORK, CITY OF	3604970126B	06-OCT-1999	99-02-1348A	02
02	NY	NEW YORK, CITY OF	3604970127C	23-JUL-1999	99-02-848A	02
02	NY	NEW YORK, CITY OF	3604970128D	22-OCT-1999	99-02-920A	02
02	NY	NEW YORK, CITY OF	3604970131C	13-AUG-1999	99-02-908A	02
02	NY	NEWSTEAD, TOWN OF	3602510020D	23-NOV-1999	99-02-1154A	02
02	NY	NORWICH, TOWN OF	3601620012B	29-OCT-1999	99-02-1290A	01
02	NY	OLIVE, TOWN OF	3608600025B	17-NOV-1999	99-02-1174A	02
02	NY	OSWEGO, CITY OF	3606560004D	30-JUL-1999	99-02-035P	05
02	NY	OWEGO, TOWN OF	3608390030C	08-DEC-1999	00-02-0094A	02
02	NY	OYSTER BAY, TOWN OF	36059C0039F	06-OCT-1999	99-02-1088A	02
02	NY	PHILIPSTOWN,TOWN OF	3610260001B	04-AUG-1999	99-02-626A	02
02	NY	PLEASANT VALLEY, TOWN OF	3602210015B	21-JUL-1999	99-02-946A	02
02	NY	PORT JERVIS, CITY OF	3609760001B	06-OCT-1999	99-02-734A	02
02	NY	POUGHKEEPSIE, TOWN OF	3611420001C	10-SEP-1999	99-02-1376V	19
02	NY	POUGHKEEPSIE, TOWN OF	3611420015B	16-JUL-1999	99-02-686A	17
02	NY	PREBLE, TOWN OF	360185B	06-AUG-1999	99-02-838A	02
02	NY	PUTNAM, TOWN OF	3612360005B	01-SEP-1999	99-02-1104A	02
02	NY	RED HOOK, TOWN OF	3611430027B	30-JUL-1999	99-02-748A	02
02	NY	RIVERHEAD, TOWN OF	36103C0479G	23-JUL-1999	99-02-894A	02
02	NY	ROME, CITY OF	3605420009C	22-DEC-1999	00-02-0242X	02
02	NY	ROME, CITY OF	3605420009C	03-NOV-1999	99-02-640A	02
02	NY	ROTTERDAM, TOWN OF	3607400004B	27-OCT-1999	99-02-1196A	02
02	NY	ROTTERDAM, TOWN OF	3607400012B	03-DEC-1999	00-02-0084A	02
02	NY	ROTTERDAM, TOWN OF	3607400012B	29-OCT-1999	99-02-1140A	02
02	NY	ROTTERDAM, TOWN OF	3607400012B	12-AUG-1999	99-02-832A	02
02	NY	SALINA, TOWN OF	3605910007A	16-JUL-1999	99-02-938A	02
02	NY	SARDINIA, TOWN OF	3602560010B	29-DEC-1999	00-02-0152A	02
02	NY	SCRIBA, TOWN OF	3606630010B	20-OCT-1999	99-02-802A	01
02	NY	SLOATSBURG, VILLAGE OF	3606900001C	01-DEC-1999	99-02-009P	05
02	NY	SMITHFIELD, TOWN OF	361294B	19-NOV-1999	99-02-1058A	02
02	NY	SOUTHAMPTON, TOWN OF	36103C0537G	27-OCT-1999	99-02-1138A	02
02	NY	SOUTHAMPTON, TOWN OF	36103C0762G	08-SEP-1999	99-02-1076A	02
02	NY	SOUTHOLD,TOWN OF	36103C0158G	06-OCT-1999	99-02-770A	02
02	NY	SPENCERPORT, VILLAGE OF	3604330005B	22-SEP-1999	99-02-1096A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
02	NY	STILLWATER, VILLAGE OF	36091C0584E	08-OCT-1999	99-02-912A	02
02	NY	STONY POINT, TOWN OF	3606930007C	22-SEP-1999	99-02-1122A	02
02	NY	STONY POINT, TOWN OF	3606930011C	22-OCT-1999	99-02-1264A	02
02	NY	SUFFERN, VILLAGE OF	3606940001B	27-OCT-1999	99-02-1156A	01
02	NY	TROY, CITY OF	3606770002B	10-DEC-1999	00-02-0042A	02
02	NY	TROY, CITY OF	3606770003B	29-SEP-1999	99-02-1106A	02
02	NY	WALLKILL, TOWN OF	3606340020B	17-NOV-1999	00-02-0074A	02
02	NY	WAPPINGER, TOWN OF	3613870015A	03-SEP-1999	99-02-1108A	02
02	NY	WARWICK, VILLAGE OF	3606370001C	19-OCT-1999	00-02-0044A	02
02	NY	WARWICK, VILLAGE OF	3606370001C	25-AUG-1999	99-02-664A	02
02	NY	WELLSVILLE, VILLAGE OF	3600360001B	28-JUL-1999	99-02-746A	02
02	NY	WHEATFIELD, TOWN OF	3605130004D	23-NOV-1999	00-02-0126A	02
02	NY	WHEATFIELD, TOWN OF	3605130007D	17-DEC-1999	00-02-0060A	02
02	NY	WILSON, TOWN OF	3605140020C	04-AUG-1999	99-02-1084A	01
02	NY	YONKERS, CITY OF	3609360005C	17-DEC-1999	00-02-0200A	02
02	NY	YONKERS, CITY OF	3609360010C	29-DEC-1999	00-02-0286A	02
02	NY	YORKTOWN, TOWN OF	3609370012C	08-SEP-1999	99-02-1110A	02
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000192C	14-JUL-1999	99-02-764A	01
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000040E	13-OCT-1999	99-02-014A	01
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000045E	18-NOV-1999	00-02-0136A	02
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000046D	18-AUG-1999	99-02-856A	01
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000047E	19-NOV-1999	99-02-028A	02
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000049C	20-AUG-1999	99-02-964A	02
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000058D	10-DEC-1999	99-02-030A	01
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000065F	10-AUG-1999	99-02-504A	01
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000114B	08-SEP-1999	99-02-936A	02
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000134E	03-NOV-1999	99-02-024A	01
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000175B	18-NOV-1999	98-02-059P	05
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000219C	29-SEP-1999	99-02-1082A	01
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000219C	20-AUG-1999	99-02-784A	01
02	PR	PUERTO RICO, COMMONWEALTH OF	7200000224B	22-OCT-1999	99-02-026A	01
03	DE	DOVER, CITY OF	1000060005C	27-OCT-1999	00-03-0018A	02
03	DE	DOVER, CITY OF	1000060005C	25-AUG-1999	99-03-1374A	02
03	DE	DOVER, CITY OF	1000060005C	16-JUL-1999	99-03-1008A	02
03	DE	ELSMERE, TOWN OF	10003C0152F	17-DEC-1999	00-03-0152A	02
03	DE	KENT COUNTY *	1000010075B	03-NOV-1999	99-03-1564A	02
03	DE	KENT COUNTY *	1000010075B	29-OCT-1999	99-03-1392A	02
03	DE	KENT COUNTY *	1000010075B	20-AUG-1999	99-03-1146A	02
03	DE	KENT COUNTY *	1000010075B	21-JUL-1999	99-03-970A	02
03	DE	KENT COUNTY *	1000010075B	30-JUL-1999	99-03-612A	02
03	DE	KENT COUNTY *	1000010080B	22-DEC-1999	00-03-0024A	02
03	DE	KENT COUNTY *	1000010090B	28-JUL-1999	98-03-1834A	02
03	DE	KENT COUNTY *	1000010130C	08-DEC-1999	00-03-0184A	02
03	DE	KENT COUNTY *	1000010130C	17-SEP-1999	99-03-822A	02
03	DE	KENT COUNTY *	1000010200B	15-OCT-1999	99-03-1534A	02
03	DE	NEW CASTLE COUNTY *	10003C0060F	21-JUL-1999	99-03-1098A	02
03	DE	NEW CASTLE COUNTY *	10003C0069F	16-JUL-1999	99-03-824A	02
03	DE	NEW CASTLE COUNTY *	10003C0145F	06-OCT-1999	99-03-1660A	17
03	DE	NEW CASTLE COUNTY *	10003C0230F	20-AUG-1999	99-03-1234A	02
03	DE	SELBYVILLE, TOWN OF	10005C0629F	17-NOV-1999	00-03-0090A	02
03	DE	SUSSEX COUNTY*	10005C0100F	05-OCT-1999	99-03-1770A	02
03	DE	SUSSEX COUNTY*	10005C0250F	12-NOV-1999	99-03-1496A	02
03	DE	SUSSEX COUNTY*	10005C0250F	06-JUL-1999	99-03-996A	02
03	DE	SUSSEX COUNTY*	10005C0355G	17-SEP-1999	99-03-1346A	01
03	DE	SUSSEX COUNTY*	10005C0355G	18-AUG-1999	99-03-1354A	02
03	DE	SUSSEX COUNTY*	10005C0505F	13-AUG-1999	99-03-1320A	02
03	DE	WILMINGTON, CITY OF	10003C0068F	12-NOV-1999	99-03-1572A	02
03	MD	ANNE ARUNDEL COUNTY *	2400080006C	30-JUL-1999	99-03-1262A	02
03	MD	ANNE ARUNDEL COUNTY *	2400080044D	20-OCT-1999	99-03-1172A	01
03	MD	ANNE ARUNDEL COUNTY *	2400080047C	01-OCT-1999	99-03-1276A	02
03	MD	BALTIMORE COUNTY*	2400100025B	14-AUG-1999	99-03-1094A	02
03	MD	BALTIMORE COUNTY*	2400100220C	20-DEC-1999	00-02	02
03	MD	BALTIMORE COUNTY*	2400100220C	20-DEC-1999	00-02	02
03	MD	BALTIMORE COUNTY*	2400100245E	06-OCT-1999	99-03-1780A	17
03	MD	BALTIMORE COUNTY*	2400100255B	22-OCT-1999	99-03-1584A	02
03	MD	BALTIMORE COUNTY*	2400100255B	23-JUL-1999	99-03-994A	02
03	MD	BALTIMORE COUNTY*	2400100290B	13-OCT-1999	99-03-918A	02
03	MD	BALTIMORE COUNTY*	2400100295B	06-OCT-1999	99-03-992A	02
03	MD	BALTIMORE COUNTY*	2400100360B	29-SEP-1999	99-03-1252A	02
03	MD	BALTIMORE COUNTY*	2400100370B	22-SEP-1999	99-03-1592A	02
03	MD	BALTIMORE COUNTY*	2400100430B	30-JUL-1999	99-03-1142A	02
03	MD	BALTIMORE COUNTY*	2400100435B	28-JUL-1999	99-03-656A	02
03	MD	BALTIMORE COUNTY*	2400100440C	22-DEC-1999	99-03-1826A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
03	MD	BALTIMORE COUNTY*	2400100445C	27-OCT-1999	99-03-1650A	02
03	MD	BALTIMORE COUNTY*	2400100445C	10-SEP-1999	99-03-1506A	02
03	MD	BALTIMORE COUNTY*	2400100505B	08-SEP-1999	99-03-1274A	02
03	MD	CAROLINE COUNTY *	2401300165B	08-OCT-1999	99-03-1398A	02
03	MD	CARROLL COUNTY *	2400150050B	24-NOV-1999	00-03-0140A	02
03	MD	CARROLL COUNTY *	2400150075B	12-NOV-1999	99-03-1658A	02
03	MD	CECIL COUNTY*	2400190054A	22-OCT-1999	99-03-1358A	02
03	MD	CECIL COUNTY*	2400190057A	17-DEC-1999	99-03-1418A	02
03	MD	CHARLES COUNTY *	2400890035B	08-DEC-1999	99-03-1850A	02
03	MD	DORCHESTER COUNTY *	2400260200A	24-NOV-1999	00-03-0178A	02
03	MD	DORCHESTER COUNTY *	2400260475A	08-DEC-1999	00-03-0176A	02
03	MD	FREDERICK COUNTY *	2400270115B	29-DEC-1999	00-03-0128A	02
03	MD	FREDERICK COUNTY *	2400270115B	02-SEP-1999	99-03-1400A	02
03	MD	FREDERICK COUNTY *	2400270115B	30-JUL-1999	99-03-1156A	02
03	MD	FREDERICK, CITY OF	2400300003C	10-OCT-1999	99-03-1280A	02
03	MD	HOWARD COUNTY*	2400440016B	14-OCT-1999	99-03-173P	05
03	MD	HOWARD COUNTY*	2400440034B	31-AUG-1999	99-03-1366A	02
03	MD	KENT COUNTY *	2400450030B	24-NOV-1999	00-03-0148A	02
03	MD	KENT COUNTY *	2400450035B	15-DEC-1999	00-03-0504X	02
03	MD	KENT COUNTY *	2400450035B	03-SEP-1999	99-03-1352A	02
03	MD	LAUREL, CITY OF	2400530001D	29-DEC-1999	00-03-0160A	02
03	MD	QUEEN ANNES COUNTY	2400540045B	28-JUL-1999	99-03-1210A	01
03	MD	QUEEN ANNES COUNTY	2400540046C	18-AUG-1999	99-03-1180A	02
03	MD	QUEEN ANNES COUNTY	2400540047B	06-OCT-1999	99-03-1456A	02
03	MD	QUEEN ANNES COUNTY	2400540052B	10-SEP-1999	99-03-1548A	02
03	MD	ST. MARYS COUNTY*	2400640041D	12-NOV-1999	99-03-1590A	02
03	MD	TALBOT COUNTY *	2400660032A	25-AUG-1999	99-03-1318A	02
03	MD	TALBOT COUNTY *	2400660037A	11-AUG-1999	99-03-1218A	02
03	MD	TALBOT COUNTY *	2400660038A	03-DEC-1999	00-03-0146A	02
03	MD	WASHINGTON COUNTY *	2400700025A	22-OCT-1999	99-03-1310A	02
03	MD	WORCESTER COUNTY *	2400830075A	06-JUL-1999	99-03-974A	02
03	MD	WORCESTER COUNTY *	2400830105D	29-DEC-1999	99-03-1788A	02
03	PA	AMELL, TOWNSHIP OF	4226150015B	04-AUG-1999	99-03-908A	02
03	PA	ANNVILLE, TOWNSHIP OF	4205700001B	16-SEP-1999	99-03-1338A	17
03	PA	BRISTOL, TOWNSHIP OF	42017C0462F	22-OCT-1999	99-03-1846A	02
03	PA	BROOKHAVEN, BOROUGH OF	42045C0057D	28-OCT-1999	99-03-167P	05
03	PA	BUTLER, TOWNSHIP OF	421247A	22-SEP-1999	99-03-1152A	02
03	PA	CALN, TOWNSHIP OF	42029C0307D	16-JUL-1999	99-03-1090A	02
03	PA	CHESTNUTHILL, TOWNSHIP OF	4218850015B	09-JUL-1999	99-03-1182A	02
03	PA	CHOCONUT, TOWNSHIP OF	4220760005A	08-OCT-1999	99-03-1432A	02
03	PA	COLLEGEVILLE, BOROUGH OF	42091C0237E	29-DEC-1999	00-03-0350A	02
03	PA	CONEMAUGH, TOWNSHIP OF	4220470005A	12-NOV-1999	99-03-1184A	02
03	PA	CONEMAUGH, TOWNSHIP OF	4220470005A	04-AUG-1999	99-03-1136A	02
03	PA	CONEWAGO, TOWNSHIP OF	4209180015B	19-NOV-1999	99-03-1570A	02
03	PA	CRANBERRY, TOWNSHIP OF	4212170010B	29-DEC-1999	00-03-0362A	02
03	PA	CRANBERRY, TOWNSHIP OF	4212170010B	09-JUL-1999	99-03-1256A	02
03	PA	CUMRU, TOWNSHIP OF	42011C0511E	19-OCT-1999	99-03-1408A	01
03	PA	EAST BRANDYWINE, TOWNSHIP OF	42029C0167D	15-DEC-1999	99-03-1594A	02
03	PA	EAST CHILLISQUAQUE, TOWNSHIP OF	4225990005A	15-SEP-1999	99-03-1404A	02
03	PA	EAST COVENTRY, TOWNSHIP OF	42029C0060D	23-JUL-1999	99-03-1278A	02
03	PA	EAST WHITELAND, TOWNSHIP OF	42029C0216D	29-OCT-1999	99-03-1672A	02
03	PA	FALLS, TOWNSHIP OF	42017C0458F	12-NOV-1999	99-03-1822A	02
03	PA	FALLS, TOWNSHIP OF	42017C0458F	22-OCT-1999	99-03-1654A	02
03	PA	FALLS, TOWNSHIP OF	42017C0461F	29-SEP-1999	99-03-1610A	02
03	PA	FERGUSON, TOWNSHIP OF	4202600010C	15-DEC-1999	00-03-0104A	02
03	PA	HAMILTON, TOWNSHIP OF	4218880010A	20-AUG-1999	99-03-1130A	02
03	PA	HARMONY, BOROUGH OF	4202170001B	15-OCT-1999	99-03-1804A	02
03	PA	HARMONY, BOROUGH OF	4202170001B	12-NOV-1999	99-03-1602A	02
03	PA	HEIDELBERG, TOWNSHIP OF	4210250006C	10-NOV-1999	98-03-247P	05
03	PA	HELLAM, TOWNSHIP OF	4209270001D	23-SEP-1999	99-03-1574V	19
03	PA	JACKSON, TOWNSHIP OF	4214200002A	28-JUL-1999	99-03-1154A	02
03	PA	JOHNSTOWN, CITY OF	4202310005C	10-DEC-1999	99-03-1776A	02
03	PA	JOHNSTOWN, CITY OF	4202310010C	29-JUL-1999	99-03-1196A	02
03	PA	LAWRENCE, TOWNSHIP OF	4215280020B	19-NOV-1999	99-03-1382A	02
03	PA	LOWER FREDERICK, TOWNSHIP OF	42091C0113E	06-AUG-1999	99-03-884A	02
03	PA	LOWER MAKEFIELD, TOWNSHIP OF	42017C0452F	14-JUL-1999	99-03-1076A	02
03	PA	LOWER MERION, TOWNSHIP OF	42091C0362E	04-AUG-1999	99-03-1144A	02
03	PA	LOWER MERION, TOWNSHIP OF	42091C0432E	28-JUL-1999	98-03-171P	05
03	PA	LOWER PAXTON, TOWNSHIP OF	4203840005B	12-NOV-1999	99-03-1806A	02
03	PA	LOWER SOUTHAMPTON, TOWNSHIP OF	42017C0437F	15-NOV-1999	99-03-185P	06
03	PA	MAIDENCREEK, TOWNSHIP OF	42011C0359E	29-OCT-1999	99-03-1632A	02
03	PA	MAIDENCREEK, TOWNSHIP OF	42011C0359E	29-JUL-1999	99-03-003P	05
03	PA	MARION, TOWNSHIP OF	42011C0460E	16-DEC-1999	99-03-1516A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
03	PA	MARSHALL, TOWNSHIP OF	42003C0177F	17-SEP-1999	99-03-976A	02
03	PA	MIFFLINBURG, BOROUGHS OF	4208320001B	22-OCT-1999	99-03-1652A	02
03	PA	MT. PLEASANT, TOWNSHIP OF	42129C0635D	18-AUG-1999	99-25	02
03	PA	NEW FREEDOM, BOROUGH OF	4209320001B	30-SEP-1999	99-03-1342A	02
03	PA	NEWTOWN, TOWNSHIP OF	42017C0433F	02-DEC-1999	99-27	02
03	PA	NORTH LONDONDERRY, TOWNSHIP OF	4205770005B	22-SEP-1999	98-03-281P	06
03	PA	NORTH MANHEIM, TOWNSHIP OF	4220130008B	27-AUG-1999	99-03-1314A	02
03	PA	NORTH UNION, TOWNSHIP OF	4216330006B	15-DEC-1999	00-03-0004A	02
03	PA	NORTH WHITEHALL, TOWNSHIP OF	4218130010B	03-DEC-1999	00-01	02
03	PA	OLD FORGE, BOROUGH OF	4205350005B	27-OCT-1999	98-03-213P	06
03	PA	PARKSIDE, BOROUGH OF	42045C0057D	28-OCT-1999	99-03-167P	05
03	PA	PENN, TOWNSHIP OF	4210250006C	10-NOV-1999	98-03-247P	05
03	PA	PENN, TOWNSHIP OF	42129C0189D	29-SEP-1999	99-03-1340A	02
03	PA	PERKASIE, BOROUGH OF	42017C0143F	19-NOV-1999	00-03-0012A	02
03	PA	PHILADELPHIA, CITY OF	4207570183F	28-JUL-1999	99-03-1212A	02
03	PA	PICTURE ROCKS, BOROUGH OF	4206540001B	24-SEP-1999	99-03-1494A	02
03	PA	PIKE, TOWNSHIP OF	42011C0411E	15-JUL-1999	R3-218-70R	02
03	PA	RADNOR, TOWNSHIP OF	42045C0002D	14-JUL-1999	99-03-1176A	02
03	PA	RADNOR, TOWNSHIP OF	42045C0008D	22-SEP-1999	99-03-1540A	02
03	PA	READING, CITY OF	42011C0512E	01-DEC-1999	99-03-1668A	02
03	PA	ROSS, TOWNSHIP OF	42003C0192F	23-JUL-1999	99-03-840A	02
03	PA	ROSS, TOWNSHIP OF	42003C0211F	18-AUG-1999	99-03-1150A	02
03	PA	RUSCOMBMANOR, TOWNSHIP OF	42011C0378E	29-OCT-1999	99-03-1616A	02
03	PA	RUSH, TOWNSHIP OF	4214680015B	24-NOV-1999	99-03-012A	01
03	PA	SALFORD, TOWNSHIP OF	42091C0128E	27-OCT-1999	99-03-1812A	02
03	PA	SILVER LAKE, TOWNSHIP OF	422091A	22-DEC-1999	00-03-0574A	02
03	PA	SILVER SPRING, TOWNSHIP OF	4203700010B	28-NOV-1999	99-03-053P	05
03	PA	SKIPPACK, TOWNSHIP OF	42091C0232E	08-OCT-1999	99-03-1532A	01
03	PA	SPRING, TOWNSHIP OF	42011C0491E	16-NOV-1999	99-03-1238A	02
03	PA	SPRINGFIELD, TOWNSHIP OF	42017C0107F	15-OCT-1999	99-03-1472A	02
03	PA	SPRINGFIELD, TOWNSHIP OF	42091C0379E	29-SEP-1999	99-03-1554A	02
03	PA	SPRINGFIELD, TOWNSHIP OF	42091C0379E	12-NOV-1999	99-03-1556A	02
03	PA	TAYLOR, TOWNSHIP OF	421469B	14-JUL-1999	99-03-616A	02
03	PA	TAYLOR, TOWNSHIP OF	421800A	17-DEC-1999	00-03-0306A	02
03	PA	TULPEHOCKEN, TOWNSHIP OF	42011C0315E	12-NOV-1999	99-03-1530A	02
03	PA	TUSCARORA, TOWNSHIP OF	4224520010B	06-OCT-1999	99-03-1694A	02
03	PA	UPPER DARBY, TOWNSHIP OF	42045C0025D	22-SEP-1999	99-03-1138A	02
03	PA	UPPER MAKEFIELD, TOWNSHIP OF	42017C0330F	25-AUG-1999	99-03-085P	05
03	PA	UWCHLAN, TOWNSHIP OF	42029C0187D	15-JUL-1999	99-03-364A	02
03	PA	WARRINGTON, TOWNSHIP OF	42017C0382F	21-JUL-1999	99-03-1326A	02
03	PA	WASHINGTON, TOWNSHIP OF	4211500020B	06-OCT-1999	99-03-1394A	02
03	PA	WASHINGTON, TOWNSHIP OF	4218160005A	29-SEP-1999	99-03-1490A	02
03	PA	WASHINGTON, TOWNSHIP OF	4225060005A	27-AUG-1999	99-03-1248A	02
03	PA	WEST BRADFORD, TOWNSHIP OF	42029C0328D	09-JUL-1999	99-03-880A	02
03	PA	WEST BRADFORD, TOWNSHIP OF	42029C0331D	14-JUL-1999	99-03-1164A	02
03	PA	WEST WHITELAND, TOWNSHIP OF	42029C0213D	08-DEC-1999	99-03-1510A	02
03	PA	WESTTOWN, TOWNSHIP OF	42029C0362D	22-SEP-1999	99-03-1498A	02
03	VA	ALEXANDRIA, CITY OF	5155190005D	08-OCT-1999	99-03-1768A	02
03	VA	ALEXANDRIA, CITY OF	5155190005D	22-SEP-1999	99-03-1542A	02
03	VA	ARLINGTON COUNTY *	5155200010B	12-NOV-1999	99-03-1802A	02
03	VA	AUGUSTA COUNTY *	5100130205B	22-DEC-1999	00-03-0572X	02
03	VA	AUGUSTA COUNTY *	5100130205B	20-OCT-1999	99-03-1304A	02
03	VA	AUGUSTA COUNTY *	5100130270B	08-JUL-1999	99-03-1224A	02
03	VA	BEDFORD COUNTY *	5100160100A	29-OCT-1999	99-03-1578A	02
03	VA	BEDFORD COUNTY *	5100160175A	03-DEC-1999	00-03-0164A	02
03	VA	BRISTOL, CITY OF	5100220004C	16-JUL-1999	99-03-1020A	01
03	VA	CHESAPEAKE, CITY OF	510034B	23-JUL-1999	99-03-920A	02
03	VA	CHESAPEAKE, CITY OF	5100340022C	21-JUL-1999	99-03-1246A	02
03	VA	CHESAPEAKE, CITY OF	5100340013C	10-NOV-1999	00-03-0092A	02
03	VA	CHESAPEAKE, CITY OF	5100340022C	14-DEC-1999	99-03-1904A	02
03	VA	CHESAPEAKE, CITY OF	5100340022C	29-OCT-1999	99-03-1604A	02
03	VA	CHESAPEAKE, CITY OF	5100340022C	29-SEP-1999	99-03-1558A	02
03	VA	CHESAPEAKE, CITY OF	5100340024C	06-OCT-1999	99-03-1786A	02
03	VA	CHESAPEAKE, CITY OF	5100340033C	07-SEP-1999	99-03-1454A	01
03	VA	CHESAPEAKE, CITY OF	5100340033C	25-AUG-1999	99-03-1380A	01
03	VA	CHESTERFIELD COUNTY *	5100350031B	06-AUG-1999	99-03-458A	02
03	VA	CHESTERFIELD COUNTY *	5100350093C	06-OCT-1999	99-03-1778A	01
03	VA	CRAIGSVILLE, TOWN OF	5100140001C	13-OCT-1999	99-03-1282A	02
03	VA	ELKTON, TOWN OF	5101370001C	25-AUG-1999	99-03-1370A	02
03	VA	FAIRFAX COUNTY *	5155250025D	27-OCT-1999	99-03-1684A	02
03	VA	FAIRFAX COUNTY *	5155250025D	27-OCT-1999	99-03-1682A	02
03	VA	FAIRFAX COUNTY *	5155250025D	08-DEC-1999	99-03-1484A	02
03	VA	FAIRFAX COUNTY *	5155250050D	09-JUL-1999	99-03-978A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
03	VA	FAIRFAX COUNTY *	5155250083D	09-JUL-1999	99-03-978A	02
03	VA	FAIRFAX COUNTY *	5155250100D	09-JUL-1999	99-03-978A	02
03	VA	FAIRFAX COUNTY *	5155250050D	08-DEC-1999	00-03-0106A	02
03	VA	FAIRFAX COUNTY *	5155250050D	01-DEC-1999	99-03-1852A	02
03	VA	FAIRFAX COUNTY *	5155250050D	08-OCT-1999	99-03-1518A	02
03	VA	FAIRFAX COUNTY *	5155250050D	18-AUG-1999	99-03-1378A	02
03	VA	FAIRFAX COUNTY *	5155250050D	14-JUL-1999	99-03-1228A	02
03	VA	FAIRFAX COUNTY *	5155250050D	14-JUL-1999	99-03-1232A	02
03	VA	FAIRFAX COUNTY *	5155250075D	23-JUL-1999	99-03-1268A	02
03	VA	FAIRFAX COUNTY *	5155250079D	30-NOV-1999	99-03-1486P	06
03	VA	FAIRFAX COUNTY *	5155250083D	09-JUL-1999	99-03-1158A	02
03	VA	FAIRFAX COUNTY *	5155250089D	30-JUL-1999	99-03-1124A	02
03	VA	FAIRFAX COUNTY *	5155250100D	22-DEC-1999	00-03-0606X	02
03	VA	FAIRFAX COUNTY *	5155250100D	23-NOV-1999	00-03-0344A	02
03	VA	FAIRFAX COUNTY *	5155250100D	12-NOV-1999	99-03-1820A	02
03	VA	FAIRFAX COUNTY *	5155250100D	03-DEC-1999	99-03-1774A	02
03	VA	FAIRFAX COUNTY *	5155250100D	29-SEP-1999	99-03-1600A	02
03	VA	FAIRFAX COUNTY *	5155250100D	29-SEP-1999	99-03-1482A	02
03	VA	FAIRFAX COUNTY *	5155250100D	08-SEP-1999	99-03-1476A	02
03	VA	FAIRFAX COUNTY *	5155250117D	18-AUG-1999	99-03-1296A	02
03	VA	FAIRFAX COUNTY *	5155250125D	20-AUG-1999	99-03-1420A	02
03	VA	FAIRFAX COUNTY *	5155250150D	06-OCT-1999	99-03-1696A	02
03	VA	FAIRFAX COUNTY *	5155250150D	10-SEP-1999	99-03-1364A	02
03	VA	FAUQUIER COUNTY *	5100550475A	22-SEP-1999	99-03-916A	02
03	VA	FRANKLIN COUNTY *	5100610210A	29-SEP-1999	99-03-1674A	02
03	VA	FRANKLIN COUNTY *	5100610210A	23-JUL-1999	99-03-1258A	02
03	VA	FRANKLIN COUNTY *	5100610215A	12-NOV-1999	99-03-1808A	02
03	VA	FRANKLIN COUNTY *	5100610220A	29-DEC-1999	00-03-0316A	02
03	VA	FRANKLIN COUNTY *	5100610220A	01-OCT-1999	99-03-1560A	02
03	VA	FRANKLIN COUNTY *	5100610220A	22-SEP-1999	99-03-1372A	02
03	VA	GLOUCESTER COUNTY*	5100710025B	21-JUL-1999	99-24	02
03	VA	GLOUCESTER COUNTY*	5100710060B	14-JUL-1999	99-03-1198A	02
03	VA	GREENSVILLE COUNTY *	5100730050A	10-SEP-1999	99-03-1428A	02
03	VA	HANOVER COUNTY *	5102370320A	12-NOV-1999	99-03-1070A	01
03	VA	HANOVER COUNTY *	5102370435A	06-OCT-1999	99-03-1692A	02
03	VA	HENRICO COUNTY *	5100770025B	03-DEC-1999	00-03-0134A	02
03	VA	HENRICO COUNTY *	5100770025B	22-OCT-1999	99-03-1814A	02
03	VA	HENRICO COUNTY *	5100770025B	27-OCT-1999	99-03-1782A	02
03	VA	HENRICO COUNTY *	5100770025B	25-AUG-1999	99-03-1512A	02
03	VA	HENRICO COUNTY *	5100770025B	22-SEP-1999	99-03-1388A	02
03	VA	HENRICO COUNTY *	5100770025B	19-NOV-1999	99-03-1344A	02
03	VA	HENRICO COUNTY *	5100770025B	20-OCT-1999	99-03-1330A	02
03	VA	HENRICO COUNTY *	5100770025B	15-JUL-1999	99-03-1168A	01
03	VA	HENRICO COUNTY *	5100770025B	27-AUG-1999	99-03-1088A	02
03	VA	HENRICO COUNTY *	5100770025B	16-JUL-1999	99-03-898A	02
03	VA	HENRICO COUNTY *	5100770025B	03-SEP-1999	99-03-800A	02
03	VA	HENRICO COUNTY *	5100770025B	22-SEP-1999	99-03-798A	02
03	VA	HENRICO COUNTY *	5100770025B	03-SEP-1999	99-03-758A	02
03	VA	HENRICO COUNTY *	5100770025B	23-JUL-1999	99-03-728A	02
03	VA	HENRICO COUNTY *	5100770025B	30-JUL-1999	99-03-676A	02
03	VA	HENRICO COUNTY *	5100770025B	29-JUL-1999	99-03-668A	02
03	VA	HENRICO COUNTY *	5100770050B	17-NOV-1999	99-03-1678A	02
03	VA	KING GEORGE COUNTY *	5103120015B	04-AUG-1999	99-03-1272A	02
03	VA	LANCASTER COUNTY*	5100840039B	03-SEP-1999	99-03-1438A	02
03	VA	LEESBURG, TOWN OF	5100900085C	19-NOV-1999	99-03-099P	05
03	VA	LOUDOUN COUNTY *	5100900085C	12-AUG-1999	99-03-1430A	01
03	VA	LOUDOUN COUNTY *	5100900110C	22-DEC-1999	00-03-013P	05
03	VA	LOUDOUN COUNTY *	5100900120C	29-DEC-1999	99-03-1800A	02
03	VA	LOUDOUN COUNTY *	5100900120C	28-JUL-1999	99-03-1350A	02
03	VA	LOUDOUN COUNTY *	5100900120C	25-SEP-1999	99-03-083P	05
03	VA	LOUDOUN COUNTY *	5100900175C	22-DEC-1999	00-03-011P	05
03	VA	LOUDOUN COUNTY *	5100900200C	17-SEP-1999	99-03-1072A	02
03	VA	LOUISA COUNTY *	51109C0025B	08-DEC-1999	00-03-0122A	02
03	VA	LOUISA COUNTY *	51109C0125B	27-OCT-1999	99-03-1784A	02
03	VA	LOUISA COUNTY *	51109C0125B	20-OCT-1999	99-03-1644A	02
03	VA	LOUISA COUNTY *	51109C0175B	22-SEP-1999	99-03-1508A	02
03	VA	LOUISA COUNTY *	51109C0200B	10-NOV-1999	99-03-1586A	02
03	VA	LOUISA COUNTY *	51109C0400B	16-DEC-1999	99-03-1160A	02
03	VA	MECKLENBURG COUNTY *	5101890200A	17-DEC-1999	00-03-0366A	02
03	VA	MIDDLESEX COUNTY *	5100980025B	21-JUL-1999	99-03-1334A	02
03	VA	NEW KENT COUNTY *	5103060020A	28-SEP-1999	99-03-1332A	02
03	VA	NEWPORT NEWS, CITY OF	5101030006C	09-JUL-1999	99-03-1148A	02
03	VA	NEWPORT NEWS, CITY OF	5101030007A	21-DEC-1999	99-03-1290A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
03	VA	NEWPORT NEWS, CITY OF	5101030010C	24-SEP-1999	99-03-1416A	02
03	VA	NEWPORT NEWS, CITY OF	5101030016C	10-NOV-1999	99-03-006A	01
03	VA	NORTHUMBERLAND COUNTY *	5101070010C	27-OCT-1999	99-03-1810A	02
03	VA	PAGE COUNTY *	5101090100B	15-JUL-1999	99-03-1298A	02
03	VA	PEMBROKE, TOWN OF	5100690001B	06-AUG-1999	99-03-1206A	01
03	VA	PORTSMOUTH, CITY OF	5155290025B	17-DEC-1999	99-03-1450A	01
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	29-DEC-1999	00-03-0204A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	08-DEC-1999	00-03-0224A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	03-NOV-1999	00-03-0074A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	10-NOV-1999	00-03-0076A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	20-OCT-1999	99-03-1878A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	10-NOV-1999	99-03-1876A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	05-NOV-1999	99-03-1882A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	20-OCT-1999	99-03-1880A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	24-NOV-1999	99-03-1892A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	20-OCT-1999	99-03-1890A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	03-DEC-1999	99-03-1888A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	20-OCT-1999	99-03-1886A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	20-OCT-1999	99-03-1884A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	08-DEC-1999	99-03-1900A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	20-OCT-1999	99-03-1898A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	03-NOV-1999	99-03-1874A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	22-OCT-1999	99-03-1896A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	29-OCT-1999	99-03-1894A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0111D	15-OCT-1999	99-03-1766A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0112D	29-DEC-1999	00-03-0196A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0112D	29-DEC-1999	00-03-0200A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0112D	29-OCT-1999	00-03-0066A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0112D	03-NOV-1999	00-03-0064A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0112D	03-NOV-1999	00-03-0062A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0112D	17-NOV-1999	00-03-0022A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0112D	03-NOV-1999	00-03-0068A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0112D	05-NOV-1999	00-03-0086A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0113D	12-NOV-1999	00-03-0072A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0113D	05-NOV-1999	00-03-0070A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0113D	05-NOV-1999	00-03-0082A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0113D	10-NOV-1999	00-03-0078A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0113D	05-NOV-1999	00-03-0084A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0113D	05-NOV-1999	00-03-0080A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0170D	10-DEC-1999	00-03-0120A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0178D	27-OCT-1999	99-03-1848A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0194D	19-NOV-1999	99-03-1842A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	08-DEC-1999	00-03-0226A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	08-DEC-1999	00-03-0228A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	10-DEC-1999	00-03-0238A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	10-DEC-1999	00-03-0240A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	08-DEC-1999	00-03-0242A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	10-DEC-1999	00-03-0244A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	10-DEC-1999	00-03-0246A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	15-DEC-1999	00-03-0248A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	15-DEC-1999	00-03-0250A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	01-DEC-1999	00-03-0252A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	03-DEC-1999	00-03-0272A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	03-DEC-1999	00-03-0270A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	03-DEC-1999	00-03-0268A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	01-DEC-1999	00-03-0264A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	01-DEC-1999	00-03-0262A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	03-DEC-1999	00-03-0260A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	03-DEC-1999	00-03-0258A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	03-DEC-1999	00-03-0256A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	01-DEC-1999	00-03-0254A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	01-DEC-1999	00-03-0282A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	01-DEC-1999	00-03-0280A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	01-DEC-1999	00-03-0278A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	01-DEC-1999	00-03-0276A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	01-DEC-1999	00-03-0284A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	01-DEC-1999	00-03-0286A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0212D	22-DEC-1999	00-03-0290A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0216D	17-DEC-1999	00-03-0436A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0216D	17-DEC-1999	00-03-0434A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0216D	17-DEC-1999	00-03-0418A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0216D	29-DEC-1999	00-03-0206A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	10-DEC-1999	99-03-1866A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	01-OCT-1999	99-03-1720A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	06-OCT-1999	99-03-1722A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	06-OCT-1999	99-03-1724A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	08-OCT-1999	99-03-1726A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	06-OCT-1999	99-03-1728A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	13-OCT-1999	99-03-1730A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	13-OCT-1999	99-03-1732A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	15-OCT-1999	99-03-1738A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	15-OCT-1999	99-03-1740A	17
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	15-OCT-1999	99-03-1742A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	15-OCT-1999	99-03-1744A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	15-OCT-1999	99-03-1746A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	15-OCT-1999	99-03-1748A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	15-OCT-1999	99-03-1750A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	15-OCT-1999	99-03-1752A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	15-OCT-1999	99-03-1754A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	06-OCT-1999	99-03-1700A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	08-OCT-1999	99-03-1702A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	08-OCT-1999	99-03-1704A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	08-OCT-1999	99-03-1706A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	13-OCT-1999	99-03-1708A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	20-OCT-1999	99-03-1710A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	13-OCT-1999	99-03-1712A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	20-OCT-1999	99-03-1716A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	20-OCT-1999	99-03-1718A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0217D	29-SEP-1999	99-03-1288A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0218D	01-DEC-1999	99-03-1734A	01
03	VA	PRINCE WILLIAM COUNTY *	51153C0218D	01-DEC-1999	99-03-1736A	01
03	VA	PRINCE WILLIAM COUNTY *	51153C0219D	12-NOV-1999	00-03-0030A	17
03	VA	PRINCE WILLIAM COUNTY *	51153C0219D	13-OCT-1999	99-03-1756A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0219D	27-OCT-1999	99-03-1758A	17
03	VA	PRINCE WILLIAM COUNTY *	51153C0219D	13-OCT-1999	99-03-1760A	17
03	VA	PRINCE WILLIAM COUNTY *	51153C0219D	13-OCT-1999	99-03-1762A	17
03	VA	PRINCE WILLIAM COUNTY *	51153C0219D	13-OCT-1999	99-03-1764A	17
03	VA	PRINCE WILLIAM COUNTY *	51153C0238D	05-NOV-1999	99-03-1858A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0238D	19-NOV-1999	99-03-1862A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0238D	05-NOV-1999	99-03-1860A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0238D	24-NOV-1999	99-03-1870A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0238D	03-NOV-1999	99-03-1864A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0238D	27-OCT-1999	99-03-1856A	02
03	VA	PRINCE WILLIAM COUNTY *	51153C0238D	03-NOV-1999	99-03-1872A	02
03	VA	ROANOKE COUNTY *	51161C0022D	01-OCT-1999	99-03-1436A	02
03	VA	ROANOKE, CITY OF	51161C0046D	28-JUL-1999	99-03-1254A	02
03	VA	SALEM, CITY OF	51161C0037D	22-SEP-1999	99-03-1546A	02
03	VA	SALEM, CITY OF	51161C0037D	23-JUL-1999	99-03-748A	01
03	VA	SHENANDOAH COUNTY *	5101470025B	12-NOV-1999	99-03-1422A	02
03	VA	SHENANDOAH COUNTY *	5101470175B	05-NOV-1999	99-03-1402A	02
03	VA	STAUNTON, CITY OF	5101550001C	24-AUG-1999	99-03-1434A	02
03	VA	STAUNTON, CITY OF	5101550003C	29-OCT-1999	99-03-1816A	02
03	VA	SUFFOLK, CITY OF	5101560004B	15-OCT-1999	99-03-1480A	02
03	VA	VINTON, TOWN OF	51161C0046D	01-DEC-1999	99-03-1504A	02
03	VA	VIRGINIA BEACH, CITY OF	5155310012E	21-JUL-1999	99-03-1186A	02
03	VA	VIRGINIA BEACH, CITY OF	5155310021E	22-DEC-1999	00-03-0136A	02
03	VA	VIRGINIA BEACH, CITY OF	5155310025E	14-JUL-1999	99-03-1270A	02
03	VA	VIRGINIA BEACH, CITY OF	5155310027E	22-OCT-1999	99-03-1794A	02
03	VA	VIRGINIA BEACH, CITY OF	5155310027E	15-OCT-1999	99-03-1458A	02
03	VA	VIRGINIA BEACH, CITY OF	5155310042E	17-NOV-1999	99-03-1308A	01
03	VA	WAYNESBORO, CITY OF	5155320010B	22-SEP-1999	99-03-1502A	02
03	VA	WAYNESBORO, CITY OF	5155320010B	21-JUL-1999	99-03-1306A	02
03	VA	WESTMORELAND COUNTY *	5102500025C	03-DEC-1999	00-03-0170A	02
03	VA	WINCHESTER, CITY OF	5101730005B	13-AUG-1999	98-03-109P	06
03	VA	WISE COUNTY *	5101740082A	12-JUL-1999	R3-218-70R	02
03	VA	WOODSTOCK, TOWN OF	510150B	16-JUL-1999	99-03-1110A	02
03	WV	BELLE, TOWN OF	5400710001C	03-DEC-1999	99-03-1830A	02
03	WV	BERKELEY COUNTY *	5402820078C	10-NOV-1999	99-03-1638A	02
03	WV	CABELL COUNTY*	5400160031A	19-NOV-1999	99-03-1648A	02
03	WV	CLAY, COUNTY *	54015C0010B	20-AUG-1999	99-03-1384A	02
03	WV	DODDRIDGE COUNTY *	54017C0135B	15-DEC-1999	99-03-1834A	02
03	WV	FAYETTE COUNTY*	5400260052B	25-AUG-1999	99-03-870A	02
03	WV	JACKSON COUNTY *	5400630100B	17-DEC-1999	99-03-1200A	02
03	WV	KANAWHA COUNTY *	5400700104C	15-DEC-1999	99-03-1536A	02
03	WV	LOGAN COUNTY *	5455360143B	10-SEP-1999	99-03-1550A	02
03	WV	MATEWAN, TOWN OF	5455380002C	15-NOV-1999	99-28	02

Region	State	Community	Map panel	Determination date	Case No.	Type
03	WV	MERCER COUNTY*	5401240134B	01-OCT-1999	99-03-984A	02
03	WV	MINERAL COUNTY *	5401290005A	21-OCT-1999	99-03-1902V	19
03	WV	MINERAL COUNTY *	5401290038A	10-DEC-1999	99-03-1840A	02
03	WV	MONONGALIA COUNTY *	5401390035B	13-OCT-1999	99-03-1538A	02
03	WV	MONONGALIA COUNTY *	5401390075B	13-OCT-1999	99-03-1442A	02
03	WV	MORGANTOWN, CITY OF	5401410001D	17-DEC-1999	99-03-1412A	02
03	WV	PRESTON COUNTY*	540160A	08-DEC-1999	99-03-1360A	02
03	WV	RALEIGH COUNTY *	5401690005B	15-DEC-1999	00-03-0322A	02
03	WV	WAYNE COUNTY*	5402000125B	25-AUG-1999	99-03-1230A	02
03	WV	WHEELING, CITY OF	5401520010C	17-SEP-1999	99-03-816A	02
03	WV	WOOD COUNTY *	5402130106A	11-AUG-1999	99-03-1190A	02
04	AL	ANNISTON, CITY OF	0100200004C	04-NOV-1999	99-04-6248A	02
04	AL	ANNISTON, CITY OF	0100200004C	21-DEC-1999	99-04-5634A	02
04	AL	AUTAUGA COUNTY *	0103140105B	17-AUG-1999	99-04-4530A	02
04	AL	BIRMINGHAM, CITY OF	01073C0189E	26-DEC-1999	98-04-149P	05
04	AL	BIRMINGHAM, CITY OF	01073C0191E	07-OCT-1999	99-04-4394A	02
04	AL	BIRMINGHAM, CITY OF	01073C0486E	28-DEC-1999	00-04-0056A	02
04	AL	CHEROKEE COUNTY*	0102340100B	21-OCT-1999	99-04-5842A	02
04	AL	CHEROKEE COUNTY*	0102340100B	19-AUG-1999	99-04-2358A	02
04	AL	CHEROKEE COUNTY*	0102340125B	18-NOV-1999	99-04-6142A	02
04	AL	CHEROKEE COUNTY*	0102340125B	23-SEP-1999	99-04-4656A	02
04	AL	CHEROKEE COUNTY*	0102340175B	13-JUL-1999	99-04-2462A	02
04	AL	COLBERT COUNTY	0103180125B	20-JUL-1999	99-04-3616A	02
04	AL	COLBERT COUNTY	0103180125B	29-JUL-1999	99-04-2030A	02
04	AL	COOSADA, TOWN OF	0150120005B	21-SEP-1999	99-04-5416A	01
04	AL	CREOLA, TOWN OF	01097C0318J	12-OCT-1999	99-04-5766A	02
04	AL	DALLAS COUNTY*	0100630070B	09-DEC-1999	00-04-0356A	02
04	AL	DECATUR, CITY OF	01103C0060D	28-DEC-1999	00-04-0494A	02
04	AL	DECATUR, CITY OF	01103C0060D	23-NOV-1999	00-04-0264A	02
04	AL	DECATUR, CITY OF	01103C0060D	16-NOV-1999	00-04-0164A	02
04	AL	DECATUR, CITY OF	01103C0060D	03-NOV-1999	99-04-5712A	02
04	AL	DECATUR, CITY OF	01103C0080D	23-NOV-1999	00-04-0232A	02
04	AL	DECATUR, CITY OF	01103C0080D	05-NOV-1999	99-04-5018A	02
04	AL	DECATUR, CITY OF	01103C0090D	03-DEC-1999	99-04-5240A	02
04	AL	HELENA, TOWN OF	0102940003B	08-OCT-1999	99-04-3250A	02
04	AL	HUEYTOWN, CITY OF	01073C0453E	30-NOV-1999	00-04-0126A	02
04	AL	HUEYTOWN, CITY OF	01073C0461E	30-DEC-1999	00-04-0162A	02
04	AL	HUNTSVILLE, CITY OF	01089C0340D	21-DEC-1999	00-04-0382A	02
04	AL	HUNTSVILLE, CITY OF	01089C0343D	09-NOV-1999	99-04-5152A	02
04	AL	HUNTSVILLE, CITY OF	01089C0365D	30-JUL-1999	99-04-099P	05
04	AL	HUNTSVILLE, CITY OF	01089C0455D	21-JUL-1999	99-04-3332A	02
04	AL	JEFFERSON COUNTY *	01073C0183F	02-SEP-1999	99-04-4136A	02
04	AL	JEFFERSON COUNTY *	01073C0189E	26-DEC-1999	98-04-149P	05
04	AL	JEFFERSON COUNTY *	01073C0191E	17-AUG-1999	98-04-317P	05
04	AL	JEFFERSON COUNTY *	01073C0194E	28-JUL-1999	99-04-4506A	02
04	AL	JEFFERSON COUNTY *	01073C0194E	07-SEP-1999	99-04-3742A	02
04	AL	JEFFERSON COUNTY *	01073C0194E	03-AUG-1999	99-04-3382A	02
04	AL	JEFFERSON COUNTY *	01073C0250E	28-DEC-1999	00-04-0712A	02
04	AL	JEFFERSON COUNTY *	01073C0493E	17-NOV-1999	00-04-0482A	01
04	AL	JEFFERSON COUNTY *	01073C0493E	17-NOV-1999	00-04-0484A	01
04	AL	JEFFERSON COUNTY *	01073C0494E	06-AUG-1999	99-04-4410A	01
04	AL	JEFFERSON COUNTY *	01073C0581E	28-SEP-1999	99-04-223P	05
04	AL	JEFFERSON COUNTY *	01073C0607E	05-NOV-1999	99-04-6306A	02
04	AL	JEFFERSON COUNTY *	01073C0627E	07-JUL-1999	99-04-2668A	01
04	AL	LANETT, CITY OF	0100290010B	23-JUL-1999	99-04-3666A	02
04	AL	LAUDERDALE COUNTY *	0103230195C	04-AUG-1999	99-04-4426A	02
04	AL	LEEDS, CITY OF	01073C0366E	30-DEC-1999	99-04-5912A	01
04	AL	MADISON COUNTY *	01089C0166D	18-NOV-1999	99-04-5604A	01
04	AL	MADISON COUNTY *	01089C0166D	20-JUL-1999	99-04-1552A	01
04	AL	MADISON COUNTY *	01089C0365D	30-JUL-1999	99-04-099P	05
04	AL	MADISON, CITY OF	01089C0284D	20-AUG-1999	99-04-2156A	01
04	AL	MARSHALL COUNTY *	0102750125B	15-DEC-1999	99-04-6296A	02
04	AL	MOBILE, CITY OF	01097C0677J	15-OCT-1999	99-04-4552A	02
04	AL	MONTGOMERY, CITY OF	01101C0070F	26-AUG-1999	99-04-4690A	01
04	AL	MONTGOMERY, CITY OF	01101C0070F	07-JUL-1999	99-04-3202A	17
04	AL	MOULTON, CITY OF	0101420002B	01-SEP-1999	99-04-5238A	02
04	AL	PELHAM, TOWN OF	0101930001B	04-NOV-1999	99-04-6232A	02
04	AL	PELHAM, TOWN OF	0101930001B	26-AUG-1999	99-04-4778A	02
04	AL	PELHAM, TOWN OF	0101930004B	12-NOV-1999	00-04-0066A	01
04	AL	RUSSELL COUNTY *	0102870350B	06-JUL-1999	99-04-3890A	02
04	AL	SHELBY COUNTY*	0101910045B	13-OCT-1999	99-04-4364A	02
04	AL	SHELBY COUNTY*	0101910050B	10-SEP-1999	99-04-3984A	01
04	AL	SHELBY COUNTY*	0101910050B	21-JUL-1999	99-04-2596A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
04	AL	SHELBY COUNTY*	0101910145B	12-OCT-1999	99-04-5128A	02
04	AL	SHELBY COUNTY*	0101910145B	12-NOV-1999	99-04-4864A	02
04	AL	SHELBY COUNTY*	0101910145B	31-AUG-1999	99-04-4654A	02
04	AL	SHELBY COUNTY*	0101910150B	07-DEC-1999	00-04-0298A	02
04	AL	SHELBY COUNTY*	0101910150B	08-SEP-1999	99-04-4502A	02
04	AL	ST. CLAIR COUNTY *	0102900325B	08-SEP-1999	99-04-4342A	02
04	AL	SYLACAUGA, CITY OF	0101990020C	21-SEP-1999	98-04-155P	05
04	AL	TALLADEGA COUNTY *	0102970075B	26-OCT-1999	99-04-4854A	02
04	AL	TALLADEGA COUNTY *	0102970100B	30-SEP-1999	99-04-4180A	01
04	AL	TALLADEGA COUNTY *	0102970125B	21-DEC-1999	00-04-0284A	02
04	AL	TALLADEGA COUNTY *	0102970200B	15-OCT-1999	99-04-4456A	02
04	AL	TALLADEGA COUNTY *	0102970225B	30-JUL-1999	99-04-4598A	02
04	AL	TUSCALOOSA, CITY OF	0102030040A	17-AUG-1999	99-04-3410A	02
04	AL	TUSCALOOSA, CITY OF	0102030045B	04-NOV-1999	00-04-0044A	02
04	AL	TUSCALOOSA, CITY OF	0102030045B	06-OCT-1999	99-04-4916A	02
04	AL	WALKER COUNTY *	0103010215B	21-JUL-1999	99-04-3854A	02
04	AL	WINSTON COUNTY *	0103040009B	17-DEC-1999	99-04-4108A	02
04	FL	ALACHUA COUNTY*	1200010259A	21-DEC-1999	00-04-0496A	02
04	FL	ALACHUA COUNTY*	1200010259A	08-SEP-1999	99-04-3930A	01
04	FL	BOCA RATON, CITY OF	1201950007C	30-DEC-1999	00-04-0654A	02
04	FL	BRADFORD COUNTY *	12007C0240D	16-JUL-1999	99-04-2600A	02
04	FL	BRADFORD COUNTY *	12007C0245D	15-OCT-1999	99-04-5524A	02
04	FL	BREVARD COUNTY *	12009C0180E	30-SEP-1999	99-04-5706A	02
04	FL	BREVARD COUNTY *	12009C0190F	17-AUG-1999	99-04-4664A	02
04	FL	BREVARD COUNTY *	12009C0260E	30-DEC-1999	00-04-0672A	01
04	FL	BREVARD COUNTY *	12009C0260E	06-OCT-1999	99-04-5058A	02
04	FL	BREVARD COUNTY *	12009C0260E	11-AUG-1999	99-04-4764A	02
04	FL	BREVARD COUNTY *	12009C0270E	10-SEP-1999	99-04-4874A	02
04	FL	BREVARD COUNTY *	12009C0275E	03-SEP-1999	99-04-4674A	02
04	FL	BREVARD COUNTY *	12009C0275E	21-OCT-1999	99-04-4316A	01
04	FL	BREVARD COUNTY *	12009C0275E	29-JUL-1999	99-04-3880A	02
04	FL	BREVARD COUNTY *	12009C0290E	02-DEC-1999	00-04-0152A	02
04	FL	BREVARD COUNTY *	12009C0350E	07-DEC-1999	00-04-0200A	02
04	FL	BREVARD COUNTY *	12009C0365E	12-OCT-1999	99-04-4584A	01
04	FL	BREVARD COUNTY *	12009C0430E	02-DEC-1999	99-04-6272A	02
04	FL	BREVARD COUNTY *	12009C0430E	21-DEC-1999	99-04-5792A	01
04	FL	BREVARD COUNTY *	12009C0430E	02-SEP-1999	99-04-5268A	02
04	FL	BREVARD COUNTY *	12009C0430E	10-SEP-1999	99-04-5032A	01
04	FL	BREVARD COUNTY *	12009C0430E	10-SEP-1999	99-04-4946A	01
04	FL	BREVARD COUNTY *	12009C0430E	26-OCT-1999	99-04-4672A	01
04	FL	BREVARD COUNTY *	12009C0435E	16-DEC-1999	00-04-0256A	02
04	FL	BREVARD COUNTY *	12009C0435E	17-SEP-1999	99-04-5464A	02
04	FL	BREVARD COUNTY *	12009C0435E	05-AUG-1999	99-04-4438A	02
04	FL	BREVARD COUNTY *	12009C0435E	20-JUL-1999	99-04-4140A	01
04	FL	BREVARD COUNTY *	12009C0435E	30-JUL-1999	99-04-3366A	02
04	FL	BREVARD COUNTY *	12009C0440E	13-JUL-1999	99-04-2754A	01
04	FL	BREVARD COUNTY *	12009C0441F	02-NOV-1999	99-04-4196A	01
04	FL	BREVARD COUNTY *	12009C0441F	16-NOV-1999	99-04-5252A	01
04	FL	BREVARD COUNTY *	12009C0441F	31-AUG-1999	99-04-4592A	01
04	FL	BREVARD COUNTY *	12009C0443E	28-JUL-1999	99-04-3826A	02
04	FL	BREVARD COUNTY *	12009C0502E	15-JUL-1999	99-04-3768A	01
04	FL	BROWARD COUNTY*	12011C0120F	01-JUL-1999	99-04-3646A	01
04	FL	BROWARD COUNTY*	12011C0190F	15-OCT-1999	99-04-6000A	01
04	FL	BROWARD COUNTY*	12011C0215F	05-NOV-1999	99-04-5196A	02
04	FL	BROWARD COUNTY*	12011C0215F	26-OCT-1999	99-04-4966A	01
04	FL	BROWARD COUNTY*	12011C0215F	19-OCT-1999	99-04-4866A	02
04	FL	BROWARD COUNTY*	12011C0215F	17-AUG-1999	99-04-4470A	02
04	FL	CALLAWAY, CITY OF	1200050002C	24-AUG-1999	99-04-4574A	02
04	FL	CAPE CORAL, CITY OF	1250950020C	04-NOV-1999	99-04-5928A	01
04	FL	CAPE CORAL, CITY OF	1250950020C	14-OCT-1999	99-04-5420A	01
04	FL	CAPE CORAL, CITY OF	1250950020C	13-OCT-1999	99-04-5374A	01
04	FL	CAPE CORAL, CITY OF	1250950020C	20-JUL-1999	99-04-4160A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	16-DEC-1999	00-04-0214A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	09-DEC-1999	00-04-0130A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	30-DEC-1999	00-04-0132A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	09-DEC-1999	00-04-0136A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	09-DEC-1999	00-04-0138A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	23-NOV-1999	99-04-6346A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	16-NOV-1999	99-04-6010A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	16-NOV-1999	99-04-6008A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	16-NOV-1999	99-04-6022A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	16-NOV-1999	99-04-6020A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	16-NOV-1999	99-04-6002A	01

Region	State	Community	Map panel	Determination date	Case No.	Type
04	FL	CAPE CORAL, CITY OF	1250950030C	28-OCT-1999	99-04-5926A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	28-OCT-1999	99-04-5924A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	26-OCT-1999	99-04-5790A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	21-OCT-1999	99-04-5760A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	21-OCT-1999	99-04-5740A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	14-OCT-1999	99-04-5602A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	28-OCT-1999	99-04-5596A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	21-OCT-1999	99-04-5492A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	14-OCT-1999	99-04-5254A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	30-SEP-1999	99-04-5050A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	16-SEP-1999	99-04-4986A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	28-SEP-1999	99-04-4994A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	10-SEP-1999	99-04-4716A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	18-AUG-1999	99-04-4538A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	12-AUG-1999	99-04-4540A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	05-AUG-1999	99-04-4446A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	12-AUG-1999	99-04-4338A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	20-JUL-1999	99-04-3916A	01
04	FL	CAPE CORAL, CITY OF	1250950030C	20-AUG-1999	99-04-3588A	02
04	FL	CAPE CORAL, CITY OF	1250950035C	23-NOV-1999	99-04-6122A	01
04	FL	CAPE CORAL, CITY OF	1250950035C	14-DEC-1999	99-04-6050A	01
04	FL	CAPE CORAL, CITY OF	1250950035C	19-OCT-1999	99-04-6156A	02
04	FL	CAPE CORAL, CITY OF	1250950035C	23-NOV-1999	99-04-5808A	01
04	FL	CAPE CORAL, CITY OF	1250950035C	28-OCT-1999	99-04-5806A	01
04	FL	CAPE CORAL, CITY OF	1250950035C	16-SEP-1999	99-04-5606A	02
04	FL	CAPE CORAL, CITY OF	1250950035C	24-AUG-1999	99-04-5498A	02
04	FL	CAPE CORAL, CITY OF	1250950035C	10-SEP-1999	99-04-5078A	01
04	FL	CAPE CORAL, CITY OF	1250950035C	10-SEP-1999	99-04-4926A	01
04	FL	CAPE CORAL, CITY OF	1250950035C	06-JUL-1999	99-04-4700A	01
04	FL	CAPE CORAL, CITY OF	1250950035C	02-JUL-1999	99-04-4586A	01
04	FL	CAPE CORAL, CITY OF	1250950035C	05-AUG-1999	99-04-4464A	01
04	FL	CAPE CORAL, CITY OF	1250950035C	20-JUL-1999	99-04-4162A	02
04	FL	CAPE CORAL, CITY OF	1250950035C	09-JUL-1999	99-04-3938A	01
04	FL	CAPE CORAL, CITY OF	1250950040C	16-NOV-1999	00-04-0294A	01
04	FL	CAPE CORAL, CITY OF	1250950040C	09-DEC-1999	00-04-0134A	01
04	FL	CAPE CORAL, CITY OF	1250950040C	23-NOV-1999	99-04-6308A	01
04	FL	CAPE CORAL, CITY OF	1250950040C	23-NOV-1999	99-04-6348A	01
04	FL	CAPE CORAL, CITY OF	1250950040C	26-OCT-1999	99-04-5744A	01
04	FL	CAPE CORAL, CITY OF	1250950040C	14-OCT-1999	99-04-5556A	01
04	FL	CAPE CORAL, CITY OF	1250950040C	16-SEP-1999	99-04-4984A	01
04	FL	CAPE CORAL, CITY OF	1250950040C	01-JUL-1999	99-04-2168A	02
04	FL	CHARLOTTE COUNTY *	1200610020D	02-SEP-1999	99-04-4892A	02
04	FL	CITRUS COUNTY *	1200630175B	09-DEC-1999	00-04-0380A	02
04	FL	CITRUS COUNTY *	1200630175B	28-OCT-1999	99-04-6204A	02
04	FL	CITRUS COUNTY *	1200630175B	12-OCT-1999	99-04-5828A	02
04	FL	CITRUS COUNTY *	1200630175B	12-OCT-1999	99-04-5560A	02
04	FL	CITRUS COUNTY *	1200630175B	20-OCT-1999	99-04-4258A	02
04	FL	CITRUS COUNTY *	1200630175B	02-SEP-1999	99-04-4276A	02
04	FL	CITRUS COUNTY *	1200630175B	06-AUG-1999	99-04-4274A	02
04	FL	CITRUS COUNTY *	1200630205C	01-DEC-1999	99-04-5898A	02
04	FL	CITRUS COUNTY *	1200630205C	05-OCT-1999	99-04-5656A	02
04	FL	CITRUS COUNTY *	1200630210B	28-DEC-1999	00-04-0548A	02
04	FL	CITRUS COUNTY *	1200630220B	19-AUG-1999	99-04-4728A	02
04	FL	CITRUS COUNTY *	1200630255B	09-NOV-1999	99-04-5858A	02
04	FL	CITRUS COUNTY *	1200630255B	24-NOV-1999	99-04-4286A	02
04	FL	CITRUS COUNTY *	1200630260B	04-NOV-1999	00-04-0080A	02
04	FL	CITRUS COUNTY *	1200630260B	21-OCT-1999	99-04-6234A	02
04	FL	CITRUS COUNTY *	1200630260B	14-OCT-1999	99-04-5920A	02
04	FL	CITRUS COUNTY *	1200630260B	13-OCT-1999	99-04-3780A	02
04	FL	CITRUS COUNTY *	1200630270B	06-AUG-1999	99-04-4454A	02
04	FL	CITRUS COUNTY *	1200630270B	05-AUG-1999	99-04-4284A	02
04	FL	CITRUS COUNTY *	1200630270B	10-AUG-1999	99-04-4282A	02
04	FL	CLAY COUNTY *	1200640070D	17-AUG-1999	99-04-4118A	02
04	FL	CLAY COUNTY *	1200640135D	16-NOV-1999	99-04-6188A	02
04	FL	CLAY COUNTY *	1200640135D	06-AUG-1999	99-04-3746A	01
04	FL	CLAY COUNTY *	1200640155D	12-NOV-1999	99-04-133A	01
04	FL	CLAY COUNTY *	1200640290D	16-NOV-1999	99-04-4638A	01
04	FL	CLAY COUNTY *	1200640350D	22-SEP-1999	99-04-5036A	02
04	FL	CLEARWATER, CITY OF	1250960010D	09-JUL-1999	99-04-2544A	02
04	FL	CLERMONT, CITY OF	1201330001B	28-DEC-1999	00-04-0576A	02
04	FL	COLLIER COUNTY *	1200670195D	16-DEC-1999	00-04-0092A	01
04	FL	COLLIER COUNTY *	1200670394D	28-DEC-1999	00-04-0890A	02
04	FL	COLLIER COUNTY *	1200670394D	28-OCT-1999	99-04-6224A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
04	FL	COLLIER COUNTY *	1200670394D	21-OCT-1999	99-04-5798A	01
04	FL	COLLIER COUNTY *	1200670394D	28-OCT-1999	99-04-5796A	01
04	FL	COLLIER COUNTY *	1200670394D	26-OCT-1999	99-04-5794A	01
04	FL	COLLIER COUNTY *	1200670582F	28-DEC-1999	00-04-0552A	01
04	FL	COLLIER COUNTY *	1200670582F	14-OCT-1999	99-04-5370A	01
04	FL	COLLIER COUNTY *	1200670605E	28-DEC-1999	00-04-0742A	01
04	FL	COLLIER COUNTY *	1200670605E	14-DEC-1999	00-04-0528A	01
04	FL	COLLIER COUNTY *	1200670605E	16-NOV-1999	00-04-0350A	01
04	FL	COLLIER COUNTY *	1200670605E	28-OCT-1999	99-04-6024A	01
04	FL	COLLIER COUNTY *	1200670605E	04-NOV-1999	99-04-6018A	01
04	FL	COLLIER COUNTY *	1200670605E	04-NOV-1999	99-04-5978A	01
04	FL	COLLIER COUNTY *	1200670605E	14-OCT-1999	99-04-5372A	01
04	FL	COLLIER COUNTY *	1200670605E	24-AUG-1999	99-04-4858A	01
04	FL	COLLIER COUNTY *	1200670605E	10-SEP-1999	99-04-4788A	01
04	FL	COLLIER COUNTY *	1200670605E	10-SEP-1999	99-04-4794A	01
04	FL	COLLIER COUNTY *	1200670605E	10-SEP-1999	99-04-4768A	01
04	FL	COLLIER COUNTY *	1200670605E	07-JUL-1999	99-04-3892A	01
04	FL	COLLIER COUNTY *	1200670605E	01-JUL-1999	99-04-3136A	01
04	FL	CORAL SPRINGS, CITY OF	12011C0095F	25-AUG-1999	99-04-4832A	01
04	FL	CORAL SPRINGS, CITY OF	12011C0095F	19-AUG-1999	99-04-4682A	02
04	FL	CORAL SPRINGS, CITY OF	12011C0095F	27-JUL-1999	99-04-4234A	02
04	FL	CORAL SPRINGS, CITY OF	12011C0115F	14-DEC-1999	99-04-6038A	01
04	FL	DADE COUNTY*	12025C0075J	14-OCT-1999	99-04-5030A	02
04	FL	DADE COUNTY*	12025C0075J	20-AUG-1999	99-04-4706A	01
04	FL	DADE COUNTY*	12025C0075J	07-JUL-1999	99-04-3200A	01
04	FL	DADE COUNTY*	12025C0080J	02-DEC-1999	00-04-0520A	01
04	FL	DADE COUNTY*	12025C0080J	02-DEC-1999	00-04-0522A	01
04	FL	DADE COUNTY*	12025C0080J	18-AUG-1999	99-04-4860A	01
04	FL	DADE COUNTY*	12025C0160J	26-AUG-1999	99-04-5358A	01
04	FL	DADE COUNTY*	12025C0160J	26-AUG-1999	99-04-5292A	01
04	FL	DADE COUNTY*	12025C0160J	18-AUG-1999	99-04-5088A	01
04	FL	DADE COUNTY*	12025C0165J	01-DEC-1999	99-04-6312A	01
04	FL	DADE COUNTY*	12025C0165J	05-OCT-1999	99-04-5396A	01
04	FL	DADE COUNTY*	12025C0165J	26-AUG-1999	99-04-4720A	01
04	FL	DADE COUNTY*	12025C0170J	29-DEC-1999	99-04-6262A	02
04	FL	DADE COUNTY*	12025C0170J	06-AUG-1999	99-04-4250A	01
04	FL	DADE COUNTY*	12025C0255J	28-DEC-1999	00-04-1264X	01
04	FL	DADE COUNTY*	12025C0255J	28-OCT-1999	99-04-5956A	01
04	FL	DADE COUNTY*	12025C0255J	14-DEC-1999	99-04-5870A	02
04	FL	DADE COUNTY*	12025C0255J	28-SEP-1999	99-04-5044A	02
04	FL	DADE COUNTY*	12025C0265J	16-DEC-1999	00-04-0738A	01
04	FL	DADE COUNTY*	12025C0265J	02-DEC-1999	00-04-0518A	01
04	FL	DADE COUNTY*	12025C0265J	02-DEC-1999	00-04-0516A	01
04	FL	DADE COUNTY*	12025C0265J	12-NOV-1999	99-04-6054A	01
04	FL	DADE COUNTY*	12025C0265J	21-OCT-1999	99-04-6052A	01
04	FL	DADE COUNTY*	12025C0265J	21-OCT-1999	99-04-5592A	01
04	FL	DADE COUNTY*	12025C0265J	28-SEP-1999	99-04-4184A	01
04	FL	DADE COUNTY*	12025C0265J	08-OCT-1999	99-04-5034A	01
04	FL	DADE COUNTY*	12025C0265J	21-SEP-1999	99-04-4878A	01
04	FL	DADE COUNTY*	12025C0265J	04-AUG-1999	99-04-4224A	01
04	FL	DADE COUNTY*	12025C0265J	07-SEP-1999	99-04-3072A	01
04	FL	DADE COUNTY*	12025C0265J	27-AUG-1999	99-04-3076A	01
04	FL	DADE COUNTY*	12025C0266J	18-AUG-1999	99-04-4580A	02
04	FL	DADE COUNTY*	12025C0268J	03-AUG-1999	99-04-4444A	02
04	FL	DADE COUNTY*	12025C0356J	01-DEC-1999	00-04-0404A	02
04	FL	DANIA, CITY OF	12011C0309F	30-JUL-1999	99-04-4428A	02
04	FL	DAVIE, CITY OF	12011C0285F	26-OCT-1999	99-04-5080A	01
04	FL	DAYTONA BEACH, CITY OF	1250990015D	14-JUL-1999	99-04-3112A	01
04	FL	DEBARY, CITY OF	1206720001F	10-SEP-1999	99-04-5010A	02
04	FL	DEERFIELD BEACH, CITY OF	12011C0105F	15-JUL-1999	99-04-4486A	01
04	FL	DELRAY BEACH, CITY OF	1251020001D	21-JUL-1999	99-04-3400A	02
04	FL	DESOTO COUNTY*	12027C0320B	23-NOV-1999	99-04-5992A	02
04	FL	ESCAMBIA COUNTY*	12033C0235E	22-JUL-1999	99-04-4172A	02
04	FL	ESCAMBIA COUNTY*	12033C0245E	16-NOV-1999	99-04-4676A	02
04	FL	ESCAMBIA COUNTY*	12033C0305E	19-AUG-1999	99-04-4610A	02
04	FL	EUSTIS, CITY OF	1201340005B	19-AUG-1999	99-04-4564A	02
04	FL	FELLSMERE, CITY OF	12061C0060E	16-DEC-1999	00-04-0052A	01
04	FL	FERNANDINA BEACH, CITY OF	1201720006D	07-DEC-1999	99-04-5136A	02
04	FL	FLAGLER COUNTY*	1200850150B	12-NOV-1999	99-04-3968A	02
04	FL	FORT LAUDERDALE, CITY OF	12011C0219F	12-NOV-1999	99-04-5054A	02
04	FL	FRUITLAND PARK, CITY OF	1203870001B	10-NOV-1999	99-04-4754A	02
04	FL	GADSDEN COUNTY *	1200910300A	26-AUG-1999	99-04-3266A	02
04	FL	GAINESVILLE, CITY OF	1251070012B	10-SEP-1999	99-04-5006A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
04	FL	GULF COUNTY *	1200980050B	03-NOV-1999	99-04-5218A	02
04	FL	GULF COUNTY *	1200980175D	12-OCT-1999	99-04-5124A	02
04	FL	HERNANDO COUNTY *	1201100075B	12-NOV-1999	99-04-5882A	02
04	FL	HERNANDO COUNTY *	1201100150B	10-SEP-1999	99-04-5338A	02
04	FL	HERNANDO COUNTY *	1201100180B	09-NOV-1999	00-04-0088A	02
04	FL	HERNANDO COUNTY *	1201100280B	28-DEC-1999	00-04-0538A	02
04	FL	HERNANDO COUNTY *	1201100300B	07-DEC-1999	00-04-0288A	02
04	FL	HERNANDO COUNTY *	1201100300B	08-SEP-1999	99-04-5334A	02
04	FL	HERNANDO COUNTY *	1201100300B	15-OCT-1999	99-04-5336A	02
04	FL	HERNANDO COUNTY *	1201100300B	02-SEP-1999	99-04-4850A	02
04	FL	HIALEAH GARDENS, CITY OF	12025C0075J	21-DEC-1999	00-04-0020A	01
04	FL	HIALEAH, CITY OF	12025C0075J	12-NOV-1999	00-04-0032A	01
04	FL	HIALEAH, CITY OF	12025C0075J	21-SEP-1999	99-04-4182A	01
04	FL	HIALEAH, CITY OF	12025C0075J	31-AUG-1999	99-04-4740A	02
04	FL	HIGHLANDS COUNTY *	1201110025B	28-OCT-1999	99-04-6218A	02
04	FL	HIGHLANDS COUNTY *	1201110025B	20-AUG-1999	99-04-2982A	02
04	FL	HIGHLANDS COUNTY *	1201110150B	28-SEP-1999	99-04-4940A	02
04	FL	HILLSBOROUGH COUNTY*	1201120045D	14-OCT-1999	99-04-5888A	02
04	FL	HILLSBOROUGH COUNTY*	1201120045D	07-DEC-1999	99-04-5598A	01
04	FL	HILLSBOROUGH COUNTY*	1201120045D	03-SEP-1999	99-04-5042A	02
04	FL	HILLSBOROUGH COUNTY*	1201120045D	05-AUG-1999	99-04-3080A	01
04	FL	HILLSBOROUGH COUNTY*	1201120045D	24-SEP-1999	99-04-2326A	01
04	FL	HILLSBOROUGH COUNTY*	1201120065D	30-NOV-1999	99-04-6216A	02
04	FL	HILLSBOROUGH COUNTY*	1201120065D	16-NOV-1999	99-04-6096A	02
04	FL	HILLSBOROUGH COUNTY*	1201120090E	05-OCT-1999	99-04-6006A	01
04	FL	HILLSBOROUGH COUNTY*	1201120090E	07-SEP-1999	99-04-3640A	01
04	FL	HILLSBOROUGH COUNTY*	1201120090E	06-JUL-1999	99-04-1604A	01
04	FL	HILLSBOROUGH COUNTY*	1201120160C	07-OCT-1999	99-04-5550A	01
04	FL	HILLSBOROUGH COUNTY*	1201120160C	10-SEP-1999	99-04-4792A	01
04	FL	HILLSBOROUGH COUNTY*	1201120160C	03-AUG-1999	99-04-4228A	01
04	FL	HILLSBOROUGH COUNTY*	1201120169C	13-JUL-1999	99-04-3810A	01
04	FL	HILLSBOROUGH COUNTY*	1201120180F	28-DEC-1999	00-04-0784A	01
04	FL	HILLSBOROUGH COUNTY*	1201120180F	23-SEP-1999	99-04-5250A	01
04	FL	HILLSBOROUGH COUNTY*	1201120180F	14-JUL-1999	99-04-3574A	01
04	FL	HILLSBOROUGH COUNTY*	1201120180F	30-JUL-1999	99-04-3206A	02
04	FL	HILLSBOROUGH COUNTY*	1201120185F	07-DEC-1999	00-04-0240A	01
04	FL	HILLSBOROUGH COUNTY*	1201120185F	02-DEC-1999	00-04-0242A	01
04	FL	HILLSBOROUGH COUNTY*	1201120185F	17-NOV-1999	99-04-6310A	01
04	FL	HILLSBOROUGH COUNTY*	1201120185F	30-DEC-1999	99-04-6166A	02
04	FL	HILLSBOROUGH COUNTY*	1201120185F	29-SEP-1999	99-04-5084A	01
04	FL	HILLSBOROUGH COUNTY*	1201120185F	07-OCT-1999	99-04-5144A	02
04	FL	HILLSBOROUGH COUNTY*	1201120185F	28-SEP-1999	99-04-5090A	02
04	FL	HILLSBOROUGH COUNTY*	1201120185F	10-SEP-1999	99-04-4900A	02
04	FL	HILLSBOROUGH COUNTY*	1201120185F	25-AUG-1999	99-04-4424A	02
04	FL	HILLSBOROUGH COUNTY*	1201120185F	08-SEP-1999	99-04-4358A	01
04	FL	HILLSBOROUGH COUNTY*	1201120190D	08-OCT-1999	99-04-5446A	01
04	FL	HILLSBOROUGH COUNTY*	1201120190D	26-AUG-1999	99-04-5404A	01
04	FL	HILLSBOROUGH COUNTY*	1201120190D	19-AUG-1999	99-04-3764A	01
04	FL	HILLSBOROUGH COUNTY*	1201120192D	02-DEC-1999	00-04-0858A	01
04	FL	HILLSBOROUGH COUNTY*	1201120192D	11-AUG-1999	99-04-3354A	01
04	FL	HILLSBOROUGH COUNTY*	1201120205D	09-DEC-1999	00-04-0042A	01
04	FL	HILLSBOROUGH COUNTY*	1201120205D	09-DEC-1999	00-04-0040A	01
04	FL	HILLSBOROUGH COUNTY*	1201120205D	02-DEC-1999	99-04-6220A	02
04	FL	HILLSBOROUGH COUNTY*	1201120205D	21-OCT-1999	99-04-6098A	02
04	FL	HILLSBOROUGH COUNTY*	1201120230E	08-JUL-1999	99-04-3980A	02
04	FL	HILLSBOROUGH COUNTY*	1201120265D	14-OCT-1999	99-04-5668A	02
04	FL	HILLSBOROUGH COUNTY*	1201120367E	13-JUL-1999	99-04-3732A	02
04	FL	HILLSBOROUGH COUNTY*	1201120387E	15-OCT-1999	99-04-3830A	01
04	FL	HILLSBOROUGH COUNTY*	1201120395E	12-NOV-1999	00-04-0208A	01
04	FL	HILLSBOROUGH COUNTY*	1201120395E	21-DEC-1999	99-04-5954A	01
04	FL	HILLSBOROUGH COUNTY*	1201120395E	11-AUG-1999	99-04-4988A	02
04	FL	HILLSBOROUGH COUNTY*	1201120395E	27-AUG-1999	99-04-4418A	01
04	FL	HILLSBOROUGH COUNTY*	1201120425C	16-NOV-1999	00-04-0236A	02
04	FL	HILLSBOROUGH COUNTY*	1201120425C	26-AUG-1999	99-04-4774A	02
04	FL	HILLSBOROUGH COUNTY*	1201120494C	03-NOV-1999	99-04-5942A	01
04	FL	HILLSBOROUGH COUNTY*	1201120494C	27-AUG-1999	99-04-5076A	01
04	FL	HILLSBOROUGH COUNTY*	1201120520C	22-SEP-1999	99-04-3744A	01
04	FL	HOLLY HILL, CITY OF	125112C	15-OCT-1999	99-04-5046A	02
04	FL	HOLLYWOOD, CITY OF	12011C0312F	21-JUL-1999	99-04-3752A	02
04	FL	INDIAN RIVER COUNTY *	12061C0060E	07-DEC-1999	00-04-0170A	01
04	FL	INDIAN RIVER COUNTY *	12061C0070E	28-DEC-1999	00-04-0718A	01
04	FL	INDIAN RIVER COUNTY *	12061C0070E	05-NOV-1999	99-04-6026A	01
04	FL	INDIAN RIVER COUNTY *	12061C0083G	14-DEC-1999	99-04-6016A	01

Region	State	Community	Map panel	Determination date	Case No.	Type
04	FL	INDIAN RIVER COUNTY *	12061C0168E	09-JUL-1999	99-04-2794A	01
04	FL	INVERNESS, CITY OF	1203480001B	19-OCT-1999	99-04-4884A	02
04	FL	ISLAMORADA, VILLAGE OF	12087C1131H	04-NOV-1999	99-04-6244A	02
04	FL	JACKSON COUNTY *	12063C0175C	31-AUG-1999	99-04-3476A	02
04	FL	JACKSONVILLE, CITY OF	1200770025E	20-JUL-1999	99-04-3088A	02
04	FL	JACKSONVILLE, CITY OF	1200770070E	21-DEC-1999	99-04-6070A	01
04	FL	JACKSONVILLE, CITY OF	1200770131E	06-AUG-1999	99-04-4336A	17
04	FL	JACKSONVILLE, CITY OF	1200770141E	14-OCT-1999	99-04-5818A	02
04	FL	JACKSONVILLE, CITY OF	1200770152E	24-AUG-1999	99-04-4556A	02
04	FL	JACKSONVILLE, CITY OF	1200770209E	30-SEP-1999	99-04-5586A	02
04	FL	JACKSONVILLE, CITY OF	1200770233E	29-JUL-1999	99-04-4382A	02
04	FL	JACKSONVILLE, CITY OF	1200770234E	01-DEC-1999	99-04-4920A	01
04	FL	JACKSONVILLE, CITY OF	1200770238E	28-OCT-1999	99-04-5388A	01
04	FL	JACKSONVILLE, CITY OF	1200770238E	28-JUL-1999	99-04-3936A	01
04	FL	JACKSONVILLE, CITY OF	1200770239E	30-SEP-1999	99-04-4776A	01
04	FL	JACKSONVILLE, CITY OF	1200770241E	28-DEC-1999	00-04-0624A	02
04	FL	JACKSONVILLE, CITY OF	1200770241E	28-DEC-1999	00-04-0734A	02
04	FL	JACKSONVILLE, CITY OF	1200770241E	16-DEC-1999	00-04-0260A	02
04	FL	JACKSONVILLE, CITY OF	1200770241E	14-DEC-1999	00-04-0262A	02
04	FL	JACKSONVILLE, CITY OF	1200770241E	16-DEC-1999	00-04-0268A	02
04	FL	JACKSONVILLE, CITY OF	1200770241E	16-DEC-1999	00-04-0270A	02
04	FL	JACKSONVILLE, CITY OF	1200770241E	16-DEC-1999	00-04-0276A	02
04	FL	JACKSONVILLE, CITY OF	1200770241E	16-DEC-1999	00-04-0278A	02
04	FL	LAKE COUNTY *	1204210100B	04-NOV-1999	99-04-6342A	02
04	FL	LAKE COUNTY *	1204210100B	28-SEP-1999	99-04-5576A	02
04	FL	LAKE COUNTY *	1204210100B	17-SEP-1999	99-04-5430A	02
04	FL	LAKE COUNTY *	1204210100B	14-OCT-1999	99-04-5310A	02
04	FL	LAKE COUNTY *	1204210125B	19-AUG-1999	99-04-4270A	02
04	FL	LAKE COUNTY *	1204210150B	28-DEC-1999	00-04-0578A	02
04	FL	LAKE COUNTY *	1204210200B	31-AUG-1999	99-04-4634A	02
04	FL	LAKE COUNTY *	1204210200B	12-AUG-1999	99-04-3918A	02
04	FL	LAKE COUNTY *	1204210225B	30-DEC-1999	99-04-6252A	02
04	FL	LAKE COUNTY *	1204210225B	04-NOV-1999	99-04-6106A	02
04	FL	LAKE COUNTY *	1204210225B	09-NOV-1999	99-04-5746A	01
04	FL	LAKE COUNTY *	1204210225B	17-SEP-1999	99-04-5506A	02
04	FL	LAKE COUNTY *	1204210225B	17-SEP-1999	99-04-5462A	02
04	FL	LAKE COUNTY *	1204210225B	24-AUG-1999	99-04-4812A	02
04	FL	LAKE COUNTY *	1204210225B	26-AUG-1999	99-04-4572A	02
04	FL	LAKE COUNTY *	1204210375B	28-DEC-1999	00-04-0580A	02
04	FL	LAKE COUNTY *	1204210425B	14-SEP-1999	99-04-027P	05
04	FL	LAKE MARY, CITY OF	12117C0040E	07-OCT-1999	99-04-4612A	01
04	FL	LAKE MARY, CITY OF	12117C0040E	07-OCT-1999	99-04-3740A	01
04	FL	LAKELAND, CITY OF	1202670010B	21-DEC-1999	00-04-0570A	02
04	FL	LARGO, CITY OF	1251220009D	07-JUL-1999	99-04-3876A	02
04	FL	LAUDERHILL, CITY OF	12011C0204F	14-JUL-1999	99-04-3952A	02
04	FL	LAUDERHILL, CITY OF	12011C0205F	02-DEC-1999	99-04-6158A	02
04	FL	LAUDERHILL, CITY OF	12011C0205F	01-SEP-1999	99-04-5526A	01
04	FL	LAUDERHILL, CITY OF	12011C0205F	14-DEC-1999	99-04-5500A	02
04	FL	LAUDERHILL, CITY OF	12011C0205F	14-OCT-1999	99-04-4668A	01
04	FL	LAUDERHILL, CITY OF	12011C0212F	28-SEP-1999	99-04-4840A	02
04	FL	LAUDERHILL, CITY OF	12011C0212F	04-AUG-1999	99-04-4352A	01
04	FL	LEE COUNTY*	1251240225C	21-OCT-1999	99-04-6174A	02
04	FL	LEE COUNTY*	1251240225C	21-OCT-1999	99-04-5738A	01
04	FL	LEE COUNTY*	1251240225C	05-OCT-1999	99-04-5494A	01
04	FL	LEE COUNTY*	1251240225C	23-SEP-1999	99-04-5332A	02
04	FL	LEE COUNTY*	1251240225C	03-AUG-1999	99-04-5062A	01
04	FL	LEE COUNTY*	1251240225C	29-SEP-1999	99-04-5026A	01
04	FL	LEE COUNTY*	1251240325C	28-SEP-1999	99-04-5380A	02
04	FL	LEE COUNTY*	1251240426C	21-OCT-1999	99-04-6048A	01
04	FL	LEE COUNTY*	1251240465C	30-NOV-1999	00-04-0358A	01
04	FL	LEE COUNTY*	1251240465C	30-NOV-1999	00-04-0202A	01
04	FL	LEE COUNTY*	1251240505E	11-AUG-1999	99-04-4144A	02
04	FL	LEON COUNTY *	12073C0110D	06-AUG-1999	99-04-4220A	02
04	FL	LEON COUNTY *	12073C0250D	12-OCT-1999	99-04-5350A	02
04	FL	LEON COUNTY *	12073C0250D	10-SEP-1999	99-04-4350A	02
04	FL	LEON COUNTY *	12073C0350D	04-NOV-1999	00-04-0086A	02
04	FL	LEON COUNTY *	12073C0431D	16-SEP-1999	99-04-5724A	01
04	FL	LONGWOOD, CITY OF	12117C0130E	02-SEP-1999	99-04-4838A	02
04	FL	MANATEE COUNTY *	1201530327C	30-SEP-1999	99-04-5594A	01
04	FL	MANATEE COUNTY *	1201530344C	01-JUL-1999	99-04-2786A	01
04	FL	MARION COUNTY *	1201600300B	19-OCT-1999	99-04-5574A	02
04	FL	MARION COUNTY *	1201600300B	03-NOV-1999	99-04-1954A	02
04	FL	MARTIN COUNTY *	1201610145C	28-JUL-1999	99-04-2890A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
04	FL	MARTIN COUNTY *	1201610485B	22-SEP-1999	99-04-3840A	02
04	FL	MARY ESTHER, CITY OF	1203370001B	16-JUL-1999	99-04-2886A	01
04	FL	MIAMI, CITY OF	12025C0191J	24-SEP-1999	99-04-259P	05
04	FL	MIRAMAR, CITY OF	12011C0290F	26-OCT-1999	99-04-5610A	01
04	FL	MIRAMAR, CITY OF	12011C0295F	10-DEC-1999	00-04-0156A	01
04	FL	MIRAMAR, CITY OF	12011C0295F	02-DEC-1999	99-04-5998A	01
04	FL	MIRAMAR, CITY OF	12011C0295F	16-DEC-1999	99-04-5754A	01
04	FL	MIRAMAR, CITY OF	12011C0295F	23-SEP-1999	99-04-4932A	01
04	FL	MIRAMAR, CITY OF	12011C0295F	01-SEP-1999	99-04-4766A	01
04	FL	MIRAMAR, CITY OF	12011C0295F	03-AUG-1999	99-04-4148A	01
04	FL	MIRAMAR, CITY OF	12011C0315F	12-AUG-1999	99-04-5322A	01
04	FL	MIRAMAR, CITY OF	12011C0315F	23-JUL-1999	99-04-3954A	02
04	FL	MONTVERDE, TOWN OF	1206140001A	11-AUG-1999	99-04-3906A	02
04	FL	NASSAU COUNTY*	1201700239C	10-NOV-1999	99-04-4750A	02
04	FL	OCOEE, CITY OF	1201850005B	13-JUL-1999	99-04-3556A	02
04	FL	OKALOOSA COUNTY *	1201730170D	30-SEP-1999	99-04-5082A	01
04	FL	OKALOOSA COUNTY *	1201730195D	15-SEP-1999	99-04-5516A	02
04	FL	OKALOOSA COUNTY *	1201730205E	28-SEP-1999	99-04-5074A	01
04	FL	OKEECHOBEE COUNTY *	1201770200B	04-NOV-1999	99-04-6014A	01
04	FL	OLDSMAR, CITY OF	1202500003B	12-NOV-1999	00-04-0140A	01
04	FL	OLDSMAR, CITY OF	1202500003B	28-SEP-1999	99-04-5548A	01
04	FL	OLDSMAR, CITY OF	1202500003B	26-AUG-1999	99-04-4230A	01
04	FL	OLDSMAR, CITY OF	1202500004B	16-NOV-1999	99-04-5950A	01
04	FL	OLDSMAR, CITY OF	1202500004B	31-AUG-1999	99-04-4790A	01
04	FL	ORANGE COUNTY *	1201790175C	24-AUG-1999	99-04-4810A	02
04	FL	ORANGE COUNTY *	1201790175C	14-JUL-1999	99-04-3800A	02
04	FL	ORANGE COUNTY *	1201790225C	16-NOV-1999	99-04-5280A	02
04	FL	ORANGE COUNTY *	1201790225C	16-SEP-1999	99-04-4488A	01
04	FL	ORANGE COUNTY *	1201790225C	12-AUG-1999	99-04-3878A	02
04	FL	ORANGE COUNTY *	1201790250D	05-NOV-1999	99-04-6012A	01
04	FL	ORANGE COUNTY *	1201790250D	02-NOV-1999	99-04-5786A	02
04	FL	ORANGE COUNTY *	1201790250D	02-DEC-1999	99-04-5290A	01
04	FL	ORANGE COUNTY *	1201790250D	04-NOV-1999	99-04-5266A	01
04	FL	ORANGE COUNTY *	1201790250D	23-SEP-1999	99-04-4588A	01
04	FL	ORANGE COUNTY *	1201790250D	15-OCT-1999	99-04-4480A	02
04	FL	ORANGE COUNTY *	1201790250D	26-OCT-1999	99-04-4460A	01
04	FL	ORANGE COUNTY *	1201790250D	12-NOV-1999	99-04-4384A	01
04	FL	ORANGE COUNTY *	1201790250D	17-DEC-1999	99-04-013P	06
04	FL	ORANGE COUNTY *	1201790275D	12-OCT-1999	99-04-5618A	02
04	FL	ORANGE COUNTY *	1201790325B	14-JUL-1999	99-04-3678A	02
04	FL	ORANGE COUNTY *	1201790350C	23-NOV-1999	99-04-6186A	02
04	FL	ORANGE COUNTY *	1201790350C	30-NOV-1999	99-04-4880A	01
04	FL	ORANGE COUNTY *	1201790375D	14-OCT-1999	99-04-5342A	01
04	FL	ORANGE COUNTY *	1201790375D	12-NOV-1999	99-04-4078A	01
04	FL	ORANGE COUNTY *	1201790375D	13-JUL-1999	99-04-4036A	02
04	FL	ORANGE COUNTY *	1201790375D	22-OCT-1999	99-04-3756A	01
04	FL	ORANGE COUNTY *	1201790375D	28-JUL-1999	99-04-2830A	02
04	FL	ORANGE COUNTY *	1201790375D	07-JUL-1999	99-04-2164A	01
04	FL	ORANGE COUNTY *	1201790375D	06-JUL-1999	99-04-2072A	01
04	FL	ORANGE COUNTY *	1201790400C	07-DEC-1999	00-04-0464A	02
04	FL	ORANGE COUNTY *	1201790400C	17-AUG-1999	99-04-4468A	02
04	FL	ORANGE COUNTY *	1201790400C	29-SEP-1999	99-04-4340A	01
04	FL	ORANGE COUNTY *	1201790400C	17-AUG-1999	99-04-3620A	02
04	FL	ORANGE COUNTY *	1201790575B	16-NOV-1999	00-04-0362A	01
04	FL	ORLANDO, CITY OF	1201860005D	28-DEC-1999	00-04-0724A	01
04	FL	ORLANDO, CITY OF	1201860020D	28-OCT-1999	99-04-5444A	01
04	FL	ORLANDO, CITY OF	1201860020D	04-AUG-1999	99-04-4060A	02
04	FL	OSCEOLA COUNTY *	1201890020C	30-DEC-1999	99-04-5452A	01
04	FL	OSCEOLA COUNTY *	1201890030B	11-AUG-1999	99-04-3066A	01
04	FL	OSCEOLA COUNTY *	1201890045C	05-OCT-1999	99-04-5652A	02
04	FL	OSCEOLA COUNTY *	1201890045C	12-OCT-1999	99-04-4744A	01
04	FL	OSCEOLA COUNTY *	1201890045C	17-SEP-1999	99-04-3526A	01
04	FL	OSCEOLA COUNTY *	1201890110B	14-DEC-1999	99-04-5442A	01
04	FL	OSCEOLA COUNTY *	1201890120B	23-NOV-1999	00-04-0104A	02
04	FL	OSCEOLA COUNTY *	1201890135C	18-NOV-1999	99-04-5554A	01
04	FL	OSCEOLA COUNTY *	1201890135C	06-OCT-1999	99-04-2332A	01
04	FL	OSCEOLA COUNTY *	1201890140B	16-NOV-1999	00-04-0106A	02
04	FL	OSCEOLA COUNTY *	1201890140B	23-SEP-1999	99-04-4922A	02
04	FL	OSCEOLA COUNTY *	1201890140B	08-JUL-1999	99-04-3920A	02
04	FL	OSCEOLA COUNTY *	1201890140B	07-JUL-1999	99-04-3922A	02
04	FL	OSCEOLA COUNTY *	1201890140B	30-JUL-1999	99-04-3924A	02
04	FL	OSCEOLA COUNTY *	1201890205B	28-DEC-1999	00-04-0412A	02
04	FL	OSCEOLA COUNTY *	1201890205B	28-DEC-1999	00-04-0414A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
04	FL	OSCEOLA COUNTY *	1201890205B	07-DEC-1999	00-04-0416A	02
04	FL	OSCEOLA COUNTY *	1201890205B	28-DEC-1999	00-04-0418A	02
04	FL	OVIEDO, CITY OF	12117C0165E	27-AUG-1999	99-04-3664A	17
04	FL	OVIEDO, CITY OF	12117C0170E	22-DEC-1999	99-04-5688A	01
04	FL	PALM BAY, CITY OF	12009C0540F	12-AUG-1999	99-04-3874A	02
04	FL	PALM BAY, CITY OF	12009C0585E	03-DEC-1999	99-04-5960A	01
04	FL	PALM BEACH COUNTY *	1201920100B	27-JUL-1999	99-04-4232A	02
04	FL	PALM BEACH COUNTY *	1201920150A	28-JUL-1999	99-04-1152A	01
04	FL	PALM BEACH COUNTY *	1201920190B	09-DEC-1999	99-04-6298A	02
04	FL	PALM BEACH COUNTY *	1201920200A	07-DEC-1999	00-04-0502A	01
04	FL	PALM BEACH COUNTY *	1201920240B	30-NOV-1999	99-04-4974A	01
04	FL	PALMETTO, CITY OF	1201590003C	14-JUL-1999	99-04-4164A	01
04	FL	PANAMA CITY, CITY OF	1200120005D	28-DEC-1999	00-04-1206X	02
04	FL	PANAMA CITY, CITY OF	1200120005D	28-SEP-1999	99-04-4560A	02
04	FL	PASCO COUNTY *	1202300125C	10-SEP-1999	99-04-5142A	02
04	FL	PASCO COUNTY *	1202300185D	28-DEC-1999	00-04-0554A	02
04	FL	PASCO COUNTY *	1202300185D	20-JUL-1999	99-04-4062A	02
04	FL	PASCO COUNTY *	1202300185D	28-JUL-1999	99-04-3784A	02
04	FL	PASCO COUNTY *	1202300195D	09-JUL-1999	99-04-4098A	02
04	FL	PASCO COUNTY *	1202300195D	20-JUL-1999	99-04-4126A	02
04	FL	PASCO COUNTY *	1202300195D	12-AUG-1999	99-04-3972A	01
04	FL	PASCO COUNTY *	1202300195D	01-SEP-1999	99-04-3832A	02
04	FL	PASCO COUNTY *	1202300205D	17-AUG-1999	99-04-4532A	02
04	FL	PASCO COUNTY *	1202300215D	26-AUG-1999	99-04-4694A	02
04	FL	PASCO COUNTY *	1202300215D	12-AUG-1999	99-04-3688A	02
04	FL	PASCO COUNTY *	1202300250E	18-AUG-1999	99-04-4772A	02
04	FL	PASCO COUNTY *	1202300335C	23-NOV-1999	99-04-6084A	02
04	FL	PASCO COUNTY *	1202300335C	31-AUG-1999	99-04-4038A	02
04	FL	PASCO COUNTY *	1202300360D	14-DEC-1999	99-04-6320A	02
04	FL	PASCO COUNTY *	1202300360D	09-DEC-1999	99-04-6322A	02
04	FL	PASCO COUNTY *	1202300360D	05-NOV-1999	99-04-6060A	01
04	FL	PASCO COUNTY *	1202300360D	02-NOV-1999	99-04-5736A	01
04	FL	PASCO COUNTY *	1202300360D	04-NOV-1999	99-04-5768A	02
04	FL	PASCO COUNTY *	1202300360D	13-OCT-1999	99-04-5366A	02
04	FL	PASCO COUNTY *	1202300360D	23-SEP-1999	99-04-4886A	01
04	FL	PASCO COUNTY *	1202300360D	26-AUG-1999	99-04-4708A	02
04	FL	PASCO COUNTY *	1202300360D	21-JUL-1999	99-04-3884A	02
04	FL	PASCO COUNTY *	1202300362D	28-SEP-1999	99-04-5134A	02
04	FL	PASCO COUNTY *	1202300410E	21-DEC-1999	00-04-0984A	01
04	FL	PASCO COUNTY *	1202300410E	20-DEC-1999	00-04-0530A	01
04	FL	PASCO COUNTY *	1202300410E	30-DEC-1999	00-04-0154A	01
04	FL	PASCO COUNTY *	1202300425E	16-DEC-1999	00-04-0226A	01
04	FL	PASCO COUNTY *	1202300425E	22-OCT-1999	00-04-0050A	01
04	FL	PASCO COUNTY *	1202300425E	26-OCT-1999	99-04-5696A	02
04	FL	PASCO COUNTY *	1202300425E	03-DEC-1999	99-04-4770A	01
04	FL	PASCO COUNTY *	1202300425E	08-OCT-1999	99-04-4576A	01
04	FL	PASCO COUNTY *	1202300450E	24-AUG-1999	99-04-3068A	01
04	FL	PASCO COUNTY *	1202300450E	01-OCT-1999	99-04-3762A	01
04	FL	PASCO COUNTY *	1202300450E	10-SEP-1999	99-04-2320A	01
04	FL	PASCO COUNTY *	1202300450E	02-JUL-1999	99-04-640A	01
04	FL	PEMBROKE PINES, CITY OF	12011C0290F	09-DEC-1999	00-04-0634A	01
04	FL	PEMBROKE PINES, CITY OF	12011C0290F	30-NOV-1999	99-04-5970A	01
04	FL	PEMBROKE PINES, CITY OF	12011C0290F	28-SEP-1999	99-04-5324A	01
04	FL	PEMBROKE PINES, CITY OF	12011C0290F	10-SEP-1999	99-04-4844A	01
04	FL	PEMBROKE PINES, CITY OF	12011C0290F	12-AUG-1999	99-04-4462A	01
04	FL	PEMBROKE PINES, CITY OF	12011C0290F	13-AUG-1999	99-04-2750A	01
04	FL	PEMBROKE PINES, CITY OF	12011C0295F	02-SEP-1999	99-04-4796A	01
04	FL	PEMBROKE PINES, CITY OF	12011C0295F	28-SEP-1999	99-04-4712A	01
04	FL	PEMBROKE PINES, CITY OF	12011C0295F	21-OCT-1999	99-04-4688A	02
04	FL	PEMBROKE PINES, CITY OF	12011C0295F	13-AUG-1999	99-04-4408A	01
04	FL	PEMBROKE PINES, CITY OF	12011C0295F	10-SEP-1999	99-04-2324A	01
04	FL	PINELLAS COUNTY *	1251390039C	16-NOV-1999	99-04-4914A	01
04	FL	PINELLAS COUNTY *	1251390077C	21-JUL-1999	99-04-4254A	01
04	FL	PINELLAS COUNTY *	1251390079C	05-AUG-1999	99-04-4450A	02
04	FL	PINELLAS COUNTY *	1251390079C	06-AUG-1999	99-04-3868A	01
04	FL	PINELLAS COUNTY *	1251390086C	24-AUG-1999	99-04-4652A	02
04	FL	PINELLAS PARK, CITY OF	1202510005E	07-JUL-1999	99-04-3996A	02
04	FL	PLANTATION, CITY OF	12011C0215F	28-DEC-1999	00-04-0668X	01
04	FL	POLK COUNTY*	1202610100B	15-JUL-1999	99-04-2664A	02
04	FL	POLK COUNTY*	1202610125B	27-OCT-1999	99-04-1990A	01
04	FL	POLK COUNTY*	1202610345B	05-OCT-1999	99-04-5666A	02
04	FL	POLK COUNTY*	1202610345B	28-JUL-1999	99-04-4600A	02
04	FL	POLK COUNTY*	1202610350B	15-DEC-1999	99-04-5236A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
04	FL	POLK COUNTY*	1202610375D	23-NOV-1999	99-04-5700A	02
04	FL	POLK COUNTY*	1202610425B	02-DEC-1999	00-04-0314A	02
04	FL	POLK COUNTY*	1202610475D	07-OCT-1999	99-04-4806A	02
04	FL	POLK COUNTY*	1202610475D	09-JUL-1999	99-04-2956A	02
04	FL	POLK COUNTY*	1202610500D	02-JUL-1999	99-04-2560A	01
04	FL	POLK COUNTY*	1202610525B	28-DEC-1999	00-04-0792A	02
04	FL	POLK COUNTY*	1202610725B	18-NOV-1999	99-04-6118A	02
04	FL	POLK COUNTY*	1202610775B	03-DEC-1999	00-04-0406A	02
04	FL	PUTNAM COUNTY *	1202720090A	23-SEP-1999	99-04-4944A	02
04	FL	ROCKLEDGE, CITY OF	12009C0350E	14-OCT-1999	99-04-5540A	02
04	FL	ROCKLEDGE, CITY OF	12009C0355E	02-SEP-1999	99-04-3976A	02
04	FL	SARASOTA COUNTY *	1251440134E	27-JUL-1999	99-04-4396A	02
04	FL	SARASOTA COUNTY *	1251440160D	14-OCT-1999	99-04-3886A	01
04	FL	SARASOTA COUNTY *	1251440163E	19-AUG-1999	99-04-4368A	02
04	FL	SARASOTA COUNTY *	1251440207E	08-JUL-1999	99-04-033P	06
04	FL	SARASOTA COUNTY *	1251440332E	01-JUL-1999	99-04-3408A	02
04	FL	SEMINOLE COUNTY*	12117C0020E	18-AUG-1999	99-04-4176A	02
04	FL	SEMINOLE COUNTY*	12117C0040E	23-NOV-1999	00-04-0078A	02
04	FL	SEMINOLE COUNTY*	12117C0110E	03-SEP-1999	99-04-4116A	02
04	FL	SEMINOLE COUNTY*	12117C0110E	18-NOV-1999	99-04-4122A	02
04	FL	SEMINOLE COUNTY*	12117C0130E	28-DEC-1999	00-04-0682A	02
04	FL	SEMINOLE COUNTY*	12117C0145E	21-OCT-1999	99-04-5820A	02
04	FL	SEMINOLE COUNTY*	12117C0145E	29-SEP-1999	99-04-5664A	02
04	FL	SEMINOLE COUNTY*	12117C0145E	21-OCT-1999	99-04-5674A	02
04	FL	SEMINOLE COUNTY*	12117C0145E	18-NOV-1999	99-04-4202A	01
04	FL	SEMINOLE COUNTY*	12117C0145E	03-SEP-1999	99-04-4962A	02
04	FL	ST. CLOUD, CITY OF	1201910005D	20-JUL-1999	99-04-4242A	01
04	FL	ST. JOHNS COUNTY *	1251470075D	30-JUL-1999	99-04-4058A	02
04	FL	ST. JOHNS COUNTY *	1251470085D	26-AUG-1999	99-04-3230A	01
04	FL	ST. JOHNS COUNTY *	1251470090D	04-AUG-1999	99-04-5166A	01
04	FL	ST. JOHNS COUNTY *	1251470090D	18-NOV-1999	99-04-2970A	02
04	FL	ST. PETERSBURG, CITY OF	1251480007B	24-SEP-1999	99-04-5364A	02
04	FL	STUART, CITY OF	1201650005D	21-JUL-1999	99-04-3186A	02
04	FL	SUMTER COUNTY *	1202960075B	05-OCT-1999	99-04-1286P	05
04	FL	SUNRISE, CITY OF	12011C0205F	08-SEP-1999	99-04-4324A	02
04	FL	SUNRISE, CITY OF	12011C0205F	06-AUG-1999	99-04-3060A	01
04	FL	TALLAHASSEE, CITY OF	12073C0115D	28-OCT-1999	99-04-5758A	01
04	FL	TALLAHASSEE, CITY OF	12073C0115D	28-OCT-1999	99-04-5756A	01
04	FL	TALLAHASSEE, CITY OF	12073C0115D	28-OCT-1999	99-04-5788A	01
04	FL	TALLAHASSEE, CITY OF	12073C0115D	19-OCT-1999	99-04-5300A	01
04	FL	TALLAHASSEE, CITY OF	12073C0115D	28-SEP-1999	99-04-4950A	01
04	FL	TALLAHASSEE, CITY OF	12073C0115D	28-SEP-1999	99-04-4948A	01
04	FL	TALLAHASSEE, CITY OF	12073C0136D	12-NOV-1999	99-04-5164A	02
04	FL	TAMARAC, CITY OF	12011C0185F	28-SEP-1999	99-04-5470A	01
04	FL	TAMARAC, CITY OF	12011C0185F	24-AUG-1999	99-04-4714A	01
04	FL	TAMARAC, CITY OF	12011C0185F	09-JUL-1999	99-04-3820A	01
04	FL	TAMPA, CITY OF	1201140031C	28-OCT-1999	99-04-5846A	02
04	FL	TARPON SPRINGS, CITY OF	1202590001B	12-AUG-1999	99-04-4214A	02
04	FL	TARPON SPRINGS, CITY OF	1202590006B	02-DEC-1999	99-04-6072A	02
04	FL	TARPON SPRINGS, CITY OF	1202590006B	28-OCT-1999	99-04-4710A	02
04	FL	TAVARES, CITY OF	1201380001B	10-SEP-1999	99-04-4356A	02
04	FL	TAVARES, CITY OF	1201380002B	08-JUL-1999	99-04-3896A	02
04	FL	TAYLOR COUNTY*	1203020195B	03-AUG-1999	99-04-3212A	02
04	FL	TAYLOR COUNTY*	1203020195B	03-AUG-1999	99-04-3212A	02
04	FL	VOLUSIA COUNTY*	1251550017F	27-AUG-1999	99-04-2028A	02
04	FL	VOLUSIA COUNTY*	1251550152E	21-JUL-1999	99-04-3706A	02
04	FL	VOLUSIA COUNTY*	1251550408E	16-DEC-1999	99-04-5440A	01
04	FL	VOLUSIA COUNTY*	1251550408E	24-AUG-1999	99-04-4174A	01
04	FL	VOLUSIA COUNTY*	1251550408E	13-JUL-1999	99-04-3026A	01
04	FL	VOLUSIA COUNTY*	1251550605E	14-DEC-1999	00-04-0468A	02
04	FL	WALTON COUNTY *	1203170355D	02-SEP-1999	99-04-4256A	02
04	FL	WINDERMERE, TOWN OF	1203810001B	19-OCT-1999	99-04-5284A	02
04	FL	WINTER GARDEN, CITY OF	1201870005B	16-SEP-1999	99-04-5060A	02
04	FL	WINTER SPRINGS, CITY OF	12117C0135E	30-DEC-1999	00-04-0978A	17
04	FL	WINTER SPRINGS, CITY OF	12117C0135E	28-JUL-1999	99-04-3864A	01
04	FL	ZEPHYRHILLS, CITY OF	1202350005C	03-NOV-1999	99-04-4650A	02
04	GA	ATHENS-CLARKE COUNTY	1300400030C	24-NOV-1999	99-04-6068A	02
04	GA	ATLANTA, CITY OF	13121C0229E	16-DEC-1999	00-04-0058A	02
04	GA	ATLANTA, CITY OF	13121C0229E	21-OCT-1999	99-04-6168A	02
04	GA	ATLANTA, CITY OF	13121C0229E	13-OCT-1999	99-04-5210A	02
04	GA	ATLANTA, CITY OF	13121C0229E	03-AUG-1999	99-04-3432A	02
04	GA	ATLANTA, CITY OF	13121C0231E	16-NOV-1999	00-04-0190A	02
04	GA	ATLANTA, CITY OF	13121C0233E	19-OCT-1999	99-04-5274A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
04	GA	ATLANTA, CITY OF	13121C0233E	25-AUG-1999	99-04-4888A	02
04	GA	ATLANTA, CITY OF	13121C0233E	03-NOV-1999	99-04-3910A	02
04	GA	ATLANTA, CITY OF	13121C0233E	02-JUL-1999	99-04-3912A	02
04	GA	ATLANTA, CITY OF	13121C0241E	03-SEP-1999	99-04-2456A	02
04	GA	ATLANTA, CITY OF	13121C0261E	26-OCT-1999	99-04-5486A	02
04	GA	AUGUSTA, CITY OF	1301580001D	16-DEC-1999	99-04-4980A	02
04	GA	BALDWIN COUNTY*	1300050050B	14-OCT-1999	99-04-5212A	02
04	GA	BALDWIN COUNTY*	1300050075B	03-AUG-1999	99-04-4288A	02
04	GA	BLACKSHEAR, CITY OF	13229C0165C	09-NOV-1999	99-04-5148A	02
04	GA	BREMEN, CITY OF	130335A	30-SEP-1999	99-04-4114A	02
04	GA	CAMDEN COUNTY*	13039C0360C	28-OCT-1999	99-04-6212A	02
04	GA	CAMDEN COUNTY*	13039C0380D	27-JUL-1999	99-04-4068A	02
04	GA	CHAMBLEE, CITY OF	1300660001B	26-OCT-1999	99-04-5762A	02
04	GA	CHATHAM COUNTY*	1300300075C	28-JUL-1999	99-04-4236A	02
04	GA	CHATHAM COUNTY*	1300300075C	15-OCT-1999	99-04-4238A	01
04	GA	CHEROKEE COUNTY*	13057C0308C	16-NOV-1999	98-04-353P	05
04	GA	CLAYTON COUNTY*	1300410015D	23-SEP-1999	99-04-5168A	02
04	GA	COBB COUNTY*	13067C0015F	12-NOV-1999	99-04-5872A	02
04	GA	COBB COUNTY*	13067C0015F	25-AUG-1999	99-04-4102A	02
04	GA	COBB COUNTY*	13067C0030F	28-DEC-1999	00-04-0196A	02
04	GA	COBB COUNTY*	13067C0030F	08-DEC-1999	99-04-6336A	02
04	GA	COBB COUNTY*	13067C0030F	09-DEC-1999	99-04-6170A	02
04	GA	COBB COUNTY*	13067C0030F	27-OCT-1999	99-04-5226A	02
04	GA	COBB COUNTY*	13067C0035F	07-DEC-1999	99-04-6202A	02
04	GA	COBB COUNTY*	13067C0035F	22-SEP-1999	99-04-5120A	02
04	GA	COBB COUNTY*	13067C0035F	05-OCT-1999	99-04-4908A	02
04	GA	COBB COUNTY*	13067C0035F	26-AUG-1999	99-04-4848A	02
04	GA	COBB COUNTY*	13067C0035F	05-OCT-1999	99-04-4260A	02
04	GA	COBB COUNTY*	13067C0035F	14-JUL-1999	99-04-4124A	02
04	GA	COBB COUNTY*	13067C0035F	26-OCT-1999	99-04-4052A	02
04	GA	COBB COUNTY*	13067C0040F	18-NOV-1999	00-04-0046A	02
04	GA	COBB COUNTY*	13067C0050F	16-NOV-1999	00-04-0192A	02
04	GA	COBB COUNTY*	13067C0050F	14-JUL-1999	99-04-4028A	02
04	GA	COBB COUNTY*	13067C0050F	23-JUL-1999	99-04-3786A	17
04	GA	COBB COUNTY*	13067C0050F	30-JUL-1999	99-04-2828A	02
04	GA	COBB COUNTY*	13067C0055F	07-OCT-1999	99-04-4504A	02
04	GA	COBB COUNTY*	13067C0055F	07-JUL-1999	99-04-2992A	02
04	GA	COBB COUNTY*	13067C0065F	16-DEC-1999	99-04-4100A	02
04	GA	COBB COUNTY*	13067C0065F	31-AUG-1999	99-04-3970A	02
04	GA	COBB COUNTY*	13067C0070F	22-JUL-1999	99-04-3814A	02
04	GA	COBB COUNTY*	13067C0070F	20-JUL-1999	99-04-2968A	02
04	GA	COBB COUNTY*	13067C0070F	09-NOV-1999	00-04-0158A	02
04	GA	COLUMBIA COUNTY*	1300590080C	05-OCT-1999	99-04-4216A	01
04	GA	COLUMBUS, CITY OF	1351580045D	28-SEP-1999	99-04-3828A	02
04	GA	DECATUR COUNTY*	1304510175C	12-AUG-1999	99-04-2404A	02
04	GA	DECATUR, CITY OF	1351590001B	28-OCT-1999	99-04-6206A	02
04	GA	DEKALB COUNTY *	1300650002F	14-DEC-1999	99-04-5910A	02
04	GA	DEKALB COUNTY *	1300650003E	28-SEP-1999	99-04-5390A	02
04	GA	DEKALB COUNTY *	1300650003E	30-JUL-1999	99-04-3806A	02
04	GA	DEKALB COUNTY *	1300650004E	21-JUL-1999	99-04-4112A	02
04	GA	DEKALB COUNTY *	1300650005G	01-JUL-1999	99-04-2872A	02
04	GA	DEKALB COUNTY *	1300650006D	24-NOV-1999	99-04-5126A	02
04	GA	DEKALB COUNTY *	1300650006D	22-OCT-1999	99-04-4246A	02
04	GA	DEKALB COUNTY *	1300650007C	20-AUG-1999	99-04-2532A	02
04	GA	DEKALB COUNTY *	1300650010C	09-NOV-1999	99-04-4956A	02
04	GA	DEKALB COUNTY *	1300650010C	29-SEP-1999	99-04-3700A	02
04	GA	DEKALB COUNTY *	1300650010C	28-JUL-1999	99-04-3004A	02
04	GA	DEKALB COUNTY *	1300650013F	27-AUG-1999	99-04-3368A	02
04	GA	DULUTH, CITY OF	1300980003C	20-JUL-1999	99-04-3738A	02
04	GA	EAST POINT, CITY OF	13121C0353E	01-JUL-1999	99-04-3774A	02
04	GA	EFFINGHAM COUNTY *	1300760155C	13-OCT-1999	99-04-4458A	02
04	GA	FANNIN COUNTY	1302490043B	08-OCT-1999	99-04-5852A	02
04	GA	FAYETTE COUNTY *	13113C0085D	23-NOV-1999	00-04-0370A	02
04	GA	FLOYD COUNTY*	1300790160A	29-SEP-1999	99-04-2258A	01
04	GA	FORSYTH COUNTY *	13117C0125C	27-JUL-1999	99-04-2492A	02
04	GA	FULTON COUNTY *	13121C0066E	04-NOV-1999	99-04-6260A	02
04	GA	FULTON COUNTY *	13121C0066E	05-NOV-1999	99-04-3592A	02
04	GA	FULTON COUNTY *	13121C0067E	23-NOV-1999	99-04-6162A	02
04	GA	FULTON COUNTY *	13121C0115E	27-JUL-1999	99-04-4166A	02
04	GA	FULTON COUNTY *	13121C0163E	12-OCT-1999	99-04-5552A	02
04	GA	FULTON COUNTY *	13121C0163E	28-SEP-1999	99-04-4704A	02
04	GA	FULTON COUNTY *	13121C0327E	20-JUL-1999	99-04-4074A	02
04	GA	FULTON COUNTY *	13121C0329E	07-DEC-1999	99-04-087P	05

Region	State	Community	Map panel	Determination date	Case No.	Type
04	GA	FULTON COUNTY *	13121C0478E	18-NOV-1999	99-04-6086A	02
04	GA	GWINNETT COUNTY *	1303220095C	29-DEC-1999	99-04-3988P	05
04	GA	GWINNETT COUNTY *	1303220160E	08-DEC-1999	99-04-5344A	02
04	GA	GWINNETT COUNTY *	1303220160E	27-OCT-1999	99-04-4412A	02
04	GA	GWINNETT COUNTY *	1303220160E	14-JUL-1999	99-04-4134A	02
04	GA	GWINNETT COUNTY *	1303220160E	22-SEP-1999	99-04-3214A	02
04	GA	GWINNETT COUNTY *	1303220165B	12-NOV-1999	99-04-2294A	01
04	GA	GWINNETT COUNTY *	1303220190C	30-NOV-1999	00-04-0254A	01
04	GA	GWINNETT COUNTY *	1303220190C	14-DEC-1999	00-04-0112A	02
04	GA	GWINNETT COUNTY *	1303220195C	10-SEP-1999	99-04-5398A	02
04	GA	GWINNETT COUNTY *	1303220205C	26-OCT-1999	99-04-4958A	02
04	GA	GWINNETT COUNTY *	1303220205C	28-OCT-1999	99-04-3934A	02
04	GA	GWINNETT COUNTY *	1303220205C	28-SEP-1999	99-04-2972A	01
04	GA	GWINNETT COUNTY *	1303220220C	30-SEP-1999	99-04-3038A	02
04	GA	GWINNETT COUNTY *	1303220280C	16-SEP-1999	99-04-4622A	02
04	GA	GWINNETT COUNTY *	1303220280C	06-JUL-1999	99-04-3218A	02
04	GA	GWINNETT COUNTY *	1303220315C	21-DEC-1999	00-04-0302A	02
04	GA	HARRIS COUNTY*	1303380150A	30-DEC-1999	99-04-6116A	02
04	GA	HARRIS COUNTY*	1303380150A	27-JUL-1999	99-04-4346A	02
04	GA	HARRIS COUNTY*	1303380150A	20-JUL-1999	99-04-3870A	02
04	GA	HARRIS COUNTY*	1303380150A	13-JUL-1999	99-04-2954A	02
04	GA	HARRIS COUNTY*	1303380175A	24-NOV-1999	99-04-5406A	02
04	GA	HARRIS COUNTY*	1303380175A	30-SEP-1999	99-04-4954A	02
04	GA	HARRIS COUNTY*	1303380175A	18-AUG-1999	99-04-1310A	02
04	GA	HENRY COUNTY *	1304680060B	09-JUL-1999	99-04-434A	02
04	GA	KENNESAW, CITY OF	13067C0030F	28-DEC-1999	99-04-6164A	02
04	GA	KINGSTON, CITY OF	13015C0060F	30-DEC-1999	99-04-5886A	02
04	GA	LAKE CITY, CITY OF	130044B	29-OCT-1999	99-04-101P	05
04	GA	LAWRENCEVILLE, CITY OF	1300990003B	01-JUL-1999	99-04-3100A	02
04	GA	LIBERTY COUNTY *	1301230190A	12-AUG-1999	99-04-5064A	02
04	GA	LILBURN, CITY OF	1301000001B	12-NOV-1999	99-04-5890A	02
04	GA	LYERLY, TOWN OF	130294A	21-JUL-1999	99-04-3950A	02
04	GA	MACON, CITY OF	1300110043D	13-AUG-1999	99-04-4262A	02
04	GA	MARIETTA, CITY OF	13067C0050F	31-AUG-1999	99-04-5122A	02
04	GA	MARIETTA, CITY OF	13067C0035F	19-OCT-1999	99-04-4904A	02
04	GA	MARIETTA, CITY OF	13067C0035F	10-SEP-1999	99-04-3862A	02
04	GA	MARIETTA, CITY OF	13067C0050F	06-AUG-1999	99-04-4606A	02
04	GA	MARIETTA, CITY OF	13067C0050F	27-JUL-1999	99-04-4348A	02
04	GA	MARIETTA, CITY OF	13067C0050F	27-JUL-1999	99-04-3534A	02
04	GA	MARIETTA, CITY OF	13067C0050F	02-SEP-1999	99-04-3342A	02
04	GA	MONROE COUNTY*	1301380025C	01-OCT-1999	99-04-4130A	02
04	GA	MOUNTAIN PARK, CITY OF	13121C0033E	31-AUG-1999	99-04-4902A	02
04	GA	PAULDING COUNTY *	1301470025A	09-NOV-1999	00-04-0148V	19
04	GA	PAULDING COUNTY *	13223C0253B	01-DEC-1999	99-04-5230A	02
04	GA	PEACHTREE CITY, CITY OF	13113C0060D	23-SEP-1999	99-04-4500A	02
04	GA	PEACHTREE CITY, CITY OF	13113C0080D	30-JUL-1999	99-04-3998A	17
04	GA	POOLER, TOWN OF	1300300075C	28-JUL-1999	99-04-4376A	02
04	GA	POWDER SPRINGS, CITY OF	13067C0065F	19-OCT-1999	99-04-5642A	02
04	GA	POWDER SPRINGS, CITY OF	13067C0065F	20-JUL-1999	99-04-3256A	02
04	GA	RICHMOND COUNTY*	1301580020E	09-NOV-1999	99-04-299P	06
04	GA	RICHMOND COUNTY*	1301580020E	07-OCT-1999	99-04-5408A	02
04	GA	RICHMOND COUNTY*	1301580070E	23-JUL-1999	99-04-4616A	02
04	GA	ROSWELL, CITY OF	13121C0042E	07-OCT-1999	99-04-4782A	01
04	GA	ROSWELL, CITY OF	13121C0061E	30-JUL-1999	99-04-4150A	02
04	GA	ROSWELL, CITY OF	13121C0061E	07-JUL-1999	99-04-3386A	02
04	GA	SMYRNA, CITY OF	13067C0070F	02-NOV-1999	99-04-5094A	02
04	GA	SMYRNA, CITY OF	13067C0075F	09-NOV-1999	99-04-5876A	02
04	GA	SUWANEE, CITY OF	1303280002A	02-SEP-1999	99-04-4960A	02
04	GA	SUWANEE, CITY OF	1303280002A	28-SEP-1999	99-04-4582A	01
04	GA	THOMASTON, CITY OF	13293C0065B	16-DEC-1999	00-04-0036A	02
04	GA	TIFTON, CITY OF	13277C0130D	06-AUG-1999	99-04-4212A	02
04	GA	TOWNS COUNTY*	13281C0035C	21-JUL-1999	99-04-4302A	02
04	GA	TOWNS COUNTY*	13281C0055C	02-DEC-1999	99-04-6076A	02
04	GA	TOWNS COUNTY*	13281C0065C	21-JUL-1999	99-04-4300A	02
04	GA	TROUPE COUNTY *	1304050100A	22-OCT-1999	99-04-5306A	02
04	GA	UNION COUNTY*	1302540025C	29-DEC-1999	99-04-6092A	02
04	GA	UNION COUNTY*	1302540100C	22-OCT-1999	99-04-4678A	02
04	GA	WAYCROSS, CITY OF	1301860003B	09-JUL-1999	99-04-3364A	01
04	KY	BOWLING GREEN, CITY OF	21227C0115D	22-OCT-1999	99-04-5216A	02
04	KY	BOYLE COUNTY*	2103220050B	07-DEC-1999	99-04-4762A	02
04	KY	BRECKINRIDGE COUNTY	2100250007B	12-OCT-1999	99-04-5776A	02
04	KY	CAMPBELL COUNTY *	2100340105B	24-NOV-1999	99-04-1800A	02
04	KY	CARTER COUNTY *	2100500120B	27-AUG-1999	99-04-3132A	02

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04	KY	COVINGTON, CITY OF	2101290005D	10-SEP-1999	99-04-3314A	02
04	KY	DAVIESS COUNTY *	21059C0255C	28-DEC-1999	00-04-0186A	02
04	KY	FLOYD COUNTY *	2100690050C	23-SEP-1999	99-04-5224A	02
04	KY	FRANKLIN COUNTY *	2102800070B	11-AUG-1999	99-04-4620A	02
04	KY	JEFFERSON COUNTY*	21111C0020D	17-SEP-1999	99-04-5534A	02
04	KY	JEFFERSON COUNTY*	21111C0020D	27-JUL-1999	99-04-2914A	02
04	KY	JEFFERSON COUNTY*	21111C0020D	10-NOV-1999	99-04-163P	06
04	KY	JEFFERSON COUNTY*	21111C0040D	12-NOV-1999	99-04-846A	01
04	KY	JEFFERSON COUNTY*	21111C0085D	22-DEC-1999	00-04-0630A	02
04	KY	JEFFERSON COUNTY*	21111C0085D	21-OCT-1999	99-04-5632A	02
04	KY	JEFFERSON COUNTY*	21111C0095D	23-NOV-1999	99-04-6140A	02
04	KY	JEFFERSON COUNTY*	21111C0095D	09-NOV-1999	99-04-5880A	02
04	KY	JEFFERSON COUNTY*	21111C0095D	24-SEP-1999	99-04-5686A	02
04	KY	JEFFERSON COUNTY*	21111C0095D	21-JUL-1999	99-04-4390A	02
04	KY	JEFFERSON COUNTY*	21111C0105D	14-OCT-1999	99-04-5824A	02
04	KY	JEFFERSON COUNTY*	21111C0105D	10-NOV-1999	99-04-5248A	02
04	KY	JEFFERSON COUNTY*	21111C0105D	28-JUL-1999	99-04-4474A	02
04	KY	JEFFERSON COUNTY*	21111C0115D	23-NOV-1999	99-04-5990A	02
04	KY	JEFFERSON COUNTY*	21111C0115D	17-NOV-1999	99-04-6138A	02
04	KY	JEFFERSON COUNTY*	21111C0115D	29-JUL-1999	99-04-4692A	02
04	KY	JEFFERSON COUNTY*	21111C0165D	28-DEC-1999	00-04-0498A	02
04	KY	JEFFERSON COUNTY*	21111C0165D	02-SEP-1999	99-04-4906A	02
04	KY	JEFFERSON COUNTY*	21111C0165D	04-AUG-1999	99-04-4362A	02
04	KY	JEFFERSON COUNTY*	21111C0165D	16-JUL-1999	99-04-3104A	02
04	KY	JEFFERSON COUNTY*	21111C0170D	12-OCT-1999	99-04-5636A	02
04	KY	JEFFERSON COUNTY*	21111C0170D	06-OCT-1999	99-04-5654A	02
04	KY	JEFFERSON COUNTY*	21111C0170D	06-OCT-1999	99-04-5362A	02
04	KY	JEFFERSON COUNTY*	21111C0170D	24-SEP-1999	99-04-5312A	02
04	KY	JEFFERSON COUNTY*	21111C0170D	17-SEP-1999	99-04-5276A	02
04	KY	JEFFERSON COUNTY*	21111C0170D	22-SEP-1999	99-04-5296A	02
04	KY	JEFFERSON COUNTY*	21111C0170D	23-JUL-1999	99-04-4380A	17
04	KY	JEFFERSON COUNTY*	21111C0170D	22-SEP-1999	99-04-3932A	01
04	KY	JEFFERSON COUNTY*	21111C0170D	19-AUG-1999	99-04-4578A	02
04	KY	JEFFERSON COUNTY*	21111C0190D	09-JUL-1999	99-04-4014A	02
04	KY	JEFFERSON COUNTY*	21111C0190D	01-SEP-1999	99-04-3948A	02
04	KY	JEFFERSON COUNTY*	21111C0195D	26-OCT-1999	99-04-4896A	02
04	KY	JEFFERSON COUNTY*	21111C0230D	21-JUL-1999	99-04-3660A	02
04	KY	KENTON COUNTY *	2101280038B	04-NOV-1999	00-04-0338A	02
04	KY	LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT.	2100670010C	20-AUG-1999	99-04-4718A	02
04	KY	LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT.	2100670060C	27-OCT-1999	99-04-6172A	01
04	KY	LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT.	2100670060C	27-OCT-1999	99-04-5530A	02
04	KY	LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT.	2100670070C	05-OCT-1999	99-04-5522A	02
04	KY	LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT.	2100670070C	28-JUL-1999	99-04-4528A	02
04	KY	LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT.	2100670070C	27-AUG-1999	99-04-3990A	02
04	KY	LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT.	2100670090C	15-DEC-1999	99-04-4918A	02
04	KY	LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT.	2100670090C	10-NOV-1999	99-04-4738A	01
04	KY	LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT.	2100670090C	17-AUG-1999	99-04-4492A	02
04	KY	LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT.	2100670090C	25-AUG-1999	99-04-3842A	02
04	KY	LOUISVILLE, CITY OF	21111C0090D	30-NOV-1999	00-04-0198A	02
04	KY	LOUISVILLE, CITY OF	21111C0090D	16-JUL-1999	99-04-3846A	02
04	KY	LOUISVILLE, CITY OF	21111C0160D	28-SEP-1999	99-04-4002A	02
04	KY	LOUISVILLE, CITY OF	21111C0160D	13-JUL-1999	99-04-3692A	02
04	KY	MARSHALL COUNTY *	2102520025B	31-AUG-1999	99-04-4808A	02
04	KY	MIDDLESBORO, CITY OF	2151900005B	12-NOV-1999	99-04-4814A	02
04	KY	MURRAY, CITY OF	2100330005B	15-JUL-1999	99-04-3170A	02
04	KY	NELSON COUNTY *	2101770165B	14-JUL-1999	99-04-4248A	02
04	KY	NICHOLASVILLE, CITY OF	2101260005B	27-JUL-1999	99-04-3264A	02
04	KY	OWENSBORO, CITY OF	21059C0120C	02-NOV-1999	99-04-6004A	01
04	KY	OWENSBORO, CITY OF	21059C0260C	30-SEP-1999	99-04-5692A	02
04	KY	OWENSBORO, CITY OF	21059C0280C	10-DEC-1999	99-04-5958A	01
04	KY	PADUCAH, CITY OF	2101520006D	21-JUL-1999	99-04-3788A	02
04	KY	SHEPHERDSVILLE, CITY OF	2100280005D	01-DEC-1999	99-04-5694A	02
04	KY	SHEPHERDSVILLE, CITY OF	2100280005D	29-SEP-1999	99-04-4546A	01

Region	State	Community	Map panel	Determination date	Case No.	Type
04	KY	SHIVELY, CITY OF	21111C0135D	14-OCT-1999	99-04-5918A	02
04	KY	WILMOR, CITY OF	2103110001A	16-SEP-1999	99-04-4392A	02
04	MS	ALCORN COUNTY *	2802670025B	10-SEP-1999	99-04-3302A	01
04	MS	BRANDON, CITY OF	2801430003B	20-JUL-1999	99-04-4372A	02
04	MS	CLARKSDALE, CITY OF	2800390005B	31-AUG-1999	99-04-2936P	06
04	MS	COAHOMA COUNTY *	2800380250C	31-AUG-1999	99-04-2936P	06
04	MS	DESOTO COUNTY *	28033C0010D	31-AUG-1999	99-04-4698A	01
04	MS	DESOTO COUNTY *	28033C0040E	30-DEC-1999	99-04-5450A	01
04	MS	FORREST COUNTY *	28035C0010C	10-DEC-1999	00-04-0274A	02
04	MS	GAUTIER, CITY OF	2803320005E	16-SEP-1999	99-04-5068A	02
04	MS	HATTIESBURG, CITY OF	28035C0040C	26-OCT-1999	99-04-5508A	02
04	MS	HATTIESBURG, CITY OF	28035C0080C	19-OCT-1999	99-04-5488A	02
04	MS	HATTIESBURG, CITY OF	28035C0080C	27-AUG-1999	99-04-4042A	02
04	MS	HINDS COUNTY*	2800700250D	07-DEC-1999	00-04-0540A	02
04	MS	HINDS COUNTY*	2800700250D	16-JUL-1999	99-04-1766A	01
04	MS	HORN LAKE, CITY OF	28033C0040E	21-DEC-1999	00-04-0352A	01
04	MS	HORN LAKE, CITY OF	28033C0040E	17-SEP-1999	99-04-5176A	02
04	MS	HORN LAKE, CITY OF	28033C0040E	27-JUL-1999	99-04-1384A	01
04	MS	JACKSON COUNTY*	2852560050D	28-DEC-1999	00-04-0266A	02
04	MS	JACKSON, CITY OF	2800720015F	26-AUG-1999	99-04-3090A	02
04	MS	LAUDERDALE COUNTY *	28075C0095D	30-SEP-1999	99-04-129P	05
04	MS	LEE COUNTY *	2802270105A	10-AUG-1999	99-04-5024A	02
04	MS	LEE COUNTY *	2802270105A	10-SEP-1999	99-04-486A	02
04	MS	LEE COUNTY *	2802270115A	05-OCT-1999	99-04-5684A	02
04	MS	LEE COUNTY *	28081C0025D	30-SEP-1999	99-04-5650A	02
04	MS	LEE COUNTY *	28081C0025D	21-OCT-1999	00-04-0144V	19
04	MS	LOWNDES COUNTY *	28087C0065J	20-AUG-1999	99-04-3960A	01
04	MS	LOWNDES COUNTY *	28087C0105J	30-JUL-1999	99-04-3944A	01
04	MS	LOWNDES COUNTY *	28087C0105J	19-AUG-1999	99-04-3536A	17
04	MS	LOWNDES COUNTY *	28087C0150J	07-SEP-1999	99-04-3946A	01
04	MS	MADISON COUNTY *	28089C0150D	09-JUL-1999	99-04-2150A	01
04	MS	MADISON, CITY OF	28089C0320D	28-DEC-1999	99-04-4314A	02
04	MS	MERIDIAN, CITY OF	28075C0160D	30-SEP-1999	99-04-129P	05
04	MS	PEARL RIVER VALLEY WATER SUPPLY DISTRICT	2803380065B	01-SEP-1999	99-04-2768A	02
04	MS	PEARL RIVER VALLEY WATER SUPPLY DISTRICT	2803380070B	28-DEC-1999	00-04-0510A	02
04	MS	PEARL, CITY OF	2801450005C	12-NOV-1999	99-04-4834A	02
04	MS	RANKIN COUNTY *	2801420070C	09-DEC-1999	99-04-5454A	01
04	MS	RIDGELAND, CITY OF	28089C0320D	15-OCT-1999	99-04-4016A	02
04	MS	SHERMAN, TOWN OF	2802960005C	19-AUG-1999	99-04-201P	06
04	MS	SOUTHHAVEN, CITY OF	28033C0030E	29-OCT-1999	99-04-1922A	01
04	MS	SOUTHHAVEN, CITY OF	28033C0035E	17-SEP-1999	99-04-4628A	01
04	MS	SOUTHHAVEN, CITY OF	28033C0040E	14-DEC-1999	00-04-0856X	01
04	MS	SOUTHHAVEN, CITY OF	28033C0040E	24-AUG-1999	99-04-4514A	01
04	MS	TATE COUNTY *	2802350200B	05-AUG-1999	99-04-2720A	02
04	MS	TUPELO, CITY OF	28081C0135D	21-OCT-1999	00-04-0146V	19
04	MS	WARREN COUNTY*	2801980050B	18-AUG-1999	99-04-2762A	02
04	MS	WASHINGTON COUNTY*	2801770135B	08-JUL-1999	99-04-1100A	01
04	MS	WASHINGTON COUNTY*	2801770145B	30-JUL-1999	99-04-4152A	01
04	NC	ASHEVILLE, CITY OF	37021C0193C	16-AUG-1999	99-04-169P	05
04	NC	ATLANTIC BEACH, TOWN OF	3700440001D	17-SEP-1999	99-04-4982A	18
04	NC	ATLANTIC BEACH, TOWN OF	3700440002E	20-AUG-1999	99-04-4334A	18
04	NC	BAKERSVILLE, TOWN OF	37121C0076C	22-NOV-1999	99-04-057P	05
04	NC	BANNER ELK, TOWN OF	3700110003B	30-DEC-1999	99-04-293P	05
04	NC	BREVARD, CITY OF	37175C0201C	25-AUG-1999	98-04-1298A	01
04	NC	BRUNSWICK COUNTY*	3702950125C	10-SEP-1999	99-04-4026A	02
04	NC	BRUNSWICK COUNTY*	3702950130C	18-NOV-1999	99-04-6228A	02
04	NC	BRUNSWICK COUNTY*	3702950215C	02-SEP-1999	99-04-2838A	02
04	NC	BRUNSWICK COUNTY*	3702950300C	28-JUL-1999	99-04-3308A	02
04	NC	BRUNSWICK COUNTY*	3702950310E	16-NOV-1999	00-04-0116A	02
04	NC	BRUNSWICK COUNTY*	3702950360E	31-AUG-1999	99-04-4666A	02
04	NC	BRUNSWICK COUNTY*	3702950360E	24-AUG-1999	99-04-4178A	02
04	NC	BUNCOMBE COUNTY *	37021C0160C	31-AUG-1999	99-04-4614A	02
04	NC	BUNCOMBE COUNTY *	37021C0270C	02-JUL-1999	99-04-2590A	02
04	NC	BUNCOMBE COUNTY *	37021C0282C	17-SEP-1999	99-04-3964A	02
04	NC	BURLINGTON, CITY OF	37001C0101E	17-DEC-1999	00-04-0892X	02
04	NC	BURLINGTON, CITY OF	37001C0101E	19-NOV-1999	99-04-5186A	02
04	NC	BURLINGTON, CITY OF	37001C0103E	03-SEP-1999	99-04-4724A	02
04	NC	CALDWELL COUNTY *	37027C0050D	21-OCT-1999	99-04-6180A	02
04	NC	CALDWELL COUNTY *	37027C0060D	30-JUL-1999	99-04-3464A	02
04	NC	CARRBORO, TOWN OF	3702750005C	16-JUL-1999	99-04-3804A	02
04	NC	CARTERET COUNTY *	3700430440C	30-SEP-1999	99-04-5570A	02
04	NC	CARTERET COUNTY *	3700430667D	13-JUL-1999	99-04-3994A	18
04	NC	CARY, TOWN OF	37183C0482F	24-AUG-1999	99-04-4828A	01

Region	State	Community	Map panel	Determination date	Case No.	Type
04	NC	CATAWBA COUNTY *	3700500040C	05-OCT-1999	99-04-5146A	02
04	NC	CATAWBA COUNTY *	3700500040C	02-NOV-1999	99-04-4210A	02
04	NC	CATAWBA COUNTY *	3700500075C	09-NOV-1999	99-04-5862A	02
04	NC	CATAWBA COUNTY *	3700500075C	01-OCT-1999	99-04-4686A	02
04	NC	CATAWBA COUNTY *	3700500200C	28-SEP-1999	99-04-5222A	02
04	NC	CATAWBA COUNTY *	3700500200C	03-SEP-1999	99-04-4734A	02
04	NC	CATAWBA COUNTY *	3700500200C	05-AUG-1999	99-04-4398A	02
04	NC	CATAWBA COUNTY *	3700500200C	17-SEP-1999	99-04-4142A	02
04	NC	CATAWBA COUNTY *	3700500200C	10-SEP-1999	99-04-4008A	02
04	NC	CATAWBA COUNTY *	3700500325B	30-DEC-1999	00-04-0656A	02
04	NC	CATAWBA COUNTY *	3700500325B	30-NOV-1999	00-04-0100A	02
04	NC	CATAWBA COUNTY *	3700500325B	22-JUL-1999	99-04-4110A	02
04	NC	CATAWBA COUNTY *	3700500350C	23-NOV-1999	00-04-0396A	02
04	NC	CATAWBA COUNTY *	3700500350C	09-DEC-1999	99-04-6258A	02
04	NC	CATAWBA COUNTY *	3700500350C	23-NOV-1999	99-04-6078A	02
04	NC	CATAWBA COUNTY *	3700500350C	16-NOV-1999	99-04-5906A	02
04	NC	CATAWBA COUNTY *	3700500350C	28-OCT-1999	99-04-5778A	02
04	NC	CATAWBA COUNTY *	3700500350C	17-DEC-1999	99-04-5472A	02
04	NC	CATAWBA COUNTY *	3700500350C	16-DEC-1999	99-04-5160A	02
04	NC	CATAWBA COUNTY *	3700500350C	30-NOV-1999	99-04-5072A	02
04	NC	CATAWBA COUNTY *	3700500350C	23-SEP-1999	99-04-4952A	02
04	NC	CATAWBA COUNTY *	3700500350C	02-SEP-1999	99-04-4936A	02
04	NC	CATAWBA COUNTY *	3700500350C	10-SEP-1999	99-04-4856A	02
04	NC	CATAWBA COUNTY *	3700500350C	05-NOV-1999	99-04-4756A	02
04	NC	CATAWBA COUNTY *	3700500350C	14-JUL-1999	99-04-4308A	02
04	NC	CATAWBA COUNTY *	3700500350C	21-JUL-1999	99-04-3724A	02
04	NC	CATAWBA COUNTY *	3700500350C	12-AUG-1999	99-04-3412A	02
04	NC	CHAPEL HILL, TOWN OF	3701800002E	23-NOV-1999	99-04-6314A	02
04	NC	CHARLOTTE, CITY OF	3701590014B	07-JUL-1999	99-04-3992A	17
04	NC	CHARLOTTE, CITY OF	3701590024B	22-SEP-1999	99-04-3834A	01
04	NC	CLEVELAND COUNTY*	3703020175B	06-AUG-1999	99-04-4436A	02
04	NC	CONCORD, CITY OF	37025C0082D	30-SEP-1999	99-04-5672A	02
04	NC	CONCORD, CITY OF	37025C0110D	14-OCT-1999	99-04-6082A	01
04	NC	CRAVEN COUNTY*	3700720305B	21-JUL-1999	99-04-3794A	02
04	NC	CRAVEN COUNTY*	3700720330B	04-NOV-1999	99-04-3674A	02
04	NC	CRAVEN COUNTY*	3700720340B	28-DEC-1999	00-04-0474A	02
04	NC	CUMBERLAND COUNTY *	3700760190B	09-DEC-1999	99-04-6108A	02
04	NC	DARE COUNTY*	3753480220C	30-NOV-1999	99-04-5496A	02
04	NC	DARE COUNTY*	3753480820D	20-JUL-1999	99-04-4066A	02
04	NC	DAVIDSON COUNTY *	3703070090B	07-DEC-1999	00-04-0296A	02
04	NC	DAVIDSON COUNTY *	3703070150B	15-OCT-1999	99-04-5232A	02
04	NC	DAVIDSON COUNTY *	3703070150B	05-OCT-1999	99-04-5140A	02
04	NC	DAVIDSON COUNTY *	3703070150B	10-SEP-1999	99-04-5014A	02
04	NC	DAVIDSON COUNTY *	3703070150B	02-DEC-1999	99-04-4942A	02
04	NC	DAVIDSON COUNTY *	3703070150B	31-AUG-1999	99-04-4608A	02
04	NC	DAVIDSON COUNTY *	3703070150B	25-AUG-1999	99-04-4544A	02
04	NC	DAVIDSON COUNTY *	3703070150B	21-JUL-1999	99-04-4304A	02
04	NC	DAVIDSON COUNTY *	3703070150B	09-JUL-1999	99-04-2252A	02
04	NC	DAVIDSON COUNTY *	3703070175B	14-DEC-1999	99-04-5002A	02
04	NC	DUPLIN COUNTY *	3700830175B	30-JUL-1999	99-04-4568A	02
04	NC	DUPLIN COUNTY *	3700830200B	07-DEC-1999	99-04-6240A	02
04	NC	DUPLIN COUNTY *	3700830200B	19-AUG-1999	99-04-4872A	02
04	NC	DURHAM COUNTY *	37063C0076G	18-NOV-1999	00-04-0128A	02
04	NC	DURHAM COUNTY *	37063C0165G	17-DEC-1999	00-04-0320A	02
04	NC	DURHAM, CITY OF	37063C0059G	02-SEP-1999	99-04-4296A	02
04	NC	DURHAM, CITY OF	37063C0159G	04-NOV-1999	99-04-6284A	02
04	NC	DURHAM, CITY OF	37063C0167G	14-DEC-1999	00-04-0962A	02
04	NC	ELON COLLEGE, TOWN OF	37001C0082E	24-NOV-1999	99-04-4990A	02
04	NC	EMERALD ISLE, TOWN OF	3700470002D	16-DEC-1999	99-04-5848A	02
04	NC	FAIRMONT, TOWN OF	37155C0275D	26-AUG-1999	99-04-4024A	02
04	NC	FAYETTEVILLE, CITY OF	3700770007D	14-OCT-1999	99-04-5922A	02
04	NC	FORSYTH COUNTY *	37067C0187H	29-SEP-1999	99-04-5662A	02
04	NC	FORSYTH COUNTY *	37067C0188H	18-AUG-1999	99-04-4432A	02
04	NC	GARNER, TOWN OF	37183C0544E	17-DEC-1999	99-04-3792A	02
04	NC	GASTONIA, CITY OF	3701000020D	15-SEP-1999	99-04-5112A	02
04	NC	GATES COUNTY *	3701030150B	20-AUG-1999	99-04-4386A	02
04	NC	GRAHAM, CITY OF	37001C0129E	06-JUL-1999	99-04-3582A	02
04	NC	GRANVILLE COUNTY*	37077C0050C	17-SEP-1999	99-04-3610A	02
04	NC	GREENSBORO, CITY OF	3753510009C	04-AUG-1999	99-04-4120A	02
04	NC	GUILFORD COUNTY *	3701110205B	19-OCT-1999	99-04-5000A	02
04	NC	HAVELOCK, CITY OF	3702650008B	01-SEP-1999	99-04-5106A	02
04	NC	HENDERSONVILLE, CITY OF	3701280004B	31-AUG-1999	99-04-4596A	01
04	NC	HERTFORD COUNTY	3701300002A	21-JUL-1999	99-04-3702A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
04	NC	HERTFORD COUNTY	3701300002A	30-JUL-1999	99-04-3652A	02
04	NC	HICKORY, CITY OF	3700540005B	16-DEC-1999	00-04-0122A	02
04	NC	HICKORY, CITY OF	3700540005B	23-SEP-1999	99-04-5340A	02
04	NC	HICKORY, CITY OF	3700540010C	30-SEP-1999	99-04-5670A	02
04	NC	HICKORY, CITY OF	3700540010C	07-OCT-1999	99-04-5572A	02
04	NC	HICKORY, CITY OF	3700540010C	28-JUL-1999	99-04-4510A	02
04	NC	HICKORY, CITY OF	3700540010C	25-AUG-1999	99-04-3908A	17
04	NC	HICKORY, CITY OF	3700540015B	10-SEP-1999	99-04-4292A	02
04	NC	HIGH POINT, CITY OF	3701130007C	29-DEC-1999	00-04-0194A	02
04	NC	HIGH POINT, CITY OF	3701130007C	20-JUL-1999	99-04-3176A	02
04	NC	INDIAN BEACH, TOWN OF	3704330001B	09-NOV-1999	99-04-4440A	18
04	NC	KINSTON, CITY OF	3701450010C	25-AUG-1999	99-04-4054A	02
04	NC	LENOIR, CITY OF	37027C0076D	12-AUG-1999	99-04-4508A	02
04	NC	LENOIR, CITY OF	37027C0079D	01-OCT-1999	99-04-4742A	01
04	NC	LONG BEACH, TOWN OF	3753540002D	09-NOV-1999	99-04-5878A	02
04	NC	LUMBERTON, CITY OF	37155C0179D	21-OCT-1999	99-04-6030A	01
04	NC	LUMBERTON, CITY OF	37155C0179D	02-DEC-1999	99-04-6112A	02
04	NC	LUMBERTON, CITY OF	37155C0179D	14-OCT-1999	99-04-4280A	02
04	NC	MEBANE, TOWN OF	37001C0132E	02-SEP-1999	99-04-4632A	02
04	NC	MECKLENBURG COUNTY *	3701580015C	28-OCT-1999	99-04-6182A	02
04	NC	MECKLENBURG COUNTY *	3701580015C	08-JUL-1999	99-04-3942A	02
04	NC	MECKLENBURG COUNTY *	3701580015C	28-JUL-1999	99-04-3790A	02
04	NC	MECKLENBURG COUNTY *	3701580015C	16-JUL-1999	99-04-3046A	02
04	NC	MECKLENBURG COUNTY *	3701580015C	19-OCT-1999	99-04-2926A	02
04	NC	MECKLENBURG COUNTY *	3701580030C	10-AUG-1999	99-04-4482A	02
04	NC	MECKLENBURG COUNTY *	3701580170C	30-JUL-1999	99-04-4602A	02
04	NC	MECKLENBURG COUNTY *	3701580190B	17-SEP-1999	99-04-524A	01
04	NC	MITCHELL COUNTY *	37121C0076C	22-NOV-1999	99-04-057P	05
04	NC	MONROE, CITY OF	37179C0090C	02-NOV-1999	99-04-3928A	01
04	NC	MONTGOMERY COUNTY	3703360055B	31-AUG-1999	99-04-4618A	02
04	NC	MONTGOMERY COUNTY	3703360025B	30-DEC-1999	00-04-0638A	02
04	NC	MONTGOMERY COUNTY	3703360025B	14-DEC-1999	00-04-0546A	02
04	NC	MONTGOMERY COUNTY	3703360025B	28-DEC-1999	00-04-0472A	02
04	NC	MONTGOMERY COUNTY	3703360025B	30-DEC-1999	00-04-0310A	02
04	NC	MONTGOMERY COUNTY	3703360025B	30-NOV-1999	00-04-0224A	02
04	NC	MONTGOMERY COUNTY	3703360025B	16-NOV-1999	00-04-0178A	02
04	NC	MONTGOMERY COUNTY	3703360025B	23-NOV-1999	99-04-6222A	02
04	NC	MONTGOMERY COUNTY	3703360025B	16-NOV-1999	99-04-6192A	02
04	NC	MONTGOMERY COUNTY	3703360025B	23-NOV-1999	99-04-6200A	02
04	NC	MONTGOMERY COUNTY	3703360025B	23-NOV-1999	99-04-6132A	02
04	NC	MONTGOMERY COUNTY	3703360025B	28-OCT-1999	99-04-5850A	02
04	NC	MONTGOMERY COUNTY	3703360025B	14-OCT-1999	99-04-5826A	02
04	NC	MONTGOMERY COUNTY	3703360025B	23-NOV-1999	99-04-5682A	02
04	NC	MONTGOMERY COUNTY	3703360025B	30-SEP-1999	99-04-5640A	02
04	NC	MONTGOMERY COUNTY	3703360025B	30-SEP-1999	99-04-5588A	02
04	NC	MONTGOMERY COUNTY	3703360025B	30-SEP-1999	99-04-5562A	02
04	NC	MONTGOMERY COUNTY	3703360025B	29-SEP-1999	99-04-5502A	02
04	NC	MONTGOMERY COUNTY	3703360025B	17-SEP-1999	99-04-5520A	02
04	NC	MONTGOMERY COUNTY	3703360025B	17-AUG-1999	99-04-5466A	02
04	NC	MONTGOMERY COUNTY	3703360025B	09-NOV-1999	99-04-5288A	02
04	NC	MONTGOMERY COUNTY	3703360025B	27-OCT-1999	99-04-5172A	02
04	NC	MONTGOMERY COUNTY	3703360025B	23-SEP-1999	99-04-5150A	02
04	NC	MONTGOMERY COUNTY	3703360025B	23-SEP-1999	99-04-5154A	02
04	NC	MONTGOMERY COUNTY	3703360025B	23-SEP-1999	99-04-5156A	02
04	NC	MONTGOMERY COUNTY	3703360025B	16-SEP-1999	99-04-5114A	02
04	NC	MONTGOMERY COUNTY	3703360025B	16-SEP-1999	99-04-5070A	02
04	NC	MONTGOMERY COUNTY	3703360025B	27-AUG-1999	99-04-5048A	02
04	NC	MONTGOMERY COUNTY	3703360025B	10-SEP-1999	99-04-4970A	02
04	NC	MONTGOMERY COUNTY	3703360025B	10-SEP-1999	99-04-4934A	02
04	NC	MONTGOMERY COUNTY	3703360025B	09-JUL-1999	99-04-4070A	02
04	NC	MONTGOMERY COUNTY	3703360025B	20-JUL-1999	99-04-4132A	02
04	NC	MONTGOMERY COUNTY	3703360025B	20-JUL-1999	99-04-4048A	02
04	NC	MONTGOMERY COUNTY	3703360025B	04-AUG-1999	99-04-3184A	02
04	NC	MONTGOMERY COUNTY	3703360025B	11-AUG-1999	99-04-2778A	02
04	NC	MONTGOMERY COUNTY	3703360065B	02-DEC-1999	99-04-6294A	02
04	NC	MONTGOMERY COUNTY	3703360065B	28-DEC-1999	99-04-6334A	02
04	NC	MONTGOMERY COUNTY	3703360065B	23-NOV-1999	99-04-6090A	02
04	NC	MONTGOMERY COUNTY	3703360065B	18-NOV-1999	99-04-6088A	02
04	NC	MONTGOMERY COUNTY	3703360065B	28-OCT-1999	99-04-5780A	02
04	NC	MONTGOMERY COUNTY	3703360065B	23-SEP-1999	99-04-5200A	02
04	NC	MONTGOMERY COUNTY	3703360065B	23-SEP-1999	99-04-5098A	02
04	NC	MONTGOMERY COUNTY	3703360065B	30-JUL-1999	99-04-4996A	02
04	NC	MONTGOMERY COUNTY	3703360065B	10-SEP-1999	99-04-4938A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
04	NC	MONTGOMERY COUNTY	3703360065B	26-AUG-1999	99-04-4842A	02
04	NC	MONTGOMERY COUNTY	3703360065B	08-JUL-1999	99-04-3982A	02
04	NC	MORGANTON,CITY OF	3700350004B	02-SEP-1999	99-04-4876A	02
04	NC	MORGANTON,CITY OF	3700350005B	09-DEC-1999	99-04-4032A	02
04	NC	MORGANTON,CITY OF	3700350009B	06-AUG-1999	99-04-3138A	01
04	NC	MORRISVILLE, TOWN OF	37183C0291E	28-DEC-1999	00-04-0852X	01
04	NC	MORRISVILLE, TOWN OF	37183C0291E	08-OCT-1999	99-04-5964A	01
04	NC	MOUNT HOLLY, CITY OF	3701020005B	27-OCT-1999	99-04-5194A	02
04	NC	NEW HANOVER COUNTY*	3701680040D	28-SEP-1999	99-04-4882A	01
04	NC	NEW HANOVER COUNTY*	3701680045E	28-DEC-1999	00-04-0150A	02
04	NC	NEW HANOVER COUNTY*	3701680090E	01-SEP-1999	99-04-4626A	02
04	NC	NEW HANOVER COUNTY*	3701680105D	26-AUG-1999	99-04-4820A	02
04	NC	ONSLOW COUNTY*	3703400225C	28-DEC-1999	99-04-4746A	02
04	NC	ONSLOW COUNTY*	3703400300C	21-OCT-1999	99-04-5704A	02
04	NC	ONSLOW COUNTY*	3703400300C	19-OCT-1999	99-04-5564A	02
04	NC	ONSLOW COUNTY*	3703400300C	03-SEP-1999	99-04-4496A	02
04	NC	ONSLOW COUNTY*	3703400305C	22-JUL-1999	99-04-4388A	02
04	NC	ONSLOW COUNTY*	3703400360C	03-DEC-1999	00-04-0184A	02
04	NC	ONSLOW COUNTY*	3703400366D	12-NOV-1999	99-04-5278A	02
04	NC	ONSLOW COUNTY*	3703400367D	02-SEP-1999	99-04-4824A	02
04	NC	ONSLOW COUNTY*	3703400380C	09-JUL-1999	99-04-4264A	02
04	NC	PENDER COUNTY*	3703440394B	21-OCT-1999	99-04-6154A	02
04	NC	PENDER COUNTY*	3703440529D	20-JUL-1999	99-04-4360A	02
04	NC	PERQUIMANS COUNTY	3703150105B	28-DEC-1999	99-04-5822A	02
04	NC	PITT COUNTY *	3703720145B	08-DEC-1999	00-04-0854X	02
04	NC	PITT COUNTY *	3703720145B	03-SEP-1999	99-04-4548A	02
04	NC	PITT COUNTY *	3703720220C	28-DEC-1999	00-04-0544A	02
04	NC	PITT COUNTY *	3703720250C	23-SEP-1999	99-04-5518A	02
04	NC	PITT COUNTY *	3703720250C	10-SEP-1999	99-04-4826A	02
04	NC	PLYMOUTH, TOWN OF	3702490003C	14-JUL-1999	99-04-2978A	02
04	NC	POLK COUNTY*	3701940003B	17-SEP-1999	99-04-3658A	02
04	NC	RALEIGH, CITY OF	37183C0110E	23-JUL-1999	99-04-4354A	01
04	NC	RALEIGH, CITY OF	37183C0337F	19-NOV-1999	99-04-4736A	02
04	NC	RALEIGH, CITY OF	37183C0352E	10-DEC-1999	99-04-4188A	01
04	NC	RALEIGH, CITY OF	37183C0352E	21-SEP-1999	99-04-4924A	01
04	NC	RALEIGH, CITY OF	37183C0353E	01-SEP-1999	99-04-4550A	02
04	NC	RALEIGH, CITY OF	37183C0555E	10-SEP-1999	99-04-4466A	02
04	NC	RANDOLPH COUNTY *	3701950150B	30-JUL-1999	99-04-4868A	02
04	NC	RIVER BEND, TOWN OF	3704320002B	28-SEP-1999	99-04-5484A	02
04	NC	ROBESON COUNTY *	37155C0250D	19-NOV-1999	99-04-4414A	01
04	NC	ROCKY MOUNT, CITY OF	3700920004C	30-NOV-1999	99-04-5948A	01
04	NC	ROCKY MOUNT, CITY OF	3700920005C	24-NOV-1999	99-04-6238A	02
04	NC	ROWAN COUNTY *	3703510150B	04-AUG-1999	99-04-3772A	02
04	NC	STANLY COUNTY *	3703610100B	04-NOV-1999	00-04-0098A	02
04	NC	STANLY COUNTY *	3703610100B	08-SEP-1999	99-04-3904A	02
04	NC	STANLY COUNTY *	3703610100B	29-JUL-1999	99-04-2634A	02
04	NC	SWAIN COUNTY*	3702270138C	02-DEC-1999	00-04-0384A	17
04	NC	TRENT WOODS, TOWNSHIPOF	3704340001B	10-SEP-1999	99-04-6046V	19
04	NC	WASHINGTON COUNTY*	3702470040C	14-OCT-1999	99-04-3604A	02
04	NC	WASHINGTON, CITY OF	3700170005C	30-NOV-1999	99-04-6114A	02
04	NC	WATAUGA COUNTY *	37189C0167F	04-AUG-1999	99-04-3966A	02
04	NC	WELDON, TOWN OF	3701190005B	08-DEC-1999	00-04-0368A	02
04	NC	WILKESBORO, TOWN OF	3702590005E	10-AUG-1999	99-04-5308A	19
04	NC	WILMINGTON, CITY OF	3701710010B	30-DEC-1999	00-04-0628A	02
04	NC	WILMINGTON, CITY OF	3701710010B	02-SEP-1999	99-04-4912A	02
04	NC	WINSTON-SALEM, CITY OF	37067C0139H	12-AUG-1999	99-04-4400A	02
04	NC	WINSTON-SALEM, CITY OF	37067C0252H	30-NOV-1999	00-04-0378A	02
04	NC	WINSTON-SALEM, CITY OF	37067C0252H	30-SEP-1999	99-04-5294A	02
04	NC	WINSTON-SALEM, CITY OF	37067C0259H	19-OCT-1999	99-04-5118A	02
04	NC	YAUPON BEACH, TOWN OF	3700300002D	26-AUG-1999	99-04-4658A	02
04	SC	ANDERSON COUNTY *	4500130215B	08-SEP-1999	99-04-079P	05
04	SC	BEAUFORT COUNTY*	4500250065D	19-AUG-1999	99-04-4452A	02
04	SC	BEAUFORT COUNTY*	4500250065D	09-JUL-1999	99-04-2866A	02
04	SC	BEAUFORT COUNTY*	4500250100D	12-AUG-1999	99-04-3978A	02
04	SC	BERKELEY COUNTY *	4500290290C	12-AUG-1999	99-04-4306A	02
04	SC	CHARLESTON COUNTY*	4554130225G	07-DEC-1999	00-04-0054A	02
04	SC	CHARLESTON, CITY OF	4554120010D	12-NOV-1999	99-04-5260A	02
04	SC	CLARENDON COUNTY *	4500510225B	08-DEC-1999	00-04-0090A	02
04	SC	COLUMBIA, CITY OF	45079C0176G	02-DEC-1999	99-04-4972A	01
04	SC	CONWAY, TOWN OF	45051CIND0	24-AUG-1999	99-04-6042V	19
04	SC	FAIRFIELD COUNTY *	4500750065B	18-AUG-1999	99-04-3306A	02
04	SC	FAIRFIELD COUNTY *	4500750135B	23-SEP-1999	99-04-4128A	02
04	SC	GEORGETOWN COUNTY *	4500850240D	14-JUL-1999	99-04-3456A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
04	SC	GEORGETOWN COUNTY *	4500850455E	17-SEP-1999	99-04-5568A	02
04	SC	GREENVILLE COUNTY *	4500890275A	09-NOV-1999	99-04-5838A	02
04	SC	GREENWOOD COUNTY*	4500940063B	09-JUL-1999	99-04-3902A	02
04	SC	HORRY COUNTY *	45051C0260F	01-SEP-1999	99-04-1742A	02
04	SC	HORRY COUNTY *	45051C0367F	24-AUG-1999	99-04-4730A	02
04	SC	HORRY COUNTY *	45051C0583H	12-NOV-1999	99-04-5304A	02
04	SC	LEXINGTON COUNTY *	45063C0100F	21-OCT-1999	99-04-5884A	02
04	SC	LEXINGTON COUNTY *	45063C0141F	06-AUG-1999	99-04-4748A	02
04	SC	LEXINGTON COUNTY *	45063C0375F	16-DEC-1999	00-04-0060A	02
04	SC	MYRTLE BEACH, CITY OF	45051CIND0	24-AUG-1999	99-04-6040V	19
04	SC	NEWBERRY COUNTY*	4502240225B	30-DEC-1999	99-04-5782A	02
04	SC	NEWBERRY COUNTY*	4502240225B	28-SEP-1999	99-04-5256A	02
04	SC	NEWBERRY, CITY OF	4501530002B	29-DEC-1999	00-04-001P	05
04	SC	ORANGEBURG COUNTY *	4501600280B	05-OCT-1999	99-04-3236A	02
04	SC	QUINBY, TOWN OF	450082B	28-JUL-1999	99-04-3222A	02
04	SC	RICHLAND COUNTY*	45079C0025G	24-SEP-1999	99-04-5658A	02
04	SC	RICHLAND COUNTY*	45079C0025G	23-SEP-1999	99-04-5428A	02
04	SC	RICHLAND COUNTY*	45079C0025G	10-SEP-1999	99-04-5056A	02
04	SC	RICHLAND COUNTY*	45079C0025G	24-AUG-1999	99-04-3438A	02
04	SC	RICHLAND COUNTY*	45079C0025G	09-JUL-1999	99-04-2732A	02
04	SC	RICHLAND COUNTY*	45079C0025G	22-JUL-1999	99-04-2702A	02
04	SC	RICHLAND COUNTY*	45079C0040H	30-JUL-1999	99-04-139P	05
04	SC	RICHLAND COUNTY*	45079C0105G	15-SEP-1999	99-04-121P	05
04	SC	RICHLAND COUNTY*	45079C0105G	15-SEP-1999	99-04-061P	05
04	SC	SUMTER COUNTY *	4501820025B	24-AUG-1999	99-04-5320V	19
04	SC	YORK COUNTY *	4501930025B	13-DEC-1999	99-04-5282A	02
04	SC	YORK COUNTY *	4501930025B	16-DEC-1999	99-04-4890A	02
04	SC	YORK COUNTY *	4501930050B	17-SEP-1999	99-04-5532A	02
04	SC	YORK COUNTY *	4501930050B	16-JUL-1999	99-04-3750A	02
04	SC	YORK COUNTY *	4501930125C	21-OCT-1999	99-04-4726A	02
04	SC	YORK COUNTY *	4501930125C	01-SEP-1999	99-04-065P	05
04	TN	BENTON COUNTY	4702180025B	12-NOV-1999	99-04-5352A	02
04	TN	BENTON COUNTY	4702180025B	14-JUL-1999	99-04-3398A	02
04	TN	BLOUNT COUNTY *	4703560025B	03-AUG-1999	99-04-4020A	02
04	TN	BLOUNT COUNTY *	4703560050B	22-DEC-1999	00-04-0844A	02
04	TN	BRADLEY COUNTY *	4703570060B	09-DEC-1999	00-04-0476A	02
04	TN	BRADLEY COUNTY *	4703570060B	21-SEP-1999	99-04-4366A	01
04	TN	BRENTWOOD, CITY OF	4702050005C	02-SEP-1999	99-04-4442A	02
04	TN	BRISTOL, CITY OF	4701820003B	07-SEP-1999	99-04-2194A	02
04	TN	CHATTANOOGA, CITY OF	4700720011C	22-JUL-1999	99-04-2660A	02
04	TN	CHATTANOOGA, CITY OF	4700720029E	16-DEC-1999	99-04-5716A	02
04	TN	CHATTANOOGA, CITY OF	4700720029E	25-AUG-1999	99-04-4804A	02
04	TN	CHEATHAM COUNTY *	4700260025B	07-DEC-1999	00-04-0968V	19
04	TN	CLARKSVILLE, CITY OF	4701370006C	07-JUL-1999	99-04-496A	02
04	TN	CLARKSVILLE, CITY OF	4701370010C	30-DEC-1999	99-04-5480A	02
04	TN	CLARKSVILLE, CITY OF	4701370013C	22-SEP-1999	99-04-4218A	02
04	TN	COLLIERVILLE, CITY OF	47157C0240E	17-NOV-1999	99-04-4192A	01
04	TN	COLLIERVILLE, CITY OF	47157C0240E	06-AUG-1999	99-04-3064A	01
04	TN	COLLIERVILLE, CITY OF	47157C0240E	15-SEP-1999	99-04-105P	05
04	TN	COLLIERVILLE, CITY OF	47157C0245E	19-AUG-1999	99-04-2382A	01
04	TN	COLUMBIA, CITY OF	4754230005D	12-NOV-1999	99-04-6136A	02
04	TN	COLUMBIA, CITY OF	4754230007D	29-DEC-1999	00-04-0706A	02
04	TN	COVINGTON, CITY OF	47167C0065E	17-DEC-1999	99-04-5742A	02
04	TN	COVINGTON, CITY OF	47167C0065E	17-DEC-1999	99-04-5584A	01
04	TN	DECATUR COUNTY	4700410004B	18-NOV-1999	00-04-0160A	02
04	TN	EAST RIDGE, CITY OF	4754240010D	14-OCT-1999	99-04-5402A	02
04	TN	EAST RIDGE, CITY OF	4754240010D	14-JUL-1999	99-04-3676A	02
04	TN	EAST RIDGE, CITY OF	4754240010D	02-SEP-1999	99-04-2402P	05
04	TN	FARRAGUT, TOWN OF	4703870015A	21-DEC-1999	99-04-5940A	01
04	TN	FARRAGUT, TOWN OF	4703870015A	15-JUL-1999	99-04-2056A	01
04	TN	FAYETTEVILLE, CITY OF	4701050001B	21-DEC-1999	00-04-0974V	19
04	TN	GERMANTOWN, CITY OF	47157C0230E	14-JUL-1999	99-04-4430A	02
04	TN	GERMANTOWN, CITY OF	47157C0230E	18-AUG-1999	99-04-4252A	02
04	TN	GERMANTOWN, CITY OF	47157C0235E	30-DEC-1999	00-04-0830A	17
04	TN	GERMANTOWN, CITY OF	47157C0235E	30-JUL-1999	99-04-4222A	01
04	TN	GERMANTOWN, CITY OF	47157C0235E	10-NOV-1999	99-04-229P	05
04	TN	HAMILTON COUNTY *	4700710135D	12-NOV-1999	00-04-0504A	02
04	TN	HAWKINS COUNTY*	4700850065B	28-DEC-1999	00-04-0652A	02
04	TN	HENDERSON COUNTY *	47077C0075C	18-NOV-1999	99-04-3274A	02
04	TN	HENDERSONVILLE, CITY OF	4701860008C	02-DEC-1999	00-04-0612A	02
04	TN	KNOX COUNTY *	4754330080B	16-DEC-1999	00-04-0176A	02
04	TN	KNOX COUNTY *	4754330115B	21-OCT-1999	99-04-6214A	02
04	TN	KNOX COUNTY *	4754330120B	04-AUG-1999	99-04-4448A	02

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04	TN	KNOX COUNTY *	4754330175B	01-DEC-1999	99-04-5202A	17
04	TN	LAVERGNE, CITY OF	47149C0014E	17-AUG-1999	99-04-5052A	01
04	TN	LAVERGNE, CITY OF	47149C0014F	16-NOV-1999	00-04-0360A	01
04	TN	LEWISBURG, CITY OF	47117C0133C	21-DEC-1999	99-04-5410A	02
04	TN	MANCHESTER, CITY OF	4700350003B	12-OCT-1999	99-04-5836A	02
04	TN	MARION COUNTY *	4701140200B	28-DEC-1999	00-04-0594A	02
04	TN	MEMPHIS, CITY OF	47157C0185E	17-DEC-1999	99-04-6292A	02
04	TN	MEMPHIS, CITY OF	47157C0225E	23-SEP-1999	99-04-3562A	02
04	TN	MEMPHIS, CITY OF	47157C0230E	23-NOV-1999	00-04-0374A	02
04	TN	MONTGOMERY COUNTY *	4701360050B	26-AUG-1999	99-04-4138A	02
04	TN	MONTGOMERY COUNTY *	4701360095B	25-AUG-1999	99-04-3594A	02
04	TN	MURFREESBORO, CITY OF	47149C0137E	09-NOV-1999	00-04-0972V	19
04	TN	MURFREESBORO, CITY OF	47149C0145E	04-NOV-1999	00-04-0084A	02
04	TN	MURFREESBORO, CITY OF	47149C0145E	09-NOV-1999	99-04-5620A	02
04	TN	MURFREESBORO, CITY OF	47149C0145E	03-AUG-1999	99-04-4278A	02
04	TN	MURFREESBORO, CITY OF	47149C0260E	10-SEP-1999	99-04-3618A	01
04	TN	MURFREESBORO, CITY OF	47149C0260E	15-OCT-1999	98-04-1738A	01
04	TN	MURFREESBORO, CITY OF	47149C0260F	16-NOV-1999	99-04-4760A	01
04	TN	NASHVILLE, CITY OF & DAVIDSON COUNTY	4700400112C	05-OCT-1999	99-04-5138A	02
04	TN	NASHVILLE, CITY OF & DAVIDSON COUNTY	4700400177B	22-DEC-1999	00-04-0686A	01
04	TN	NASHVILLE, CITY OF & DAVIDSON COUNTY	4700400177B	22-DEC-1999	00-04-0688A	01
04	TN	NASHVILLE, CITY OF & DAVIDSON COUNTY	4700400177B	28-DEC-1999	00-04-0620A	01
04	TN	NASHVILLE, CITY OF & DAVIDSON COUNTY	4700400177B	28-DEC-1999	00-04-0606A	01
04	TN	NASHVILLE, CITY OF & DAVIDSON COUNTY	4700400177B	21-DEC-1999	00-04-0250A	01
04	TN	NASHVILLE, CITY OF & DAVIDSON COUNTY	4700400177B	12-NOV-1999	99-04-5982A	01
04	TN	NASHVILLE, CITY OF & DAVIDSON COUNTY	4700400177B	23-SEP-1999	99-04-4536A	01
04	TN	NASHVILLE, CITY OF & DAVIDSON COUNTY	4700400192C	30-NOV-1999	99-04-5984A	01
04	TN	NASHVILLE, CITY OF & DAVIDSON COUNTY	4700400192C	17-NOV-1999	99-04-5376A	01
04	TN	NASHVILLE, CITY OF & DAVIDSON COUNTY	4700400192C	05-AUG-1999	99-04-4320A	01
04	TN	NASHVILLE, CITY OF & DAVIDSON COUNTY	4700400234B	15-DEC-1999	99-04-4534A	01
04	TN	OAK RIDGE, CITY OF	4754410015E	23-SEP-1999	99-04-5346A	02
04	TN	OAK RIDGE, CITY OF	4754410015E	22-DEC-1999	99-04-4722A	01
04	TN	PEGRAM, TOWNSHIP OF	47021C0215C	07-DEC-1999	00-04-0976V	19
04	TN	RUTHERFORD COUNTY *	47149C0010E	09-NOV-1999	00-04-0970V	19
04	TN	RUTHERFORD COUNTY *	47149C0137E	23-SEP-1999	99-04-5514A	02
04	TN	RUTHERFORD COUNTY *	47149C0137E	30-JUL-1999	99-04-3894A	02
04	TN	RUTHERFORD COUNTY *	47149C0161F	09-NOV-1999	99-04-5720A	02
04	TN	RUTHERFORD COUNTY *	47149C0286E	05-NOV-1999	99-04-4646A	02
04	TN	SELMER, CITY OF	4701320005C	07-DEC-1999	99-04-5028A	02
04	TN	SHELBY COUNTY *	47157C0095E	16-SEP-1999	99-04-4998A	02
04	TN	SHELBY COUNTY *	47157C0145E	04-NOV-1999	99-04-6236A	02
04	TN	SHELBY COUNTY *	47157C0185E	05-NOV-1999	99-04-5184A	02
04	TN	SHELBY COUNTY *	47157C0185E	10-SEP-1999	99-04-5008A	02
04	TN	SHELBY COUNTY *	47157C0185E	01-DEC-1999	99-04-4870A	01
04	TN	SHELBY COUNTY *	47157C0185E	02-SEP-1999	99-04-095P	05
04	TN	SHELBY COUNTY *	47157C0240E	10-SEP-1999	99-04-5286A	01
04	TN	SHELBY COUNTY *	47157C0240E	10-SEP-1999	99-04-4910A	02
04	TN	SHELBY COUNTY *	47157C0290E	07-DEC-1999	00-04-0204A	02
04	TN	SHELBYVILLE, CITY OF	4700080028C	15-SEP-1999	99-04-3182A	01
04	TN	SMYRNA, TOWN OF	47149C0106E	29-SEP-1999	99-04-5772A	02
04	TN	SOMERVILLE, TOWN OF	4700510005B	10-SEP-1999	99-04-3578A	01
04	TN	SUMNER COUNTY*	4703490095B	06-AUG-1999	99-04-4312A	02
04	TN	SUMNER COUNTY*	4703490120B	17-DEC-1999	00-04-0626A	02
04	TN	TRENTON, CITY OF	4700620002B	22-SEP-1999	99-04-4494A	02
04	TN	UNION CITY, CITY OF	4701420010B	07-DEC-1999	00-04-0462A	02
04	TN	WAVERLY, CITY OF	4700950005B	12-NOV-1999	99-04-6104A	02
05	IL	ADAMS COUNTY*	1700010160C	28-JUL-1999	99-05-4416A	02
05	IL	ADDISON, VILLAGE OF	1701980004C	15-DEC-1999	99-05-6930A	02
05	IL	ADDISON, VILLAGE OF	1701980004C	17-NOV-1999	99-05-6888A	02
05	IL	ADDISON, VILLAGE OF	1701980004C	10-NOV-1999	99-05-5390A	02
05	IL	ALGONQUIN, VILLAGE OF	1704740001B	18-AUG-1999	99-05-5114A	02
05	IL	ANTIOCH, VILLAGE OF	17097C0027F	01-SEP-1999	99-05-3818A	02
05	IL	AURORA, CITY OF	1703200015D	22-SEP-1999	99-05-6324A	02
05	IL	AURORA, CITY OF	17197C0030E	23-JUL-1999	99-05-5040A	01
05	IL	AURORA, CITY OF	17197C0030E	04-AUG-1999	99-05-4874A	01
05	IL	AURORA, CITY OF	17197C0030E	01-SEP-1999	99-05-3900A	01
05	IL	BARTONVILLE, VILLAGE OF	1705340005C	30-JUL-1999	99-05-5118A	02
05	IL	BATAVIA, CITY OF	1703210002B	27-OCT-1999	99-05-5812A	02
05	IL	BATAVIA, CITY OF	1703210004B	23-JUL-1999	99-05-5266A	02
05	IL	BEACH PARK, VILLAGE OF	17097C0087F	23-JUL-1999	99-05-4686A	02
05	IL	BEECHER, VILLAGE OF	17197C0507E	18-OCT-1999	99-05-037P	06
05	IL	BELLWOOD, VILLAGE OF	1700610001B	30-DEC-1999	00-05-0228A	02
05	IL	BLOOMINGTON, CITY OF	1704900005C	15-DEC-1999	99-05-7036A	02

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05	IL	BLOOMINGTON, CITY OF	1704900005C	05-NOV-1999	99-05-6812A	02
05	IL	BLOOMINGTON, CITY OF	1704900005C	17-SEP-1999	99-05-6010A	01
05	IL	BLOOMINGTON, CITY OF	1704900005C	27-AUG-1999	99-05-5328A	02
05	IL	BLOOMINGTON, CITY OF	1704900010C	22-OCT-1999	99-05-6582A	17
05	IL	BLOOMINGTON, CITY OF	1704900010C	12-NOV-1999	99-05-5508A	17
05	IL	BUFFALO GROVE, VILLAGE OF	17097C0261F	30-DEC-1999	00-05-0186A	02
05	IL	BUFFALO GROVE, VILLAGE OF	17097C0261F	05-NOV-1999	99-05-6034A	02
05	IL	BUFFALO GROVE, VILLAGE OF	17097C0261F	29-OCT-1999	99-05-5614A	02
05	IL	BUFFALO GROVE, VILLAGE OF	17097C0261F	04-AUG-1999	99-05-5070A	02
05	IL	BUFFALO GROVE, VILLAGE OF	17097C0262F	04-AUG-1999	99-05-5060A	17
05	IL	BUFFALO GROVE, VILLAGE OF	17097C0262F	22-JUL-1999	99-05-087P	05
05	IL	CAHOKIA, VILLAGE OF	1706200005C	11-AUG-1999	99-05-5164A	02
05	IL	CARLOCK, VILLAGE OF	170491B	17-DEC-1999	99-05-6738A	02
05	IL	CARMI, CITY OF	1706810005B	03-DEC-1999	00-05-0188A	02
05	IL	CARMI, CITY OF	1706810005B	08-DEC-1999	99-05-7400A	02
05	IL	CARMI, CITY OF	1706810005B	27-AUG-1999	99-05-6128A	02
05	IL	CARMI, CITY OF	1706810005B	01-SEP-1999	99-05-6178A	02
05	IL	CARMI, CITY OF	1706810005B	27-AUG-1999	99-05-5828A	02
05	IL	CARMI, CITY OF	1706810005B	07-JUL-1999	99-05-4512A	02
05	IL	CARMI, CITY OF	1706810005B	28-JUL-1999	99-05-4364A	02
05	IL	CAROL STREAM, VILLAGE OF	1702020005C	03-NOV-1999	99-05-6358A	01
05	IL	CAROL STREAM, VILLAGE OF	1702020005C	23-JUL-1999	99-05-5168A	01
05	IL	CAROL STREAM, VILLAGE OF	1702020005C	04-AUG-1999	99-05-115P	05
05	IL	CHAMPAIGN COUNTY *	1708940100B	27-OCT-1999	99-05-6090A	02
05	IL	CHAMPAIGN COUNTY *	1708940150B	03-SEP-1999	99-05-5602A	02
05	IL	CHAMPAIGN COUNTY *	1708940275B	10-SEP-1999	99-05-5820A	02
05	IL	CHAMPAIGN COUNTY *	1708940275B	13-AUG-1999	99-05-4478A	02
05	IL	CHATHAM, VILLAGE OF	1706010250C	29-OCT-1999	99-05-4594A	01
05	IL	CHICAGO RIDGE, VILLAGE OF	1700760001B	11-AUG-1999	99-05-5530A	02
05	IL	CLINTON COUNTY*	170044B	22-SEP-1999	99-05-3530A	02
05	IL	COOK COUNTY *	1700540040B	17-SEP-1999	99-05-6114A	02
05	IL	COOK COUNTY *	1700540165B	30-JUL-1999	99-05-5102A	02
05	IL	COOK COUNTY *	1700540190B	23-JUL-1999	99-05-4892A	02
05	IL	COOK COUNTY *	1700540215B	02-NOV-1999	98-05-025P	06
05	IL	COOK COUNTY *	1700540235C	10-SEP-1999	99-05-5398A	01
05	IL	COOK COUNTY *	1701330001C	21-JUL-1999	99-05-3920A	01
05	IL	CRAWFORD COUNTY*	1709390125B	22-DEC-1999	99-05-5668A	02
05	IL	CRESTWOOD, VILLAGE OF	1700800001E	28-JUL-1999	99-05-5606A	02
05	IL	DARIEN, CITY OF	1701970060B	08-DEC-1999	00-05-0982X	01
05	IL	DARIEN, CITY OF	1701970060B	17-NOV-1999	99-05-4854A	01
05	IL	DARIEN, CITY OF	1707500002A	17-NOV-1999	99-05-6588A	02
05	IL	DECATUR, CITY OF	1704290005C	29-DEC-1999	00-05-1124A	02
05	IL	DECATUR, CITY OF	1704290005C	11-AUG-1999	99-05-3768A	02
05	IL	DECATUR, CITY OF	1704290015C	15-DEC-1999	00-05-0226A	17
05	IL	DEERFIELD, VILLAGE OF	17097C0286F	10-DEC-1999	99-05-6306A	02
05	IL	DEERFIELD, VILLAGE OF	17097C0288F	24-SEP-1999	99-05-5992A	02
05	IL	DES PLAINES, CITY OF	1700810005C	03-SEP-1999	99-05-5720A	02
05	IL	DES PLAINES, CITY OF	1700810005C	14-JUL-1999	99-05-5016A	02
05	IL	DEWITT COUNTY *	17039C0025D	02-DEC-1999	99-05-5818A	02
05	IL	DIXON, CITY OF	17103C0018E	09-JUL-1999	99-05-4110A	02
05	IL	DIXON, CITY OF	17103C0018E	17-SEP-1999	99-05-119P	06
05	IL	DOUGLAS COUNTY*	1701940100B	14-JUL-1999	99-05-4708A	02
05	IL	DOWNERS GROVE, VILLAGE OF	1702040004B	12-NOV-1999	99-05-6360A	02
05	IL	DOWNERS GROVE, VILLAGE OF	1702040004B	16-JUL-1999	99-05-3132A	02
05	IL	DOWNERS GROVE, VILLAGE OF	1702040006C	29-SEP-1999	99-05-6340A	02
05	IL	DOWNERS GROVE, VILLAGE OF	1702040008B	03-DEC-1999	99-05-6444A	02
05	IL	DUPAGE COUNTY*	1701970010C	18-AUG-1999	99-05-5484A	02
05	IL	DUPAGE COUNTY*	1701970025B	27-AUG-1999	99-05-4482A	02
05	IL	DUPAGE COUNTY*	1701970025B	04-AUG-1999	99-05-115P	05
05	IL	DUPAGE COUNTY*	1701970030D	06-AUG-1999	99-05-2830A	02
05	IL	DUPAGE COUNTY*	1701970040B	03-DEC-1999	99-05-5748A	17
05	IL	DUPAGE COUNTY*	1701970040B	15-OCT-1999	99-05-4266A	01
05	IL	DUPAGE COUNTY*	1701970050B	02-JUL-1999	99-05-4712A	01
05	IL	ELGIN, CITY OF	1700870003C	03-SEP-1999	99-05-161P	05
05	IL	FLOSSMOOR, VILLAGE OF	1700910001D	23-JUL-1999	99-05-5646A	02
05	IL	FOX LAKE, VILLAGE OF	17097C0015F	20-OCT-1999	99-05-6500A	02
05	IL	FOX LAKE, VILLAGE OF	17097C0015F	03-DEC-1999	99-05-6336A	02
05	IL	FOX LAKE, VILLAGE OF	17097C0015F	27-AUG-1999	99-05-5740A	02
05	IL	FOX LAKE, VILLAGE OF	17097C0015F	15-OCT-1999	99-05-4406A	02
05	IL	FOX LAKE, VILLAGE OF	17097C0020F	08-DEC-1999	00-05-0356A	02
05	IL	FOX LAKE, VILLAGE OF	17097C0020F	09-JUL-1999	99-05-4960A	02
05	IL	FOX LAKE, VILLAGE OF	17097C0020F	09-JUL-1999	99-05-4958A	02
05	IL	FOX LAKE, VILLAGE OF	17097C0020F	28-JUL-1999	99-05-3628A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
05	IL	FRANKLIN COUNTY*	1708990005B	01-SEP-1999	99-05-5354A	02
05	IL	GLEN ELLYN, VILLAGE OF	1702070005C	30-NOV-1999	99-05-187P	05
05	IL	GLENVIEW, VILLAGE OF	1700960005C	03-NOV-1999	99-05-5414A	17
05	IL	GLENVIEW, VILLAGE OF	1700960008C	21-SEP-1999	99-05-6840A	17
05	IL	GLENVIEW, VILLAGE OF	1700960008C	11-AUG-1999	99-05-4760A	02
05	IL	GRAYSLAKE, VILLAGE OF	17097C0131F	25-AUG-1999	99-05-6298A	02
05	IL	GRAYSLAKE, VILLAGE OF	17097C0132F	18-AUG-1999	99-05-5116A	02
05	IL	GRUNDY COUNTY *	1702560040C	24-SEP-1999	99-05-6326A	01
05	IL	GURNEE, VILLAGE OF	17097C0063F	18-AUG-1999	99-05-063P	05
05	IL	GURNEE, VILLAGE OF	17097C0157F	15-DEC-1999	00-05-0490A	02
05	IL	GURNEE, VILLAGE OF	17097C0157F	30-JUL-1999	99-05-4036A	02
05	IL	HAINESVILLE, VILLAGE OF	17097C0127F	30-SEP-1999	99-05-251P	05
05	IL	HAMILTON, CITY OF	1702710005B	21-JUL-1999	99-05-5276A	02
05	IL	HAMPSHIRE, VILLAGE OF	1703270002C	27-JUL-1999	99-05-103P	05
05	IL	HAWTHORN WOODS, VILLAGE OF	17097C0231F	13-OCT-1999	99-05-5342A	02
05	IL	HIGHLAND PARK, CITY OF	17097C0279F	03-SEP-1999	99-05-5378A	02
05	IL	HINSDALE, VILLAGE OF	1701050002B	13-OCT-1999	99-05-5656A	02
05	IL	HINSDALE, VILLAGE OF	1701050002B	15-DEC-1999	99-05-5574A	02
05	IL	HOFFMAN ESTATES, VILLAGE OF	1701070007C	01-OCT-1999	99-05-5830A	02
05	IL	HOFFMAN ESTATES, VILLAGE OF	1701070007C	16-JUL-1999	99-05-4830A	02
05	IL	HOFFMAN ESTATES, VILLAGE OF	1701070007C	02-JUL-1999	99-05-4812A	02
05	IL	HOFFMAN ESTATES, VILLAGE OF	1701070008B	12-NOV-1999	99-05-6918A	02
05	IL	HOLIDAY HILLS, VILLAGE OF	1709360001B	10-DEC-1999	00-05-0230A	02
05	IL	HOLIDAY HILLS, VILLAGE OF	1709360001B	22-SEP-1999	99-05-5752A	02
05	IL	HOMEWOOD, VILLAGE OF	170109C	29-DEC-1999	00-05-0164A	02
05	IL	HOMEWOOD, VILLAGE OF	170109C	30-JUL-1999	99-05-4598A	02
05	IL	HOMEWOOD, VILLAGE OF	170109C	09-JUL-1999	99-05-3368A	02
05	IL	HUNTLEY, VILLAGE OF	1704800002C	18-AUG-1999	99-05-5036A	01
05	IL	HUNTLEY, VILLAGE OF	1704800004C	13-OCT-1999	99-05-5966A	02
05	IL	HUNTLEY, VILLAGE OF	1704800004C	06-OCT-1999	99-05-5968A	01
05	IL	HUNTLEY, VILLAGE OF	1704800004C	08-OCT-1999	99-05-4900A	01
05	IL	ISLAND LAKE, VILLAGE OF	1703700001B	15-OCT-1999	99-05-5754A	02
05	IL	ISLAND LAKE, VILLAGE OF	1703700001B	20-OCT-1999	99-05-5718A	02
05	IL	JACKSONVILLE, CITY OF	1705160010C	14-JUL-1999	99-05-4212A	17
05	IL	JEFFERSON COUNTY	170305A	05-NOV-1999	99-05-6376A	02
05	IL	JOHNSBURG, VILLAGE OF	1704860001B	29-DEC-1999	00-05-0206A	02
05	IL	JOLIET, CITY OF	17197C0130E	17-DEC-1999	99-05-5400A	02
05	IL	JOLIET, CITY OF	17197C0135E	12-AUG-1999	99-05-5138A	01
05	IL	JOLIET, CITY OF	17197C0141E	24-SEP-1999	99-05-5808A	02
05	IL	JOLIET, CITY OF	17197C0141E	08-SEP-1999	99-05-3568A	01
05	IL	KANE COUNTY *	1708960044B	23-AUG-1999	99-05-5416A	02
05	IL	KANE COUNTY *	1708960044B	23-JUL-1999	99-05-3640A	02
05	IL	KANE COUNTY *	1708960061B	30-DEC-1999	00-05-1134A	02
05	IL	KANE COUNTY *	1708960061B	10-DEC-1999	00-05-0130A	02
05	IL	KANE COUNTY *	1708960102B	03-SEP-1999	99-05-5362A	02
05	IL	KANE COUNTY *	1708960106B	28-JUL-1999	99-05-4360A	02
05	IL	KANKAKEE COUNTY *	1703360190C	08-DEC-1999	00-05-0100A	02
05	IL	KANKAKEE COUNTY *	1703360190C	30-DEC-1999	99-05-7372A	02
05	IL	KANKAKEE COUNTY *	1703360190C	29-SEP-1999	99-05-4798A	02
05	IL	KENDALL COUNTY *	1703410090C	15-SEP-1999	99-05-5594A	01
05	IL	LA SALLE COUNTY *	1704000003B	03-DEC-1999	99-05-7392A	02
05	IL	LA SALLE COUNTY *	1704000003B	12-NOV-1999	99-05-6678A	02
05	IL	LAKE COUNTY *	17097C0005F	22-JUL-1999	99-05-087P	05
05	IL	LAKE COUNTY *	17097C0010F	25-AUG-1999	99-05-5758A	02
05	IL	LAKE COUNTY *	17097C0015F	01-DEC-1999	99-05-2964A	02
05	IL	LAKE COUNTY *	17097C0019F	29-OCT-1999	99-05-6144A	02
05	IL	LAKE COUNTY *	17097C0019F	30-JUL-1999	99-05-5338A	02
05	IL	LAKE COUNTY *	17097C0019F	04-AUG-1999	99-05-4904A	02
05	IL	LAKE COUNTY *	17097C0063F	18-AUG-1999	99-05-063P	05
05	IL	LAKE COUNTY *	17097C0110G	29-DEC-1999	00-05-0080A	02
05	IL	LAKE COUNTY *	17097C0110G	19-NOV-1999	99-05-7118A	02
05	IL	LAKE COUNTY *	17097C0116F	18-AUG-1999	99-05-4758A	02
05	IL	LAKE COUNTY *	17097C0126F	30-DEC-1999	00-05-1116A	02
05	IL	LAKE COUNTY *	17097C0126F	10-DEC-1999	99-05-6044A	02
05	IL	LAKE COUNTY *	17097C0141F	19-NOV-1999	99-05-3648A	01
05	IL	LAKE COUNTY *	17097C0155F	15-DEC-1999	00-05-0676A	02
05	IL	LAKE COUNTY *	17097C0205F	06-AUG-1999	99-05-2238A	02
05	IL	LAKE COUNTY *	17097C0206F	08-SEP-1999	99-05-5364A	02
05	IL	LAKE COUNTY *	17097C0206F	24-SEP-1999	99-05-6946A	02
05	IL	LAKE FOREST, CITY OF	17097C0169F	27-AUG-1999	99-05-5882A	02
05	IL	LAKE FOREST, CITY OF	17097C0276F	10-NOV-1999	99-05-6200A	17
05	IL	LAKE FOREST, CITY OF	17097C0276F	07-JUL-1999	99-05-4756A	02
05	IL	LAKE FOREST, CITY OF	17097C0277F	01-DEC-1999	99-05-5532A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
05	IL	LAKE-IN-THE-HILLS, VILLAGE OF	1704810002E	29-SEP-1999	99-05-6942A	01
05	IL	LAKE-IN-THE-HILLS, VILLAGE OF	1704810002E	01-SEP-1999	99-05-4696A	01
05	IL	LAKEWOOD, VILLAGE OF	170805B	20-OCT-1999	99-05-6402A	02
05	IL	LAWRENCE COUNTY *	1704090050B	29-SEP-1999	99-05-5920A	02
05	IL	LIBERTYVILLE, VILLAGE OF	17097C0164F	30-SEP-1999	99-05-7070A	02
05	IL	LINDENHURST, VILLAGE OF	17097C0041F	09-JUL-1999	99-05-3618A	02
05	IL	LINDENHURST, VILLAGE OF	17097C0042F	23-AUG-1999	99-05-193P	06
05	IL	LIVINGSTON COUNTY*	1709290001A	19-NOV-1999	99-05-4682A	02
05	IL	LOCKPORT, CITY OF	17197C0156E	22-DEC-1999	00-05-0836A	02
05	IL	LOMBARD, VILLAGE OF	1702120005B	03-SEP-1999	99-05-6148A	02
05	IL	LYNWOOD, VILLAGE OF	1701190005C	03-NOV-1999	99-05-6304A	01
05	IL	LYNWOOD, VILLAGE OF	1701190005C	24-SEP-1999	99-05-5746A	01
05	IL	LYNWOOD, VILLAGE OF	1701190005C	23-JUL-1999	99-05-4868A	01
05	IL	MADISON COUNTY *	1704360085B	17-DEC-1999	00-05-0182A	02
05	IL	MADISON COUNTY *	1704360085B	08-OCT-1999	99-05-5924A	02
05	IL	MADISON COUNTY *	1704360110B	28-DEC-1999	99-05-149P	05
05	IL	MASON COUNTY *	170466C	23-JUL-1999	99-05-5406A	02
05	IL	MASSAC COUNTY *	1704670100B	20-OCT-1999	99-05-5540A	01
05	IL	MCHENRY COUNTY*	1707320095B	03-NOV-1999	99-05-6694A	02
05	IL	MCHENRY COUNTY*	1707320115B	05-NOV-1999	99-05-6274A	02
05	IL	MCHENRY COUNTY*	1707320240B	21-DEC-1999	99-05-7154A	02
05	IL	MCHENRY COUNTY*	1707320240B	02-JUL-1999	99-05-3456A	01
05	IL	MCHENRY COUNTY*	1707320355B	22-OCT-1999	99-05-3214A	02
05	IL	MCLEAN COUNTY *	1709310125B	10-NOV-1999	99-05-4422A	02
05	IL	METROPOLIS, CITY OF	1704670100B	29-OCT-1999	99-05-5544A	01
05	IL	METROPOLIS, CITY OF	1704670100B	29-OCT-1999	99-05-5542A	01
05	IL	MIDLOTHIAN, VILLAGE OF	1701270001C	03-AUG-1999	99-05-185P	05
05	IL	MOLINE, CITY OF	1705910010B	19-NOV-1999	99-05-4672A	01
05	IL	MONTGOMERY, VILLAGE OF	1703280005B	29-SEP-1999	99-05-5744A	02
05	IL	MONTICELLO, CITY OF	1705500001C	17-SEP-1999	99-05-6686A	02
05	IL	MORRIS, CITY OF	1702630005C	08-SEP-1999	99-05-5822A	01
05	IL	MORRIS, CITY OF	1702630005C	10-SEP-1999	99-05-5374A	02
05	IL	NEW LENOX, VILLAGE OF	17197C0190E	09-AUG-1999	99-05-075P	05
05	IL	NEW LENOX, VILLAGE OF	17197C0305E	01-DEC-1999	99-05-6636A	02
05	IL	NEW LENOX, VILLAGE OF	17197C0305E	23-JUL-1999	99-05-5394A	01
05	IL	NILES, VILLAGE OF	1701300005B	05-NOV-1999	99-05-6564A	01
05	IL	NORMAL, TOWN OF	1705020005B	15-DEC-1999	99-05-6448A	02
05	IL	NORMAL, TOWN OF	1705020005B	28-JUL-1999	99-05-5318A	17
05	IL	NORMAL, TOWN OF	1705020005B	06-AUG-1999	99-05-5316A	17
05	IL	NORTHBROOK, VILLAGE OF	1701320002E	27-OCT-1999	99-05-5984A	02
05	IL	NORTHBROOK, VILLAGE OF	1701320007E	27-OCT-1999	99-05-6948A	01
05	IL	NORTHBROOK, VILLAGE OF	1701320007E	24-NOV-1999	99-05-6212A	02
05	IL	NORTHBROOK, VILLAGE OF	1701320007E	18-AUG-1999	99-05-5946A	02
05	IL	NORTHBROOK, VILLAGE OF	1701320007E	04-AUG-1999	99-05-5294A	02
05	IL	NORTHFIELD, VILLAGE OF	1701330001C	11-AUG-1999	99-05-4616A	02
05	IL	OAK FOREST, CITY OF	1701360005C	12-NOV-1999	99-05-4894A	02
05	IL	OAK FOREST, CITY OF	1701360005C	30-JUL-1999	99-05-3866A	02
05	IL	OAK LAWN, VILLAGE OF	1701370001C	20-OCT-1999	99-05-7206A	02
05	IL	OAK LAWN, VILLAGE OF	1701370002C	06-OCT-1999	99-05-5938A	02
05	IL	OAK LAWN, VILLAGE OF	1701370004C	08-OCT-1999	99-05-5736A	02
05	IL	OFALLON, CITY OF	1706160020B	29-OCT-1999	99-05-181P	05
05	IL	ORLAND PARK, VILLAGE OF	1701400001D	22-OCT-1999	99-05-5430A	02
05	IL	ORLAND PARK, VILLAGE OF	1701400005D	02-NOV-1999	98-05-025P	06
05	IL	PALATINE, VILLAGE OF	1751700005B	16-JUL-1999	99-05-3418A	02
05	IL	PALATINE, VILLAGE OF	1751700005B	26-SEP-1999	99-05-031P	05
05	IL	PALOS HEIGHTS, CITY OF	1701420002C	17-SEP-1999	99-05-5852A	02
05	IL	PALOS HEIGHTS, CITY OF	1701420002C	30-DEC-1999	99-05-5136A	17
05	IL	PALOS HILLS, CITY OF	1701430001C	13-OCT-1999	99-05-6656A	02
05	IL	PALOS HILLS, CITY OF	1701430003C	17-SEP-1999	99-05-5922A	17
05	IL	PALOS HILLS, CITY OF	1701430003C	17-SEP-1999	99-05-5810A	02
05	IL	PALOS HILLS, CITY OF	1701430003C	27-AUG-1999	99-05-5494A	17
05	IL	PEORIA COUNTY *	1705330050B	06-OCT-1999	99-05-5620A	02
05	IL	PEORIA, CITY OF	1705360015B	15-SEP-1999	99-05-5522A	17
05	IL	PROSPECT HEIGHTS, CITY OF	1709190005C	22-DEC-1999	99-05-5534A	01
05	IL	RIVERWOODS, VILLAGE OF	17097C0267F	15-OCT-1999	99-05-5848A	02
05	IL	ROCHELLE, CITY OF	1705320001B	12-NOV-1999	99-05-7330A	02
05	IL	ROMEOVILLE, VILLAGE OF	17197C0045F	23-SEP-1999	99-05-6898V	19
05	IL	ROMEOVILLE, VILLAGE OF	17197C0061E	06-OCT-1999	99-05-4502A	01
05	IL	ROMEOVILLE, VILLAGE OF	17197C0065E	28-JUL-1999	99-05-4954A	02
05	IL	ROSELLE, VILLAGE OF	1702160002B	15-OCT-1999	99-05-5586A	02
05	IL	ROSELLE, VILLAGE OF	1702160002B	10-SEP-1999	99-05-4658A	01
05	IL	ROUND LAKE BEACH, VILLAGE OF	17097C0126F	20-AUG-1999	99-05-5298A	02
05	IL	SANGAMON COUNTY *	1709120125C	29-DEC-1999	00-05-0674A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
05	IL	SANGAMON COUNTY *	1709120130C	15-SEP-1999	99-05-4350A	02
05	IL	SANGAMON COUNTY *	1709120250C	01-OCT-1999	99-05-5974A	01
05	IL	SCHAUMBURG, VILLAGE OF	1700540060B	29-DEC-1999	99-05-319P	05
05	IL	SCHAUMBURG, VILLAGE OF	1701580010D	02-DEC-1999	99-05-5598A	02
05	IL	SCHAUMBURG, VILLAGE OF	1701580010D	17-SEP-1999	97-05-049P	06
05	IL	SHOREWOOD,VILLAGE OF	17197C0139E	12-AUG-1999	99-05-201P	05
05	IL	SLEEPY HOLLOW, VILLAGE OF	1703310001B	15-DEC-1999	99-05-7176A	02
05	IL	SOUTH BARRINGTON, VILLAGE OF	1701610004C	16-AUG-1999	98-05-335P	05
05	IL	ST. CLAIR COUNTY *	1706160020B	29-OCT-1999	99-05-181P	05
05	IL	ST. CLAIR COUNTY *	1706160065A	10-SEP-1999	99-05-5208A	02
05	IL	ST. CLAIR COUNTY *	1706160070B	29-SEP-1999	99-05-4382A	02
05	IL	ST. CLAIR COUNTY *	1706160070B	22-NOV-1999	99-05-4092A	02
05	IL	ST. CLAIR COUNTY *	1706160070B	22-NOV-1999	99-05-2688A	02
05	IL	ST. MARIE, VILLAGE OF	1708200001B	29-DEC-1999	00-05-0606A	02
05	IL	SWANSEA, VILLAGE OF	1706370001B	10-SEP-1999	99-05-4846A	02
05	IL	TOLUCA, CITY OF	170460B	24-NOV-1999	99-05-4828A	02
05	IL	VERMILION COUNTY	1709350005B	22-DEC-1999	99-05-4312A	02
05	IL	VERMILION COUNTY	1709350005B	29-OCT-1999	99-05-1308A	02
05	IL	WASHINGTON, CITY OF	1706550005C	03-SEP-1999	99-05-5572A	02
05	IL	WATSEKA, CITY OF	17075C0120D	29-OCT-1999	99-05-5524A	02
05	IL	WAUCONDA, VILLAGE OF	17097C0119F	30-DEC-1999	99-05-6510A	02
05	IL	WAUCONDA, VILLAGE OF	17097C0119F	20-OCT-1999	99-05-5886A	02
05	IL	WHITE COUNTY *	1709060100B	12-NOV-1999	99-05-6940A	02
05	IL	WILL COUNTY *	17197C0010E	23-SEP-1999	99-05-6944V	19
05	IL	WILL COUNTY *	17197C0030E	03-NOV-1999	99-05-6408A	02
05	IL	WILL COUNTY *	17197C0090E	01-DEC-1999	99-05-6716A	02
05	IL	WILL COUNTY *	17197C0095E	25-AUG-1999	99-05-3838A	02
05	IL	WILL COUNTY *	17197C0135E	10-SEP-1999	99-05-5714A	02
05	IL	WILL COUNTY *	17197C0135F	12-NOV-1999	00-05-0302A	02
05	IL	WILL COUNTY *	17197C0139E	08-OCT-1999	99-05-4772A	02
05	IL	WILL COUNTY *	17197C0218E	27-OCT-1999	99-05-6198A	02
05	IL	WILL COUNTY *	17197C0218E	05-NOV-1999	99-05-3106A	01
05	IL	WILL COUNTY *	17197C0350E	30-DEC-1999	99-05-7012A	01
05	IL	WILL COUNTY *	17197C0379E	15-SEP-1999	99-05-5018A	02
05	IL	WILL COUNTY *	17197C0385E	08-DEC-1999	00-05-0834X	02
05	IL	WILL COUNTY *	17197C0385E	03-NOV-1999	99-05-6310A	02
05	IL	WILL COUNTY *	17197C0385E	29-OCT-1999	99-05-6208A	02
05	IL	WILL COUNTY *	17197C0385E	13-OCT-1999	99-05-5512A	02
05	IL	WILL COUNTY *	17197C0385E	16-JUL-1999	99-05-5292A	02
05	IL	WILL COUNTY *	17197C0420E	20-OCT-1999	99-05-5926A	02
05	IL	WILL COUNTY *	17197C0420E	04-AUG-1999	99-05-3798A	17
05	IL	WILL COUNTY *	17197C0580E	30-DEC-1999	00-05-0842A	02
05	IL	WILLOW SPRINGS, CITY OF	1700540170B	15-JUL-1999	99-05-5672A	01
05	IL	WINNEBAGO COUNTY *	1707200050B	17-NOV-1999	99-05-6860A	02
05	IL	WINNETKA, VILLAGE OF	1701760003B	01-SEP-1999	99-05-5020A	02
05	IN	ALLEN COUNTY *	18003C0065D	29-SEP-1999	99-05-4342A	02
05	IN	ALLEN COUNTY *	18003C0165E	28-JUL-1999	99-05-6080A	02
05	IN	ALLEN COUNTY *	18003C0170D	24-NOV-1999	00-05-0070A	02
05	IN	ALLEN COUNTY *	18003C0170D	11-AUG-1999	99-05-5324A	02
05	IN	ALLEN COUNTY *	18003C0265D	08-DEC-1999	00-05-0112A	17
05	IN	ALLEN COUNTY *	18003C0265D	23-JUL-1999	99-05-2328A	02
05	IN	ALLEN COUNTY *	18003C0265D	29-JUL-1999	99-05-1822A	02
05	IN	ALLEN COUNTY *	18003C0285E	20-OCT-1999	99-05-7310A	02
05	IN	ALLEN COUNTY *	18003C0285E	09-JUL-1999	99-05-4630A	01
05	IN	ALLEN COUNTY *	18003C0325D	29-SEP-1999	99-05-6578A	02
05	IN	ANDERSON, CITY OF	1801500004C	24-NOV-1999	99-05-191P	05
05	IN	AUBURN, CITY OF	1800460005C	08-SEP-1999	99-05-5864A	02
05	IN	BARTHOLOMEW COUNTY *	1800060025B	08-OCT-1999	99-05-6348A	02
05	IN	BARTHOLOMEW COUNTY *	1800060100B	14-JUL-1999	99-05-4334A	02
05	IN	BARTHOLOMEW COUNTY *	1800060125B	06-OCT-1999	99-05-4982A	01
05	IN	BEECH GROVE, CITY OF—USE CID 180159	1801590075D	15-OCT-1999	99-05-6950A	02
05	IN	BEECH GROVE, CITY OF—USE CID 180159	1801590075D	03-NOV-1999	99-05-7076A	02
05	IN	BROWN COUNTY*	1851740065B	28-JUL-1999	99-05-3272A	02
05	IN	CARMEL, CITY OF	1800810001C	30-JUL-1999	99-05-4720A	02
05	IN	CARMEL, CITY OF	1800810009C	22-OCT-1999	99-05-6596A	02
05	IN	CARMEL, CITY OF	1800810013C	20-OCT-1999	99-05-6602A	01
05	IN	CARMEL, CITY OF	1800810013C	07-JUL-1999	99-05-5056A	01
05	IN	CARMEL, CITY OF	1800810013C	03-SEP-1999	99-05-4716A	01
05	IN	CLARK COUNTY *	1804260075B	01-DEC-1999	00-05-0058A	02
05	IN	CLARK COUNTY *	1804260125C	10-DEC-1999	99-05-6764A	02
05	IN	CLARK COUNTY *	1804260125C	24-SEP-1999	99-05-6112A	02
05	IN	CLARK COUNTY *	1804260125C	20-OCT-1999	99-05-6108A	02
05	IN	CLARK COUNTY *	1804260175C	16-DEC-1999	99-05-6286A	01

Region	State	Community	Map panel	Determination date	Case No.	Type
05	IN	CLARK COUNTY *	1804260175C	15-DEC-1999	99-05-6070A	01
05	IN	CLARK COUNTY *	1804260175C	18-AUG-1999	99-05-5546A	01
05	IN	CLARK COUNTY *	1804260175C	13-AUG-1999	99-05-4912A	17
05	IN	CLARK COUNTY *	1804260175C	24-SEP-1999	99-05-3044A	01
05	IN	CLINTON, CITY OF	1802599999A	11-AUG-1999	99-05-4822A	02
05	IN	COLUMBUS, CITY OF	1800070005D	10-SEP-1999	99-05-5976A	01
05	IN	COLUMBUS, CITY OF	1800070020D	16-NOV-1999	99-05-5244A	17
05	IN	COLUMBUS, CITY OF	1800070020D	14-JUL-1999	99-05-4718A	02
05	IN	COLUMBUS, CITY OF	1800070020D	30-JUL-1999	99-05-3872A	17
05	IN	COLUMBUS, CITY OF	1800070030D	11-AUG-1999	99-05-5352A	02
05	IN	CORYDON, TOWN OF	1800860005B	01-OCT-1999	99-05-6142A	02
05	IN	DECATUR, CITY OF	1800010005C	10-SEP-1999	99-05-5956A	02
05	IN	DELAWARE COUNTY*	1800510150B	13-OCT-1999	99-05-5262A	02
05	IN	ELKHART COUNTY *	1800560005A	03-DEC-1999	99-05-6772A	02
05	IN	ELKHART COUNTY *	1800560005A	01-SEP-1999	99-05-4418A	02
05	IN	ELKHART COUNTY *	1800560010B	23-JUL-1999	99-05-4704A	02
05	IN	ELKHART COUNTY *	1800560010B	26-SEP-1999	98-05-331P	05
05	IN	ELKHART COUNTY *	1800560020B	22-SEP-1999	99-05-5962A	02
05	IN	ELKHART, CITY OF	1800570010C	20-AUG-1999	99-05-3802A	02
05	IN	ELLETSVILLE, TOWN OF	180170C	28-JUL-1999	99-05-2346A	02
05	IN	EVANSVILLE, CITY OF	1802570005B	13-AUG-1999	99-05-6036A	01
05	IN	EVANSVILLE, CITY OF	1802570006B	15-OCT-1999	99-05-6236A	02
05	IN	EVANSVILLE, CITY OF	1802570006B	27-AUG-1999	99-05-5694A	02
05	IN	EVANSVILLE, CITY OF	1802570008B	03-NOV-1999	00-05-0174A	02
05	IN	EVANSVILLE, CITY OF	1802570008B	18-AUG-1999	99-05-4516A	02
05	IN	FLOYD COUNTY *	1804320025B	01-DEC-1999	99-05-7216A	17
05	IN	FORT WAYNE, CITY OF	18003C0260E	29-DEC-1999	99-05-265P	05
05	IN	FORT WAYNE, CITY OF	18003C0260E	18-AUG-1999	99-05-5682A	02
05	IN	FORT WAYNE, CITY OF	18003C0260E	14-JUL-1999	99-05-3800A	02
05	IN	FORT WAYNE, CITY OF	18003C0270E	22-DEC-1999	00-05-0866A	02
05	IN	FORT WAYNE, CITY OF	18003C0270E	22-OCT-1999	99-05-7232A	02
05	IN	FORT WAYNE, CITY OF	18003C0290D	24-NOV-1999	00-05-0282A	01
05	IN	FORT WAYNE, CITY OF	18003C0290D	06-OCT-1999	99-05-6370A	02
05	IN	FOUNTAIN COUNTY	1800640002A	08-SEP-1999	99-05-5290A	02
05	IN	FOUNTAIN COUNTY	1800640002A	03-SEP-1999	99-05-4848A	02
05	IN	FRANKLIN, CITY OF	1801140002B	02-JUL-1999	99-05-3346A	02
05	IN	FRANKLIN, CITY OF	1801140002B	15-OCT-1999	99-05-2952A	01
05	IN	GIBSON COUNTY *	1804340005A	15-SEP-1999	98-05-5876A	02
05	IN	GRANT COUNTY*	1804350075B	01-OCT-1999	99-05-6574A	02
05	IN	GREENFIELD, CITY OF	1800840001C	30-SEP-1999	99-05-083P	05
05	IN	GREENFIELD, CITY OF	1800840002C	21-JUL-1999	99-05-3604A	01
05	IN	GREENSBURG, CITY OF	1800430001B	20-OCT-1999	99-05-6334A	02
05	IN	GREENWOOD, CITY OF	1801150002B	29-DEC-1999	00-05-0418A	02
05	IN	GREENWOOD, CITY OF	1801150004B	15-OCT-1999	99-05-3876A	02
05	IN	GREENWOOD, CITY OF	1801150004B	04-AUG-1999	99-05-2788A	01
05	IN	HAMMOND, CITY OF	1801340008B	02-JUL-1999	99-05-3790A	02
05	IN	HANCOCK COUNTY *	1804190050B	29-SEP-1999	99-05-5912A	02
05	IN	HANCOCK COUNTY *	1804190100B	30-DEC-1999	99-05-6204A	02
05	IN	HENDRICKS COUNTY *	1804150050B	01-OCT-1999	99-05-6872A	02
05	IN	HENDRICKS COUNTY *	1804150050B	23-JUL-1999	99-05-3656A	17
05	IN	HENDRICKS COUNTY *	1804150100B	14-JUL-1999	99-05-4632A	01
05	IN	HENDRICKS COUNTY *	1804150100B	27-OCT-1999	99-05-4430A	17
05	IN	HIGHLAND, TOWN OF	1851760001C	27-OCT-1999	99-05-7106A	01
05	IN	HIGHLAND, TOWN OF	1851760001C	27-DEC-1999	99-05-325P	05
05	IN	HOBART, CITY OF	1801360005B	12-NOV-1999	99-05-5502A	17
05	IN	HOWARD COUNTY *	1804140027B	06-OCT-1999	99-05-6642A	02
05	IN	HUNTINGBURG, CITY OF	1803620005B	29-DEC-1999	00-05-0268A	02
05	IN	HUNTINGTON COUNTY *	1804380100C	20-OCT-1999	99-05-6838A	02
05	IN	INDIANAPOLIS, CITY OF	1801590005D	18-AUG-1999	99-05-4372A	02
05	IN	INDIANAPOLIS, CITY OF	1801590010D	03-NOV-1999	00-05-0132A	02
05	IN	INDIANAPOLIS, CITY OF	1801590010D	17-DEC-1999	99-05-6760A	02
05	IN	INDIANAPOLIS, CITY OF	1801590010D	08-DEC-1999	99-05-6106A	17
05	IN	INDIANAPOLIS, CITY OF	1801590015D	01-SEP-1999	99-05-6778A	01
05	IN	INDIANAPOLIS, CITY OF	1801590015D	15-DEC-1999	99-05-6238A	02
05	IN	INDIANAPOLIS, CITY OF	1801590015D	13-AUG-1999	99-05-5098A	02
05	IN	INDIANAPOLIS, CITY OF	1801590025D	10-NOV-1999	99-05-6254A	02
05	IN	INDIANAPOLIS, CITY OF	1801590025D	15-SEP-1999	99-05-6152A	02
05	IN	INDIANAPOLIS, CITY OF	1801590025D	23-JUL-1999	99-05-4876A	02
05	IN	INDIANAPOLIS, CITY OF	1801590030D	08-DEC-1999	99-05-6234A	02
05	IN	INDIANAPOLIS, CITY OF	1801590030D	15-OCT-1999	99-05-5692A	02
05	IN	INDIANAPOLIS, CITY OF	1801590035D	10-NOV-1999	00-05-0204A	02
05	IN	INDIANAPOLIS, CITY OF	1801590035D	01-DEC-1999	99-05-7230A	02
05	IN	INDIANAPOLIS, CITY OF	1801590035D	30-DEC-1999	99-05-6154A	01

Region	State	Community	Map panel	Determination date	Case No.	Type
05	IN	INDIANAPOLIS, CITY OF	1801590035D	04-AUG-1999	99-05-3278A	02
05	IN	INDIANAPOLIS, CITY OF	1801590040D	27-OCT-1999	99-05-6984A	01
05	IN	INDIANAPOLIS, CITY OF	1801590040D	01-OCT-1999	99-05-6908A	02
05	IN	INDIANAPOLIS, CITY OF	1801590045D	10-DEC-1999	00-05-0572A	02
05	IN	INDIANAPOLIS, CITY OF	1801590045D	22-OCT-1999	99-05-7388A	02
05	IN	INDIANAPOLIS, CITY OF	1801590045D	01-OCT-1999	99-05-6834A	02
05	IN	INDIANAPOLIS, CITY OF	1801590045D	13-AUG-1999	99-05-5344A	02
05	IN	INDIANAPOLIS, CITY OF	1801590055D	08-OCT-1999	99-05-6502A	02
05	IN	INDIANAPOLIS, CITY OF	1801590075D	10-SEP-1999	99-05-6666A	02
05	IN	INDIANAPOLIS, CITY OF	1801590075D	23-JUL-1999	99-05-3722A	02
05	IN	INDIANAPOLIS, CITY OF	1801590090D	10-DEC-1999	00-05-0734A	01
05	IN	INDIANAPOLIS, CITY OF	1801590090D	22-DEC-1999	00-05-0096A	01
05	IN	INDIANAPOLIS, CITY OF	1801590090D	09-JUL-1999	99-05-4546A	01
05	IN	INDIANAPOLIS, CITY OF	1801590090D	29-OCT-1999	99-05-4238A	01
05	IN	INDIANAPOLIS, CITY OF	1801590095D	30-SEP-1999	99-05-7064A	01
05	IN	INDIANAPOLIS, CITY OF	1801590095D	01-OCT-1999	99-05-6932A	02
05	IN	INDIANAPOLIS, CITY OF	1801590095D	06-AUG-1999	99-05-5626A	02
05	IN	INDIANAPOLIS, CITY OF	1801590095D	07-JUL-1999	99-05-3912A	02
05	IN	JEFFERSONVILLE, CITY OF	1800270005D	17-SEP-1999	99-05-6570A	02
05	IN	JENNINGS COUNTY *	1801080003B	17-DEC-1999	00-05-0336A	02
05	IN	JENNINGS COUNTY *	1801080003B	13-OCT-1999	99-05-6680A	02
05	IN	JENNINGS COUNTY *	1801080004B	04-AUG-1999	99-05-3582A	02
05	IN	JOHNSON COUNTY *	1801110050C	13-AUG-1999	99-05-3482A	02
05	IN	KOSCIUSKO COUNTY*	18085C0035C	01-OCT-1999	99-05-5680A	02
05	IN	KOSCIUSKO COUNTY*	18085C0067C	11-AUG-1999	99-05-5172A	02
05	IN	KOSCIUSKO COUNTY*	18085C0080C	20-OCT-1999	99-05-6800A	02
05	IN	KOSCIUSKO COUNTY*	18085C0080C	13-OCT-1999	99-05-6412A	02
05	IN	KOSCIUSKO COUNTY*	18085C0080C	15-SEP-1999	99-05-6224A	02
05	IN	KOSCIUSKO COUNTY*	18085C0080C	29-SEP-1999	99-05-5996A	02
05	IN	KOSCIUSKO COUNTY*	18085C0100C	01-OCT-1999	99-05-6410A	02
05	IN	KOSCIUSKO COUNTY*	18085C0100C	13-OCT-1999	99-05-5650A	02
05	IN	KOSCIUSKO COUNTY*	18085C0125C	15-DEC-1999	99-05-7264A	02
05	IN	KOSCIUSKO COUNTY*	18085C0125C	24-SEP-1999	99-05-6282A	02
05	IN	KOSCIUSKO COUNTY*	18085C0125C	29-DEC-1999	99-05-5712A	01
05	IN	LA PORTE COUNTY*	1801440125C	13-OCT-1999	99-05-4158A	02
05	IN	LAGRANGE COUNTY	1801250001B	13-OCT-1999	99-05-6826A	02
05	IN	LAGRANGE COUNTY	1801250004B	05-NOV-1999	00-05-0156A	02
05	IN	LAGRANGE COUNTY	1801250004B	27-OCT-1999	99-05-7344A	02
05	IN	LAGRANGE COUNTY	1801250004B	22-OCT-1999	99-05-7300A	02
05	IN	LAGRANGE COUNTY	1801250004B	22-OCT-1999	99-05-7296A	02
05	IN	LAGRANGE COUNTY	1801250004B	22-OCT-1999	99-05-6794A	02
05	IN	LAGRANGE COUNTY	1801250004B	10-SEP-1999	99-05-6428A	02
05	IN	LAGRANGE COUNTY	1801250004B	01-SEP-1999	99-05-6356A	02
05	IN	LAGRANGE COUNTY	1801250004B	15-SEP-1999	99-05-5084A	02
05	IN	LAGRANGE COUNTY	1801250004B	14-JUL-1999	99-05-2824A	02
05	IN	LAKE COUNTY *	1801260200B	15-OCT-1999	99-05-7052A	02
05	IN	LAWRENCE, CITY OF—USE CID 180159	1801590020D	01-DEC-1999	99-05-6644A	01
05	IN	LAWRENCE, CITY OF—USE CID 180159	1801590020D	03-SEP-1999	99-05-6232A	02
05	IN	LEBANON, CITY OF	1800130001D	15-DEC-1999	00-05-0446A	01
05	IN	LEBANON, CITY OF	1800130001D	27-AUG-1999	99-05-6184A	02
05	IN	LEBANON, CITY OF	1800130001D	11-AUG-1999	99-05-5644A	02
05	IN	LIBERTY, TOWNSHIP OF	1804880001A	12-NOV-1999	99-05-4646A	02
05	IN	LIBERTY, TOWNSHIP OF	1804880001A	13-AUG-1999	99-05-3860A	02
05	IN	LIBERTY, TOWNSHIP OF	1804880002A	18-AUG-1999	99-05-4648A	02
05	IN	LONG BEACH, TOWN OF	185177A	01-DEC-1999	00-05-0390A	02
05	IN	MADISON COUNTY *	1804420007B	12-NOV-1999	00-05-0416A	02
05	IN	MARSHALL COUNTY *	1804430125B	23-JUL-1999	99-05-4404A	02
05	IN	MICHIGAN CITY, CITY OF	1801470015B	05-NOV-1999	99-05-7236A	02
05	IN	MORGAN COUNTY *	1801760100B	24-NOV-1999	99-05-5960A	02
05	IN	MUNCIE, CITY OF	1800530002C	16-SEP-1999	99-05-5944A	02
05	IN	NASHVILLE, TOWN OF	1800180001D	18-AUG-1999	99-05-4722A	02
05	IN	NEW ALBANY, CITY OF	1800620005C	01-DEC-1999	00-05-0244A	02
05	IN	NEW ALBANY, CITY OF	1800620005C	01-OCT-1999	99-05-6600A	02
05	IN	NEW ALBANY, CITY OF	1800620005C	30-JUL-1999	99-05-4588A	17
05	IN	NEW ALBANY, CITY OF	1800620010C	27-OCT-1999	99-05-6900A	02
05	IN	NEW CASTLE, CITY OF	18065C0175C	30-OCT-1999	99-05-133P	06
05	IN	NEW HAVEN, CITY OF	18003C0295D	15-OCT-1999	99-05-7024A	02
05	IN	NOBLE COUNTY *	1801830075B	01-SEP-1999	99-05-6048A	02
05	IN	NOBLE COUNTY *	1801830075B	27-AUG-1999	99-05-6056A	02
05	IN	NOBLE COUNTY *	1801830075B	23-JUL-1999	99-05-4896A	02
05	IN	NOBLESVILLE, CITY OF	1800820015E	22-OCT-1999	99-05-6480A	02
05	IN	NOBLESVILLE, CITY OF	1800820025E	28-JUL-1999	99-05-5162A	02
05	IN	NORTH WEBSTER, TOWN OF	18085C0045C	15-OCT-1999	99-05-7238A	02

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05	IN	OHIO COUNTY*	180406B	24-NOV-1999	00-05-0102A	02
05	IN	PLAINFIELD, TOWN OF	1800890001B	03-NOV-1999	99-05-7240A	02
05	IN	PORTER COUNTY *	1804250060B	24-SEP-1999	99-05-6188A	02
05	IN	PORTER COUNTY *	1804250060B	27-AUG-1999	99-05-5890A	02
05	IN	PORTER COUNTY *	1804250060B	11-AUG-1999	99-05-2836A	02
05	IN	PORTER COUNTY *	1804250060B	21-JUL-1999	99-05-2834A	02
05	IN	PORTER COUNTY *	1804250125B	11-AUG-1999	99-05-5072A	02
05	IN	POSEY COUNTY*	180209B	20-AUG-1999	99-05-4356A	02
05	IN	ROME CITY, TOWN OF	1803850001B	28-JUL-1999	99-05-5150A	02
05	IN	SEYMOUR, CITY OF	1800990004C	15-DEC-1999	00-05-0558A	02
05	IN	SEYMOUR, CITY OF	1800990004C	12-NOV-1999	00-05-0144A	02
05	IN	SEYMOUR, CITY OF	1800990004C	01-OCT-1999	99-05-7002A	02
05	IN	SEYMOUR, CITY OF	1800990004C	29-OCT-1999	99-05-6584A	02
05	IN	SEYMOUR, CITY OF	1800990004C	17-SEP-1999	99-05-6468A	02
05	IN	SEYMOUR, CITY OF	1800990004C	20-SEP-1999	99-05-6174A	02
05	IN	SEYMOUR, CITY OF	1800990004C	18-AUG-1999	99-05-5710A	02
05	IN	SEYMOUR, CITY OF	1800990004C	29-NOV-1999	99-05-085P	05
05	IN	SPENCER COUNTY *	1802370125A	12-NOV-1999	99-05-6240A	02
05	IN	STEUBEN COUNTY*	1802430025B	10-DEC-1999	00-05-0992X	02
05	IN	STEUBEN COUNTY*	1802430025B	10-NOV-1999	99-05-7308A	02
05	IN	STEUBEN COUNTY*	1802430025B	20-OCT-1999	99-05-7042A	02
05	IN	STEUBEN COUNTY*	1802430025B	15-OCT-1999	99-05-6222A	02
05	IN	STEUBEN COUNTY*	1802430025B	07-JUL-1999	99-05-5230A	02
05	IN	STEUBEN COUNTY*	1802430050B	23-JUL-1999	99-05-5086A	02
05	IN	STEUBEN COUNTY*	1802430075B	29-DEC-1999	00-05-0514A	02
05	IN	STEUBEN COUNTY*	1802430100B	10-SEP-1999	99-05-6586A	02
05	IN	STEUBEN COUNTY*	1802430100B	06-AUG-1999	99-05-5658A	02
05	IN	STEUBEN COUNTY*	1802430100B	04-AUG-1999	99-05-5434A	02
05	IN	SYRACUSE, TOWN OF	18085C0035C	12-NOV-1999	99-05-6688A	02
05	IN	TELL CITY, CITY OF	180197B	30-JUL-1999	99-05-5470A	02
05	IN	TIPPECANOE COUNTY *	1804280050B	03-DEC-1999	00-05-0782X	02
05	IN	TIPPECANOE COUNTY *	1804280050B	03-DEC-1999	00-05-0062A	02
05	IN	TIPPECANOE COUNTY *	1804280050B	13-AUG-1999	99-05-4532A	02
05	IN	TIPPECANOE COUNTY *	1804280060B	28-JUL-1999	99-05-4398A	02
05	IN	TIPPECANOE COUNTY *	1804280080B	29-DEC-1999	00-05-0432A	02
05	IN	TIPTON, CITY OF	1802550001C	29-OCT-1999	99-05-5846A	02
05	IN	VANDERBURGH COUNTY *	1802560025C	30-DEC-1999	00-05-1060A	01
05	IN	VANDERBURGH COUNTY *	1802560025C	03-DEC-1999	00-05-0476A	02
05	IN	VANDERBURGH COUNTY *	1802560025C	03-DEC-1999	00-05-0478A	02
05	IN	VANDERBURGH COUNTY *	1802560025C	03-DEC-1999	00-05-0480A	02
05	IN	VANDERBURGH COUNTY *	1802560025C	27-OCT-1999	00-05-0064A	02
05	IN	VANDERBURGH COUNTY *	1802560025C	08-SEP-1999	99-05-6452A	02
05	IN	VANDERBURGH COUNTY *	1802560025C	15-OCT-1999	99-05-6172A	02
05	IN	VANDERBURGH COUNTY *	1802560025C	15-SEP-1999	99-05-6166A	02
05	IN	VANDERBURGH COUNTY *	1802560025C	03-SEP-1999	99-05-5690A	01
05	IN	VANDERBURGH COUNTY *	1802560025C	22-OCT-1999	99-05-5536A	01
05	IN	VANDERBURGH COUNTY *	1802560025C	04-AUG-1999	99-05-5278A	01
05	IN	VANDERBURGH COUNTY *	1802560025C	02-JUL-1999	99-05-4246A	02
05	IN	VANDERBURGH COUNTY *	1802560050B	10-DEC-1999	00-05-0968A	01
05	IN	VANDERBURGH COUNTY *	1802560050B	27-OCT-1999	99-05-7046A	02
05	IN	VANDERBURGH COUNTY *	1802560075C	20-OCT-1999	99-05-7000A	02
05	IN	VANDERBURGH COUNTY *	1802560075C	03-NOV-1999	99-05-6798A	02
05	IN	VANDERBURGH COUNTY *	1802560075C	20-AUG-1999	99-05-5688A	02
05	IN	VANDERBURGH COUNTY *	1802560075C	06-AUG-1999	99-05-4008A	02
05	IN	VANDERBURGH COUNTY *	1802560100B	15-DEC-1999	00-05-0706A	01
05	IN	VANDERBURGH COUNTY *	1802560100B	10-DEC-1999	00-05-0462A	02
05	IN	VANDERBURGH COUNTY *	1802560100B	01-DEC-1999	00-05-0464A	02
05	IN	VANDERBURGH COUNTY *	1802560100B	12-NOV-1999	99-05-6780A	02
05	IN	VANDERBURGH COUNTY *	1802560100B	29-DEC-1999	99-05-6300A	01
05	IN	VANDERBURGH COUNTY *	1802560100B	27-AUG-1999	99-05-5686A	02
05	IN	VANDERBURGH COUNTY *	1802560100B	01-SEP-1999	99-05-5184A	02
05	IN	VIGO COUNTY *	1802630120B	29-SEP-1999	99-05-5762A	02
05	IN	WARRICK COUNTY *	1804180125B	20-AUG-1999	99-05-6004A	02
05	IN	WARRICK COUNTY *	1804180175B	09-JUL-1999	99-05-4838A	02
05	IN	WARSAW, CITY OF	18085C0078C	03-NOV-1999	00-05-0184A	02
05	IN	WARSAW, CITY OF	18085C0086C	10-DEC-1999	00-05-0288A	02
05	IN	WARSAW, CITY OF	18085C0086C	20-OCT-1999	99-05-7282A	02
05	IN	WELLS COUNTY *	1802880125C	01-DEC-1999	00-05-0352A	02
05	IN	WESTFIELD, TOWN OF	1800830011C	19-OCT-1999	00-05-0088A	01
05	IN	WESTFIELD, TOWN OF	1800830011C	20-OCT-1999	00-05-0086A	01
05	IN	WESTFIELD, TOWN OF	1800830011C	19-OCT-1999	00-05-0084A	01
05	IN	WESTFIELD, TOWN OF	1800830011C	19-OCT-1999	00-05-0082A	01
05	IN	WESTFIELD, TOWN OF	1800830011C	13-AUG-1999	99-05-4770A	01

Region	State	Community	Map panel	Determination date	Case No.	Type
05	IN	WHITE COUNTY *	1804470002C	20-AUG-1999	99-05-5472A	02
05	IN	WHITE COUNTY *	1804470005C	29-SEP-1999	99-05-5312A	02
05	IN	WHITLEY COUNTY*	1802980001B	08-DEC-1999	99-05-6724A	02
05	IN	WHITLEY COUNTY*	1802980001B	24-SEP-1999	99-05-6190A	02
05	IN	WHITLEY COUNTY*	1802980001B	07-SEP-1999	99-05-5590A	02
05	IN	WHITLEY COUNTY*	1802980002B	22-OCT-1999	99-05-7318A	02
05	MI	ANN ARBOR, CITY OF	2602130009C	08-SEP-1999	99-05-6302A	02
05	MI	ARENAC, TOWNSHIP OF	260251B	08-DEC-1999	99-05-5950A	01
05	MI	ARGENTINE, TOWNSHIP OF	2603920010A	20-AUG-1999	99-05-5346A	02
05	MI	AUGRES, TOWNSHIP OF	2600130010B	28-JUL-1999	99-05-2204A	02
05	MI	BALDWIN, TOWNSHIP OF	2600990016D	29-DEC-1999	00-05-0760A	02
05	MI	BANGOR, TOWNSHIP OF	26017C0140D	27-OCT-1999	99-05-6568A	02
05	MI	BANGOR, TOWNSHIP OF	26017C0140D	09-JUL-1999	99-05-4308A	02
05	MI	BAY DE NOC, TOWNSHIP OF	26041C0835C	27-OCT-1999	99-05-6522A	02
05	MI	BAY MILLS, TOWNSHIP OF	2603740025B	27-OCT-1999	99-05-7148A	02
05	MI	BAY MILLS, TOWNSHIP OF	2603740050B	22-OCT-1999	99-05-7298A	02
05	MI	BAY MILLS, TOWNSHIP OF	2603740050B	15-OCT-1999	99-05-7022A	02
05	MI	BAY MILLS, TOWNSHIP OF	2603740050B	13-OCT-1999	99-05-6876A	02
05	MI	BEDFORD, TOWNSHIP OF	2601420009B	14-JUL-1999	99-05-3688A	02
05	MI	BEDFORD, TOWNSHIP OF	2601420009B	14-JUL-1999	99-05-4888A	02
05	MI	BEDFORD, TOWNSHIP OF	2601420009B	28-JUL-1999	99-05-2376A	02
05	MI	BEDFORD, TOWNSHIP OF	2601420012B	21-JUL-1999	99-05-3958A	02
05	MI	BIG RAPIDS, CITY OF	260136B	01-OCT-1999	99-05-4804A	02
05	MI	BIG RAPIDS, TOWNSHIP OF	260135B	15-DEC-1999	00-05-0984X	02
05	MI	BIG RAPIDS, TOWNSHIP OF	2601359999	29-SEP-1999	99-05-5032A	02
05	MI	BLOOMFIELD, TOWNSHIP OF	2601690004C	27-JUL-1999	99-05-5628A	02
05	MI	BRAMPTON, TOWNSHIP OF	26041C0415C	17-SEP-1999	99-05-6608A	02
05	MI	BROOMFIELD, TOWNSHIP OF	26073C0280C	15-OCT-1999	99-05-3188A	02
05	MI	BROWNSTOWN, CHARTERED TOWNSHIP OF	2602180010B	05-NOV-1999	99-05-7242A	02
05	MI	BROWNSTOWN, CHARTERED TOWNSHIP OF	2602180010B	27-JUL-1999	99-05-3600A	01
05	MI	BUCHANAN, TOWNSHIP OF	2605550005A	01-DEC-1999	99-05-6052A	02
05	MI	BUENA VISTA, TOWNSHIP OF	26145C0085D	24-NOV-1999	99-05-6912A	02
05	MI	BUENA VISTA, TOWNSHIP OF	26145C0085D	16-JUL-1999	99-05-3684A	02
05	MI	CANNON, TOWNSHIP OF	2607340025A	13-OCT-1999	99-05-6890A	02
05	MI	CANNON, TOWNSHIP OF	2607340025A	10-NOV-1999	99-05-5256A	02
05	MI	CANNON, TOWNSHIP OF	2607340025A	30-DEC-1999	99-05-2968A	02
05	MI	CARP LAKE, TOWNSHIP OF	2605480002B	03-NOV-1999	00-05-0046A	02
05	MI	CASCADE CHARTER, TOWNSHIP OF	2608140025A	22-OCT-1999	99-05-4624A	02
05	MI	CASEVILLE, TOWNSHIP OF	2602570002A	10-NOV-1999	99-05-7286A	02
05	MI	CASEVILLE, TOWNSHIP OF	2602570002A	15-SEP-1999	99-05-5226A	02
05	MI	CASTLETON, TOWNSHIP OF	2606410010B	24-NOV-1999	99-05-6934A	02
05	MI	CEDARVILLE, TOWNSHIP OF	2606590030C	04-AUG-1999	99-05-5550A	02
05	MI	CHERRY GROVE, TOWNSHIP OF	26165C0451C	27-OCT-1999	99-05-7244A	02
05	MI	CHESTERFIELD, TOWNSHIP OF	2601200010B	13-OCT-1999	99-05-5970A	02
05	MI	CHESTERFIELD, TOWNSHIP OF	2601200010B	05-OCT-1999	99-05-147P	05
05	MI	CLARK, TOWNSHIP OF	2607590025B	13-AUG-1999	99-05-5504A	02
05	MI	CLARK, TOWNSHIP OF	2607590050B	10-SEP-1999	99-05-6654A	02
05	MI	CLARK, TOWNSHIP OF	2607590050B	15-OCT-1999	99-05-6426A	02
05	MI	CLAY, TOWNSHIP OF	2601940003B	27-AUG-1999	99-05-6182A	02
05	MI	CLAY, TOWNSHIP OF	2601940003B	20-OCT-1999	99-05-5880A	02
05	MI	CLAY, TOWNSHIP OF	2601940003B	01-OCT-1999	99-05-5372A	02
05	MI	CLAY, TOWNSHIP OF	2601940003B	28-JUL-1999	99-05-1542A	02
05	MI	CLEVELAND, TOWNSHIP OF	260302A	22-OCT-1999	99-05-7142A	02
05	MI	CLINTON, TOWNSHIP OF	2601210005E	03-SEP-1999	99-05-5554A	02
05	MI	CLINTON, TOWNSHIP OF	2601210005E	06-AUG-1999	99-05-5092A	01
05	MI	CLINTON, TOWNSHIP OF	2601210005E	02-SEP-1999	99-05-3252A	01
05	MI	CLINTON, TOWNSHIP OF	2601210010E	18-AUG-1999	99-05-5432A	02
05	MI	CLINTON, TOWNSHIP OF	2601210010E	16-JUL-1999	99-05-4204A	02
05	MI	CLINTON, TOWNSHIP OF	2601210010E	21-JUL-1999	99-05-3550A	02
05	MI	COLOMA, TOWNSHIP OF	2600340005B	26-AUG-1999	99-05-4972A	02
05	MI	COMMERCE, TOWNSHIP OF	2604730015B	08-SEP-1999	99-05-6134A	02
05	MI	CORUNNA, CITY OF	2606020001A	17-NOV-1999	99-05-6194A	02
05	MI	CORUNNA, CITY OF	2606020001A	18-AUG-1999	99-05-3474A	02
05	MI	COTTRELLVILLE, TOWNSHIP OF	2601960005B	23-JUL-1999	99-05-4174A	02
05	MI	CROTON, TOWNSHIP OF	2604680025A	28-JUL-1999	99-05-4836A	02
05	MI	DEARBORN HEIGHTS, CITY OF	2602210006B	15-JUL-1999	99-05-2390A	02
05	MI	DEARBORN HEIGHTS, CITY OF	2602210007C	03-DEC-1999	00-05-0116A	02
05	MI	DEERFIELD, TOWNSHIP OF	26073C0305C	11-AUG-1999	99-05-4602A	02
05	MI	DELTA, CHARTER TOWNSHIP OF	2600660005D	01-OCT-1999	99-05-7026A	02
05	MI	DELTA, CHARTER TOWNSHIP OF	2600660005D	29-SEP-1999	99-05-6796A	02
05	MI	EAST GRAND RAPIDS, CITY OF	2601050001B	29-DEC-1999	00-05-0656A	02
05	MI	EAST LANSING, CITY OF	2600890005B	27-OCT-1999	99-05-3430A	01
05	MI	EATON RAPIDS, TOWNSHIP OF	2603910005A	15-SEP-1999	99-05-5652A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
05	MI	ERIE, TOWNSHIP OF	2601450010C	17-SEP-1999	99-05-6192A	02
05	MI	ESCANABA, TOWNSHIP OF	26041C0605C	09-DEC-1999	00-05-0994A	02
05	MI	FABIUS, TOWNSHIP OF	2607810025A	27-OCT-1999	99-05-7350A	02
05	MI	FABIUS, TOWNSHIP OF	2607810025A	27-OCT-1999	99-05-7144A	02
05	MI	FABIUS, TOWNSHIP OF	2607810025A	13-OCT-1999	99-05-5994A	02
05	MI	FABIUS, TOWNSHIP OF	2607810025A	18-AUG-1999	99-05-5856A	02
05	MI	FABIUS, TOWNSHIP OF	2607810025A	21-JUL-1999	99-05-4824A	02
05	MI	FARMINGTON HILLS, CITY OF	2601720001C	08-DEC-1999	00-05-0584A	02
05	MI	FARMINGTON HILLS, CITY OF	2601720001C	09-NOV-1999	00-05-0574V	19
05	MI	FARMINGTON HILLS, CITY OF	2601720007C	15-DEC-1999	00-05-0628A	02
05	MI	FARMINGTON HILLS, CITY OF	2601720010B	22-JUL-1999	99-05-2416A	02
05	MI	FARMINGTON HILLS, CITY OF	2601720010C	24-NOV-1999	99-05-7130A	02
05	MI	FARMINGTON HILLS, CITY OF	2601720010C	15-DEC-1999	99-05-3104A	01
05	MI	FARMINGTON HILLS, CITY OF	2601720015B	11-AUG-1999	99-05-4436A	02
05	MI	FARMINGTON HILLS, CITY OF	2601720020B	14-JUL-1999	99-05-5388A	01
05	MI	FARMINGTON HILLS, CITY OF	2601720020B	09-JUL-1999	99-05-2586A	02
05	MI	FENTON, TOWNSHIP OF	2603940008B	13-OCT-1999	99-05-4998A	02
05	MI	FENTON, TOWNSHIP OF	2603940011B	29-OCT-1999	99-05-5764A	02
05	MI	FERRYSBURG, CITY OF	2601840001B	15-DEC-1999	00-05-0554A	02
05	MI	FERRYSBURG, CITY OF	2601840001B	27-OCT-1999	99-05-7054A	02
05	MI	FLAT ROCK, CITY OF	2602240003B	12-NOV-1999	00-05-0172A	02
05	MI	FLAT ROCK, CITY OF	2602240003B	29-DEC-1999	99-05-6474A	02
05	MI	FLAT ROCK, CITY OF	2602240003B	15-OCT-1999	99-05-4508A	01
05	MI	FRANKENLUST, TOWNSHIP OF	26017C0200D	06-AUG-1999	99-05-3996A	02
05	MI	FRASER, CITY OF	2601220001B	17-DEC-1999	99-05-5988A	01
05	MI	FRASER, CITY OF	2601220001B	14-JUL-1999	99-05-3858A	02
05	MI	FRASER, TOWNSHIP OF	26017C0065D	01-DEC-1999	99-05-6000A	02
05	MI	FRASER, TOWNSHIP OF	26017C0110D	15-OCT-1999	99-05-2628A	02
05	MI	GARDEN, TOWNSHIP OF	26041C0715C	07-SEP-1999	99-05-4562A	02
05	MI	GRAND HAVEN, TOWNSHIP OF	2602700005B	27-OCT-1999	00-05-0034A	02
05	MI	GRAND HAVEN, TOWNSHIP OF	2602700005B	12-NOV-1999	99-05-7066A	02
05	MI	GRAND HAVEN, TOWNSHIP OF	2602700005B	29-SEP-1999	99-05-6536A	02
05	MI	GREEN OAK, TOWNSHIP OF	2604400015B	22-OCT-1999	99-05-5236A	02
05	MI	GREEN OAK, TOWNSHIP OF	2604400020B	29-DEC-1999	00-05-0802A	02
05	MI	GREEN OAK, TOWNSHIP OF	2604400020B	10-NOV-1999	00-05-0440A	02
05	MI	GREEN OAK, TOWNSHIP OF	2604400020B	10-SEP-1999	99-05-6526A	02
05	MI	GREENBUSH, TOWNSHIP OF	2600010004C	19-NOV-1999	99-05-6804A	02
05	MI	GREENBUSH, TOWNSHIP OF	2600010004C	16-JUL-1999	99-05-3518A	02
05	MI	GREENBUSH, TOWNSHIP OF	2600010007C	08-DEC-1999	99-05-7164A	02
05	MI	GREENBUSH, TOWNSHIP OF	2600010007C	08-SEP-1999	99-05-6544A	02
05	MI	GREENBUSH, TOWNSHIP OF	2600010007C	10-SEP-1999	99-05-5798A	02
05	MI	GREENBUSH, TOWNSHIP OF	2600010007C	25-AUG-1999	99-05-4442A	02
05	MI	GREENBUSH, TOWNSHIP OF	2600010007C	14-JUL-1999	99-05-4208A	02
05	MI	GROSSE ILE, TOWNSHIP OF	2602270005B	27-AUG-1999	99-05-6060A	02
05	MI	GROSSE ILE, TOWNSHIP OF	2602270005B	27-AUG-1999	99-05-5030A	02
05	MI	HAMBURG, TOWNSHIP OF	2601180005C	15-DEC-1999	99-05-4806A	02
05	MI	HAMBURG, TOWNSHIP OF	2601180010C	24-SEP-1999	99-05-6288A	02
05	MI	HAMPTON, TOWNSHIP OF	26017C0180D	03-NOV-1999	00-05-0262A	02
05	MI	HAMPTON, TOWNSHIP OF	26017C0185D	06-AUG-1999	99-05-4964A	01
05	MI	HAMPTON, TOWNSHIP OF	26017C0185D	27-AUG-1999	99-05-2762A	01
05	MI	HAMPTON, TOWNSHIP OF	26017C0190D	15-DEC-1999	99-05-5026A	02
05	MI	HAMPTON, TOWNSHIP OF	26017C0190D	25-AUG-1999	99-05-4132A	01
05	MI	HARRISON, TOWNSHIP OF	2601230005C	03-DEC-1999	00-05-0774X	02
05	MI	HARRISON, TOWNSHIP OF	2601230005C	29-DEC-1999	00-05-0788A	02
05	MI	HARRISON, TOWNSHIP OF	2601230005C	22-OCT-1999	99-05-7268A	02
05	MI	HARRISON, TOWNSHIP OF	2601230005C	17-SEP-1999	99-05-6692A	02
05	MI	HARRISON, TOWNSHIP OF	2601230005C	22-OCT-1999	99-05-6554A	02
05	MI	HARRISON, TOWNSHIP OF	2601230005C	08-SEP-1999	99-05-6538A	02
05	MI	HARRISON, TOWNSHIP OF	2601230005C	10-SEP-1999	99-05-6506A	02
05	MI	HARRISON, TOWNSHIP OF	2601230005C	10-SEP-1999	99-05-6138A	02
05	MI	HARRISON, TOWNSHIP OF	2601230005C	01-SEP-1999	99-05-5766A	02
05	MI	HARRISON, TOWNSHIP OF	2601230005C	29-SEP-1999	99-05-5802A	02
05	MI	HARRISON, TOWNSHIP OF	2601230005C	15-OCT-1999	99-05-5420A	02
05	MI	HARRISON, TOWNSHIP OF	2601230005C	11-AUG-1999	99-05-5264A	02
05	MI	HARRISON, TOWNSHIP OF	2601230005C	16-JUL-1999	99-05-5014A	02
05	MI	HARRISON, TOWNSHIP OF	2601230005C	24-NOV-1999	99-05-4066A	02
05	MI	HARRISON, TOWNSHIP OF	2601230010C	05-NOV-1999	00-05-0406A	02
05	MI	HARRISON, TOWNSHIP OF	2601230010C	01-DEC-1999	00-05-0238A	02
05	MI	HARRISON, TOWNSHIP OF	2601230010C	27-AUG-1999	99-05-6140A	02
05	MI	HASTINGS, TOWNSHIP OF	2606480003B	27-OCT-1999	99-05-5696A	01
05	MI	HAYNES, TOWNSHIP OF	260274A	27-AUG-1999	99-05-6028A	02
05	MI	HAYNES, TOWNSHIP OF	260274A	29-OCT-1999	99-05-5978A	02
05	MI	HIGHLAND, TOWNSHIP OF	2606500020A	28-JUL-1999	99-05-5074A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
05	MI	HOLLY, TOWNSHIP OF	2604740001B	10-SEP-1999	99-05-4976A	02
05	MI	HOWELL, CITY OF	260441A	29-SEP-1999	99-05-5160A	02
05	MI	INDEPENDENCE, TOWNSHIP OF	2604750006B	13-AUG-1999	99-05-3438A	02
05	MI	INDEPENDENCE, TOWNSHIP OF	2604750007B	20-AUG-1999	99-05-5548A	02
05	MI	INDEPENDENCE, TOWNSHIP OF	2604750008B	03-SEP-1999	99-05-5380A	02
05	MI	IRONWOOD, TOWNSHIP OF	2604030002B	23-JUL-1999	99-05-5376A	02
05	MI	IRONWOOD, TOWNSHIP OF	2604030002B	23-JUL-1999	99-05-4474A	02
05	MI	JAMES, TOWNSHIP OF	26145C0130D	20-OCT-1999	99-05-6830A	02
05	MI	JAMES, TOWNSHIP OF	26145C0130D	18-AUG-1999	99-05-5804A	02
05	MI	JAMES, TOWNSHIP OF	26145C0130D	21-JUL-1999	99-05-5252A	02
05	MI	JOHNSTOWN, TOWNSHIP OF	260355A	28-JUL-1999	99-05-4614A	02
05	MI	JOHNSTOWN, TOWNSHIP OF	260355A	18-AUG-1999	99-05-3472A	02
05	MI	KAWKAWLIN, TOWNSHIP OF	26017C0110D	18-AUG-1999	99-05-5942A	02
05	MI	KEEGO HARBOR, CITY OF	2601730001B	16-JUL-1999	99-05-3832A	02
05	MI	KIMBALL, TOWNSHIP OF	260594A	29-JUL-1999	99-05-5862A	02
05	MI	LAKE ODESSA, VILLAGE OF	260419A	22-DEC-1999	00-05-0778X	02
05	MI	LAKE ODESSA, VILLAGE OF	260419A	08-SEP-1999	99-05-6042A	02
05	MI	LAKE ORION, VILLAGE OF	2605880001A	13-OCT-1999	99-05-6926A	02
05	MI	LAKE, TOWNSHIP OF	260030A	29-OCT-1999	99-05-7222A	02
05	MI	LEELANAU, TOWNSHIP OF	260114B	22-OCT-1999	99-05-7262A	02
05	MI	LEELANAU, TOWNSHIP OF	260114B	10-SEP-1999	99-05-6660A	02
05	MI	LEELANAU, TOWNSHIP OF	260114B	08-SEP-1999	99-05-6260A	02
05	MI	LEELANAU, TOWNSHIP OF	260114B	24-SEP-1999	99-05-5556A	02
05	MI	LINCOLN, TOWNSHIP OF	2600370001B	29-SEP-1999	99-05-5560A	02
05	MI	LIVONIA, CITY OF	2602330002B	03-SEP-1999	99-05-4862A	02
05	MI	LIVONIA, CITY OF	2602330003B	02-JUL-1999	99-05-4752A	02
05	MI	LONG LAKE, TOWNSHIP OF	2607820025A	01-DEC-1999	00-05-0136A	02
05	MI	LONG LAKE, TOWNSHIP OF	2607820025A	29-SEP-1999	99-05-6472A	02
05	MI	LONG LAKE, TOWNSHIP OF	2607820025A	24-SEP-1999	99-05-6146A	02
05	MI	MACOMB, TOWNSHIP OF	2604450010B	29-DEC-1999	99-05-6728A	01
05	MI	MACOMB, TOWNSHIP OF	2604450010B	10-SEP-1999	99-05-6530A	02
05	MI	MACOMB, TOWNSHIP OF	2604450010B	10-DEC-1999	99-05-6540A	01
05	MI	MACOMB, TOWNSHIP OF	2604450010B	29-SEP-1999	99-05-4330A	01
05	MI	MACOMB, TOWNSHIP OF	2604450010B	16-JUL-1999	99-05-143P	05
05	MI	MACOMB, TOWNSHIP OF	2604450010B	03-SEP-1999	99-05-2316P	05
05	MI	MACOMB, TOWNSHIP OF	2604450010B	16-JUL-1999	99-05-2044P	05
05	MI	MACOMB, TOWNSHIP OF	2604450020B	28-DEC-1999	99-05-253P	05
05	MI	MACOMB, TOWNSHIP OF	2604450020B	12-NOV-1999	99-05-5600A	02
05	MI	MAPLE GROVE, TOWNSHIP OF	2606440001B	23-JUL-1999	99-05-4604A	02
05	MI	MASONVILLE, TOWNSHIP OF	26041C0429C	12-NOV-1999	00-05-0052A	02
05	MI	MASONVILLE, TOWNSHIP OF	26041C0439C	05-NOV-1999	00-05-0250A	02
05	MI	MENDON, TOWNSHIP OF	2605130015B	15-DEC-1999	99-05-7062A	01
05	MI	MERIDIAN, CHARTER TOWNSHIP OF	2600930001A	01-DEC-1999	99-05-7068A	02
05	MI	MERIDIAN, CHARTER TOWNSHIP OF	2600930001A	20-OCT-1999	99-05-6808A	02
05	MI	MERIDIAN, CHARTER TOWNSHIP OF	2600930001A	28-JUL-1999	99-05-5964A	01
05	MI	MERIDIAN, CHARTER TOWNSHIP OF	2600930001A	29-SEP-1999	99-05-5850A	02
05	MI	MERIDIAN, CHARTER TOWNSHIP OF	2600930001A	21-JUL-1999	99-05-5734A	02
05	MI	MERIDIAN, CHARTER TOWNSHIP OF	2600930001A	03-SEP-1999	99-05-5698A	02
05	MI	MERIDIAN, CHARTER TOWNSHIP OF	2600930001A	21-JUL-1999	99-05-5334A	02
05	MI	MERIDIAN, CHARTER TOWNSHIP OF	2600930001A	23-JUL-1999	99-05-4300A	02
05	MI	MERIDIAN, CHARTER TOWNSHIP OF	2600930002A	13-AUG-1999	99-05-4270A	02
05	MI	MIDLAND, CITY OF	2601400007D	15-OCT-1999	99-05-7060A	02
05	MI	MIDLAND, CITY OF	2601400007D	10-SEP-1999	99-05-6246A	02
05	MI	MIDLAND, CITY OF	2601400007D	19-NOV-1999	99-05-5482A	02
05	MI	MIDLAND, CITY OF	2601400007D	23-JUL-1999	99-05-4786A	02
05	MI	MIDLAND, CITY OF	2601400008D	03-DEC-1999	99-05-7370A	02
05	MI	MIDLAND, CITY OF	2601400008D	20-OCT-1999	99-05-6022A	02
05	MI	NILES, TOWNSHIP OF	260041B	29-DEC-1999	00-05-1246X	02
05	MI	NILES, TOWNSHIP OF	260041B	03-DEC-1999	99-05-5868A	02
05	MI	NORTHVILLE, CITY OF	2602350001A	07-DEC-1999	00-05-0986V	19
05	MI	NORTON SHORES, CITY OF	2601650001A	29-SEP-1999	99-05-5866A	02
05	MI	NOTTAWA, TOWNSHIP OF	26073C0175C	01-OCT-1999	99-05-4792A	02
05	MI	NOVI, CITY OF	2601750006C	10-SEP-1999	99-05-4650A	02
05	MI	NOVI, CITY OF	2601750008C	27-OCT-1999	99-05-7320A	02
05	MI	NOVI, CITY OF	2601750009C	04-AUG-1999	99-05-5382A	02
05	MI	OWOSSO, CITY OF	2605960002A	12-NOV-1999	99-05-7096A	02
05	MI	PARK, TOWNSHIP OF	2601850001B	17-SEP-1999	99-05-6604A	02
05	MI	PONTIAC, CITY OF	2601770010B	23-JUL-1999	99-05-4480A	02
05	MI	PORTAGE, CITY OF	2605770005A	28-JUL-1999	99-05-4544A	02
05	MI	REDFORD, TOWNSHIP OF	2602380005B	20-OCT-1999	99-05-7348A	02
05	MI	SAGINAW, TOWNSHIP OF	26145C0070D	27-AUG-1999	99-05-5506A	02
05	MI	SAGINAW, TOWNSHIP OF	26145C0130D	15-DEC-1999	99-05-5842A	02
05	MI	SAGINAW, TOWNSHIP OF	26145C0130D	28-JUL-1999	99-05-5010A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
05	MI	SELMA, TOWNSHIP OF	26165C0336C	04-AUG-1999	99-05-4734A	02
05	MI	SELMA, TOWNSHIP OF	26165C0338C	29-OCT-1999	99-05-7006A	02
05	MI	SHELBY, TOWNSHIP OF	2601260010B	29-SEP-1999	99-05-6802A	02
05	MI	SHERMAN, TOWNSHIP OF	26073C0175C	10-NOV-1999	00-05-0294A	02
05	MI	SILVER CREEK, TOWNSHIP OF	260369B	24-SEP-1999	99-05-4352A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	29-DEC-1999	00-05-0894A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	17-DEC-1999	00-05-0784X	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	10-NOV-1999	00-05-0438A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	12-NOV-1999	00-05-0420A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	05-NOV-1999	00-05-0266A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	22-OCT-1999	99-05-7218A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	20-OCT-1999	99-05-7040A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	29-OCT-1999	99-05-7038A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	20-OCT-1999	99-05-6904A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	24-SEP-1999	99-05-6810A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	15-SEP-1999	99-05-6746A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	27-OCT-1999	99-05-6560A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	01-OCT-1999	99-05-6590A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	13-OCT-1999	99-05-6440A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	05-NOV-1999	99-05-6454A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	25-AUG-1999	99-05-5564A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	04-AUG-1999	99-05-5528A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	06-AUG-1999	99-05-5224A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	20-AUG-1999	99-05-5096A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	30-JUL-1999	99-05-4814A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	09-JUL-1999	99-05-4728A	02
05	MI	ST. CLAIR SHORES, CITY OF	2601270005B	23-JUL-1999	99-05-4660A	02
05	MI	ST. LOUIS, CITY OF	2600850001B	20-AUG-1999	99-05-3840A	02
05	MI	STERLING HEIGHTS, CITY OF	2601280010E	03-NOV-1999	99-05-5774A	02
05	MI	STERLING HEIGHTS, CITY OF	2601280010E	29-OCT-1999	99-05-5562A	02
05	MI	STERLING HEIGHTS, CITY OF	2601280015F	12-NOV-1999	99-05-7146A	02
05	MI	STERLING HEIGHTS, CITY OF	2601280015F	08-SEP-1999	99-05-5282A	02
05	MI	STERLING HEIGHTS, CITY OF	2601280015F	16-JUL-1999	99-05-3284A	02
05	MI	STERLING HEIGHTS, CITY OF	2601280015F	03-SEP-1999	99-05-2828A	01
05	MI	STERLING HEIGHTS, CITY OF	2601280015F	14-JUL-1999	99-05-2618A	02
05	MI	STERLING HEIGHTS, CITY OF	2601280020E	22-DEC-1999	00-05-0614A	02
05	MI	STERLING HEIGHTS, CITY OF	2601280020E	05-NOV-1999	99-05-7220A	02
05	MI	STEVENSVILLE, VILLAGE OF	260557	25-AUG-1999	99-05-4936A	02
05	MI	SUMPTER, TOWNSHIP OF	2602430010C	13-AUG-1999	99-05-6002A	02
05	MI	SUPERIOR, TOWNSHIP OF	2603800002B	15-OCT-1999	99-05-7058A	02
05	MI	SWAN CREEK, TOWNSHIP OF	26145C0125D	30-JUL-1999	99-05-5100A	02
05	MI	TALLMADGE, TOWNSHIP OF	2604940010B	17-DEC-1999	99-05-6920A	02
05	MI	TAWAS CITY, CITY OF	2601020001C	21-JUL-1999	99-05-4410A	02
05	MI	TAYLOR, CITY OF	2607280003A	01-OCT-1999	99-05-6788A	17
05	MI	TAYLOR, CITY OF	2607280003A	20-JUL-1999	99-05-5418A	02
05	MI	THOMAS, TOWNSHIP OF	26145C0065D	17-DEC-1999	99-05-6490A	02
05	MI	THOMAS, TOWNSHIP OF	26145C0070D	08-SEP-1999	99-05-5836A	02
05	MI	THOMAS, TOWNSHIP OF	26145C0070D	21-JUL-1999	99-05-5134A	02
05	MI	THOMAS, TOWNSHIP OF	26145C0125D	29-OCT-1999	99-05-6388A	02
05	MI	THOMAS, TOWNSHIP OF	26145C0130D	10-SEP-1999	99-05-5250A	02
05	MI	TRAVERSE CITY, CITY OF	2600820003B	21-JUL-1999	99-05-4852A	02
05	MI	TROY, CITY OF	2601800002D	24-SEP-1999	99-05-5240A	02
05	MI	TROY, CITY OF	2601800003E	24-NOV-1999	99-05-7382A	02
05	MI	TROY, CITY OF	2601800003E	13-OCT-1999	99-05-6672A	02
05	MI	TROY, CITY OF	2601800004E	15-DEC-1999	00-05-0552A	02
05	MI	TROY, CITY OF	2601800004E	10-SEP-1999	99-05-6550A	02
05	MI	TROY, CITY OF	2601800004E	29-JUL-1999	99-05-6018A	02
05	MI	TROY, CITY OF	2601800006E	22-OCT-1999	99-05-4802A	17
05	MI	TROY, CITY OF	2601800006E	09-JUL-1999	99-05-4344A	02
05	MI	UNION, TOWNSHIP OF	2608050025A	02-JUL-1999	99-05-2818A	02
05	MI	VICTOR, TOWNSHIP OF	2607200010B	03-SEP-1999	99-05-5584A	02
05	MI	WATERFORD, CHARTER TOWNSHIP OF	2602840010B	08-DEC-1999	99-05-6244A	02
05	MI	WATERFORD, CHARTER TOWNSHIP OF	2602840020B	01-OCT-1999	99-05-6914A	02
05	MI	WATERFORD, CHARTER TOWNSHIP OF	2602840020B	01-OCT-1999	99-05-6632A	02
05	MI	WEST BLOOMFIELD, TOWNSHIP OF	2601820012B	10-SEP-1999	99-05-6272A	02
05	MI	WHITEHALL, CITY OF	2601660005B	24-SEP-1999	99-05-3824A	01
05	MI	WHITEWATER, TOWNSHIP OF	2607940025A	22-OCT-1999	99-05-7234A	02
05	MI	WHITEWATER, TOWNSHIP OF	2607940025A	03-SEP-1999	99-05-5288A	02
05	MI	WILLIAMSTON, CITY OF	2600940001B	08-SEP-1999	99-05-4172A	17
05	MI	WILLIAMSTOWN, TOWNSHIP OF	2600950010A	06-AUG-1999	99-05-3178A	02
05	MI	WOLVERINE LAKE, VILLAGE OF	260480A	20-AUG-1999	99-05-5356A	02
05	MI	WOLVERINE LAKE, VILLAGE OF	260480A	27-OCT-1999	99-05-4586A	02
05	MI	WOODHAVEN, CITY OF	2607300005A	15-DEC-1999	99-05-030P	05

Region	State	Community	Map panel	Determination date	Case No.	Type
05	MI	ZILWAUKEE, CITY OF	26145C0085D	10-DEC-1999	00-05-0108A	02
05	MI	ZILWAUKEE, CITY OF	26145C0085D	12-NOV-1999	99-05-6748A	01
05	MI	ZILWAUKEE, CITY OF	26145C0085D	21-JUL-1999	99-05-4946A	02
05	MI	ZILWAUKEE, CITY OF	26145C0085D	11-AUG-1999	99-05-4006A	01
05	MN	AITKIN COUNTY *	2706280120C	24-NOV-1999	99-05-7328A	02
05	MN	AITKIN COUNTY *	2706280215C	08-OCT-1999	99-05-5724A	02
05	MN	AITKIN COUNTY *	2706280400C	27-AUG-1999	99-05-5888A	02
05	MN	AITKIN COUNTY *	2706280475B	30-JUL-1999	99-05-3736A	02
05	MN	ANDOVER, CITY OF	2706890015B	03-DEC-1999	99-05-4974A	02
05	MN	ANOKA COUNTY *	2700050025A	15-OCT-1999	99-05-6446A	02
05	MN	ANOKA COUNTY *	2700050050A	22-DEC-1999	00-05-0800A	02
05	MN	ANOKA COUNTY *	2700050050A	06-OCT-1999	99-05-6312A	02
05	MN	ARDEN HILLS, CITY OF	2703750002B	22-DEC-1999	99-05-4878A	02
05	MN	AUSTIN, CITY OF	2752280004B	11-AUG-1999	99-05-4198A	02
05	MN	BENTON COUNTY *	2700190050B	24-NOV-1999	99-05-4528A	02
05	MN	BENTON COUNTY *	2700190100C	04-AUG-1999	99-05-5106A	17
05	MN	BLAINE, CITY OF	2700070005C	30-DEC-1999	00-05-1028A	02
05	MN	BLAINE, CITY OF	2700070005C	30-DEC-1999	00-05-0998A	02
05	MN	BLAINE, CITY OF	2700070005C	22-DEC-1999	00-05-0510A	02
05	MN	BLAINE, CITY OF	2700070005C	03-NOV-1999	00-05-0134A	02
05	MN	BLAINE, CITY OF	2700070005C	03-NOV-1999	99-05-7322A	02
05	MN	BLAINE, CITY OF	2700070005C	03-NOV-1999	99-05-7324A	02
05	MN	BLAINE, CITY OF	2700070005C	03-NOV-1999	99-05-7326A	02
05	MN	BLAINE, CITY OF	2700070005C	17-DEC-1999	99-05-6598A	02
05	MN	BLAINE, CITY OF	2700070005C	05-NOV-1999	99-05-3138A	02
05	MN	BLAINE, CITY OF	2700070010C	03-NOV-1999	99-05-5832A	01
05	MN	BLAINE, CITY OF	2700070010C	11-AUG-1999	99-05-5260A	01
05	MN	BLOOMINGTON, CITY OF	2752300001B	29-SEP-1999	99-05-5178A	01
05	MN	BLUE EARTH COUNTY *	2752310025E	22-JUL-1999	99-05-5634V	19
05	MN	BROOKLYN CENTER, CITY OF	2701510003B	22-DEC-1999	00-05-0472A	02
05	MN	BROOKLYN PARK, CITY OF	2701520003D	21-JUL-1999	99-05-4690A	02
05	MN	BURNSVILLE, CITY OF	2701020002B	29-OCT-1999	99-05-6848A	02
05	MN	CENTERVILLE, CITY OF	2700080001C	17-DEC-1999	99-05-6652A	02
05	MN	CENTERVILLE, CITY OF	2700080001C	10-SEP-1999	99-05-5742A	02
05	MN	CHANHASSEN, CITY OF	2700510005B	16-JUL-1999	99-05-4288A	02
05	MN	CHISAGO COUNTY *	2706820150C	14-JUL-1999	99-05-4684A	02
05	MN	CHISAGO COUNTY *	2706820175C	11-AUG-1999	99-05-5108A	02
05	MN	CIRCLE PINES, CITY OF	2700090005A	28-SEP-1999	99-05-4484A	01
05	MN	COOK, CITY OF	2704200001A	04-AUG-1999	98-05-295P	05
05	MN	COON RAPIDS,CITY OF	2700110002A	29-DEC-1999	00-05-0386A	02
05	MN	COON RAPIDS,CITY OF	2700110002A	10-NOV-1999	99-05-6994A	01
05	MN	COON RAPIDS,CITY OF	2700110002A	12-NOV-1999	99-05-6634A	02
05	MN	COON RAPIDS,CITY OF	2700110002A	15-JUL-1999	97-05-379P	05
05	MN	CROSSLAKE, CITY OF	270095B	27-OCT-1999	99-05-6880A	02
05	MN	CROSSLAKE, CITY OF	270095B	24-NOV-1999	99-05-5898A	02
05	MN	CROSSLAKE, CITY OF	270095B	17-SEP-1999	99-05-5514A	02
05	MN	CROSSLAKE, CITY OF	270095B	28-JUL-1999	99-05-4424A	02
05	MN	CROW WING COUNTY *	2700910275B	24-NOV-1999	00-05-0212A	02
05	MN	CROW WING COUNTY *	2700910275B	22-OCT-1999	99-05-7364A	02
05	MN	DAKOTA COUNTY *	2701010150B	11-AUG-1999	99-05-4346A	02
05	MN	DAKOTA COUNTY *	2701010175B	12-NOV-1999	99-05-6878A	02
05	MN	DAKOTA COUNTY *	2701010200B	16-JUL-1999	99-05-2768A	02
05	MN	DAKOTA COUNTY *	2701010275B	01-SEP-1999	99-05-4552A	02
05	MN	DODGE COUNTY *	2705480125B	02-JUL-1999	99-05-3128A	02
05	MN	EAST BETHEL, CITY OF	2700120010A	15-DEC-1999	00-05-0598A	02
05	MN	EAST GRAND FORKS, CITY OF	2752360005C	29-OCT-1999	99-05-6210A	02
05	MN	EDEN PRAIRIE, CITY OF	2701590005C	07-JUL-1999	99-05-4636A	02
05	MN	EDEN PRAIRIE, CITY OF	2701590010C	01-DEC-1999	99-05-6836A	02
05	MN	EDEN PRAIRIE, CITY OF	2701590010C	28-JUL-1999	99-05-4820A	02
05	MN	EDINA, CITY OF	2701600001B	09-JUL-1999	99-05-4302A	02
05	MN	EDINA, CITY OF	2701600004B	02-JUL-1999	99-05-4570A	02
05	MN	FREEBORN COUNTY *	2701340185B	17-NOV-1999	00-05-0054A	02
05	MN	GOODHUE COUNTY *	2701400125A	22-DEC-1999	00-05-0880A	02
05	MN	GOODHUE COUNTY *	2701400125A	01-SEP-1999	99-05-6330A	02
05	MN	GOODVIEW, CITY OF	2705280005B	22-OCT-1999	99-05-5520A	02
05	MN	GREENFIELD, CITY OF	2706730010C	10-DEC-1999	99-05-5518A	02
05	MN	GREENFIELD, CITY OF	2706730010C	30-JUL-1999	99-05-2998A	01
05	MN	HAM LAKE, CITY OF	2706740005B	22-DEC-1999	00-05-0662A	02
05	MN	HAM LAKE, CITY OF	2706740005B	08-DEC-1999	99-05-6168A	02
05	MN	HAM LAKE, CITY OF	2706740005B	03-SEP-1999	99-05-5918A	02
05	MN	HAM LAKE, CITY OF	2706740005B	12-NOV-1999	99-05-5002A	02
05	MN	HUGO, CITY OF	2705040010C	03-DEC-1999	99-05-6670A	02
05	MN	ISANTI COUNTY *	2701970025B	18-AUG-1999	99-05-5348A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
05	MN	ISANTI COUNTY *	2701970035B	03-DEC-1999	00-05-0348A	02
05	MN	ISANTI COUNTY *	2701970035B	19-NOV-1999	99-05-6072A	02
05	MN	ISANTI COUNTY *	2701970060B	08-DEC-1999	00-05-0780X	02
05	MN	ISANTI COUNTY *	2701970060B	22-DEC-1999	00-05-0138A	02
05	MN	ISANTI COUNTY *	2701970060B	03-SEP-1999	99-05-5940A	02
05	MN	ISANTI COUNTY *	2701970090A	16-JUL-1999	99-05-4626A	02
05	MN	ITASCA COUNTY *	2702000775A	08-DEC-1999	99-05-7120A	02
05	MN	KANABEC COUNTY *	2702140250A	26-OCT-1999	99-05-7122A	02
05	MN	KOOCHICHING COUNTY *	2702330006B	29-DEC-1999	00-05-0978A	02
05	MN	KOOCHICHING COUNTY *	2702330006B	19-NOV-1999	00-05-0448A	02
05	MN	KOOCHICHING COUNTY *	2702330011B	27-OCT-1999	99-05-6720A	02
05	MN	LE SUEUR COUNTY *	27079C0020D	22-JUL-1999	99-05-5630V	19
05	MN	LE SUEUR COUNTY *	27079C0230D	16-OCT-1999	99-05-231P	05
05	MN	LINO LAKES, CITY OF	2700150010B	06-OCT-1999	99-05-6504A	02
05	MN	LITTLE CANADA, CITY OF	2703770002A	03-DEC-1999	00-05-0048A	02
05	MN	LITTLE CANADA, CITY OF	2703770002A	16-JUL-1999	99-05-3898A	02
05	MN	MAPLE GROVE, CITY OF	2701690001B	08-DEC-1999	99-05-4840A	02
05	MN	MAPLE GROVE, CITY OF	2701690003B	19-NOV-1999	99-05-6268A	02
05	MN	MEDINA, CITY OF	2701710002B	01-DEC-1999	00-05-0644A	02
05	MN	MEEKER COUNTY *	2702800008B	02-JUL-1999	99-05-3558A	02
05	MN	MILACA, CITY OF	2702890002B	27-AUG-1999	99-05-3168A	01
05	MN	MINNETONKA, CITY OF	2701730003C	03-SEP-1999	99-05-5488A	02
05	MN	MINNETONKA, CITY OF	2701730003C	05-NOV-1999	99-05-3596A	02
05	MN	MINNETONKA, CITY OF	2701730003C	05-NOV-1999	99-05-3124A	02
05	MN	MINNETRISTA, CITY OF	270175B	08-OCT-1999	99-05-6038A	02
05	MN	MOORHEAD, CITY OF	2752440010D	24-SEP-1999	99-05-6832A	02
05	MN	MORRISON COUNTY *	2706170290B	20-OCT-1999	99-05-6228A	02
05	MN	NEWPORT, CITY OF	2705100001B	01-SEP-1999	99-05-5248A	02
05	MN	PINE COUNTY *	2707040340B	22-DEC-1999	00-05-0564A	02
05	MN	POLK COUNTY *	2705030175B	27-AUG-1999	99-05-5314A	02
05	MN	PRIOR LAKE, CITY OF	2704320002C	16-JUL-1999	99-05-4700A	01
05	MN	PRIOR LAKE, CITY OF	2704320002C	22-SEP-1999	99-05-4120A	01
05	MN	PRIOR LAKE, CITY OF	2704320003C	27-OCT-1999	99-05-6910A	02
05	MN	RICE COUNTY *	2706460025C	05-NOV-1999	99-05-6820A	02
05	MN	RICE COUNTY *	2706460025C	25-AUG-1999	99-05-5660A	02
05	MN	RICE COUNTY *	2706460025C	07-SEP-1999	99-05-5360A	02
05	MN	RICE COUNTY *	2706460025C	14-JUL-1999	99-05-5196A	02
05	MN	RICE COUNTY *	2706460025C	02-JUL-1999	99-05-4550A	02
05	MN	ROBBINSDALE, CITY OF	2701810001B	20-AUG-1999	99-05-4736A	02
05	MN	ROCHESTER, CITY OF	27109C0144E	12-NOV-1999	99-05-7044A	01
05	MN	ROCHESTER, CITY OF	27109C0161E	14-JUL-1999	99-05-5156A	02
05	MN	ROCHESTER, CITY OF	27109C0301E	15-OCT-1999	99-05-5756A	01
05	MN	SCOTT COUNTY*	2704280100C	15-DEC-1999	00-05-0424A	02
05	MN	SHERBURNE COUNTY *	2704350050C	12-NOV-1999	99-05-7192A	02
05	MN	SHERBURNE COUNTY *	2704350050C	22-SEP-1999	99-05-5958A	02
05	MN	SHERBURNE COUNTY *	2704350050C	27-AUG-1999	99-05-5154A	02
05	MN	SHERBURNE COUNTY *	2704350065C	04-AUG-1999	99-05-3740A	02
05	MN	ST. FRANCIS, CITY OF	2700170010B	03-DEC-1999	99-05-7198A	02
05	MN	ST. LOUIS COUNTY *	2704160200C	01-OCT-1999	99-05-5580A	02
05	MN	ST. LOUIS COUNTY *	2704160575C	02-JUL-1999	99-05-2966A	02
05	MN	ST. LOUIS COUNTY *	2704161395C	12-NOV-1999	99-05-3244A	02
05	MN	ST. LOUIS COUNTY *	2704161475C	15-DEC-1999	99-05-6482A	02
05	MN	ST. LOUIS PARK, CITY OF	2701840005B	19-NOV-1999	99-05-6936A	02
05	MN	STEARNS COUNTY*	2705460025A	30-DEC-1999	00-05-1004A	01
05	MN	STEARNS COUNTY*	2705460270B	10-SEP-1999	99-05-5424A	02
05	MN	STEARNS COUNTY*	2705460270B	22-SEP-1999	99-05-5368A	02
05	MN	WADENA COUNTY*	2706370400B	03-DEC-1999	99-05-7334A	02
05	MN	WASECA COUNTY *	270647B	01-OCT-1999	99-05-6610A	02
05	MN	WASHINGTON COUNTY *	2704990025B	15-DEC-1999	00-05-0404A	02
05	MN	WASHINGTON COUNTY *	2704990025B	05-NOV-1999	00-05-0200A	02
05	MN	WASHINGTON COUNTY *	2704990025B	15-OCT-1999	99-05-6928A	02
05	MN	WASHINGTON COUNTY *	2704990025B	03-SEP-1999	99-05-6404A	02
05	MN	WASHINGTON COUNTY *	2704990025B	16-JUL-1999	99-05-4476A	02
05	MN	WASHINGTON COUNTY *	2704990125B	15-OCT-1999	99-05-5728A	02
05	MN	WATERVILLE, CITY OF	27079C0427D	03-DEC-1999	00-05-0368A	02
05	MN	WATERVILLE, CITY OF	27079C0427D	22-JUL-1999	99-05-5632V	19
05	MN	WHITE BEAR,TOWNSHIP OF	2706880005B	03-NOV-1999	00-05-0118A	02
05	MN	WHITE BEAR,TOWNSHIP OF	2706880005B	01-DEC-1999	99-05-6854A	02
05	MN	WHITE BEAR,TOWNSHIP OF	2706880005B	05-NOV-1999	99-05-6576A	02
05	MN	WHITE BEAR,TOWNSHIP OF	2706880005B	13-OCT-1999	99-05-6520A	02
05	MN	WHITE BEAR,TOWNSHIP OF	2706880005B	08-OCT-1999	99-05-6470A	02
05	MN	WHITE BEAR,TOWNSHIP OF	2706880005B	06-OCT-1999	99-05-4182A	02
05	MN	WHITE BEAR,TOWNSHIP OF	2706880010B	20-OCT-1999	99-05-2842A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
05	MN	WINDOM, CITY OF	2700900001C	28-JUL-1999	99-05-2816A	17
05	MN	WINONA COUNTY *	2705250086C	03-DEC-1999	99-05-7270A	02
05	MN	WINONA COUNTY *	2705250086C	08-DEC-1999	99-05-7272A	02
05	MN	WRIGHT COUNTY *	2705340009B	29-DEC-1999	00-05-0684A	02
05	MN	WRIGHT COUNTY *	2705340033B	29-OCT-1999	99-05-6702A	02
05	MN	WRIGHT COUNTY *	2705340033B	18-AUG-1999	99-05-5500A	02
05	OH	ADAMS COUNTY *	3900010008A	15-OCT-1999	99-05-3362A	02
05	OH	AKRON, CITY OF	3905230020B	07-JUL-1999	99-05-029P	05
05	OH	ARCANUM, VILLAGE OF	3906840001B	20-OCT-1999	99-05-6158A	02
05	OH	ASHLAND COUNTY	3907590005B	24-SEP-1999	99-05-5708A	02
05	OH	AUGLAIZE COUNTY *	39011C0080C	24-SEP-1999	99-05-6814A	02
05	OH	AUGLAIZE COUNTY *	39011C0090C	05-NOV-1999	99-05-7292A	02
05	OH	AVON LAKE, CITY OF	3906020002B	19-NOV-1999	99-05-5624A	02
05	OH	AVON LAKE, CITY OF	3906020002B	19-NOV-1999	99-05-878A	02
05	OH	BALTIMORE, VILLAGE OF	3901590001B	10-NOV-1999	00-05-0350A	02
05	OH	BEXLEY, CITY OF	39049C0255G	10-DEC-1999	99-05-6074A	01
05	OH	BRUNSWICK, CITY OF	3903800001B	28-JUL-1999	99-05-2096A	02
05	OH	BUTLER COUNTY *	3900370040C	06-JUL-1999	99-05-4968A	02
05	OH	BUTLER COUNTY *	3900370060B	15-OCT-1999	99-05-6292A	02
05	OH	BUTLER COUNTY *	3900370070C	15-SEP-1999	99-05-5986A	02
05	OH	BUTLER COUNTY *	3900370070C	29-SEP-1999	99-05-5908A	02
05	OH	CANAL FULTON, VILLAGE OF	3905110001B	08-DEC-1999	99-05-6478A	01
05	OH	CARROLL COUNTY *	3907630075B	10-DEC-1999	99-05-7082A	02
05	OH	CINCINNATI, CITY OF	3902100027B	08-SEP-1999	99-05-4670A	02
05	OH	CLARK COUNTY*	3907320180A	23-JUL-1999	99-05-4590A	02
05	OH	CLARK COUNTY*	3907320200A	06-OCT-1999	99-05-5408A	02
05	OH	COLUMBUS, CITY OF	39049C0158G	13-OCT-1999	99-05-6338A	01
05	OH	COLUMBUS, CITY OF	39049C0227G	20-OCT-1999	99-05-7288A	02
05	OH	COLUMBUS, CITY OF	39049C0229G	27-OCT-1999	99-05-6150A	02
05	OH	COLUMBUS, CITY OF	39049C0270G	24-SEP-1999	99-05-4338A	02
05	OH	COLUMBUS, CITY OF	39049C0290G	06-AUG-1999	99-05-5858A	01
05	OH	COLUMBUS, CITY OF	39049C0290G	16-JUL-1999	99-05-3968A	01
05	OH	CUYAHOGA FALLS, CITY OF	3905260005B	12-AUG-1999	99-05-6424A	02
05	OH	DARKE COUNTY *	3901370130C	14-JUL-1999	99-05-3176A	02
05	OH	DAYTON, CITY OF	3904090010C	10-NOV-1999	99-05-6548A	01
05	OH	DELAWARE COUNTY *	39041C0165J	23-JUL-1999	99-05-4668A	01
05	OH	DELAWARE COUNTY *	39041C0216J	24-SEP-1999	99-05-6392A	01
05	OH	DELAWARE, CITY OF	39041C0105J	01-SEP-1999	99-05-4744A	01
05	OH	DUBLIN, CITY OF	39041C0195J	05-NOV-1999	99-05-5270A	01
05	OH	DUBLIN, CITY OF	39049C0018H	29-SEP-1999	99-05-3100A	01
05	OH	DUBLIN, CITY OF	39049C0019G	04-AUG-1999	99-05-1506A	02
05	OH	DUBLIN, CITY OF	39049C0106G	11-AUG-1999	99-05-4966A	02
05	OH	DUBLIN, CITY OF	39049C0107G	24-NOV-1999	99-05-4774A	01
05	OH	ELYRIA, CITY OF	3903500010B	30-JUL-1999	98-05-5360A	02
05	OH	FAIRFIELD COUNTY *	3901580020D	27-OCT-1999	99-05-7090A	02
05	OH	FAIRFIELD COUNTY *	3901580055D	25-AUG-1999	99-05-5870A	02
05	OH	FAIRFIELD, CITY OF	3900380005B	21-JUL-1999	99-05-3638A	02
05	OH	FINDLAY, CITY	3902440004B	23-JUL-1999	99-05-5228A	02
05	OH	FINDLAY, CITY	3902440004B	28-JUL-1999	99-05-5090A	02
05	OH	FINDLAY, CITY	3902440005C	08-DEC-1999	00-05-0060A	02
05	OH	FINDLAY, CITY	3902440005C	01-SEP-1999	99-05-6284A	02
05	OH	FINDLAY, CITY	3902440005C	27-AUG-1999	99-05-5768A	02
05	OH	FINDLAY, CITY	3902440005C	02-JUL-1999	99-05-4534A	02
05	OH	FINDLAY, CITY	3902440009B	13-AUG-1999	99-05-4610A	01
05	OH	FINDLAY, CITY	3907670080B	19-NOV-1999	99-05-7124A	01
05	OH	FINDLAY, CITY	3907670080B	03-NOV-1999	99-05-5952A	01
05	OH	FINDLAY, CITY	3907670080B	12-AUG-1999	99-05-4226A	01
05	OH	FORT JENNINGS, VILLAGE OF	390468B	16-DEC-1999	00-05-0770X	02
05	OH	FORT JENNINGS, VILLAGE OF	390468B	22-SEP-1999	99-05-5144A	02
05	OH	FORT JENNINGS, VILLAGE OF	390468B	22-SEP-1999	99-05-5082A	02
05	OH	FORT JENNINGS, VILLAGE OF	390468B	22-SEP-1999	99-05-5080A	02
05	OH	FRANKLIN COUNTY*	39049C0277G	12-NOV-1999	99-05-6980A	02
05	OH	FREDERICKSBURG, VILLAGE OF	39169C0275C	12-NOV-1999	99-05-2974A	02
05	OH	GAHANNA, CITY OF	39049C0186G	06-AUG-1999	99-05-5796A	02
05	OH	GAHANNA, CITY OF	39049C0188G	10-AUG-1999	99-05-163P	05
05	OH	GROVE CITY, CITY OF	39049C0238G	26-OCT-1999	99-05-183P	05
05	OH	GUERNSEY COUNTY *	39059C0206C	04-AUG-1999	99-05-5148A	02
05	OH	HAMILTON COUNTY *	3902040040C	08-DEC-1999	99-05-6206A	02
05	OH	HAMILTON COUNTY *	3902040060B	14-JUL-1999	99-05-4674A	02
05	OH	HARRISON, CITY OF	3902200005C	24-SEP-1999	99-05-6884A	02
05	OH	HIGHLAND HEIGHTS, CITY OF	3901100001D	08-SEP-1999	98-05-281P	05
05	OH	HILLIARD, CITY OF	39049C0116G	28-DEC-1999	00-05-1142X	01
05	OH	HILLIARD, CITY OF	39049C0116G	08-DEC-1999	99-05-7156A	01

Region	State	Community	Map panel	Determination date	Case No.	Type
05	OH	HILLIARD, CITY OF	39049C0116G	03-NOV-1999	99-05-6380A	01
05	OH	JEFFERSON COUNTY *	3902940140C	19-NOV-1999	99-05-724A	01
05	OH	KETTERING, CITY OF	3904120010B	08-SEP-1999	99-05-4920A	02
05	OH	KETTERING, CITY OF	3904120020B	08-SEP-1999	99-05-6398A	02
05	OH	KNOX COUNTY *	3903060120C	24-NOV-1999	99-05-5932A	02
05	OH	LAKE COUNTY *	3907710014C	29-DEC-1999	99-05-7102A	02
05	OH	LANCASTER, CITY OF	3901610003D	15-OCT-1999	99-05-6278A	02
05	OH	LANCASTER, CITY OF	3901610003D	10-SEP-1999	99-05-5906A	02
05	OH	LANCASTER, CITY OF	3901610003D	23-JUL-1999	99-05-5242A	02
05	OH	LICKING COUNTY *	3903280125B	19-OCT-1999	99-05-095P	05
05	OH	LOGAN COUNTY *	3907720025C	29-OCT-1999	99-05-6696A	02
05	OH	LORAIN COUNTY*	3903460150B	18-AUG-1999	99-05-5384A	02
05	OH	LORAIN COUNTY*	3903460150B	18-AUG-1999	99-05-4858A	02
05	OH	LUCAS COUNTY*	3903590015B	01-DEC-1999	00-05-0768X	01
05	OH	LUCAS COUNTY*	3903590015B	01-OCT-1999	99-05-6868A	02
05	OH	LUCAS COUNTY*	3903590015B	13-OCT-1999	99-05-6870A	02
05	OH	LUCAS COUNTY*	3903590015B	29-OCT-1999	99-05-6552A	01
05	OH	LUCAS COUNTY*	3903590050B	27-OCT-1999	99-05-6378A	02
05	OH	LUCAS COUNTY*	3903590050B	29-SEP-1999	99-05-6842A	02
05	OH	LUCAS COUNTY*	3903590065B	29-SEP-1999	99-05-6488A	02
05	OH	MAUMEE, CITY OF	3903600005B	24-NOV-1999	99-05-4810A	02
05	OH	MEDINA COUNTY *	3903780005B	10-SEP-1999	99-05-215P	06
05	OH	MEDINA COUNTY *	3903780005B	13-AUG-1999	99-05-4180A	02
05	OH	MERCER COUNTY *	3903920100B	10-DEC-1999	00-05-0686A	02
05	OH	MERCER COUNTY *	3903920100B	08-DEC-1999	00-05-0044A	02
05	OH	MERCER COUNTY *	3903920100B	20-OCT-1999	99-05-7276A	02
05	OH	MERCER COUNTY *	3903920100B	22-OCT-1999	99-05-7278A	02
05	OH	MERCER COUNTY *	3903920100B	29-DEC-1999	99-05-6992A	02
05	OH	MERCER COUNTY *	3903920100B	10-NOV-1999	99-05-6698A	02
05	OH	MERCER COUNTY *	3903920100B	08-SEP-1999	99-05-6546A	02
05	OH	MERCER COUNTY *	3903920100B	29-DEC-1999	99-05-6462A	01
05	OH	MERCER COUNTY *	3903920100B	10-SEP-1999	99-05-6124A	02
05	OH	MERCER COUNTY *	3903920100B	24-SEP-1999	99-05-6066A	02
05	OH	MERCER COUNTY *	3903920100B	16-JUL-1999	99-05-3396A	02
05	OH	MIAMI COUNTY *	3903980075C	22-DEC-1999	00-05-1006A	02
05	OH	MIAMI COUNTY *	3903980090B	24-SEP-1999	99-05-6556A	02
05	OH	MIAMI COUNTY *	3903980090B	22-SEP-1999	99-05-4164A	02
05	OH	MIAMI COUNTY *	3903980090B	20-AUG-1999	99-05-4108A	02
05	OH	MIAMI COUNTY *	3903980110C	04-AUG-1999	99-05-4652A	02
05	OH	MIAMISBURG, CITY OF	3904130005C	01-OCT-1999	99-05-3586A	02
05	OH	MONTGOMERY COUNTY *	3907750035C	09-JUL-1999	99-05-3216A	17
05	OH	MONTGOMERY COUNTY *	3907750035C	30-JUL-1999	99-05-3224A	01
05	OH	MONTGOMERY COUNTY *	3907750040C	16-DEC-1999	00-05-0916A	02
05	OH	MONTGOMERY COUNTY *	3907750040C	15-OCT-1999	99-05-5174A	02
05	OH	MONTGOMERY COUNTY *	3907750040C	09-DEC-1999	99-05-097P	05
05	OH	NEW KNOXVILLE, VILLAGE OF	39011C0095C	20-OCT-1999	99-05-5770A	02
05	OH	NEW RICHMOND, VILLAGE OF	3900710005C	04-AUG-1999	99-05-5088A	02
05	OH	NEWARK,CITY OF	3903350015E	01-DEC-1999	99-05-6016A	02
05	OH	NEWARK,CITY OF	3903350015E	19-OCT-1999	99-05-095P	05
05	OH	NORTH CANTON, CITY OF	3905210003B	03-DEC-1999	00-05-0786X	02
05	OH	NORTH CANTON, CITY OF	3905210003B	20-AUG-1999	99-05-5436A	02
05	OH	OLMSTED FALLS, CITY OF	3906720001B	03-DEC-1999	00-05-0040A	02
05	OH	OLMSTED FALLS, CITY OF	3906720001B	15-OCT-1999	99-05-5012A	02
05	OH	OTTAWA COUNTY *	3904320050B	27-AUG-1999	99-05-5592A	02
05	OH	OTTAWA COUNTY *	3904320200B	09-JUL-1999	99-05-4094A	01
05	OH	PORTAGE COUNTY*	390453C	18-AUG-1999	99-05-5914A	02
05	OH	PORTAGE COUNTY*	390453C	18-AUG-1999	99-05-3910A	02
05	OH	PREBLE COUNTY *	3904600015B	09-NOV-1999	00-05-0166A	02
05	OH	PUTNAM COUNTY *	3904650040B	08-DEC-1999	99-05-6612A	02
05	OH	PUTNAM COUNTY *	3904650100B	15-DEC-1999	00-05-0540A	02
05	OH	PUTNAM COUNTY *	3904650100B	03-DEC-1999	00-05-0542A	02
05	OH	PUTNAM COUNTY *	3904650100B	08-OCT-1999	99-05-5366A	02
05	OH	REYNOLDSBURG, CITY OF	39049C0283G	30-DEC-1999	00-05-0376A	02
05	OH	RICHLAND COUNTY*	3904760060B	27-AUG-1999	99-05-2930A	01
05	OH	ROCKY RIVER, CITY OF	3953720003B	29-OCT-1999	99-05-5930A	02
05	OH	ROSS COUNTY *	3904800125B	24-SEP-1999	99-05-4216A	17
05	OH	RUSSIA, VILLAGE OF	3908800001A	29-OCT-1999	99-05-5340A	02
05	OH	SANDUSKY COUNTY *	3904860100B	13-AUG-1999	99-05-3292A	02
05	OH	SANDUSKY COUNTY *	3904860115B	22-DEC-1999	00-05-0410A	02
05	OH	SANDUSKY COUNTY *	3904860200B	10-SEP-1999	99-05-6566A	02
05	OH	SANDUSKY COUNTY *	3904860250B	22-SEP-1999	99-05-5234A	02
05	OH	SENECA COUNTY *	3907790025B	16-JUL-1999	99-05-3814A	02
05	OH	SENECA COUNTY *	3907790085B	15-JUL-1999	99-05-5860A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
05	OH	SENECA COUNTY *	3907790085B	05-NOV-1999	99-05-5176A	02
05	OH	SENECA COUNTY *	3907790085B	09-JUL-1999	99-05-3844A	02
05	OH	SHADYSIDE, VILLAGE OF	3900310005D	13-OCT-1999	99-05-6098A	02
05	OH	SHELBY COUNTY *	3905030070C	14-JUL-1999	99-05-5308A	02
05	OH	SHELBY COUNTY *	3905030060C	13-AUG-1999	99-05-4764A	01
05	OH	SOLON, CITY OF	3901300001B	22-JUL-1999	99-05-5636V	19
05	OH	ST. MARYS, CITY OF	39011C0080C	09-JUL-1999	99-05-5024A	02
05	OH	STARK COUNTY*	3907800036B	15-OCT-1999	99-05-6648A	02
05	OH	STARK COUNTY*	3907800110B	15-OCT-1999	99-05-4526A	02
05	OH	STOW, CITY OF	3905320005B	01-DEC-1999	99-05-7016A	02
05	OH	TOLEDO, CITY OF	3953730005A	15-OCT-1999	99-05-6456A	02
05	OH	TOLEDO, CITY OF	3953730005A	29-OCT-1999	99-05-6250A	02
05	OH	TOLEDO, CITY OF	3953730005A	08-OCT-1999	99-05-6248A	02
05	OH	TOLEDO, CITY OF	3953730005A	02-JUL-1999	99-05-4408A	02
05	OH	TOLEDO, CITY OF	3953730005A	05-NOV-1999	99-05-4386A	02
05	OH	TOLEDO, CITY OF	3953730010A	17-DEC-1999	99-05-6722A	02
05	OH	TOLEDO, CITY OF	3953730020A	11-AUG-1999	99-05-5146A	02
05	OH	TROY, CITY OF	3904020005B	10-SEP-1999	99-05-5982A	02
05	OH	TWINSBURG, CITY OF	3905340002C	10-NOV-1999	99-05-3354A	02
05	OH	UNION COUNTY *	3908080050B	02-JUL-1999	99-05-4510A	02
05	OH	UNION COUNTY *	3908080150B	12-NOV-1999	99-05-6542A	02
05	OH	WALBRIDGE, VILLAGE OF	3906350001A	22-DEC-1999	99-05-3102A	01
05	OH	WAYNE COUNTY *	39169C0025C	29-SEP-1999	99-05-5438A	02
05	OH	WAYNE COUNTY *	39169C0060C	13-OCT-1999	99-05-5558A	02
05	OH	WAYNE COUNTY *	39169C0075D	01-SEP-1999	99-05-4768A	01
05	OH	WHITEHALL, CITY OF	39049C0260G	20-OCT-1999	99-05-7226A	02
05	OH	WILLIAMS COUNTY*	3907850050B	04-AUG-1999	99-05-5732A	02
05	OH	WOOD COUNTY *	3908090105B	15-DEC-1999	99-05-6708A	02
05	OH	YOUNGSTOWN, CITY OF	3903730002B	15-OCT-1999	99-05-6758A	02
05	WI	ADAMS COUNTY *	55001C0450C	08-DEC-1999	99-05-6978A	02
05	WI	ANTIGO, CITY OF	555541A	11-AUG-1999	99-05-4622A	02
05	WI	BARRON COUNTY *	5505680185C	24-NOV-1999	00-05-0298A	02
05	WI	BAYFIELD COUNTY *	5505390025B	27-OCT-1999	99-05-5120A	02
05	WI	BAYFIELD COUNTY *	5505390026B	04-AUG-1999	99-05-2436A	02
05	WI	BIRCHWOOD, VILLAGE OF	550574B	10-NOV-1999	99-05-3852A	02
05	WI	BROOKFIELD, CITY OF	5504780005B	16-NOV-1999	00-05-0576A	02
05	WI	BROWN COUNTY *	5500200150B	27-OCT-1999	99-05-5422A	01
05	WI	BURNETT COUNTY *	5500320200B	22-DEC-1999	00-05-0872A	02
05	WI	BURNETT COUNTY *	5500320200B	15-OCT-1999	99-05-5350A	02
05	WI	CECIL, VILLAGE OF	550416B	06-OCT-1999	99-05-5462A	02
05	WI	CHIPPEWA COUNTY *	5555490125B	27-AUG-1999	99-05-4924A	02
05	WI	CHIPPEWA COUNTY *	5555490125B	15-SEP-1999	99-05-3850A	02
05	WI	CHIPPEWA COUNTY *	5555490250C	26-AUG-1999	99-05-6668A	02
05	WI	CHIPPEWA COUNTY *	5555490250C	30-JUL-1999	99-05-5268A	02
05	WI	CHIPPEWA COUNTY *	5555490275C	17-NOV-1999	99-05-5496A	02
05	WI	CLARK COUNTY *	5500480030B	13-OCT-1999	99-05-5450A	02
05	WI	COLUMBIA COUNTY *	5505810050C	10-NOV-1999	99-05-4518A	02
05	WI	COLUMBIA COUNTY *	5505810075C	04-AUG-1999	99-05-5412A	02
05	WI	COLUMBIA COUNTY *	5505810150C	09-JUL-1999	99-05-4548A	02
05	WI	COLUMBIA COUNTY *	5505810200C	15-DEC-1999	00-05-0520A	02
05	WI	COLUMBIA COUNTY *	5505810200C	29-DEC-1999	99-05-7254A	02
05	WI	CUDAHY, CITY OF	5502720001B	20-AUG-1999	98-05-225A	01
05	WI	DANE COUNTY*	5500770375A	11-AUG-1999	99-05-5928A	02
05	WI	DOOR COUNTY *	5501090150A	09-JUL-1999	99-05-4872A	02
05	WI	DOUSMAN, VILLAGE OF	5504800001C	06-JUL-1999	98-05-6080A	01
05	WI	DOYLESTOWN, VILLAGE OF	550059B	21-JUL-1999	99-05-5126A	02
05	WI	EAU CLAIRE COUNTY *	5555520400B	08-JUL-1999	99-05-4380A	02
05	WI	EAU CLAIRE, CITY OF	5501280005D	10-DEC-1999	00-05-0340A	02
05	WI	FOND DU LAC COUNTY *	5501310060B	12-NOV-1999	99-05-5894A	02
05	WI	FOND DU LAC COUNTY *	5501310070C	11-AUG-1999	99-05-4462A	01
05	WI	FOND DU LAC COUNTY *	5501310165B	19-NOV-1999	99-05-6594A	02
05	WI	FOND DU LAC, CITY OF	5501360005D	15-DEC-1999	00-05-0382A	02
05	WI	FOND DU LAC, CITY OF	5501360005D	12-NOV-1999	99-05-6664A	02
05	WI	FOND DU LAC, CITY OF	5501360005D	10-SEP-1999	99-05-6396A	02
05	WI	FOND DU LAC, CITY OF	5501360005D	19-NOV-1999	99-05-6368A	02
05	WI	FOND DU LAC, CITY OF	5501360005D	04-AUG-1999	99-05-5180A	02
05	WI	FOND DU LAC, CITY OF	5501360005D	09-JUL-1999	99-05-3322A	01
05	WI	FOREST COUNTY *	5506030006A	03-DEC-1999	99-05-7032A	02
05	WI	FORT ATKINSON, CITY OF	5555540002B	10-DEC-1999	00-05-0708A	02
05	WI	GREEN BAY, CITY OF	5500220010E	27-OCT-1999	99-05-5210A	02
05	WI	GREENDALE, VILLAGE OF	5502760001B	22-OCT-1999	99-05-6216A	02
05	WI	HIXTON, VILLAGE OF	5501870001B	03-DEC-1999	99-05-5726A	02
05	WI	HOWARD, VILLAGE OF	5500230005B	21-JUL-1999	99-05-1262A	01

Region	State	Community	Map panel	Determination date	Case No.	Type
05	WI	IRON COUNTY*	5501820006B	17-DEC-1999	99-05-5566A	02
05	WI	IRON COUNTY*	5501820008B	06-OCT-1999	99-05-5570A	02
05	WI	IRON COUNTY*	5501820008B	24-SEP-1999	99-05-5568A	02
05	WI	JACKSON COUNTY *	5505830225B	30-DEC-1999	99-05-5204A	02
05	WI	JANESVILLE, CITY OF	5555600005B	22-DEC-1999	99-05-6528A	02
05	WI	JANESVILLE, CITY OF	5555600010B	01-DEC-1999	99-05-2868A	02
05	WI	JEFFERSON COUNTY *	5501910075B	17-NOV-1999	99-05-6230A	17
05	WI	KENOSHA COUNTY *	5505230005B	19-NOV-1999	99-05-6534A	02
05	WI	KEWASKUM, VILLAGE OF	5504740001C	01-DEC-1999	99-05-6046A	02
05	WI	LA CROSSE COUNTY *	5502170120A	28-JUL-1999	99-05-4710A	02
05	WI	LA CROSSE COUNTY *	5502170120A	08-DEC-1999	99-05-3789A	01
05	WI	LA CROSSE, CITY OF	5555620008B	22-SEP-1999	99-05-5904A	02
05	WI	LA CROSSE, CITY OF	5555620008B	11-AUG-1999	99-05-4844A	02
05	WI	LA CROSSE, CITY OF	5555620008B	09-JUL-1999	99-05-4842A	02
05	WI	LAC LA BELLE, VILLAGE OF	5505650001B	17-SEP-1999	98-05-375P	06
05	WI	LUCK, VILLAGE OF	550335B	19-NOV-1999	99-05-6076A	02
05	WI	MANITOWOC, CITY OF	550240B	10-NOV-1999	99-05-5410A	02
05	WI	MARATHON COUNTY *	5502450225B	10-SEP-1999	99-05-6322A	02
05	WI	MARATHON COUNTY *	5502450375B	03-SEP-1999	99-05-5272A	02
05	WI	MARATHON COUNTY *	5502450525B	22-OCT-1999	99-05-4950A	02
05	WI	MARINETTE COUNTY *	5502590625B	05-NOV-1999	99-05-6014A	02
05	WI	MARINETTE COUNTY *	5502590625B	01-SEP-1999	99-05-5948A	02
05	WI	MARINETTE COUNTY *	5502590725B	03-DEC-1999	99-05-5458A	02
05	WI	MARINETTE COUNTY *	5502590755B	29-OCT-1999	99-05-6438A	02
05	WI	MARINETTE COUNTY *	5502590765B	08-SEP-1999	99-05-5608A	02
05	WI	MARINETTE, CITY OF	5502610001B	16-JUL-1999	99-05-4486A	02
05	WI	MENASHA, CITY OF	5505100005C	30-DEC-1999	00-05-0066A	02
05	WI	MENASHA, CITY OF	5505100005C	01-SEP-1999	99-05-4994A	02
05	WI	MENASHA, CITY OF	5505100005C	09-JUL-1999	99-05-5022A	02
05	WI	MEQUON, CITY OF	55089C0079D	17-NOV-1999	99-05-6460A	02
05	WI	MEQUON, CITY OF	55089C0085D	03-SEP-1999	99-05-5300A	02
05	WI	MEQUON, CITY OF	55089C0085D	01-SEP-1999	99-05-5304A	02
05	WI	MILWAUKEE, CITY OF	5502780025B	01-DEC-1999	98-05-3794P	05
05	WI	MONONA, CITY OF	5500880001B	30-JUL-1999	99-05-1246A	01
05	WI	MONROE COUNTY *	5505710130B	04-AUG-1999	99-05-4020A	02
05	WI	MUSKEGO, CITY OF	5504860001B	29-OCT-1999	99-05-5622A	02
05	WI	NEENAH, CITY OF	5505090001B	07-DEC-1999	98-05-6100P	05
05	WI	NEW HOLSTEIN, CITY OF	5500390001B	03-NOV-1999	99-05-6196A	01
05	WI	OAK CREEK, CITY OF	5502790002B	10-NOV-1999	99-05-6782A	02
05	WI	OAK CREEK, CITY OF	5502790002B	11-AUG-1999	99-05-482A	01
05	WI	OCONTO COUNTY *	5502940085A	30-JUL-1999	99-05-4310A	02
05	WI	OCONTO COUNTY *	5502940290A	03-AUG-1999	99-05-131P	05
05	WI	OCONTO COUNTY *	5502940365A	28-JUL-1999	99-05-5188A	02
05	WI	OCONTO, CITY OF	5502970001B	03-AUG-1999	99-05-131P	05
05	WI	ONEIDA COUNTY *	55085C0150B	20-OCT-1999	99-05-5814A	02
05	WI	ONEIDA COUNTY *	55085C0200B	13-OCT-1999	99-05-5198A	02
05	WI	OSHKOSH, CITY OF	5505110010D	29-OCT-1999	99-05-6058A	02
05	WI	OUTAGAMIE COUNTY *	5503020084C	29-OCT-1999	99-05-6012A	02
05	WI	OUTAGAMIE COUNTY *	5503020084C	02-JUL-1999	99-05-5110A	02
05	WI	OUTAGAMIE COUNTY *	5503020150B	14-JUL-1999	99-05-4914A	02
05	WI	OZAUKEE COUNTY *	55089C0010D	07-DEC-1999	00-05-0988V	19
05	WI	OZAUKEE COUNTY *	55089C0056D	29-DEC-1999	99-05-4426A	01
05	WI	OZAUKEE COUNTY *	55089C0065D	08-JUL-1999	99-05-3786A	02
05	WI	PORTAGE COUNTY *	5505720150C	08-DEC-1999	99-05-7074A	02
05	WI	PORTAGE COUNTY *	5505720150C	06-OCT-1999	99-05-6218A	02
05	WI	PRAIRIE DU CHIEN, CITY OF	555573A	01-DEC-1999	00-05-0396A	02
05	WI	RACINE COUNTY *	5503470010B	25-AUG-1999	99-05-5286A	02
05	WI	RACINE COUNTY *	5503470010B	09-JUL-1999	99-05-4098A	02
05	WI	RACINE COUNTY *	5503470040B	29-DEC-1999	99-05-6766A	02
05	WI	RUSK COUNTY*	5506020245B	29-DEC-1999	00-05-0604A	02
05	WI	SAUK COUNTY *	5503910195B	29-DEC-1999	99-05-4584A	17
05	WI	SAUK COUNTY *	5503910210B	30-DEC-1999	99-05-5274A	02
05	WI	SAUK COUNTY *	5503910215B	22-DEC-1999	99-05-6342A	02
05	WI	SAUKVILLE, VILLAGE OF	55089C0055D	07-DEC-1999	00-05-0990V	19
05	WI	SAUKVILLE, VILLAGE OF	55089C0056D	11-AUG-1999	99-05-4638A	02
05	WI	SAUKVILLE, VILLAGE OF	55089C0056D	06-AUG-1999	99-05-4500A	02
05	WI	SAWYER COUNTY *	5505910045B	10-DEC-1999	99-05-6372A	02
05	WI	SAWYER COUNTY *	5505910050B	03-NOV-1999	99-05-6420A	02
05	WI	SAWYER COUNTY *	5505910050B	14-JUL-1999	99-05-3756A	02
05	WI	SAWYER COUNTY *	5505910100B	15-OCT-1999	99-05-5124A	02
05	WI	SAWYER COUNTY *	5505910100B	08-JUL-1999	99-05-3504A	02
05	WI	SAWYER COUNTY *	5505910100B	08-JUL-1999	99-05-3296A	02
05	WI	SAWYER COUNTY *	5505910125B	13-AUG-1999	99-05-3762A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
05	WI	SHAWANO COUNTY *	5504120150B	01-DEC-1999	99-05-7210A	02
05	WI	SHAWANO COUNTY *	5504120150B	10-DEC-1999	99-05-6732A	02
05	WI	SHAWANO COUNTY *	5504120150B	28-JUL-1999	99-05-4780A	02
05	WI	SHAWANO COUNTY *	5504120150B	17-SEP-1999	99-05-916A	02
05	WI	SHEBOYGAN COUNTY *	5504240090A	24-NOV-1999	99-05-6494A	02
05	WI	SHEBOYGAN COUNTY *	5504240090A	06-OCT-1999	99-05-5182A	02
05	WI	SHEBOYGAN, CITY OF	5504300004D	12-NOV-1999	99-05-6684A	02
05	WI	SHIOCTON, VILLAGE OF	5503090001B	27-OCT-1999	99-05-6176A	02
05	WI	SILVER LAKE, VILLAGE OF	5502100005B	04-AUG-1999	99-05-4916A	02
05	WI	SOLDIERS GROVE, VILLAGE OF	5500740001C	30-DEC-1999	99-05-6318A	01
05	WI	ST. CROIX COUNTY *	555578B	06-AUG-1999	99-05-5750A	02
05	WI	STURGEON BAY, CITY OF	5501110005B	10-DEC-1999	99-05-7088A	02
05	WI	STURGEON BAY, CITY OF	5501110005B	27-AUG-1999	99-05-5218C	01
05	WI	WALPACA COUNTY*	5504920115A	06-OCT-1999	99-05-6062A	02
05	WI	WALWORTH COUNTY *	5504620135B	05-NOV-1999	99-05-5200A	02
05	WI	WASHBURN COUNTY*	5506060025B	29-SEP-1999	99-05-6706A	02
05	WI	WASHBURN COUNTY*	5506060075B	02-JUL-1999	99-05-5004A	02
05	WI	WASHBURN COUNTY*	5506060150B	27-OCT-1999	99-05-6518A	02
05	WI	WASHBURN COUNTY*	5506060200B	17-NOV-1999	99-05-5980A	02
05	WI	WASHBURN COUNTY*	5506060200B	28-JUL-1999	99-05-4676A	02
05	WI	WASHINGTON COUNTY *	5504710010B	08-DEC-1999	99-05-6450A	02
05	WI	WASHINGTON COUNTY *	5504710020B	01-OCT-1999	99-05-6718A	02
05	WI	WASHINGTON COUNTY *	5504710045B	08-DEC-1999	99-05-7188A	01
05	WI	WAUKESHA COUNTY*	5504760020B	24-NOV-1999	99-05-6768A	02
05	WI	WAUKESHA COUNTY*	5504760020B	20-OCT-1999	99-05-5578A	17
05	WI	WAUKESHA COUNTY*	5504760030B	23-JUL-1999	99-05-5192A	02
05	WI	WAUKESHA COUNTY*	5504760065B	10-NOV-1999	99-05-5576A	02
05	WI	WAUPUN, CITY OF	5501080001E	03-NOV-1999	99-05-6988A	02
05	WI	WAUPUN, CITY OF	5501080001E	29-OCT-1999	99-05-5190A	02
05	WI	WAUWATOSA, CITY OF	5502840005B	30-DEC-1999	00-05-0394A	02
05	WI	WAUWATOSA, CITY OF	5502840005B	08-DEC-1999	99-05-6120A	02
05	WI	WINNEBAGO COUNTY *	5505370025C	23-JUL-1999	99-05-5130A	02
05	WI	WINNEBAGO COUNTY *	5505370050C	12-NOV-1999	99-05-7190A	02
05	WI	WINNEBAGO COUNTY *	5505370100C	22-DEC-1999	99-05-5896A	02
05	WI	WINNEBAGO COUNTY *	5505370100C	01-SEP-1999	99-05-5492A	02
05	WI	WISCONSIN RAPIDS, CITY OF	55141C0315E	24-NOV-1999	99-05-5604A	02
06	AR	BENTON COUNTY	05007C0065E	01-SEP-1999	99-06-1807A	02
06	AR	BENTONVILLE, CITY OF	05007C0045E	09-AUG-1999	99-06-1654A	02
06	AR	BRYANT, CITY OF	0503080001C	30-SEP-1999	99-06-1947A	02
06	AR	BRYANT, CITY OF	0503080001C	26-OCT-1999	99-06-2083A	02
06	AR	CABOT, CITY OF	0503090005C	09-DEC-1999	00-06-087A	01
06	AR	CLEBURNE COUNTY	0504240125C	15-OCT-1999	99-06-1895A	02
06	AR	CONWAY, CITY OF	05045C0135F	22-NOV-1999	00-06-112A	02
06	AR	CONWAY, CITY OF	05045C0140E	05-AUG-1999	99-06-1506A	01
06	AR	CONWAY, CITY OF	05045C0140E	02-SEP-1999	99-06-1817A	02
06	AR	DARDANELLE, CITY OF	0502330005D	19-OCT-1999	99-06-1950A	01
06	AR	DE QUEEN, CITY OF	050204B	17-DEC-1999	99-06-2022A	02
06	AR	ELKINS, CITY OF	05143C0115D	30-DEC-1999	00-06-230A	02
06	AR	ELKINS, CITY OF	05143C0115D	25-OCT-1999	99-06-1982A	02
06	AR	FAULKNER COUNTY	05045C0185F	15-DEC-1999	00-06-267A	02
06	AR	FAULKNER COUNTY	05045C0145F	22-JUL-1999	99-06-1570A	02
06	AR	FAULKNER COUNTY	05045C0135F	15-OCT-1999	99-06-1707A	02
06	AR	FAYETTEVILLE, CITY OF	05143C0083D	22-JUL-1999	99-06-1948V	19
06	AR	FAYETTEVILLE, CITY OF	05143C0084D	22-JUL-1999	99-06-1948V	19
06	AR	FORT SMITH, CITY OF	0550130010D	22-NOV-1999	00-06-122A	02
06	AR	FORT SMITH, CITY OF	0550130010D	10-SEP-1999	99-06-1835A	02
06	AR	GARLAND COUNTY	05051C0050C	27-DEC-1999	00-06-315A	02
06	AR	GARLAND COUNTY	05051C0152C	15-JUL-1999	99-06-1475A	02
06	AR	GARLAND COUNTY	05051C0050C	23-AUG-1999	99-06-1724A	02
06	AR	HELENA, CITY OF	0501680005B	22-NOV-1999	99-06-1918A	02
06	AR	INDEPENDENCE COUNTY	0500900300B	19-OCT-1999	99-06-1906A	01
06	AR	JACKSONVILLE, CITY OF	0501800010E	01-JUL-1999	99-06-1453A	02
06	AR	JACKSONVILLE, CITY OF	0501800010E	27-JUL-1999	99-06-1491A	02
06	AR	JACKSONVILLE, CITY OF	0501800010E	12-OCT-1999	99-06-1842A	01
06	AR	JACKSONVILLE, CITY OF	0501800005E	29-NOV-1999	99-06-1865A	01
06	AR	JACKSONVILLE, CITY OF	0501800010E	19-OCT-1999	99-06-2036A	02
06	AR	JEFFERSON COUNTY	0504400095B	26-OCT-1999	00-06-004A	02
06	AR	JONESBORO, CITY OF	05031C0132C	10-SEP-1999	98-06-1349P	05
06	AR	LITTLE ROCK, CITY OF	0501810002E	30-DEC-1999	00-06-038A	01
06	AR	LITTLE ROCK, CITY OF	0501810003E	09-DEC-1999	00-06-228A	02
06	AR	LITTLE ROCK, CITY OF	0501810006E	13-AUG-1999	99-06-1613A	01
06	AR	LITTLE ROCK, CITY OF	0501810002E	30-SEP-1999	99-06-1693P	05
06	AR	LITTLE ROCK, CITY OF	0501810006E	22-OCT-1999	99-06-2079A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
06	AR	LONOKE COUNTY	0504480015B	03-NOV-1999	00-06-125A	01
06	AR	LONOKE COUNTY	0504480015B	27-AUG-1999	99-06-1648A	01
06	AR	NORTH LITTLE ROCK, CITY OF	0501820003D	13-AUG-1999	99-06-1317P	05
06	AR	OUACHITA COUNTY	0501610050C	08-NOV-1999	00-06-067A	02
06	AR	PERRY COUNTY	05105C0150B	25-OCT-1999	00-06-033A	02
06	AR	PERRY COUNTY	05105C0150B	29-NOV-1999	00-06-158A	02
06	AR	PULASKI COUNTY	0501790440C	05-AUG-1999	99-06-1489A	02
06	AR	RANDOLPH COUNTY	0504600003B	23-AUG-1999	99-06-1523A	02
06	AR	SEBASTIAN COUNTY	050462C	02-JUL-1999	99-06-1439A	02
06	AR	SHERWOOD, CITY OF	0502350001E	07-JUL-1999	99-06-1477A	02
06	AR	SHERWOOD, CITY OF	0502350002E	19-OCT-1999	99-06-1717A	02
06	AR	SPRINGDALE, CITY OF	05143C0017C	22-JUL-1999	99-06-989A	01
06	AR	STUTTGART, CITY OF	0500020005C	25-OCT-1999	00-06-006A	02
06	AR	STUTTGART, CITY OF	0500020005C	06-JUL-1999	99-06-1472A	02
06	AR	VAN BUREN, CITY OF	05033C0170G	24-AUG-1999	99-06-1657V	19
06	AR	WASHINGTON COUNTY	05143C0050C	16-AUG-1999	99-06-1434A	02
06	AR	WASHINGTON COUNTY	05143C0170C	22-OCT-1999	99-06-1968A	02
06	AR	WEST FORK, CITY OF	05143C0170C	02-SEP-1999	99-06-1818A	02
06	AR	WOODRUFF COUNTY	050468A	29-OCT-1999	99-06-1858A	02
06	LA	ALEXANDRIA, CITY OF	2201460015F	08-DEC-1999	00-06-260A	02
06	LA	ALEXANDRIA, CITY OF	2201460015F	15-JUL-1999	99-06-1476A	02
06	LA	ALEXANDRIA, CITY OF	2201460015F	05-AUG-1999	99-06-1642A	02
06	LA	ALEXANDRIA, CITY OF	2201460015F	23-SEP-1999	99-06-1930A	02
06	LA	ALEXANDRIA, CITY OF	2201460015F	30-SEP-1999	99-06-1965A	02
06	LA	ALEXANDRIA, CITY OF	2201460015F	22-OCT-1999	99-06-2071A	02
06	LA	ALLEN PARISH	2200090225B	28-OCT-1999	00-06-028A	02
06	LA	ALLEN PARISH	2200090225B	10-SEP-1999	99-06-1732A	02
06	LA	ASCENSION PARISH	2200130035C	12-NOV-1999	00-06-095A	02
06	LA	ASCENSION PARISH	2200130130D	12-JUL-1999	99-06-1027A	01
06	LA	ASCENSION PARISH	2200130030C	13-AUG-1999	99-06-1319A	02
06	LA	ASCENSION PARISH	2200130045C	28-JUL-1999	99-06-1485A	02
06	LA	ASCENSION PARISH	2200130025B	24-SEP-1999	99-06-1540A	02
06	LA	ASCENSION PARISH	2200130040B	19-AUG-1999	99-06-1589A	02
06	LA	ASCENSION PARISH	2200130040B	07-SEP-1999	99-06-1832A	02
06	LA	ASCENSION PARISH	2200130040B	22-SEP-1999	99-06-1926A	02
06	LA	ASCENSION PARISH	2200130025B	30-SEP-1999	99-06-1962A	02
06	LA	ASSUMPTION PARISH	2200170125C	22-OCT-1999	99-06-2072A	02
06	LA	AVOYELLES PARISH	2200190075B	22-DEC-1999	00-06-151A	02
06	LA	AVOYELLES PARISH	2200190075B	30-DEC-1999	00-06-388A	02
06	LA	AVOYELLES PARISH	2200190150B	19-AUG-1999	99-06-1726A	02
06	LA	AVOYELLES PARISH	2200190075B	13-SEP-1999	99-06-1852A	02
06	LA	AVOYELLES PARISH	2200190075B	09-DEC-1999	99-06-1887A	02
06	LA	BOSSIER CITY, CITY OF	2200330030C	26-OCT-1999	00-06-010A	02
06	LA	BOSSIER CITY, CITY OF	2200330030C	12-NOV-1999	00-06-085A	02
06	LA	BOSSIER CITY, CITY OF	2200330030C	01-DEC-1999	00-06-259A	02
06	LA	BOSSIER CITY, CITY OF	2200330030C	21-DEC-1999	00-06-294A	02
06	LA	BOSSIER CITY, CITY OF	2200330005C	09-JUL-1999	99-06-1361A	02
06	LA	BOSSIER CITY, CITY OF	2200330005C	11-AUG-1999	99-06-1683A	02
06	LA	BOSSIER CITY, CITY OF	2200330005C	25-AUG-1999	99-06-1776A	02
06	LA	BOSSIER CITY, CITY OF	2200330030C	08-SEP-1999	99-06-1856A	02
06	LA	BOSSIER PARISH	2200310285B	28-OCT-1999	00-06-014A	02
06	LA	BOSSIER PARISH	2200310285B	08-DEC-1999	00-06-194A	02
06	LA	BOSSIER PARISH	2200310285B	08-DEC-1999	00-06-201A	02
06	LA	BOSSIER PARISH	2200310285B	01-JUL-1999	99-06-1424A	02
06	LA	BOSSIER PARISH	2200310305B	07-JUL-1999	99-06-1474A	02
06	LA	BOSSIER PARISH	2200310390B	22-JUL-1999	99-06-1527A	02
06	LA	BOSSIER PARISH	2200310315B	11-AUG-1999	99-06-1689A	02
06	LA	BOSSIER PARISH	2200310285B	16-AUG-1999	99-06-1709A	02
06	LA	BOSSIER PARISH	2200310285B	01-SEP-1999	99-06-1809A	02
06	LA	BOSSIER PARISH	2200310390B	01-SEP-1999	99-06-1816A	02
06	LA	BOSSIER PARISH	2200310390B	15-SEP-1999	99-06-1869A	02
06	LA	BOSSIER PARISH	2200310315B	17-DEC-1999	99-06-1997A	02
06	LA	BOSSIER PARISH	2200310390B	22-OCT-1999	99-06-2069A	02
06	LA	BROUSSARD, TOWN OF	22055C0070G	13-OCT-1999	99-06-2042A	02
06	LA	CALCASIEU PARISH	2200370350C	13-DEC-1999	00-06-241A	02
06	LA	CALCASIEU PARISH	2200370250D	19-JUL-1999	99-06-1517A	02
06	LA	CALCASIEU PARISH	2200370125C	29-JUL-1999	99-06-1603A	02
06	LA	CLAIBORNE PARISH	2203620090B	27-JUL-1999	99-06-1584A	02
06	LA	DUSON, TOWN OF	22055C0040H	08-SEP-1999	99-06-1562A	02
06	LA	EAST BATON ROUGE PARISH	2200580110D	12-NOV-1999	00-06-091A	02
06	LA	EAST BATON ROUGE PARISH	2200580115D	06-DEC-1999	00-06-199A	02
06	LA	EAST BATON ROUGE PARISH	2200580110D	23-AUG-1999	99-06-1368A	01
06	LA	EAST BATON ROUGE PARISH	2200580100D	15-JUL-1999	99-06-1505A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
06	LA	EAST BATON ROUGE PARISH	2200580115D	24-AUG-1999	99-06-1564A	02
06	LA	EAST BATON ROUGE PARISH	2200580110D	16-NOV-1999	99-06-1692A	02
06	LA	EAST BATON ROUGE PARISH	2200580095D	30-SEP-1999	99-06-1841A	02
06	LA	EAST BATON ROUGE PARISH	2200580100D	08-NOV-1999	99-06-1850A	01
06	LA	EAST BATON ROUGE PARISH	2200580110D	29-NOV-1999	99-06-2081A	02
06	LA	EVANGELINE PARISH	2200640006B	01-JUL-1999	99-06-1340A	02
06	LA	EVANGELINE PARISH	2200640002B	01-SEP-1999	99-06-1438A	02
06	LA	EVANGELINE PARISH	2200640007C	17-SEP-1999	99-06-1883A	02
06	LA	GRANT PARISH	2200760085C	22-NOV-1999	00-06-262A	01
06	LA	GRANT PARISH	2200760095C	05-OCT-1999	99-06-1798A	02
06	LA	GREENWOOD, TOWN OF	2202920001A	28-OCT-1999	00-06-015A	02
06	LA	GREENWOOD, TOWN OF	2202920001A	22-JUL-1999	99-06-1528A	02
06	LA	HAMMOND, CITY OF	2202080001D	22-JUL-1999	99-06-1543V	19
06	LA	HAMMOND, CITY OF	2202080002D	22-JUL-1999	99-06-1543V	19
06	LA	HARAHAN, CITY OF	22051C0040E	05-AUG-1999	99-06-1515A	02
06	LA	IBERIA PARISH	2200780250C	20-DEC-1999	00-06-290A	02
06	LA	JEFFERSON PARISH	22051C0135E	22-NOV-1999	00-06-062A	02
06	LA	JEFFERSON PARISH	22051C0145E	15-DEC-1999	00-06-118A	02
06	LA	LAFAYETTE PARISH	22055C0040H	12-NOV-1999	00-06-083A	02
06	LA	LAFAYETTE PARISH	22055C0065G	12-NOV-1999	00-06-093A	02
06	LA	LAFAYETTE PARISH	22055C0060G	29-NOV-1999	00-06-165A	02
06	LA	LAFAYETTE PARISH	22055C0065G	01-DEC-1999	00-06-171A	02
06	LA	LAFAYETTE PARISH	22055C0080G	10-AUG-1999	99-06-1414A	02
06	LA	LAFAYETTE PARISH	22055C0065G	16-AUG-1999	99-06-1447A	01
06	LA	LAFAYETTE PARISH	22055C0025G	16-AUG-1999	99-06-1736A	02
06	LA	LAFAYETTE PARISH	22055C0025G	01-SEP-1999	99-06-1806A	01
06	LA	LAFAYETTE PARISH	22055C0010G	01-SEP-1999	99-06-1820A	02
06	LA	LAFAYETTE PARISH	22055C0080G	17-SEP-1999	99-06-1901A	02
06	LA	LAFAYETTE PARISH	22055C0040H	22-SEP-1999	99-06-1903A	02
06	LA	LAFAYETTE, CITY OF	22055C0045G	03-NOV-1999	00-06-042A	02
06	LA	LAFAYETTE, CITY OF	22055C0025G	30-SEP-1999	99-06-1823A	02
06	LA	LAFAYETTE, CITY OF	22055C0045G	22-SEP-1999	99-06-1928A	02
06	LA	LAFAYETTE, CITY OF	22055C0065G	05-OCT-1999	99-06-1952A	02
06	LA	LAFAYETTE, CITY OF	22055C0045G	30-SEP-1999	99-06-1959A	02
06	LA	LAFAYETTE, CITY OF	22055C0060G	08-DEC-1999	99-06-1995A	02
06	LA	LAFAYETTE, CITY OF	22055C0065G	13-OCT-1999	99-06-2013A	02
06	LA	LAFAYETTE, CITY OF	22055C0025G	26-OCT-1999	99-06-2039A	02
06	LA	LAKE CHARLES, CITY OF	2200400005E	09-JUL-1999	99-06-1425A	02
06	LA	LIVINGSTON PARISH	2201130100B	08-NOV-1999	00-06-074A	02
06	LA	LIVINGSTON PARISH	2201130025B	29-NOV-1999	00-06-256A	01
06	LA	LIVINGSTON PARISH	2201130100B	25-OCT-1999	99-06-1101A	02
06	LA	LIVINGSTON PARISH	2201130100B	19-JUL-1999	99-06-1436A	02
06	LA	LIVINGSTON PARISH	2201130025B	16-AUG-1999	99-06-1507A	02
06	LA	LIVINGSTON PARISH	2201130025B	15-NOV-1999	99-06-1635A	01
06	LA	LIVINGSTON PARISH	2201130100B	10-SEP-1999	99-06-1748A	02
06	LA	LIVINGSTON PARISH	2201130025B	22-SEP-1999	99-06-1794A	02
06	LA	LIVINGSTON PARISH	2201130025B	01-SEP-1999	99-06-1802A	02
06	LA	LIVINGSTON PARISH	2201130025B	07-SEP-1999	99-06-1836A	02
06	LA	LIVINGSTON PARISH	2201130100B	30-DEC-1999	99-06-1851A	02
06	LA	LIVINGSTON PARISH	2201130100B	30-SEP-1999	99-06-1949A	02
06	LA	LIVINGSTON PARISH	2201130025B	22-NOV-1999	99-06-2023A	02
06	LA	LIVINGSTON PARISH	2201130025B	03-NOV-1999	99-06-2054A	02
06	LA	MINDEN, CITY OF	2202370005D	22-OCT-1999	99-06-1915A	01
06	LA	MORSE, VILLAGE OF	2200070001B	26-OCT-1999	00-06-005A	02
06	LA	MORSE, VILLAGE OF	2200070001B	22-NOV-1999	00-06-041A	02
06	LA	NATCHITOCHES PARISH	2201290235C	08-NOV-1999	00-06-046A	02
06	LA	NATCHITOCHES PARISH	2201290255C	09-AUG-1999	99-06-1664A	02
06	LA	NATCHITOCHES PARISH	2201290265C	22-DEC-1999	99-06-2010A	02
06	LA	OUACHITA PARISH	22073C0045E	04-NOV-1999	00-06-054A	02
06	LA	OUACHITA PARISH	22073C0050E	08-OCT-1999	99-06-1996A	01
06	LA	PINEVILLE, CITY OF	2201510005B	10-SEP-1999	99-06-1593A	02
06	LA	RAPIDES PARISH	2201450140D	09-JUL-1999	99-06-1494A	02
06	LA	RAPIDES PARISH	2201450175B	01-SEP-1999	99-06-1712A	02
06	LA	SABINE PARISH	22085C0205C	20-DEC-1999	00-06-284A	01
06	LA	SCOTT, CITY OF	22055C0040H	30-JUL-1999	99-06-1518A	02
06	LA	SCOTT, CITY OF	22055C0040H	14-JUL-1999	99-06-1552A	02
06	LA	SCOTT, CITY OF	22055C0040H	22-JUL-1999	99-06-1571A	02
06	LA	SCOTT, CITY OF	22055C0040H	08-OCT-1999	99-06-2004A	02
06	LA	SCOTT, CITY OF	22055C0045G	08-OCT-1999	99-06-2004A	02
06	LA	SHREVEPORT, CITY OF	2200360028E	12-NOV-1999	00-06-092A	02
06	LA	SHREVEPORT, CITY OF	2200360028E	12-NOV-1999	00-06-097A	02
06	LA	SHREVEPORT, CITY OF	2200360034E	22-NOV-1999	00-06-103A	02
06	LA	SHREVEPORT, CITY OF	2200360030E	13-DEC-1999	00-06-227A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
06	LA	SHREVEPORT, CITY OF	2200360034E	13-DEC-1999	00-06-231A	02
06	LA	SHREVEPORT, CITY OF	2200360028E	30-DEC-1999	00-06-327A	02
06	LA	SHREVEPORT, CITY OF	2200360029E	12-JUL-1999	99-06-1508A	02
06	LA	SHREVEPORT, CITY OF	2200360034E	12-JUL-1999	99-06-1520A	02
06	LA	SHREVEPORT, CITY OF	2200360029E	26-JUL-1999	99-06-1522A	01
06	LA	SHREVEPORT, CITY OF	2200360028E	18-AUG-1999	99-06-1731A	02
06	LA	SHREVEPORT, CITY OF	2200360013D	23-AUG-1999	99-06-1738A	02
06	LA	SHREVEPORT, CITY OF	2200360028E	25-AUG-1999	99-06-1782A	02
06	LA	SHREVEPORT, CITY OF	2200360028E	08-OCT-1999	99-06-1845A	02
06	LA	SHREVEPORT, CITY OF	2200360028E	13-SEP-1999	99-06-1864A	02
06	LA	SHREVEPORT, CITY OF	2200360013D	15-SEP-1999	99-06-1875A	02
06	LA	SHREVEPORT, CITY OF	2200360033E	19-OCT-1999	99-06-1886A	02
06	LA	SHREVEPORT, CITY OF	2200360033E	22-OCT-1999	99-06-1937A	02
06	LA	SHREVEPORT, CITY OF	2200360034E	22-NOV-1999	99-06-2009A	02
06	LA	SHREVEPORT, CITY OF	2200360029E	13-OCT-1999	99-06-2040A	02
06	LA	SHREVEPORT, CITY OF	2200360028E	13-OCT-1999	99-06-2041A	02
06	LA	SLIDELL, CITY OF	2202040005C	28-OCT-1999	00-06-013A	02
06	LA	SLIDELL, CITY OF	2202040010C	23-SEP-1999	99-06-1898P	06
06	LA	ST. LANDRY PARISH	2201650125C	20-DEC-1999	00-06-285A	02
06	LA	ST. LANDRY PARISH	2201650400C	27-AUG-1999	99-06-1669A	02
06	LA	ST. MARTIN PARISH	2201780150B	15-JUL-1999	99-06-1390A	02
06	LA	ST. MARTIN PARISH	2201780175B	11-AUG-1999	99-06-1513A	02
06	LA	ST. TAMMANY PARISH	2252050150C	08-DEC-1999	00-06-206A	02
06	LA	ST. TAMMANY PARISH	2252050420E	23-SEP-1999	99-06-1898P	06
06	LA	ST. TAMMANY PARISH	2252050210C	22-NOV-1999	99-06-2080A	01
06	LA	SULPHUR, CITY OF	2200410001B	30-JUL-1999	99-06-1085A	02
06	LA	SULPHUR, CITY OF	2200410001C	05-AUG-1999	99-06-1784A	02
06	LA	TANGIPAHOA PARISH	2202060165D	04-NOV-1999	00-06-059A	02
06	LA	TANGIPAHOA PARISH	2202060165D	29-NOV-1999	00-06-160A	01
06	LA	TANGIPAHOA PARISH	2202060205D	01-JUL-1999	99-06-1426A	02
06	LA	TANGIPAHOA PARISH	2202060245D	30-SEP-1999	99-06-1684A	02
06	LA	TANGIPAHOA PARISH	2202060225D	13-AUG-1999	99-06-1686A	02
06	LA	TANGIPAHOA PARISH	2202060165D	23-SEP-1999	99-06-1919A	02
06	LA	UNION PARISH	2203590150C	10-DEC-1999	00-06-008A	02
06	LA	UNION PARISH	2203590105C	23-NOV-1999	98-06-088V	19
06	LA	UNION PARISH	2203590250C	23-NOV-1999	98-06-088V	19
06	LA	VERNON PARISH	2202280006B	13-DEC-1999	00-06-247A	02
06	LA	VILLE PLATTE, TOWN OF	2200700001C	22-JUL-1999	99-06-1549A	02
06	LA	WALKER, TOWN OF	2201210001A	15-SEP-1999	99-06-1729A	02
06	LA	WEBSTER PARISH	2203570175C	26-JUL-1999	99-06-1252A	02
06	LA	WEBSTER PARISH	2203570150C	22-NOV-1999	99-06-1778A	01
06	LA	WEBSTER PARISH	2203570200C	22-NOV-1999	99-06-1778A	01
06	LA	WEST CARROLL PARISH	220243B	28-OCT-1999	00-06-026A	02
06	LA	WEST CARROLL PARISH	220243B	29-JUL-1999	99-06-1605A	02
06	LA	WINN PARISH	2203690070B	27-JUL-1999	99-06-1326A	02
06	LA	WINN PARISH	2203690105B	02-SEP-1999	99-06-1581A	02
06	LA	ZACHARY, CITY OF	2200580035D	09-JUL-1999	99-06-1292A	01
06	NM	ALBUQUERQUE, CITY OF	35001C0128D	29-SEP-1999	99-06-1803P	05
06	NM	ALBUQUERQUE, CITY OF	35001C0129D	29-SEP-1999	99-06-1803P	05
06	NM	ALBUQUERQUE, CITY OF	35001C0136D	29-SEP-1999	99-06-1803P	05
06	NM	ALBUQUERQUE, CITY OF	35001C0137D	29-SEP-1999	99-06-1803P	05
06	NM	ALBUQUERQUE, CITY OF	35001C0357D	19-OCT-1999	99-06-2051A	02
06	NM	ALBUQUERQUE, CITY OF	35001C0336D	27-SEP-1999	99-06-815P	06
06	NM	BERNALILLO COUNTY	35001C0287D	03-NOV-1999	00-06-039A	02
06	NM	BERNALILLO COUNTY	35001C0343D	06-DEC-1999	00-06-181A	02
06	NM	BERNALILLO COUNTY	35001C0333D	05-AUG-1999	99-06-1649A	02
06	NM	BERNALILLO, TOWN OF	35043C0908C	05-AUG-1999	99-06-1470A	02
06	NM	BERNALILLO, TOWN OF	35043C0908C	13-AUG-1999	99-06-1486A	02
06	NM	BERNALILLO, TOWN OF	35043C0902C	14-DEC-1999	99-06-575P	05
06	NM	BERNALILLO, TOWN OF	35043C0904C	14-DEC-1999	99-06-575P	05
06	NM	BERNALILLO, TOWN OF	35043C0906C	14-DEC-1999	99-06-575P	05
06	NM	BERNALILLO, TOWN OF	35043C0908C	14-DEC-1999	99-06-575P	05
06	NM	CLOVIS, CITY OF	3500100037C	24-AUG-1999	99-06-1656V	19
06	NM	CLOVIS, CITY OF	3500100039C	19-OCT-1999	99-06-2065A	02
06	NM	DONA ANA COUNTY	35013C0925E	29-NOV-1999	99-06-1961A	01
06	NM	LAS CRUCES, CITY OF	35013C0613E	04-NOV-1999	00-06-053A	02
06	NM	LAS CRUCES, CITY OF	35013C0631E	14-DEC-1999	00-06-304A	02
06	NM	LAS CRUCES, CITY OF	35013C0632F	14-JUL-1999	99-06-1530A	02
06	NM	LOS ALAMOS COUNTY	3500350001B	28-JUL-1999	99-06-1538A	02
06	NM	PORTALES, CITY OF	3500540001C	16-AUG-1999	99-06-1716A	02
06	NM	RIO RANCHO, CITY OF	35043C0902C	14-DEC-1999	99-06-575P	05
06	NM	RIO RANCHO, CITY OF	35043C0904C	14-DEC-1999	99-06-575P	05
06	NM	RIO RANCHO, CITY OF	35043C0906C	14-DEC-1999	99-06-575P	05

Region	State	Community	Map panel	Determination date	Case No.	Type
06	NM	RIO RANCHO, CITY OF	35043C0908C	14-DEC-1999	99-06-575P	05
06	NM	SANDOVAL COUNTY	35043C0902C	14-DEC-1999	99-06-575P	05
06	NM	SANDOVAL COUNTY	35043C0904C	14-DEC-1999	99-06-575P	05
06	NM	SANDOVAL COUNTY	35043C0906C	14-DEC-1999	99-06-575P	05
06	NM	SANDOVAL COUNTY	35043C0908C	14-DEC-1999	99-06-575P	05
06	NM	SANDOVAL COUNTY	35043C0908C	29-NOV-1999	99-06-787P	05
06	NM	SANTA FE, CITY OF	3500700008B	22-JUL-1999	99-06-1556A	02
06	NM	SILVER CITY, TOWN OF	3500220002C	30-SEP-1999	99-06-1948A	01
06	NM	SILVER CITY, TOWN OF	3500220002B	23-AUG-1999	99-06-792A	01
06	NM	VALENCIA COUNTY	3500860185C	22-OCT-1999	99-06-2061A	02
06	OK	BARTLESVILLE, CITY OF	4002200009C	13-OCT-1999	99-06-2030A	02
06	OK	BIXBY, TOWN OF	40143C0610H	08-DEC-1999	00-06-220A	02
06	OK	BIXBY, TOWN OF	40143C0610H	13-DEC-1999	00-06-225A	02
06	OK	BIXBY, TOWN OF	40143C0610H	10-DEC-1999	00-06-237A	02
06	OK	BIXBY, TOWN OF	40143C0610H	02-NOV-1999	99-06-1754V	19
06	OK	BIXBY, TOWN OF	40143C0630H	02-NOV-1999	99-06-1754V	19
06	OK	BIXBY, TOWN OF	40143C0640H	02-NOV-1999	99-06-1754V	19
06	OK	BROKEN ARROW, CITY OF	40143C0540H	08-DEC-1999	00-06-050A	01
06	OK	BROKEN ARROW, CITY OF	40143C0540H	15-DEC-1999	00-06-174A	02
06	OK	BROKEN ARROW, CITY OF	4002360001D	08-SEP-1999	99-06-1348P	05
06	OK	BROKEN ARROW, CITY OF	4002360004D	08-SEP-1999	99-06-1348P	05
06	OK	BROKEN ARROW, CITY OF	4002360005D	08-SEP-1999	99-06-1348P	05
06	OK	BROKEN ARROW, CITY OF	4002360007D	08-SEP-1999	99-06-1348P	05
06	OK	BROKEN ARROW, CITY OF	4002360007D	02-JUL-1999	99-06-1521A	02
06	OK	BROKEN ARROW, CITY OF	40143C0562H	28-SEP-1999	99-06-1524P	05
06	OK	BROKEN ARROW, CITY OF	40143C0530H	02-NOV-1999	99-06-1754V	19
06	OK	BROKEN ARROW, CITY OF	40143C0534H	02-NOV-1999	99-06-1754V	19
06	OK	BROKEN ARROW, CITY OF	40143C0540H	02-NOV-1999	99-06-1754V	19
06	OK	BROKEN ARROW, CITY OF	40143C0541H	02-NOV-1999	99-06-1754V	19
06	OK	BROKEN ARROW, CITY OF	40143C0543H	02-NOV-1999	99-06-1754V	19
06	OK	BROKEN ARROW, CITY OF	40143C0544H	02-NOV-1999	99-06-1754V	19
06	OK	BROKEN ARROW, CITY OF	40143C0562H	02-NOV-1999	99-06-1754V	19
06	OK	BROKEN ARROW, CITY OF	40143C0631H	02-NOV-1999	99-06-1754V	19
06	OK	BROKEN ARROW, CITY OF	4002360004D	17-SEP-1999	99-06-1760A	01
06	OK	CHICKASHA, CITY OF	4002340002D	05-AUG-1999	99-06-1534A	02
06	OK	CREEK COUNTY	4004900008B	13-OCT-1999	99-06-2026A	02
06	OK	DEL CITY, CITY OF	4002330002D	12-JUL-1999	99-06-1242A	02
06	OK	DEL CITY, CITY OF	4002330002D	15-JUL-1999	99-06-1533A	02
06	OK	DEL CITY, CITY OF	4002330002D	16-AUG-1999	99-06-1703A	02
06	OK	DELAWARE COUNTY	4005020025C	21-DEC-1999	00-06-299A	02
06	OK	DELAWARE COUNTY	4005020075C	22-SEP-1999	99-06-1391A	02
06	OK	DELAWARE COUNTY	4005020050C	16-AUG-1999	99-06-1704A	02
06	OK	DELAWARE COUNTY	4005020025C	22-SEP-1999	99-06-1916A	02
06	OK	DUNCAN, CITY OF	40137C0085D	28-OCT-1999	00-06-027A	02
06	OK	DUNCAN, CITY OF	40137C0085D	29-DEC-1999	00-06-278P	05
06	OK	DUNCAN, CITY OF	40137C0095D	29-DEC-1999	00-06-278P	05
06	OK	EDMOND, CITY OF	4002520020B	26-AUG-1999	99-06-1785A	02
06	OK	ENID, CITY OF	40047C0115C	04-NOV-1999	00-06-064A	02
06	OK	ENID, CITY OF	40047C0115C	28-JUL-1999	99-06-1600A	02
06	OK	ENID, CITY OF	40047C0160C	13-AUG-1999	99-06-1697A	02
06	OK	GARVIN COUNTY	4004720050A	28-JUL-1999	99-06-1595A	02
06	OK	GLENPOOL, TOWN OF	40143C0582H	02-NOV-1999	99-06-1754V	19
06	OK	GLENPOOL, TOWN OF	40143C0584H	02-NOV-1999	99-06-1754V	19
06	OK	GROVE, TOWN OF	4003850004C	06-DEC-1999	00-06-169A	02
06	OK	HARRAH, CITY OF	4001400004C	22-NOV-1999	00-06-123A	02
06	OK	HASKELL, TOWN OF	40104C0025D	05-AUG-1999	99-06-1592A	02
06	OK	HUGHES COUNTY	4004670002B	19-OCT-1999	00-06-029A	02
06	OK	HUGHES COUNTY	4004670002B	23-SEP-1999	99-06-1762A	02
06	OK	JENKS, CITY OF	4002090002B	07-JUL-1999	99-06-1482A	02
06	OK	JENKS, CITY OF	40143C0494H	02-NOV-1999	99-06-1754V	19
06	OK	JENKS, CITY OF	40143C0513H	02-NOV-1999	99-06-1754V	19
06	OK	JENKS, CITY OF	40143C0582H	02-NOV-1999	99-06-1754V	19
06	OK	JENKS, CITY OF	40143C0605H	02-NOV-1999	99-06-1754V	19
06	OK	LAWTON, CITY OF	40031C0252C	08-NOV-1999	00-06-063A	02
06	OK	LAWTON, CITY OF	40031C0252C	02-SEP-1999	99-06-1821A	02
06	OK	MAYES COUNTY	4004580110C	15-SEP-1999	99-06-1812A	01
06	OK	MAYES COUNTY	4004580100C	17-SEP-1999	99-06-1893A	02
06	OK	MIDWEST CITY, CITY OF	4004050010E	01-DEC-1999	00-06-152A	02
06	OK	MIDWEST CITY, CITY OF	4004050015E	08-DEC-1999	00-06-189A	02
06	OK	MIDWEST CITY, CITY OF	4004050010E	22-OCT-1999	99-06-2050A	02
06	OK	MOORE, CITY OF	40027C0037F	27-OCT-1999	00-06-022A	02
06	OK	MOORE, CITY OF	40027C0039F	24-SEP-1999	99-06-1399P	05
06	OK	MOORE, CITY OF	40027C0037F	01-JUL-1999	99-06-1430A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
06	OK	MOORE, CITY OF	40027C0037F	08-SEP-1999	99-06-1728A	02
06	OK	MOORE, CITY OF	40027C0037F	02-SEP-1999	99-06-1825A	02
06	OK	MUSKOGEE COUNTY	40101C0250D	30-DEC-1999	00-06-086A	02
06	OK	MUSTANG, CITY OF	4004090005A	17-DEC-1999	00-06-291A	02
06	OK	MUSTANG, CITY OF	4004090005A	01-JUL-1999	99-06-1431A	02
06	OK	MUSTANG, CITY OF	4004090005A	19-JUL-1999	99-06-1532A	02
06	OK	MUSTANG, CITY OF	4004090005A	28-JUL-1999	99-06-1577A	02
06	OK	MUSTANG, CITY OF	4004090005A	15-SEP-1999	99-06-1881A	02
06	OK	NORMAN,CITY OF	40027C0115F	09-AUG-1999	99-06-1661A	02
06	OK	NORMAN,CITY OF	40027C0095G	23-AUG-1999	99-06-1749A	02
06	OK	NORMAN,CITY OF	40027C0095G	05-OCT-1999	99-06-1834A	02
06	OK	NORMAN,CITY OF	40027C0090F	19-OCT-1999	99-06-1860A	02
06	OK	NORMAN,CITY OF	40027C0080F	17-SEP-1999	99-06-1889A	02
06	OK	NORTH ENID, TOWN OF	40047C0115C	22-SEP-1999	99-06-1622A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780170F	28-OCT-1999	00-06-020A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780195C	28-OCT-1999	00-06-021A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780195C	02-NOV-1999	00-06-045A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780130D	04-NOV-1999	00-06-060A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780190F	22-NOV-1999	00-06-098A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780160D	08-DEC-1999	00-06-207A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780195C	22-JUL-1999	99-06-1215A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780195C	22-JUL-1999	99-06-1249A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780195C	06-JUL-1999	99-06-1339A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780170F	01-JUL-1999	99-06-1420A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780175F	01-JUL-1999	99-06-1429A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780195C	01-JUL-1999	99-06-1432A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780265D	27-JUL-1999	99-06-1578A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780205D	29-JUL-1999	99-06-1602A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780195C	03-AUG-1999	99-06-1604A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780195C	30-JUL-1999	99-06-1606A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780195C	03-AUG-1999	99-06-1608A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780160D	03-AUG-1999	99-06-1610A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780080C	29-JUL-1999	99-06-1618A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780160D	27-JUL-1999	99-06-1621A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780175F	05-AUG-1999	99-06-1634A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780225F	06-AUG-1999	99-06-1660A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780110C	13-AUG-1999	99-06-1685A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780275C	08-SEP-1999	99-06-1847A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780160D	15-SEP-1999	99-06-1854A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780170F	15-SEP-1999	99-06-1877A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780175F	30-SEP-1999	99-06-1964A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780225F	30-SEP-1999	99-06-1966A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780195C	07-OCT-1999	99-06-1989A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780195C	07-OCT-1999	99-06-1994A	02
06	OK	OKLAHOMA CITY, CITY OF	4053780160D	13-OCT-1999	99-06-2027A	02
06	OK	OKMULGEE COUNTY	4004920120B	23-SEP-1999	99-06-1931A	02
06	OK	OWASSO, CITY OF	40143C0238H	02-NOV-1999	99-06-1754V	19
06	OK	OWASSO, CITY OF	40143C0239H	02-NOV-1999	99-06-1754V	19
06	OK	PAWNEE, CITY OF	4001630001C	14-DEC-1999	00-06-261A	02
06	OK	PAWNEE, CITY OF	4001630001C	28-JUL-1999	99-06-1445A	02
06	OK	PITTSBURG COUNTY	4004940004A	20-SEP-1999	99-06-1713A	02
06	OK	POCOLA, TOWN OF	4004320010A	06-DEC-1999	00-06-170A	02
06	OK	PONCA CITY, CITY OF	4000800005C	05-AUG-1999	99-06-1484A	02
06	OK	ROGERS COUNTY	4053790100B	29-NOV-1999	00-06-144A	02
06	OK	ROGERS COUNTY	4053790025B	15-DEC-1999	00-06-270A	02
06	OK	ROGERS COUNTY	4053790130C	23-AUG-1999	99-06-1744A	02
06	OK	ROGERS COUNTY	4053790105C	02-SEP-1999	99-06-1811A	02
06	OK	ROGERS COUNTY	4053790150B	07-SEP-1999	99-06-1843A	02
06	OK	ROGERS COUNTY	4053790105C	05-OCT-1999	99-06-1969A	02
06	OK	SAND SPRINGS, CITY OF	4002110004C	12-JUL-1999	99-06-1483A	02
06	OK	SAND SPRINGS, CITY OF	40143C0339H	02-NOV-1999	99-06-1754V	19
06	OK	SAPULPA, CITY OF	4000530005B	03-SEP-1999	99-06-1416P	06
06	OK	SEMINOLE, CITY OF	40133C0107C	18-AUG-1999	99-06-1503A	02
06	OK	SHAWNEE, CITY OF	40125C0102D	08-DEC-1999	00-06-178A	02
06	OK	SHAWNEE, CITY OF	40125C0101D	13-DEC-1999	00-06-245A	02
06	OK	SHAWNEE, CITY OF	40125C0125D	02-JUL-1999	99-06-1407A	02
06	OK	SHAWNEE, CITY OF	40125C0125D	03-AUG-1999	99-06-1619A	02
06	OK	SHAWNEE, CITY OF	40125C0101D	07-OCT-1999	99-06-1977A	02
06	OK	SHAWNEE, CITY OF	40125C0101D	07-OCT-1999	99-06-1999A	02
06	OK	STILLWATER, CITY OF	4053800005D	28-OCT-1999	00-06-019A	02
06	OK	STILLWATER, CITY OF	4053800004E	06-DEC-1999	00-06-187A	02
06	OK	STILLWATER, CITY OF	4053800001D	06-DEC-1999	00-06-195A	02
06	OK	STILLWATER, CITY OF	4053800004E	22-JUL-1999	99-06-1357A	02

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06	OK	STILLWATER, CITY OF	4053800005D	20-SEP-1999	99-06-1892A	02
06	OK	TULSA COUNTY	40143C0114H	15-DEC-1999	00-06-271A	02
06	OK	TULSA COUNTY	40143C0204H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA COUNTY	40143C0211H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA COUNTY	40143C0320H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA COUNTY	40143C0455H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA COUNTY	40143C0494H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA COUNTY	40143C0630H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA COUNTY	40143C0632H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA COUNTY	40143C0315H	22-SEP-1999	99-06-1927A	02
06	OK	TULSA, CITY OF	40143C0510H	08-NOV-1999	00-06-056A	02
06	OK	TULSA, CITY OF	40143C0530H	13-DEC-1999	00-06-238A	02
06	OK	TULSA, CITY OF	40143C0530H	13-DEC-1999	00-06-239A	02
06	OK	TULSA, CITY OF	4053810095E	08-SEP-1999	99-06-1348P	05
06	OK	TULSA, CITY OF	4053810060F	23-AUG-1999	99-06-1735A	02
06	OK	TULSA, CITY OF	40143C0370H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA, CITY OF	40143C0390H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA, CITY OF	40143C0505H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA, CITY OF	40143C0510H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA, CITY OF	40143C0512H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA, CITY OF	40143C0520H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA, CITY OF	40143C0530H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA, CITY OF	40143C0540H	02-NOV-1999	99-06-1754V	19
06	OK	TULSA, CITY OF	40143C0530H	05-OCT-1999	99-06-1970A	02
06	OK	TULSA, CITY OF	40143C0505H	13-OCT-1999	99-06-2025A	02
06	OK	TULSA, CITY OF	40143C0530H	22-OCT-1999	99-06-2070A	02
06	OK	TULSA, CITY OF	4053810085G	16-SEP-1999	99-06-879P	05
06	OK	TULSA, CITY OF	4053810090F	16-SEP-1999	99-06-879P	05
06	OK	VINITA, CITY OF	4000500003C	23-AUG-1999	99-06-1761A	02
06	OK	WAGONER COUNTY	4002150012B	22-NOV-1999	00-06-117A	02
06	OK	WAGONER COUNTY	4002150027B	08-DEC-1999	99-06-1638A	02
06	OK	WAGONER COUNTY	4002150031B	08-SEP-1999	99-06-1849A	02
06	OK	WARR ACRES, CITY OF	4004490001A	06-DEC-1999	00-06-182A	02
06	OK	YUKON, CITY OF	4000280010B	08-DEC-1999	00-06-202A	02
06	OK	YUKON, CITY OF	4000280005B	01-JUL-1999	99-06-1433A	02
06	TX	ABILENE, CITY OF	4854500020D	22-JUL-1999	99-06-1374A	01
06	TX	ABILENE, CITY OF	4854500035D	25-AUG-1999	99-06-1774A	02
06	TX	ABILENE, CITY OF	4854500020D	08-OCT-1999	99-06-1985A	02
06	TX	ALICE, CITY OF	4803940005C	16-NOV-1999	00-06-109A	01
06	TX	ALLEN, CITY OF	48085C0430G	10-NOV-1999	00-06-016P	06
06	TX	ALLEN, CITY OF	48085C0435G	17-AUG-1999	99-06-1135P	06
06	TX	ALLEN, CITY OF	48085C0435G	02-NOV-1999	99-06-1455P	05
06	TX	ALLEN, CITY OF	48085C0435G	23-NOV-1999	99-06-666P	05
06	TX	ARLINGTON, CITY OF	48439C0576H	04-NOV-1999	00-06-047A	01
06	TX	ARLINGTON, CITY OF	48439C0463H	03-DEC-1999	00-06-257P	05
06	TX	ARLINGTON, CITY OF	48439C0437H	01-JUL-1999	99-06-1452A	02
06	TX	ARLINGTON, CITY OF	48439C0443H	30-DEC-1999	99-06-1457A	01
06	TX	ARLINGTON, CITY OF	48439C0336H	27-JUL-1999	99-06-1480A	02
06	TX	ARLINGTON, CITY OF	48439C0463H	09-AUG-1999	99-06-1594A	01
06	TX	ARLINGTON, CITY OF	48439C0464H	09-AUG-1999	99-06-1594A	01
06	TX	ARLINGTON, CITY OF	48439C0576H	11-AUG-1999	99-06-1646A	01
06	TX	ARLINGTON, CITY OF	48439C0463H	25-OCT-1999	99-06-1705P	05
06	TX	ARLINGTON, CITY OF	48439C0437H	23-AUG-1999	99-06-1730A	02
06	TX	ARLINGTON, CITY OF	48439C0464H	15-SEP-1999	99-06-1876A	01
06	TX	ARLINGTON, CITY OF	48439C0441H	15-SEP-1999	99-06-1885A	02
06	TX	ARLINGTON, CITY OF	48439C0463H	08-DEC-1999	99-06-1951A	02
06	TX	ARLINGTON, CITY OF	48439C0440H	20-SEP-1999	99-06-658P	05
06	TX	ARLINGTON, CITY OF	48439C0444H	03-NOV-1999	99-06-890P	05
06	TX	AUSTIN, CITY OF	48453C0205E	08-DEC-1999	00-06-080A	02
06	TX	AUSTIN, CITY OF	48453C0205E	06-DEC-1999	00-06-185A	02
06	TX	AUSTIN, CITY OF	48453C0160E	03-AUG-1999	99-06-1629A	02
06	TX	AUSTIN, CITY OF	48453C0205E	05-AUG-1999	99-06-1641A	02
06	TX	AUSTIN, CITY OF	48453C0170F	30-SEP-1999	99-06-1720P	06
06	TX	AUSTIN, CITY OF	48453C0195E	05-OCT-1999	99-06-1764A	02
06	TX	AUSTIN, CITY OF	48453C0205E	19-OCT-1999	99-06-2067A	02
06	TX	BANDERA COUNTY	4800200265A	22-NOV-1999	00-06-111A	02
06	TX	BANDERA COUNTY	4800200135B	27-JUL-1999	99-06-764P	05
06	TX	BANDERA, CITY OF	4800210001D	27-JUL-1999	99-06-764P	05
06	TX	BASTROP COUNTY	48021C0200C	29-OCT-1999	00-06-001A	02
06	TX	BASTROP COUNTY	48021C0075C	19-OCT-1999	99-06-1942A	01
06	TX	BEXAR COUNTY	48029C0240E	08-DEC-1999	00-06-234A	02
06	TX	BEXAR COUNTY	48029C0240E	12-JUL-1999	99-06-1351A	02
06	TX	BEXAR COUNTY	48029C0313E	05-AUG-1999	99-06-1650A	02

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06	TX	BEXAR COUNTY	48029C0145E	24-AUG-1999	99-06-1741A	02
06	TX	BEXAR COUNTY	48029C0130E	12-OCT-1999	99-06-1789P	05
06	TX	BEXAR COUNTY	48029C0140E	12-OCT-1999	99-06-1789P	05
06	TX	BEXAR COUNTY	48029C0590E	26-AUG-1999	99-06-1791A	02
06	TX	BEXAR COUNTY	48029C0252E	09-AUG-1999	99-06-292P	05
06	TX	BEXAR COUNTY	48029C0254E	09-AUG-1999	99-06-292P	05
06	TX	BEXAR COUNTY	48029C0258E	09-AUG-1999	99-06-292P	05
06	TX	BEXAR COUNTY	48029C0262E	09-AUG-1999	99-06-292P	05
06	TX	BEXAR COUNTY	48029C0266E	09-AUG-1999	99-06-292P	05
06	TX	BEXAR COUNTY	48029C0268E	09-AUG-1999	99-06-292P	05
06	TX	BEXAR COUNTY	48029C0269E	09-AUG-1999	99-06-292P	05
06	TX	BEXAR COUNTY	48029C0314E	15-DEC-1999	99-06-653A	02
06	TX	BRAZORIA COUNTY	48039C0010I	30-SEP-1999	99-06-1751V	19
06	TX	BRAZORIA COUNTY	48039C0030I	30-SEP-1999	99-06-1751V	19
06	TX	BRAZORIA COUNTY	48039C0010I	30-DEC-1999	99-06-1980A	01
06	TX	BRAZORIA COUNTY	48039C0030I	30-DEC-1999	99-06-1980A	01
06	TX	BRAZORIA COUNTY	48039C0010I	05-OCT-1999	99-06-2063A	01
06	TX	BROWN COUNTY	4807170004B	19-OCT-1999	99-06-1861A	02
06	TX	BRYAN, CITY OF	48041C0142C	04-NOV-1999	00-06-048A	02
06	TX	BRYAN, CITY OF	48041C0141C	23-AUG-1999	99-06-1446A	02
06	TX	BRYAN, CITY OF	48041C0133C	28-JUL-1999	99-06-1526P	06
06	TX	BRYAN, CITY OF	48041C0134C	28-JUL-1999	99-06-1526P	06
06	TX	BURLESON, CITY OF	48251C0029H	06-JUL-1999	99-06-1260A	02
06	TX	BURLESON, CITY OF	48251C0029H	26-JUL-1999	99-06-1565A	02
06	TX	CALDWELL COUNTY	4800940350C	22-JUL-1999	99-06-1545V	19
06	TX	CAMERON COUNTY	4801010275C	26-JUL-1999	99-06-1294P	05
06	TX	CAMERON COUNTY	4801010350B	02-JUL-1999	99-06-1461P	05
06	TX	CARRIZO SPRINGS, CITY OF	480199B	28-OCT-1999	00-06-011A	02
06	TX	CARROLLTON, CITY OF	4801670005G	15-DEC-1999	00-06-277A	02
06	TX	CARROLLTON, CITY OF	4801670015F	01-SEP-1999	99-06-1481A	02
06	TX	CARROLLTON, CITY OF	4801670005G	24-SEP-1999	99-06-1844A	01
06	TX	CASTLE HILLS, CITY OF	48029C0252E	09-AUG-1999	99-06-292P	05
06	TX	CASTLE HILLS, CITY OF	48029C0254E	09-AUG-1999	99-06-292P	05
06	TX	CASTLE HILLS, CITY OF	48029C0258E	09-AUG-1999	99-06-292P	05
06	TX	CASTLE HILLS, CITY OF	48029C0262E	09-AUG-1999	99-06-292P	05
06	TX	CASTLE HILLS, CITY OF	48029C0266E	09-AUG-1999	99-06-292P	05
06	TX	CASTLE HILLS, CITY OF	48029C0268E	09-AUG-1999	99-06-292P	05
06	TX	CASTLE HILLS, CITY OF	48029C0269E	09-AUG-1999	99-06-292P	05
06	TX	CEDAR PARK, CITY OF	48491C0214C	12-OCT-1999	99-06-877P	05
06	TX	CEDAR PARK, CITY OF	48491C0218C	12-OCT-1999	99-06-877P	05
06	TX	CEDAR PARK, CITY OF	48491C0325D	12-OCT-1999	99-06-877P	05
06	TX	CHINA GROVE, CITY OF	48029C0490E	30-DEC-1999	99-06-1127A	02
06	TX	CLEBURNE, CITY OF	48251C0114F	01-JUL-1999	99-06-1441A	02
06	TX	COLLEGE STATION, CITY OF	48041C0205C	08-OCT-1999	99-06-1336P	05
06	TX	COLLEGE STATION, CITY OF	48041C0144C	14-OCT-1999	99-06-1626P	06
06	TX	COLLEGE STATION, CITY OF	48041C0205C	25-OCT-1999	99-06-1960P	06
06	TX	COMAL COUNTY	4854630075D	05-AUG-1999	98-06-448P	06
06	TX	COOKE COUNTY	4807650008B	20-SEP-1999	99-06-1896A	02
06	TX	COPPELL, CITY OF	4801700010E	06-JUL-1999	99-06-831P	05
06	TX	CORINTH, TOWN OF	48121C0393E	29-DEC-1999	00-06-030P	06
06	TX	CORINTH, TOWN OF	48121C0393E	22-DEC-1999	99-06-1769A	02
06	TX	CROWLEY, CITY OF	48439C0530H	19-OCT-1999	99-06-2064A	01
06	TX	CROWLEY, CITY OF	48439C0530H	20-JUL-1999	99-06-649P	05
06	TX	DALLAS COUNTY	4801650045B	08-DEC-1999	00-06-073A	02
06	TX	DALLAS, CITY OF	4801710140D	10-DEC-1999	00-06-177A	02
06	TX	DALLAS, CITY OF	4801710055C	08-DEC-1999	00-06-188A	02
06	TX	DALLAS, CITY OF	4801710185D	22-DEC-1999	00-06-332A	02
06	TX	DALLAS, CITY OF	4801710010D	10-AUG-1999	98-06-1555P	05
06	TX	DALLAS, CITY OF	4801710185D	20-DEC-1999	99-06-1010P	05
06	TX	DALLAS, CITY OF	4801710205D	01-NOV-1999	99-06-1011P	05
06	TX	DALLAS, CITY OF	4801710085D	01-JUL-1999	99-06-1164A	01
06	TX	DALLAS, CITY OF	4801710145D	16-AUG-1999	99-06-1355A	02
06	TX	DALLAS, CITY OF	4801710060D	02-JUL-1999	99-06-1365A	02
06	TX	DALLAS, CITY OF	4801710025C	17-SEP-1999	99-06-1382P	05
06	TX	DALLAS, CITY OF	4801710030D	17-SEP-1999	99-06-1382P	05
06	TX	DALLAS, CITY OF	4801710085D	01-JUL-1999	99-06-1388A	01
06	TX	DALLAS, CITY OF	4801710085D	09-JUL-1999	99-06-1396A	01
06	TX	DALLAS, CITY OF	4801710090D	09-JUL-1999	99-06-1397A	02
06	TX	DALLAS, CITY OF	4801710215C	01-JUL-1999	99-06-1421A	01
06	TX	DALLAS, CITY OF	4801710060D	15-DEC-1999	99-06-1448P	05
06	TX	DALLAS, CITY OF	4801710095C	06-JUL-1999	99-06-1467A	02
06	TX	DALLAS, CITY OF	4801710140D	23-AUG-1999	99-06-1561A	02
06	TX	DALLAS, CITY OF	4801710030D	30-JUL-1999	99-06-1563A	01

Region	State	Community	Map panel	Determination date	Case No.	Type
06	TX	DALLAS, CITY OF	4801710065C	22-SEP-1999	99-06-1566A	02
06	TX	DALLAS, CITY OF	4801710085D	10-AUG-1999	99-06-1599A	01
06	TX	DALLAS, CITY OF	4801710085D	25-AUG-1999	99-06-1601A	01
06	TX	DALLAS, CITY OF	4801710140D	02-SEP-1999	99-06-1810A	02
06	TX	DALLAS, CITY OF	4801710055C	09-DEC-1999	99-06-1880A	02
06	TX	DALLAS, CITY OF	4801710010D	06-OCT-1999	99-06-1913P	05
06	TX	DALLAS, CITY OF	4801710030D	06-OCT-1999	99-06-1913P	05
06	TX	DALLAS, CITY OF	4801710100D	07-OCT-1999	99-06-1991A	02
06	TX	DALLAS, CITY OF	4801710100D	19-OCT-1999	99-06-2018A	02
06	TX	DALLAS, CITY OF	4801710170D	02-DEC-1999	99-06-2037P	05
06	TX	DALLAS, CITY OF	4801710085D	01-SEP-1999	99-06-947A	01
06	TX	DALWORTHINGTON GARDENS, TOWN OF	48439C0442H	15-DEC-1999	00-06-266A	02
06	TX	DEER PARK, CITY OF	48201C0930J	22-JUL-1999	99-06-1451A	02
06	TX	DENTON, CITY OF	48121C0240F	12-JUL-1999	99-06-1359A	01
06	TX	DENTON, CITY OF	48121C0387E	05-NOV-1999	99-06-1537P	06
06	TX	DENTON, CITY OF	48121C0360E	15-SEP-1999	99-06-1870A	02
06	TX	DOUBLE OAK, TOWN OF	48121C0540E	27-JUL-1999	99-06-640P	05
06	TX	EL PASO, CITY OF	4802140021D	19-JUL-1999	99-06-1400A	02
06	TX	EL PASO, CITY OF	4802140026D	12-OCT-1999	99-06-1597A	01
06	TX	EL PASO, CITY OF	4802140044B	15-SEP-1999	99-06-1678A	01
06	TX	EL PASO, CITY OF	4802140036B	27-OCT-1999	99-06-2074A	01
06	TX	EL PASO, CITY OF	4802140043B	30-AUG-1999	99-06-793P	05
06	TX	ELLIS COUNTY	48139C0300D	09-DEC-1999	00-06-214A	02
06	TX	EULESS, CITY OF	48439C0330H	22-DEC-1999	00-06-100P	05
06	TX	FARMERS BRANCH, CITY OF	4801740005C	01-SEP-1999	99-06-1670P	05
06	TX	FIRST COLONY L.I.D.	48157C0255J	30-SEP-1999	99-06-1743P	06
06	TX	FLOWER MOUND, TOWN OF	48121C0545E	29-NOV-1999	00-06-032P	05
06	TX	FLOWER MOUND, TOWN OF	48121C0545E	29-NOV-1999	00-06-164A	02
06	TX	FLOWER MOUND, TOWN OF	48121C0545E	05-OCT-1999	99-06-1488A	01
06	TX	FLOWER MOUND, TOWN OF	48121C0520E	15-JUL-1999	99-06-1551A	02
06	TX	FLOWER MOUND, TOWN OF	48121C0545E	16-AUG-1999	99-06-1706A	02
06	TX	FLOWER MOUND, TOWN OF	48121C0545E	19-OCT-1999	99-06-2046A	02
06	TX	FLOWER MOUND, TOWN OF	48121C0540E	27-JUL-1999	99-06-640P	05
06	TX	FORT BEND COUNTY	48157C0245J	05-NOV-1999	99-06-1722P	05
06	TX	FORT BEND COUNTY L.I.D. ι2	48157C0255J	09-AUG-1999	99-06-1640A	01
06	TX	FORT BEND COUNTY L.I.D. ι2	48157C0255J	08-OCT-1999	99-06-1917A	01
06	TX	FORT WORTH, CITY OF	48439C0169H	16-NOV-1999	00-06-012A	01
06	TX	FORT WORTH, CITY OF	48439C0330H	22-DEC-1999	00-06-100P	05
06	TX	FORT WORTH, CITY OF	48439C0170H	09-DEC-1999	00-06-215A	02
06	TX	FORT WORTH, CITY OF	48439C0405H	02-SEP-1999	99-06-1671A	02
06	TX	FORT WORTH, CITY OF	48439C0382H	17-SEP-1999	99-06-1805A	02
06	TX	FORT WORTH, CITY OF	48439C0395H	13-OCT-1999	99-06-2035A	02
06	TX	FORT WORTH, CITY OF	48439C0440H	20-SEP-1999	99-06-658P	05
06	TX	FRIENDSWOOD, CITY OF	4854680005E	29-OCT-1999	00-06-077A	02
06	TX	FRIENDSWOOD, CITY OF	4854680005E	24-SEP-1999	99-06-1853A	02
06	TX	FRISCO, CITY OF	48085C0265G	31-AUG-1999	99-06-1289P	06
06	TX	FRISCO, CITY OF	48085C0405G	13-JUL-1999	99-06-817P	05
06	TX	GARLAND, CITY OF	4854710015D	08-NOV-1999	00-06-072A	02
06	TX	GARLAND, CITY OF	4854710015D	22-NOV-1999	00-06-116A	02
06	TX	GARLAND, CITY OF	4854710030E	01-DEC-1999	00-06-146A	02
06	TX	GARLAND, CITY OF	4854710020D	01-DEC-1999	00-06-147A	02
06	TX	GARLAND, CITY OF	4854710030E	01-DEC-1999	00-06-148A	02
06	TX	GARLAND, CITY OF	4854710020D	01-DEC-1999	00-06-149A	02
06	TX	GARLAND, CITY OF	4854710005E	08-DEC-1999	00-06-193A	02
06	TX	GARLAND, CITY OF	4854710020D	15-DEC-1999	00-06-268A	02
06	TX	GARLAND, CITY OF	4854710015D	15-DEC-1999	00-06-269A	02
06	TX	GARLAND, CITY OF	4854710015D	15-SEP-1999	99-06-1276P	05
06	TX	GARLAND, CITY OF	4854710020D	01-JUL-1999	99-06-1422A	02
06	TX	GARLAND, CITY OF	4854710030E	02-JUL-1999	99-06-1464A	02
06	TX	GARLAND, CITY OF	4854710030E	02-JUL-1999	99-06-1468A	02
06	TX	GARLAND, CITY OF	4854710010D	12-OCT-1999	99-06-1499P	05
06	TX	GARLAND, CITY OF	4854710030E	03-AUG-1999	99-06-1639A	02
06	TX	GARLAND, CITY OF	4854710030E	05-AUG-1999	99-06-1644A	02
06	TX	GARLAND, CITY OF	4854710015D	25-AUG-1999	99-06-1772A	02
06	TX	GARLAND, CITY OF	4854710020D	25-AUG-1999	99-06-1781A	02
06	TX	GARLAND, CITY OF	4854710015D	13-OCT-1999	99-06-2029A	02
06	TX	GILLESPIE COUNTY	4806960007B	03-NOV-1999	00-06-031A	02
06	TX	GILLESPIE COUNTY	4806960010B	03-NOV-1999	00-06-034A	02
06	TX	GILLESPIE COUNTY	4806960007B	30-SEP-1999	99-06-1325A	02
06	TX	GILLESPIE COUNTY	4806960003B	15-SEP-1999	99-06-1344A	02
06	TX	GILLESPIE COUNTY	4806960011B	15-SEP-1999	99-06-1490A	02
06	TX	GILLESPIE COUNTY	4806960006B	22-NOV-1999	99-06-2056A	01
06	TX	GRAND PRAIRIE, CITY OF	4854720035G	15-SEP-1999	99-06-1866A	01

Region	State	Community	Map panel	Determination date	Case No.	Type
06	TX	GRAND PRAIRIE, CITY OF	4854720010F	22-SEP-1999	99-06-1907A	02
06	TX	GRAND PRAIRIE, CITY OF	4854720035G	15-NOV-1999	99-06-2034A	01
06	TX	GRAPEVINE, CITY OF	48439C0215H	06-DEC-1999	00-06-166A	02
06	TX	GRAPEVINE, CITY OF	48439C0205H	13-OCT-1999	99-06-2020A	02
06	TX	GRAYSON COUNTY	48181C0207E	11-AUG-1999	99-06-1688A	02
06	TX	GREENVILLE, CITY OF	48231C0180F	12-OCT-1999	99-06-2001P	06
06	TX	GREENVILLE, CITY OF	48231C0190F	12-OCT-1999	99-06-2001P	06
06	TX	HARKER HEIGHTS, CITY OF	4800290001B	28-JUL-1999	99-06-892A	01
06	TX	HARRIS COUNTY	48201C0310J	08-DEC-1999	00-06-078A	02
06	TX	HARRIS COUNTY	48201C0220J	15-DEC-1999	00-06-242A	01
06	TX	HARRIS COUNTY	48201C0410J	15-DEC-1999	00-06-242A	01
06	TX	HARRIS COUNTY	48201C0515J	20-DEC-1999	00-06-297A	02
06	TX	HARRIS COUNTY	48201C0235J	29-SEP-1999	98-06-1991P	05
06	TX	HARRIS COUNTY	48201C0245J	29-SEP-1999	98-06-1991P	05
06	TX	HARRIS COUNTY	48201C0595J	15-DEC-1999	99-06-1105P	05
06	TX	HARRIS COUNTY	48201C0615J	15-DEC-1999	99-06-1105P	05
06	TX	HARRIS COUNTY	48201C0440J	01-JUL-1999	99-06-1440A	02
06	TX	HARRIS COUNTY	48201C0315J	09-AUG-1999	99-06-1665A	02
06	TX	HARRIS COUNTY	48201C0265J	12-NOV-1999	99-06-1833P	06
06	TX	HARRIS COUNTY	48201C0320J	06-AUG-1999	99-06-423A	01
06	TX	HAYS COUNTY	48209C0227E	13-OCT-1999	99-06-2032A	02
06	TX	HENDERSON COUNTY	48213C0045D	12-NOV-1999	00-06-088A	02
06	TX	HENDERSON COUNTY	48213C0225C	01-SEP-1999	99-06-1822A	02
06	TX	HIDALGO COUNTY	4803340425C	20-DEC-1999	00-06-172A	01
06	TX	HIDALGO COUNTY	4803340350B	19-JUL-1999	99-06-1386A	02
06	TX	HIGHLAND PARK, TOWN OF	4801780005B	24-AUG-1999	99-06-705P	05
06	TX	HIGHLAND VILLAGE, VILLAGE OF	48121C0527E	20-SEP-1999	99-06-1201P	06
06	TX	HIGHLAND VILLAGE, VILLAGE OF	48121C0529E	20-SEP-1999	99-06-1201P	06
06	TX	HIGHLAND VILLAGE, VILLAGE OF	48121C0533F	13-AUG-1999	99-06-1695A	02
06	TX	HIGHLAND VILLAGE, VILLAGE OF	48121C0533F	15-SEP-1999	99-06-1863A	02
06	TX	HOOD COUNTY	4803560130C	24-SEP-1999	99-06-1462A	02
06	TX	HOOD COUNTY	4803560110C	11-AUG-1999	99-06-1680A	02
06	TX	HOOD COUNTY	4803560065B	02-NOV-1999	99-06-1975P	06
06	TX	HOUSTON, CITY OF	48201C0640J	01-DEC-1999	00-06-173A	02
06	TX	HOUSTON, CITY OF	48201C0670J	19-OCT-1999	99-06-1929A	02
06	TX	HUNT COUNTY	48231C0180F	12-OCT-1999	99-06-2001P	06
06	TX	HUNT COUNTY	48231C0190F	12-OCT-1999	99-06-2001P	06
06	TX	HURST, CITY OF	48439C0195H	15-JUL-1999	99-06-1345P	05
06	TX	HURST, CITY OF	48439C0306H	06-AUG-1999	99-06-1666A	02
06	TX	HURST, CITY OF	48439C0306H	07-OCT-1999	99-06-1993A	02
06	TX	IRVING, CITY OF	4801800045D	09-JUL-1999	99-06-1376A	01
06	TX	IRVING, CITY OF	4801800035C	01-SEP-1999	99-06-1808A	02
06	TX	JOHNSON COUNTY	48251C0041H	15-DEC-1999	00-06-233A	02
06	TX	JOHNSON COUNTY	48251C0050H	23-AUG-1999	99-06-1721A	02
06	TX	JOSHUA, CITY OF	48251C0039G	05-AUG-1999	99-06-1645A	02
06	TX	JOSHUA, CITY OF	48251C0039G	18-AUG-1999	99-06-1725A	02
06	TX	KELLER, CITY OF	48439C0170H	30-AUG-1999	99-06-1262P	05
06	TX	KELLER, CITY OF	48439C0190H	06-JUL-1999	99-06-372P	05
06	TX	KENDALL COUNTY	4804170175B	15-SEP-1999	99-06-1380P	05
06	TX	KENDALL COUNTY	4804170250B	15-SEP-1999	99-06-1380P	05
06	TX	KENNEDALE, CITY OF	48439C0439H	15-SEP-1999	99-06-1963A	01
06	TX	KERR COUNTY	4804190175B	19-OCT-1999	99-06-1837A	02
06	TX	KERRVILLE, CITY OF	4804200005D	22-OCT-1999	99-06-2028A	02
06	TX	KILLEEN, CITY OF	4800310002B	13-AUG-1999	99-06-1702A	02
06	TX	LAKE DALLAS, CITY OF	48121C0394E	08-DEC-1999	00-06-192A	02
06	TX	LAKEWAY, CITY OF	48453C0330E	01-JUL-1999	99-06-1458A	02
06	TX	LANCASTER, CITY OF	4801820015C	07-SEP-1999	98-06-1876P	05
06	TX	LAREDO, CITY OF	4806510005B	01-SEP-1999	99-06-1800A	02
06	TX	LAREDO, CITY OF	4810590730B	03-NOV-1999	99-06-2000P	06
06	TX	LEAGUE CITY, CITY OF	4854880011D	01-NOV-1999	99-06-1753V	19
06	TX	LEANDER, CITY OF	48491C0214C	12-OCT-1999	99-06-877P	05
06	TX	LEANDER, CITY OF	48491C0218C	12-OCT-1999	99-06-877P	05
06	TX	LEWISVILLE, CITY OF	48121C0533F	15-DEC-1999	00-06-258A	02
06	TX	LEWISVILLE, CITY OF	48121C0533F	02-SEP-1999	99-06-1815A	02
06	TX	LEWISVILLE, CITY OF	48121C0545E	22-JUL-1999	99-06-811P	05
06	TX	LEWISVILLE, CITY OF	48121C0685E	06-JUL-1999	99-06-831P	05
06	TX	LONGVIEW, CITY OF	4802640015E	22-DEC-1999	00-06-213A	01
06	TX	LONGVIEW, CITY OF	4802640015E	22-DEC-1999	00-06-309A	02
06	TX	LONGVIEW, CITY OF	4802640010D	18-OCT-1999	99-06-357P	05
06	TX	LUBBOCK COUNTY	4809150004A	05-AUG-1999	99-06-1651A	02
06	TX	LUBBOCK, CITY OF	4804520045C	22-NOV-1999	00-06-081A	02
06	TX	LUBBOCK, CITY OF	4804520045C	06-DEC-1999	00-06-154A	01
06	TX	LUBBOCK, CITY OF	4804520045C	13-DEC-1999	00-06-208A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
06	TX	LUBBOCK, CITY OF	4804520045C	30-DEC-1999	00-06-389A	01
06	TX	LUBBOCK, CITY OF	4804520045C	30-DEC-1999	00-06-390A	01
06	TX	LUBBOCK, CITY OF	4804520045C	01-JUL-1999	99-06-1427A	02
06	TX	LUBBOCK, CITY OF	4804520045C	09-JUL-1999	99-06-1495A	02
06	TX	LUBBOCK, CITY OF	4804520045C	13-AUG-1999	99-06-1687A	01
06	TX	LUBBOCK, CITY OF	4809150007A	13-AUG-1999	99-06-1687A	01
06	TX	LUBBOCK, CITY OF	4804520030B	13-OCT-1999	99-06-2011A	02
06	TX	LUBBOCK, CITY OF	4804520025C	19-OCT-1999	99-06-2052A	02
06	TX	MANSFIELD, CITY OF	48439C0580H	22-DEC-1999	00-06-191A	01
06	TX	MANSFIELD, CITY OF	48439C0580H	09-DEC-1999	00-06-223A	02
06	TX	MANSFIELD, CITY OF	48439C0557H	22-DEC-1999	00-06-306A	02
06	TX	MARBLE FALLS, CITY OF	48053C0312C	22-OCT-1999	99-06-1795A	02
06	TX	MCKINNEY, CITY OF	48085C0295G	10-AUG-1999	99-06-1567A	02
06	TX	MCLENNAN COUNTY	4804560050B	22-NOV-1999	99-06-2060A	01
06	TX	MEDINA COUNTY	4804720100B	06-AUG-1999	99-06-1428A	02
06	TX	MESQUITE, CITY OF	4854900005H	15-SEP-1999	99-06-1747A	02
06	TX	MIDLAND COUNTY	48329C0068E	07-DEC-1999	99-06-1617P	06
06	TX	MIDLAND COUNTY	48329C0100E	07-DEC-1999	99-06-1617P	06
06	TX	MIDLAND COUNTY	48329C0200E	07-DEC-1999	99-06-1617P	06
06	TX	MIDLAND COUNTY	48329C0203E	07-DEC-1999	99-06-1617P	06
06	TX	MIDLAND COUNTY	48329C0109C	22-DEC-1999	99-06-1981A	02
06	TX	MIDLAND, CITY OF	48329C0101D	08-NOV-1999	00-06-076A	02
06	TX	MIDLAND, CITY OF	48329C0088E	08-DEC-1999	00-06-130A	02
06	TX	MIDLAND, CITY OF	48329C0087E	09-DEC-1999	00-06-217A	02
06	TX	MIDLAND, CITY OF	48329C0088E	09-DEC-1999	00-06-218A	02
06	TX	MIDLAND, CITY OF	48329C0039C	23-AUG-1999	99-06-1554A	02
06	TX	MIDLAND, CITY OF	48329C0068E	07-DEC-1999	99-06-1617P	05
06	TX	MIDLAND, CITY OF	48329C0069E	07-DEC-1999	99-06-1617P	05
06	TX	MIDLAND, CITY OF	48329C0087E	07-DEC-1999	99-06-1617P	05
06	TX	MIDLAND, CITY OF	48329C0088E	07-DEC-1999	99-06-1617P	05
06	TX	MIDLAND, CITY OF	48329C0100E	07-DEC-1999	99-06-1617P	05
06	TX	MIDLAND, CITY OF	48329C0200E	07-DEC-1999	99-06-1617P	05
06	TX	MIDLAND, CITY OF	48329C0101D	10-AUG-1999	99-06-1672A	02
06	TX	MIDLAND, CITY OF	48329C0019D	23-SEP-1999	99-06-1908A	01
06	TX	MIDLAND, CITY OF	48329C0082C	28-OCT-1999	99-06-1936A	01
06	TX	MISSOURI CITY, CITY OF	48157C0255J	30-SEP-1999	99-06-1743P	06
06	TX	MISSOURI CITY, CITY OF	48157C0260J	22-OCT-1999	99-06-1773A	02
06	TX	MONTGOMERY COUNTY	48339C0195F	29-NOV-1999	00-06-037A	01
06	TX	MONTGOMERY COUNTY	48339C0215F	20-DEC-1999	00-06-084A	01
06	TX	MONTGOMERY COUNTY	48339C0210F	08-DEC-1999	00-06-197A	02
06	TX	MONTGOMERY COUNTY	48339C0530F	15-DEC-1999	00-06-255A	01
06	TX	MONTGOMERY COUNTY	48339C0539G	18-OCT-1999	98-06-085V	19
06	TX	MONTGOMERY COUNTY	48339C0510F	01-JUL-1999	99-06-1224A	01
06	TX	MONTGOMERY COUNTY	48339C0215F	06-AUG-1999	99-06-1454A	02
06	TX	MONTGOMERY COUNTY	48339C0560F	29-OCT-1999	99-06-1466A	02
06	TX	MONTGOMERY COUNTY	48339C0510F	27-JUL-1999	99-06-1588A	02
06	TX	MONTGOMERY COUNTY	48339C0520F	29-NOV-1999	99-06-1655A	02
06	TX	MONTGOMERY COUNTY	48339C0540F	09-AUG-1999	99-06-1662A	02
06	TX	MONTGOMERY COUNTY	48339C0195F	16-AUG-1999	99-06-1677A	01
06	TX	MONTGOMERY COUNTY	48339C0195F	16-AUG-1999	99-06-1679A	01
06	TX	MONTGOMERY COUNTY	48339C0205F	13-SEP-1999	99-06-1715A	02
06	TX	MONTGOMERY COUNTY	48339C0529F	30-SEP-1999	99-06-1734A	01
06	TX	MONTGOMERY COUNTY	48339C0510F	22-SEP-1999	99-06-1848A	01
06	TX	MONTGOMERY COUNTY	48339C0485F	29-NOV-1999	99-06-1894P	05
06	TX	MONTGOMERY COUNTY	48339C0210F	22-OCT-1999	99-06-1921A	02
06	TX	MONTGOMERY COUNTY	48339C0210F	28-OCT-1999	99-06-1972A	02
06	TX	MONTGOMERY COUNTY	48339C0370F	13-OCT-1999	99-06-2007A	02
06	TX	MONTGOMERY COUNTY	48339C0539G	18-OCT-1999	99-06-2090V	19
06	TX	NACOGDOCHES, CITY OF	4804970005B	05-AUG-1999	99-06-1643A	02
06	TX	NORTH RICHLAND HILLS, CITY OF	48439C0189H	06-JUL-1999	99-06-895A	02
06	TX	ODESSA, CITY OF	48135C0170D	26-OCT-1999	00-06-003A	02
06	TX	ODESSA, CITY OF	48135C0170D	28-JUL-1999	99-06-1504A	02
06	TX	ODESSA, CITY OF	48329C0100C	25-AUG-1999	99-06-1615A	02
06	TX	ODESSA, CITY OF	48135C0170D	11-AUG-1999	99-06-1690A	02
06	TX	ODESSA, CITY OF	48135C0170D	23-AUG-1999	99-06-1742A	02
06	TX	ODESSA, CITY OF	48135C0170D	22-OCT-1999	99-06-1780A	02
06	TX	ODESSA, CITY OF	48135C0140D	01-SEP-1999	99-06-1799A	02
06	TX	ODESSA, CITY OF	48135C0175D	01-SEP-1999	99-06-1799A	02
06	TX	ODESSA, CITY OF	48135C0135D	15-SEP-1999	99-06-1872A	02
06	TX	ODESSA, CITY OF	48135C0135D	15-NOV-1999	99-06-1933A	02
06	TX	PARKER COUNTY	4805200150C	30-JUL-1999	99-06-179P	05
06	TX	PASADENA, CITY OF	48201C0920J	25-AUG-1999	99-06-1775A	02
06	TX	PLANO, CITY OF	48085C0440G	03-DEC-1999	00-06-024P	06

Region	State	Community	Map panel	Determination date	Case No.	Type
06	TX	PLANO, CITY OF	48085C0440G	30-DEC-1999	00-06-090A	02
06	TX	PLANO, CITY OF	48085C0445G	09-DEC-1999	00-06-222A	02
06	TX	PLANO, CITY OF	48085C0420G	10-AUG-1999	98-06-1555P	05
06	TX	PLANO, CITY OF	48085C0420G	07-SEP-1999	98-06-1835P	05
06	TX	PLANO, CITY OF	48085C0420G	01-JUL-1999	99-06-1161A	02
06	TX	PLANO, CITY OF	48085C0440G	13-AUG-1999	99-06-1178A	02
06	TX	PLANO, CITY OF	48085C0445G	19-JUL-1999	99-06-1559A	02
06	TX	PLANO, CITY OF	48085C0445G	22-JUL-1999	99-06-1568A	02
06	TX	PLANO, CITY OF	48085C0445G	29-JUL-1999	99-06-1611A	02
06	TX	PLANO, CITY OF	48085C0420G	01-SEP-1999	99-06-1614A	02
06	TX	PLANO, CITY OF	48085C0420G	10-SEP-1999	99-06-1827A	02
06	TX	PLANO, CITY OF	48085C0410G	30-DEC-1999	99-06-1862A	02
06	TX	PLANO, CITY OF	48085C0445G	23-SEP-1999	99-06-1925A	02
06	TX	PLEASANT VALLEY, CITY OF	4806610001B	25-OCT-1999	99-06-2006A	02
06	TX	PRINCETON, CITY OF	48085C0325G	10-SEP-1999	99-06-1828A	02
06	TX	PRINCETON, CITY OF	48085C0325G	12-NOV-1999	99-06-1988A	02
06	TX	PRINCETON, CITY OF	48085C0350G	12-NOV-1999	99-06-1988A	02
06	TX	RANDALL COUNTY	4805320050B	13-AUG-1999	99-06-1682A	02
06	TX	RICHARDSON, CITY OF	4801840010C	26-AUG-1999	99-06-1745A	02
06	TX	RICHARDSON, CITY OF	4801840015C	27-AUG-1999	99-06-1788A	02
06	TX	RICHARDSON, CITY OF	4801840015C	22-NOV-1999	99-06-2044A	02
06	TX	ROCKWALL, CITY OF	4805470005C	13-SEP-1999	99-06-1838A	02
06	TX	ROCKWALL, CITY OF	4805470005C	22-NOV-1999	99-06-1857A	02
06	TX	SAN ANGELO, CITY OF	4806230035D	14-JUL-1999	99-06-1512A	02
06	TX	SAN ANGELO, CITY OF	4806230035D	01-SEP-1999	99-06-1801A	02
06	TX	SAN ANTONIO, CITY OF	48029C0278E	19-OCT-1999	99-06-1223A	02
06	TX	SAN ANTONIO, CITY OF	48029C0291E	26-JUL-1999	99-06-1582A	02
06	TX	SAN ANTONIO, CITY OF	48029C0291E	24-AUG-1999	99-06-1831A	01
06	TX	SAN ANTONIO, CITY OF	48029C0257E	13-SEP-1999	99-06-1839A	02
06	TX	SAN ANTONIO, CITY OF	48029C0279E	09-DEC-1999	99-06-2012A	02
06	TX	SAN ANTONIO, CITY OF	48029C0140E	13-OCT-1999	99-06-2016A	02
06	TX	SAN ANTONIO, CITY OF	48029C0279E	15-DEC-1999	99-06-2043A	02
06	TX	SAN ANTONIO, CITY OF	48029C0252E	09-AUG-1999	99-06-292P	05
06	TX	SAN ANTONIO, CITY OF	48029C0254E	09-AUG-1999	99-06-292P	05
06	TX	SAN ANTONIO, CITY OF	48029C0258E	09-AUG-1999	99-06-292P	05
06	TX	SAN ANTONIO, CITY OF	48029C0262E	09-AUG-1999	99-06-292P	05
06	TX	SAN ANTONIO, CITY OF	48029C0266E	09-AUG-1999	99-06-292P	05
06	TX	SAN ANTONIO, CITY OF	48029C0268E	09-AUG-1999	99-06-292P	05
06	TX	SAN ANTONIO, CITY OF	48029C0269E	09-AUG-1999	99-06-292P	05
06	TX	SAN ANTONIO, CITY OF	48029C0256E	19-OCT-1999	99-06-557P	05
06	TX	SAN BENITO, CITY OF	4801130005B	23-AUG-1999	99-06-1739A	02
06	TX	SAN PATRICIO COUNTY	4855060225C	03-AUG-1999	99-06-1628A	01
06	TX	SHADY SHORES, CITY OF	48121C0394E	15-SEP-1999	99-06-1616A	02
06	TX	SHAVANO PARK, TOWN OF	48029C0252E	09-AUG-1999	99-06-292P	05
06	TX	SHAVANO PARK, TOWN OF	48029C0254E	09-AUG-1999	99-06-292P	05
06	TX	SHAVANO PARK, TOWN OF	48029C0258E	09-AUG-1999	99-06-292P	05
06	TX	SHAVANO PARK, TOWN OF	48029C0262E	09-AUG-1999	99-06-292P	05
06	TX	SHAVANO PARK, TOWN OF	48029C0266E	09-AUG-1999	99-06-292P	05
06	TX	SHAVANO PARK, TOWN OF	48029C0268E	09-AUG-1999	99-06-292P	05
06	TX	SHAVANO PARK, TOWN OF	48029C0269E	09-AUG-1999	99-06-292P	05
06	TX	SHERMAN, CITY OF	48181C0145E	29-OCT-1999	99-06-1974A	02
06	TX	SMITH COUNTY	4811850250B	03-NOV-1999	00-06-058A	02
06	TX	SMITH COUNTY	4811850250B	15-DEC-1999	00-06-115A	02
06	TX	SMITH COUNTY	4811850250B	27-DEC-1999	00-06-347A	02
06	TX	SMITH COUNTY	4811850250B	15-SEP-1999	99-06-1766A	02
06	TX	SOUTH PADRE ISLAND, TOWN OF	4801150001D	12-OCT-1999	99-06-1796P	05
06	TX	SPRINGTOWN, CITY OF	4805210005B	12-JUL-1999	99-06-1347A	01
06	TX	TARRANT COUNTY	48439C0140H	03-NOV-1999	00-06-044A	02
06	TX	TAYLOR COUNTY	4810140009B	11-AUG-1999	99-06-1681A	02
06	TX	TOOL, CITY OF	48213C0040D	26-JUL-1999	99-06-1553A	02
06	TX	TYLER COUNTY	4810340011B	30-SEP-1999	99-06-1967A	02
06	TX	TYLER, CITY OF	4805710015B	11-AUG-1999	99-06-1558A	01
06	TX	TYLER, CITY OF	4805710014B	16-AUG-1999	99-06-1733A	02
06	TX	VICTORIA, CITY OF	4806380005G	22-JUL-1999	99-06-1544V	19
06	TX	VICTORIA, CITY OF	4806380005G	05-AUG-1999	99-06-657A	02
06	TX	WALKER COUNTY	4810420007B	15-DEC-1999	00-06-243A	02
06	TX	WATAUGA, TOWN OF	48439C0188H	05-OCT-1999	99-06-1973A	02
06	TX	WHITE SETTLEMENT, CITY OF	48439C0265H	13-OCT-1999	99-06-1569A	02
06	TX	WHITNEY, TOWN OF	4808650001A	22-DEC-1999	00-06-049A	02
06	TX	WYLIE, CITY OF	48085C0470G	22-DEC-1999	99-06-1674A	01
07	IA	AMES, CITY OF	1902540004B	28-SEP-1999	98-07-055P	05
07	IA	AMES, CITY OF	1909070065B	28-SEP-1999	98-07-055P	05
07	IA	BLACK HAWK COUNTY	1905350045B	01-SEP-1999	99-07-827A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
07	IA	BUCHANAN COUNTY	1908480025C	22-JUL-1999	99-07-727V	19
07	IA	BUCHANAN COUNTY	1908480100C	22-JUL-1999	99-07-727V	19
07	IA	BUCHANAN COUNTY	1908480200C	22-JUL-1999	99-07-727V	19
07	IA	CAMANCHE, CITY OF	1900860005B	22-SEP-1999	99-07-875A	02
07	IA	CARROLL, CITY OF	1900410005A	05-AUG-1999	99-07-683A	01
07	IA	CEDAR COUNTY	190050B	02-SEP-1999	99-07-842A	02
07	IA	CEDAR FALLS, CITY OF	1900170006B	30-DEC-1999	00-07-133A	02
07	IA	CEDAR RAPIDS, CITY OF	1901870010B	11-AUG-1999	99-07-698A	02
07	IA	CLEAR LAKE, CITY OF	1900590001B	30-DEC-1999	00-07-043A	02
07	IA	CLEAR LAKE, CITY OF	1900590003B	30-DEC-1999	00-07-043A	02
07	IA	CLEAR LAKE, CITY OF	1900590003B	22-NOV-1999	00-07-047A	02
07	IA	CLEAR LAKE, CITY OF	1900590003B	06-DEC-1999	00-07-074A	02
07	IA	CLEAR LAKE, CITY OF	1900590003B	07-JUL-1999	99-07-704A	02
07	IA	CLERMONT, CITY OF	190374A	08-DEC-1999	00-07-070A	02
07	IA	CLINTON, CITY OF	1900880015C	15-DEC-1999	99-07-347A	01
07	IA	CLIVE, CITY OF	1904880005C	15-DEC-1999	00-07-087A	02
07	IA	CLIVE, CITY OF	1904880005C	30-DEC-1999	00-07-109A	02
07	IA	CLIVE, CITY OF	1904880005C	03-AUG-1999	99-07-763A	02
07	IA	COUNCIL BLUFFS, CITY OF	1902350010B	01-SEP-1999	99-07-682A	01
07	IA	COUNCIL BLUFFS, CITY OF	1902350010B	23-SEP-1999	99-07-904A	02
07	IA	CRESCENT, CITY OF	1907230001A	26-AUG-1999	99-07-815A	02
07	IA	DAVENPORT, CITY OF	1902420005B	22-SEP-1999	99-07-848A	02
07	IA	DYERSVILLE, CITY OF	1901200001D	16-NOV-1999	99-07-831A	17
07	IA	FAYETTE COUNTY	1908660003B	25-OCT-1999	99-07-914A	02
07	IA	FREDERICKSBURG, CITY OF	190066B	22-JUL-1999	99-07-732A	02
07	IA	HUDSON, CITY OF	1900220005B	19-JUL-1999	99-07-666A	02
07	IA	HUMBOLDT, CITY OF	1901550005B	08-NOV-1999	00-07-018A	02
07	IA	HUMBOLDT, CITY OF	1901550005B	17-AUG-1999	99-07-794A	02
07	IA	MITCHELL COUNTY	1908920003A	28-SEP-1999	99-07-854A	02
07	IA	MUSCATINE COUNTY	1908360250B	22-DEC-1999	00-07-107A	02
07	IA	NORTHWOOD, CITY OF	190302B	30-DEC-1999	00-07-080A	02
07	IA	PALO, CITY OF	1904420001A	15-DEC-1999	00-07-086A	02
07	IA	POTTAWATTAMIE COUNTY	1902320226B	01-DEC-1999	00-07-054A	02
07	IA	ROCK VALLEY, CITY OF	190253B	06-DEC-1999	00-07-002A	02
07	IA	SCOTT COUNTY	1902390050B	22-DEC-1999	00-07-100A	02
07	IA	SHELLSBURG, CITY OF	1903190001A	09-AUG-1999	99-07-117A	01
07	IA	SPENCER, CITY OF	1900710005B	28-JUL-1999	99-07-746A	02
07	IA	WALCOTT, CITY OF	190675	03-NOV-1999	00-07-017A	01
07	IA	WALCOTT, CITY OF	190675	29-NOV-1999	00-07-102A	01
07	IA	WATERLOO, CITY OF	1900250015E	23-AUG-1999	99-07-802A	02
07	IA	WAVERLY, CITY OF	19017C0054C	13-AUG-1999	99-07-777A	02
07	IA	WAVERLY, CITY OF	19017C0054C	22-OCT-1999	99-07-949A	02
07	IA	WEST LIBERTY, CITY OF	1902150001B	27-JUL-1999	99-07-773A	02
07	KS	ANDOVER, CITY OF	2000370230B	20-DEC-1999	00-07-061A	01
07	KS	BASEHOR, CITY OF	200187B	29-JUL-1999	99-07-748A	02
07	KS	BURRTON, CITY OF	2005850100B	09-AUG-1999	99-07-755A	02
07	KS	BURRTON, CITY OF	2005850100B	26-OCT-1999	99-07-957A	02
07	KS	BUTLER COUNTY	2000370240B	08-DEC-1999	00-07-035A	01
07	KS	BUTLER COUNTY	2000370170B	05-AUG-1999	99-07-681A	02
07	KS	CHEROKEE COUNTY	2000440075B	15-SEP-1999	99-07-833A	02
07	KS	COFFEYVILLE, CITY OF	200232A	30-JUL-1999	99-07-694A	02
07	KS	DERBY, CITY OF	2003230001C	07-JUL-1999	99-07-690A	02
07	KS	DERBY, CITY OF	2003230002C	07-OCT-1999	99-07-912A	02
07	KS	DERBY, CITY OF	2003230001C	13-OCT-1999	99-07-930A	01
07	KS	DERBY, CITY OF	2003230002C	13-OCT-1999	99-07-930A	01
07	KS	FRANKLIN COUNTY	2005650075B	06-DEC-1999	00-07-066A	02
07	KS	HALSTEAD, CITY OF	2001310001D	22-DEC-1999	00-07-062A	17
07	KS	HAYSVILLE, CITY OF	2003240001C	23-AUG-1999	99-07-847A	02
07	KS	MCPHERSON COUNTY	2002140200B	22-JUL-1999	99-07-723A	02
07	KS	MCPHERSON COUNTY	2002140025B	16-AUG-1999	99-07-790A	02
07	KS	MCPHERSON COUNTY	2002140275B	25-OCT-1999	99-07-918A	02
07	KS	MCPHERSON, CITY OF	2002170010D	22-NOV-1999	00-07-041A	01
07	KS	MCPHERSON, CITY OF	2002170015D	08-OCT-1999	99-07-717A	02
07	KS	MIAMI COUNTY	200220A	15-DEC-1999	00-07-094A	02
07	KS	MIAMI COUNTY	200220A	27-JUL-1999	99-07-729A	02
07	KS	NEWTON, CITY OF	2001330005C	15-JUL-1999	99-07-673A	02
07	KS	NEWTON, CITY OF	2001330005C	03-AUG-1999	99-07-761A	02
07	KS	NEWTON, CITY OF	2001330005C	01-SEP-1999	99-07-828A	02
07	KS	NICKERSON, CITY OF	20155C0090D	12-NOV-1999	00-07-029A	02
07	KS	OLATHE, CITY OF	20091C0056D	18-AUG-1999	99-07-408P	05
07	KS	OLATHE, CITY OF	20091C0057D	18-AUG-1999	99-07-408P	05
07	KS	OVERLAND PARK, CITY OF	20091C0079E	16-AUG-1999	99-07-428P	05
07	KS	OVERLAND PARK, CITY OF	20092C0077D	12-OCT-1999	99-07-740P	05

Region	State	Community	Map panel	Determination date	Case No.	Type
07	KS	PRATT, CITY OF	2002780020D	30-DEC-1999	00-07-050A	02
07	KS	SALINA, CITY OF	2003190005B	28-OCT-1999	00-07-006A	02
07	KS	SALINA, CITY OF	2003190015B	04-NOV-1999	00-07-020A	02
07	KS	SALINA, CITY OF	2003190015B	12-NOV-1999	00-07-034A	02
07	KS	SALINA, CITY OF	2003190015B	08-DEC-1999	00-07-039A	01
07	KS	SALINA, CITY OF	2003160060B	29-NOV-1999	00-07-058A	02
07	KS	SALINA, CITY OF	2003190015B	01-DEC-1999	00-07-069A	02
07	KS	SALINA, CITY OF	2003190005B	15-DEC-1999	00-07-089A	02
07	KS	SALINA, CITY OF	2003190015B	15-DEC-1999	00-07-090A	02
07	KS	SALINA, CITY OF	2003190015B	22-SEP-1999	99-07-669A	02
07	KS	SALINA, CITY OF	2003190015B	28-JUL-1999	99-07-745A	02
07	KS	SALINA, CITY OF	2003190015B	29-JUL-1999	99-07-751A	02
07	KS	SALINA, CITY OF	2003190015B	05-AUG-1999	99-07-756A	02
07	KS	SALINA, CITY OF	2003160060B	10-AUG-1999	99-07-775A	02
07	KS	SALINA, CITY OF	2003190015B	13-AUG-1999	99-07-778A	02
07	KS	SALINA, CITY OF	2003190015B	13-AUG-1999	99-07-783A	02
07	KS	SALINA, CITY OF	2003190015B	13-AUG-1999	99-07-785A	02
07	KS	SALINA, CITY OF	2003190015B	23-AUG-1999	99-07-799A	02
07	KS	SALINA, CITY OF	2003190015B	25-AUG-1999	99-07-811A	02
07	KS	SALINA, CITY OF	2003190015B	01-SEP-1999	99-07-830A	02
07	KS	SALINA, CITY OF	2003190015B	13-SEP-1999	99-07-838A	02
07	KS	SALINA, CITY OF	2003190015B	07-SEP-1999	99-07-863A	02
07	KS	SALINA, CITY OF	2003190015B	30-SEP-1999	99-07-868A	01
07	KS	SALINA, CITY OF	2003160060B	17-SEP-1999	99-07-878A	02
07	KS	SALINA, CITY OF	2003190015B	15-SEP-1999	99-07-885A	02
07	KS	SALINA, CITY OF	2003190015B	19-OCT-1999	99-07-943A	02
07	KS	SALINA, CITY OF	2003190015B	19-OCT-1999	99-07-947A	02
07	KS	SALINA, CITY OF	2003160060B	19-OCT-1999	99-07-948A	02
07	KS	SALINA, CITY OF	2003190015B	22-OCT-1999	99-07-953A	02
07	KS	SALINA, CITY OF	2003190015B	25-OCT-1999	99-07-962A	02
07	KS	SALINE COUNTY	2003160090B	04-NOV-1999	00-07-012A	02
07	KS	SALINE COUNTY	2003160060B	01-DEC-1999	00-07-023A	01
07	KS	SALINE COUNTY	2003160125B	12-NOV-1999	00-07-030A	02
07	KS	SALINE COUNTY	2003160060B	03-AUG-1999	99-07-677A	02
07	KS	SALINE COUNTY	2003160025B	19-AUG-1999	99-07-789A	02
07	KS	SALINE COUNTY	2003160025B	13-SEP-1999	99-07-858A	02
07	KS	SALINE COUNTY	2003160065B	30-SEP-1999	99-07-921A	02
07	KS	SALINE COUNTY	2003160025B	26-OCT-1999	99-07-939A	02
07	KS	SEDGWICK COUNTY	2003210300A	08-DEC-1999	00-07-085A	02
07	KS	SEDGWICK COUNTY	2003210225A	11-AUG-1999	99-07-525A	01
07	KS	SEDGWICK COUNTY	2003210225A	12-JUL-1999	99-07-701A	02
07	KS	SEDGWICK COUNTY	2003210300A	12-JUL-1999	99-07-702A	02
07	KS	SEDGWICK COUNTY	2003210150A	12-JUL-1999	99-07-710A	02
07	KS	SEDGWICK COUNTY	2003210150A	19-OCT-1999	99-07-864A	01
07	KS	SEDGWICK COUNTY	2003210300A	22-OCT-1999	99-07-952A	02
07	KS	SHAWNEE COUNTY	2003310025C	06-JUL-1999	99-07-583A	02
07	KS	SHAWNEE COUNTY	2003310065C	02-JUL-1999	99-07-598A	02
07	KS	TOPEKA, CITY OF	2051870011C	30-SEP-1999	99-07-880A	02
07	KS	WICHITA, CITY OF	2003280035B	28-OCT-1999	00-07-010A	02
07	KS	WICHITA, CITY OF	2003280015B	12-NOV-1999	00-07-028A	02
07	KS	WICHITA, CITY OF	2003280005B	22-NOV-1999	00-07-044A	02
07	KS	WICHITA, CITY OF	2003280020B	29-NOV-1999	00-07-059A	02
07	KS	WICHITA, CITY OF	2003280020B	08-DEC-1999	00-07-083A	02
07	KS	WICHITA, CITY OF	2003280030B	12-JUL-1999	99-07-711A	02
07	KS	WICHITA, CITY OF	2003280005B	19-JUL-1999	99-07-715A	02
07	KS	WICHITA, CITY OF	2003280015B	30-JUL-1999	99-07-752A	01
07	KS	WICHITA, CITY OF	2003280020B	27-JUL-1999	99-07-788A	02
07	KS	WICHITA, CITY OF	2003280035B	25-AUG-1999	99-07-808A	02
07	KS	WICHITA, CITY OF	2003280035B	01-SEP-1999	99-07-824A	02
07	KS	WICHITA, CITY OF	2003280005B	01-SEP-1999	99-07-825A	02
07	KS	WICHITA, CITY OF	2003280035B	02-SEP-1999	99-07-840A	02
07	KS	WICHITA, CITY OF	2003280035B	15-SEP-1999	99-07-861A	02
07	KS	WICHITA, CITY OF	2003280020B	15-SEP-1999	99-07-870A	02
07	KS	WICHITA, CITY OF	2003280035B	15-SEP-1999	99-07-874A	02
07	KS	WICHITA, CITY OF	2003280005B	17-SEP-1999	99-07-882A	02
07	KS	WICHITA, CITY OF	2003280025B	17-SEP-1999	99-07-884A	02
07	KS	WICHITA, CITY OF	2003280035B	23-SEP-1999	99-07-897A	02
07	KS	WICHITA, CITY OF	2003280035B	23-SEP-1999	99-07-905A	02
07	KS	WICHITA, CITY OF	2003280035B	28-SEP-1999	99-07-907A	02
07	KS	WICHITA, CITY OF	2003280015B	07-OCT-1999	99-07-922A	02
07	MO	BLUE SPRINGS, CITY OF	2904920137B	30-SEP-1999	99-07-394A	02
07	MO	BOONE COUNTY	2900340108B	08-NOV-1999	00-07-022A	02
07	MO	BUCKNER, CITY OF	2901700001B	08-OCT-1999	99-07-923A	02

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07	MO	CAMDEN COUNTY	2907890001B	13-OCT-1999	99-07-843A	02
07	MO	CAMDEN COUNTY	2907890006A	15-NOV-1999	99-07-934A	02
07	MO	CAMDEN COUNTY	2907890005B	04-NOV-1999	99-07-950A	02
07	MO	CAPE GIRARDEAU COUNTY	2907900130B	12-JUL-1999	99-07-703A	02
07	MO	CAPE GIRARDEAU, CITY OF	2904580007B	28-JUL-1999	99-07-736A	02
07	MO	CAPE GIRARDEAU, CITY OF	2904580006B	17-AUG-1999	99-07-779A	01
07	MO	CASS COUNTY	2907830050C	06-JUL-1999	99-07-689A	02
07	MO	CASS COUNTY	2907830025C	24-SEP-1999	99-07-820A	02
07	MO	CHESTERFIELD, CITY OF	29189C0120H	24-NOV-1999	99-07-656P	05
07	MO	CHESTERFIELD, CITY OF	29189C0138H	24-NOV-1999	99-07-656P	05
07	MO	CHESTERFIELD, CITY OF	29189C0140H	24-NOV-1999	99-07-656P	05
07	MO	CHRISTIAN COUNTY	2908470003A	19-OCT-1999	99-07-944A	02
07	MO	CLAY COUNTY	2900860050B	19-OCT-1999	99-07-945A	02
07	MO	COLE COUNTY	2901070080B	29-NOV-1999	00-07-038A	02
07	MO	COLUMBIA, CITY OF	2900360005C	15-DEC-1999	00-07-001A	02
07	MO	COTTLEVILLE, CITY OF	29183C0244E	08-SEP-1999	99-07-814A	01
07	MO	CRAWFORD COUNTY	2907950003B	24-AUG-1999	99-07-576A	02
07	MO	CRAWFORD COUNTY	2907950006B	05-OCT-1999	99-07-894A	02
07	MO	CREVE COEUR, CITY OF	29189C0166H	13-DEC-1999	00-07-139A	02
07	MO	CREVE COEUR, CITY OF	29189C0164H	06-JUL-1999	99-07-676A	02
07	MO	CRYSTAL CITY,CITY OF	2901890005C	28-SEP-1999	99-07-169P	05
07	MO	DARDENNE PRAIRIE, TOWN OF	29183C0430E	15-DEC-1999	00-07-091A	01
07	MO	DES PERES, CITY OF	29189C0281H	07-JUL-1999	99-07-538A	02
07	MO	DES PERES, CITY OF	29189C0279H	27-AUG-1999	99-07-818A	02
07	MO	EXCELSIOR SPRINGS, CITY OF	2900900002B	30-JUL-1999	99-07-758A	02
07	MO	FENTON, CITY OF	29189C0289H	07-JUL-1999	99-07-575A	01
07	MO	FERGUSON, CITY OF	29189C0181H	15-NOV-1999	99-07-941A	01
07	MO	FLORISSANT, CITY OF	29189C0062H	30-DEC-1999	00-07-073A	02
07	MO	FLORISSANT, CITY OF	29189C0062H	14-JUL-1999	99-07-728A	02
07	MO	GASCONADE COUNTY	2908010125B	13-OCT-1999	99-07-862A	02
07	MO	GREEN PARK, CITY OF	29189C0315H	23-AUG-1999	99-07-851A	01
07	MO	GREENE COUNTY	2907820070B	16-NOV-1999	00-07-014A	02
07	MO	GREENE COUNTY	2907820125B	27-JUL-1999	99-07-741A	02
07	MO	JACKSON, CITY OF	2952650001C	07-JUL-1999	99-07-693A	02
07	MO	JASPER COUNTY	2908070200B	16-NOV-1999	00-07-008A	02
07	MO	JEFFERSON COUNTY	2908080020B	12-NOV-1999	00-07-040A	02
07	MO	JEFFERSON COUNTY	290808IND0	09-DEC-1999	99-07-642P	06
07	MO	JEFFERSON COUNTY	2908080080C	09-JUL-1999	99-07-699A	02
07	MO	JEFFERSON COUNTY	2908080090D	13-AUG-1999	99-07-707A	02
07	MO	JEFFERSON COUNTY	2908080080C	14-JUL-1999	99-07-716A	02
07	MO	JEFFERSON COUNTY	2908080085C	07-OCT-1999	99-07-821A	01
07	MO	JEFFERSON COUNTY	2908080120C	23-SEP-1999	99-07-849A	02
07	MO	JEFFERSON COUNTY	2908080080C	07-SEP-1999	99-07-871A	02
07	MO	JEFFERSON COUNTY	2908080090D	07-SEP-1999	99-07-871A	02
07	MO	JEFFERSON COUNTY	2908080105C	22-SEP-1999	99-07-898A	02
07	MO	KANSAS CITY, CITY OF	2901730115C	08-SEP-1999	99-07-551P	05
07	MO	KIRKWOOD, CITY OF	29189C0283H	01-SEP-1999	99-07-691A	02
07	MO	KIRKWOOD, CITY OF	29189C0284H	23-AUG-1999	99-07-776A	01
07	MO	LADUE,CITY OF	29189C0188H	26-JUL-1999	99-07-738A	02
07	MO	LAKE ST. LOUIS, CITY OF	29183C0220E	09-JUL-1999	99-07-705A	02
07	MO	LAKE ST. LOUIS, CITY OF	29183C0220E	05-AUG-1999	99-07-759A	02
07	MO	LAKE WINNEBAGO, CITY OF	2908770001A	09-JUL-1999	99-07-709A	01
07	MO	LAKE WINNEBAGO, CITY OF	2908770001A	13-SEP-1999	99-07-856A	02
07	MO	LAMAR, CITY OF	2900250001C	03-AUG-1999	99-07-762A	02
07	MO	MANCHESTER, CITY OF	29189C0259H	12-NOV-1999	99-07-865A	01
07	MO	MARYLAND HEIGHTS, CITY OF	29189C0158H	20-SEP-1999	99-07-363P	05
07	MO	MILLER COUNTY	2902260200A	11-AUG-1999	99-07-784A	02
07	MO	MORGAN COUNTY	2902440150A	30-SEP-1999	99-07-908A	02
07	MO	NODAWAY COUNTY	2908210120B	22-SEP-1999	99-07-886A	02
07	MO	O'FALLON, CITY OF	29183C0235E	28-OCT-1999	00-07-005A	01
07	MO	O'FALLON, CITY OF	29183C0230E	08-SEP-1999	99-07-899A	02
07	MO	O'FALLON, CITY OF	29183C0237E	01-DEC-1999	99-07-902A	01
07	MO	O'FALLON, CITY OF	29183C0240E	01-DEC-1999	99-07-902A	01
07	MO	O'FALLON, CITY OF	29183C0239E	19-OCT-1999	99-07-940A	02
07	MO	PEVELY, CITY OF	290677A	15-DEC-1999	00-07-092A	02
07	MO	PLATTE COUNTY	2904750125A	30-JUL-1999	99-07-647A	01
07	MO	PLATTE COUNTY	2904750165A	17-AUG-1999	99-07-793A	02
07	MO	PLATTE COUNTY	2904750075A	15-SEP-1999	99-07-837A	02
07	MO	PLEASANT VALLEY, CITY OF	2901000001A	22-SEP-1999	99-07-800A	02
07	MO	POPLAR BLUFF, CITY OF	2900470004C	30-DEC-1999	00-07-112A	02
07	MO	POPLAR BLUFF, CITY OF	2900470002C	27-DEC-1999	99-07-946P	05
07	MO	POPLAR BLUFF, CITY OF	2900470004C	27-DEC-1999	99-07-946P	05
07	MO	RALLS COUNTY	2903020002B	12-NOV-1999	99-07-959A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
07	MO	RIPLEY COUNTY	2908300125A	16-AUG-1999	99-07-524A	02
07	MO	ST. ANN, CITY OF	29189C0157H	03-AUG-1999	99-07-760A	02
07	MO	ST. CHARLES COUNTY	29183C0451E	05-AUG-1999	99-07-764A	02
07	MO	ST. CHARLES, CITY OF	29183C0286E	22-NOV-1999	00-07-048A	02
07	MO	ST. CHARLES, CITY OF	29183C0260E	06-DEC-1999	00-07-068A	01
07	MO	ST. CHARLES, CITY OF	29183C0286E	20-DEC-1999	00-07-098A	02
07	MO	ST. CHARLES, CITY OF	29183C0260E	21-DEC-1999	00-07-124A	01
07	MO	ST. CHARLES, CITY OF	29183C0280E	22-DEC-1999	00-07-135A	01
07	MO	ST. CHARLES, CITY OF	29183C0286E	29-JUL-1999	99-07-750A	02
07	MO	ST. CHARLES, CITY OF	29183C0286E	22-NOV-1999	99-07-960A	02
07	MO	ST. LOUIS COUNTY	29189C0415H	20-DEC-1999	00-07-103A	02
07	MO	ST. LOUIS COUNTY	29189C0320H	30-DEC-1999	00-07-119A	02
07	MO	ST. LOUIS COUNTY	29189C0069H	15-JUL-1999	99-07-272A	02
07	MO	ST. LOUIS COUNTY	29189C0069H	03-AUG-1999	99-07-521A	02
07	MO	ST. LOUIS COUNTY	29189C0267H	30-JUL-1999	99-07-661A	01
07	MO	ST. LOUIS COUNTY	29189C0315H	09-JUL-1999	99-07-692A	01
07	MO	ST. LOUIS COUNTY	29189C0267H	30-JUL-1999	99-07-772A	01
07	MO	ST. LOUIS COUNTY	29189C0405H	25-AUG-1999	99-07-810A	02
07	MO	ST. LOUIS COUNTY	29189C0410H	01-SEP-1999	99-07-822A	01
07	MO	ST. LOUIS COUNTY	29189C0278H	01-SEP-1999	99-07-823A	01
07	MO	ST. LOUIS COUNTY	29189C0267H	23-SEP-1999	99-07-887A	17
07	MO	ST. LOUIS COUNTY	29189C0316H	17-SEP-1999	99-07-891A	02
07	MO	ST. LOUIS COUNTY	29189C0182H	28-SEP-1999	99-07-906A	01
07	MO	ST. PETERS, CITY OF	29183C0244E	22-NOV-1999	00-07-042A	02
07	MO	ST. PETERS, CITY OF	29183C0264E	08-DEC-1999	00-07-064A	02
07	MO	ST. PETERS, CITY OF	29183C0264E	15-DEC-1999	00-07-096A	02
07	MO	ST. PETERS, CITY OF	29183C0242E	02-JUL-1999	99-07-599A	01
07	MO	ST. PETERS, CITY OF	29183C0242E	18-AUG-1999	99-07-612A	01
07	MO	ST. PETERS, CITY OF	29183C0242E	06-JUL-1999	99-07-685A	02
07	MO	ST. PETERS, CITY OF	29183C0264E	06-JUL-1999	99-07-688A	02
07	MO	ST. PETERS, CITY OF	29183C0242E	13-AUG-1999	99-07-713A	02
07	MO	ST. PETERS, CITY OF	29183C0264E	22-JUL-1999	99-07-719A	02
07	MO	ST. PETERS, CITY OF	29183C0263E	22-JUL-1999	99-07-734A	02
07	MO	ST. PETERS, CITY OF	29183C0242E	15-JUL-1999	99-07-767A	01
07	MO	ST. PETERS, CITY OF	29183C0262E	22-OCT-1999	99-07-797A	01
07	MO	ST. PETERS, CITY OF	29183C0242E	25-AUG-1999	99-07-812A	02
07	MO	ST. PETERS, CITY OF	29183C0242E	10-SEP-1999	99-07-841A	01
07	MO	ST. PETERS, CITY OF	29183C0244E	13-OCT-1999	99-07-935A	02
07	MO	ST. PETERS, CITY OF	29183C0242E	19-OCT-1999	99-07-942A	02
07	MO	STEELE, CITY OF	2902790005B	20-DEC-1999	00-07-053P	05
07	MO	SUNSET HILLS, CITY OF	29189C0293H	29-NOV-1999	99-07-872A	02
07	MO	TROY, CITY OF	2906410002A	09-JUL-1999	99-07-253P	05
07	MO	UNIVERSITY CITY, CITY OF	29189C0187H	26-AUG-1999	99-07-817A	02
07	MO	WARREN COUNTY	2904430075C	08-NOV-1999	00-07-015A	02
07	MO	WARREN COUNTY	2904430125B	01-DEC-1999	00-07-060A	02
07	MO	WARREN COUNTY	2904430075C	04-AUG-1999	99-07-801P	06
07	MO	WARREN COUNTY	2904430075C	12-NOV-1999	99-07-916A	02
07	NE	AURORA, CITY OF	3101050005C	29-OCT-1999	99-07-938A	01
07	NE	BELLEVUE, CITY OF	31153C0070F	15-DEC-1999	00-07-093A	01
07	NE	BELLEVUE, CITY OF	31153C0065F	09-JUL-1999	99-07-700A	02
07	NE	BELLEVUE, CITY OF	31153C0070F	27-JUL-1999	99-07-721A	01
07	NE	BUFFALO COUNTY	3104190015B	10-DEC-1999	00-07-076A	02
07	NE	BURT COUNTY	3104200005A	05-AUG-1999	99-07-774A	02
07	NE	COLFAX COUNTY	3104260005B	30-JUL-1999	99-07-735A	02
07	NE	COLUMBUS, CITY OF	3152720005D	25-OCT-1999	99-07-553P	06
07	NE	CRETE, CITY OF	3101860003C	29-NOV-1999	00-07-049A	02
07	NE	CUMING COUNTY	3104270004B	15-JUL-1999	99-07-679A	02
07	NE	CUMING COUNTY	3104270004B	13-AUG-1999	99-07-782A	02
07	NE	CUMING COUNTY	3104270004B	30-SEP-1999	99-07-909A	02
07	NE	DEWITT, VILLAGE OF	3101870005A	06-DEC-1999	00-07-057A	01
07	NE	DODGE COUNTY	3100680150B	22-OCT-1999	00-07-007A	02
07	NE	FREMONT, CITY OF	3100690002C	29-JUL-1999	99-07-749A	01
07	NE	GAGE COUNTY	3100880001B	15-SEP-1999	99-07-845A	02
07	NE	GOTHENBURG, CITY OF	3100620005B	08-NOV-1999	00-07-027A	02
07	NE	GRAND ISLAND, CITY OF	3101030050C	29-OCT-1999	00-07-004A	02
07	NE	GRAND ISLAND, CITY OF	3101030015B	29-OCT-1999	00-07-011A	02
07	NE	GRAND ISLAND, CITY OF	3101030015B	29-OCT-1999	00-07-013A	02
07	NE	GRAND ISLAND, CITY OF	3101030015B	08-NOV-1999	00-07-025A	02
07	NE	GRAND ISLAND, CITY OF	3101030015B	29-NOV-1999	00-07-063A	02
07	NE	GRAND ISLAND, CITY OF	3101030015B	15-DEC-1999	00-07-088A	02
07	NE	GRAND ISLAND, CITY OF	3101030010B	21-DEC-1999	00-07-104A	02
07	NE	GRAND ISLAND, CITY OF	3101030015B	26-JUL-1999	99-07-737A	02
07	NE	GRAND ISLAND, CITY OF	3101030005B	14-JUL-1999	99-07-739A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
07	NE	GRAND ISLAND, CITY OF	3101030020B	26-JUL-1999	99-07-747A	02
07	NE	GRAND ISLAND, CITY OF	3101030010B	05-AUG-1999	99-07-766A	02
07	NE	GRAND ISLAND, CITY OF	3101030010B	18-AUG-1999	99-07-791A	02
07	NE	GRAND ISLAND, CITY OF	3101030010B	18-AUG-1999	99-07-792A	02
07	NE	GRAND ISLAND, CITY OF	3101030020B	23-AUG-1999	99-07-804A	02
07	NE	GRAND ISLAND, CITY OF	3101030020B	26-AUG-1999	99-07-813A	02
07	NE	GRAND ISLAND, CITY OF	3101030020B	27-AUG-1999	99-07-819A	02
07	NE	GRAND ISLAND, CITY OF	3101030015B	02-SEP-1999	99-07-836A	02
07	NE	GRAND ISLAND, CITY OF	3101030010B	17-SEP-1999	99-07-877A	02
07	NE	GRAND ISLAND, CITY OF	3101030020B	13-SEP-1999	99-07-883A	02
07	NE	GRAND ISLAND, CITY OF	3101030020B	22-SEP-1999	99-07-893A	02
07	NE	GRAND ISLAND, CITY OF	3101030015B	30-SEP-1999	99-07-901A	02
07	NE	GRAND ISLAND, CITY OF	3101030020B	30-SEP-1999	99-07-903A	02
07	NE	GRAND ISLAND, CITY OF	3101030010B	08-OCT-1999	99-07-924A	02
07	NE	GRAND ISLAND, CITY OF	3101030010B	08-OCT-1999	99-07-926A	02
07	NE	GRAND ISLAND, CITY OF	3101030015B	13-OCT-1999	99-07-928A	02
07	NE	HALL COUNTY	3101000100C	15-SEP-1999	99-07-754P	06
07	NE	HALL COUNTY	3101000100C	08-SEP-1999	99-07-765A	02
07	NE	HALL COUNTY	3101000025C	13-AUG-1999	99-07-781A	02
07	NE	HALL COUNTY	3101000100C	15-SEP-1999	99-07-873A	02
07	NE	HAMILTON COUNTY	3104410075A	15-JUL-1999	99-07-718A	02
07	NE	HAMILTON COUNTY	3104410050A	15-SEP-1999	99-07-860A	01
07	NE	HAMILTON COUNTY	3104410025A	15-SEP-1999	99-07-869A	02
07	NE	HARTINGTON, CITY OF	3103760005A	27-JUL-1999	99-07-720A	02
07	NE	LINCOLN, CITY OF	3152730025D	22-NOV-1999	00-07-046A	02
07	NE	LINCOLN, CITY OF	3152730025D	18-AUG-1999	99-07-809A	01
07	NE	LINCOLN, CITY OF	3152730025D	13-SEP-1999	99-07-846A	02
07	NE	LINCOLN, CITY OF	3152730025D	24-SEP-1999	99-07-919A	01
07	NE	MERRICK COUNTY	3104570150A	22-NOV-1999	00-07-055A	02
07	NE	MERRICK COUNTY	3104570150A	14-JUL-1999	99-07-696A	02
07	NE	NEMAHA COUNTY	3104600075A	28-JUL-1999	99-07-617A	02
07	NE	NORFOLK, CITY OF	3101470020C	13-AUG-1999	99-07-744A	02
07	NE	OMAHA, CITY OF	3152740045G	15-DEC-1999	00-07-036A	01
07	NE	OMAHA, CITY OF	3152740045G	29-NOV-1999	00-07-045A	02
07	NE	OMAHA, CITY OF	3152740045G	01-DEC-1999	00-07-105A	02
07	NE	OMAHA, CITY OF	3152740040F	23-JUL-1999	99-07-405P	05
07	NE	OMAHA, CITY OF	3152740045G	23-JUL-1999	99-07-405P	05
07	NE	OMAHA, CITY OF	3152740050F	30-SEP-1999	99-07-915A	02
07	NE	OMAHA, CITY OF	3152740025F	22-OCT-1999	99-07-955A	02
07	NE	PAPILLION, CITY OF	31153C0045F	14-JUL-1999	99-07-772P	05
07	NE	PAPILLION, CITY OF	31153C0065F	14-JUL-1999	99-07-772P	05
07	NE	PLATTE COUNTY	3104670009C	17-AUG-1999	99-07-803A	02
07	NE	SARPY COUNTY	31153C0135F	03-NOV-1999	00-07-019A	02
07	NE	SARPY COUNTY	31153C0045F	14-JUL-1999	99-07-772P	05
07	NE	SARPY COUNTY	31153C0065F	14-JUL-1999	99-07-772P	05
07	NE	SCHUYLER, CITY OF	3100460005B	13-OCT-1999	99-07-895A	02
07	NE	SCHUYLER, CITY OF	3100460005B	13-OCT-1999	99-07-937A	02
07	NE	STUART, VILLAGE OF	310400B	14-JUL-1999	99-07-695A	01
07	NE	WASHINGTON COUNTY	3104830100B	15-SEP-1999	99-07-852A	02
07	NE	YORK, CITY OF	3102370010B	01-SEP-1999	99-07-826A	02
08	CO	ADAMS COUNTY	08001C0010G	05-AUG-1999	99-08-109P	06
08	CO	ARAPAHOE COUNTY	08005C0480J	15-JUL-1999	98-08-452P	05
08	CO	ARAPAHOE COUNTY	08005C0345J	12-OCT-1999	99-08-192P	05
08	CO	ARAPAHOE COUNTY	08005C0480J	26-AUG-1999	99-08-193P	05
08	CO	ARAPAHOE COUNTY	08005C0485J	12-OCT-1999	99-08-218P	05
08	CO	ARAPAHOE COUNTY	08005C0505J	19-OCT-1999	99-08-397P	06
08	CO	ARAPAHOE COUNTY	08005C0480J	29-OCT-1999	99-08-421A	01
08	CO	ARAPAHOE COUNTY	08005C0485J	29-OCT-1999	99-08-421A	01
08	CO	BOULDER COUNTY	08013C0288F	05-OCT-1999	99-08-260P	05
08	CO	BOULDER COUNTY	08013C0289F	05-OCT-1999	99-08-260P	05
08	CO	BOULDER, CITY OF	08013C0415F	15-DEC-1999	00-08-017A	02
08	CO	BOULDER, CITY OF	08013C0395F	09-NOV-1999	98-08-169P	05
08	CO	BOULDER, CITY OF	08013C0395F	01-JUL-1999	99-08-258P	06
08	CO	BOULDER, CITY OF	08013C0395F	15-JUL-1999	99-08-268A	02
08	CO	BOULDER, CITY OF	08013C0395F	12-OCT-1999	99-08-343P	05
08	CO	BOULDER, CITY OF	08013C0395F	22-JUL-1999	99-08-347A	02
08	CO	CASTLE ROCK, TOWN OF	0800500170C	03-DEC-1999	99-08-304P	06
08	CO	CASTLE ROCK, TOWN OF	0800500188C	03-DEC-1999	99-08-304P	06
08	CO	CHAFFEE COUNTY	0802690210B	13-OCT-1999	99-08-437A	02
08	CO	CHERRY HILLS VILLAGE, CITY OF	08005C0170J	27-JUL-1999	99-08-330A	01
08	CO	COLORADO SPRINGS, CITY OF	08041C0761F	14-DEC-1999	98-08-372P	06
08	CO	COLORADO SPRINGS, CITY OF	08041C0503F	01-JUL-1999	99-08-074P	05
08	CO	COLUMBINE VALLEY, TOWN OF	08005C0345J	12-OCT-1999	99-08-192P	05

Region	State	Community	Map panel	Determination date	Case No.	Type
08	CO	DENVER, CITY AND COUNTY OF	0800460008C	22-DEC-1999	98-08-440P	06
08	CO	DENVER, CITY AND COUNTY OF	0800460018C	24-SEP-1999	99-08-388A	02
08	CO	DENVER, CITY AND COUNTY OF	0800460012F	22-OCT-1999	99-08-446A	02
08	CO	DOUGLAS COUNTY	0800490070E	12-OCT-1999	99-08-218P	05
08	CO	DOUGLAS COUNTY	0800490170C	03-DEC-1999	99-08-304P	06
08	CO	DOUGLAS COUNTY	0800490188C	03-DEC-1999	99-08-304P	06
08	CO	EAGLE COUNTY	0800510240C	11-AUG-1999	99-08-300A	02
08	CO	EATON, TOWN OF	0801800001C	08-DEC-1999	00-08-046A	02
08	CO	EL PASO COUNTY	08041C0490F	20-DEC-1999	00-08-030A	02
08	CO	EL PASO COUNTY	08041C0575F	07-JUL-1999	99-08-322A	02
08	CO	EL PASO COUNTY	08041C0276F	05-OCT-1999	99-08-415A	17
08	CO	ESTES PARK,TOWN OF	0801930002B	17-SEP-1999	99-08-379A	02
08	CO	ESTES PARK,TOWN OF	0801930001B	18-AUG-1999	99-08-384A	02
08	CO	FORT COLLINS, CITY OF	0801020004C	22-DEC-1999	99-08-307P	05
08	CO	FORT COLLINS, CITY OF	0801020012C	22-DEC-1999	99-08-307P	05
08	CO	FORT COLLINS, CITY OF	0801020016C	22-DEC-1999	99-08-307P	05
08	CO	FREMONT COUNTY	0800670275B	22-OCT-1999	99-08-443A	02
08	CO	FREMONT COUNTY	0800670325B	13-DEC-1999	99-08-451A	02
08	CO	GILPIN COUNTY	080075B	02-SEP-1999	99-08-339A	02
08	CO	GILPIN COUNTY	080075B	08-SEP-1999	99-08-394A	02
08	CO	GUNNISON COUNTY	0800780775B	30-JUL-1999	99-08-338A	02
08	CO	GUNNISON COUNTY	0800780755B	13-SEP-1999	99-08-406A	02
08	CO	GUNNISON COUNTY	0800780800B	12-NOV-1999	99-08-440A	02
08	CO	GYPSUM, TOWN OF	0802950001C	05-OCT-1999	99-08-434P	05
08	CO	JEFFERSON COUNTY	0800870380C	22-NOV-1999	00-08-018A	02
08	CO	JEFFERSON COUNTY	0800870170B	15-DEC-1999	00-08-053A	02
08	CO	JEFFERSON COUNTY	0800870165B	22-DEC-1999	99-08-365P	05
08	CO	LARIMER COUNTY	0801010179E	22-DEC-1999	99-08-307P	05
08	CO	LARIMER COUNTY	0801010193E	22-DEC-1999	99-08-307P	05
08	CO	LOGAN COUNTY	0801100335B	15-DEC-1999	00-08-052A	01
08	CO	LOGAN COUNTY	0801100335B	12-JUL-1999	99-08-299A	02
08	CO	LONGMONT, CITY OF	08013C0288F	05-OCT-1999	99-08-260P	05
08	CO	LONGMONT, CITY OF	08013C0289F	05-OCT-1999	99-08-260P	05
08	CO	MONTEZUMA COUNTY	0802850225B	15-SEP-1999	99-08-407A	02
08	CO	MORGAN COUNTY	0801290175C	03-NOV-1999	99-08-423A	02
08	CO	SEVERANCE, TOWN OF	0803170001A	03-NOV-1999	99-08-427A	01
08	CO	TELLURIDE, TOWN OF	08113C0287D	24-AUG-1999	99-08-372A	01
08	CO	THORNTON, CITY OF	08001C0030G	06-DEC-1999	00-08-011P	06
08	CO	THORNTON, CITY OF	08001C0036G	06-DEC-1999	00-08-011P	06
08	CO	WALDEN, TOWN OF	080086B	28-OCT-1999	00-08-003A	02
08	CO	WESTMINSTER, CITY OF	08001C0010G	05-AUG-1999	99-08-109P	06
08	CO	WESTMINSTER, CITY OF	0800080007D	16-AUG-1999	99-08-284P	05
08	MT	FLATHEAD COUNTY	3000232290C	22-NOV-1999	00-08-021A	02
08	MT	FLATHEAD COUNTY	3000232290C	30-SEP-1999	99-08-398A	02
08	MT	GALLATIN COUNTY	3000270315B	17-AUG-1999	99-08-316A	02
08	MT	GALLATIN COUNTY	3000270305B	07-JUL-1999	99-08-323A	02
08	MT	MISSOULA COUNTY	30063C1215D	27-AUG-1999	99-08-362A	02
08	MT	MISSOULA COUNTY	30063C1465D	06-AUG-1999	99-08-368A	02
08	MT	MISSOULA COUNTY	30063C1480D	01-SEP-1999	99-08-370A	02
08	MT	MISSOULA COUNTY	30063C1460D	10-SEP-1999	99-08-380A	02
08	MT	MISSOULA, CITY OF	30063C1480D	07-OCT-1999	99-08-432A	02
08	MT	PARK COUNTY	3001600016B	17-SEP-1999	99-08-320A	02
08	MT	PARK COUNTY	3001600016B	22-OCT-1999	99-08-381A	02
08	MT	RAVALLI COUNTY	30081C0035C	30-SEP-1999	99-08-290A	02
08	MT	RAVALLI COUNTY	30081C0035C	24-AUG-1999	99-08-302A	02
08	MT	RAVALLI COUNTY	30081C0035C	01-SEP-1999	99-08-389A	02
08	MT	RAVALLI COUNTY	30081C0035C	07-SEP-1999	99-08-402A	02
08	MT	RICHLAND COUNTY	3001650525B	05-AUG-1999	99-08-361A	02
08	MT	SANDERS COUNTY	3000720023B	22-OCT-1999	99-08-310A	02
08	MT	SIDNEY, CITY OF	3000650005B	25-AUG-1999	99-08-350A	01
08	MT	TETON COUNTY	3001680400B	15-NOV-1999	00-08-007A	02
08	MT	THREE FORKS, TOWN OF	3000290001B	29-NOV-1999	00-08-025A	02
08	MT	WHITEFISH, CITY OF	3000231090C	25-OCT-1999	00-08-009A	02
08	ND	BISMARCK, CITY OF	3801490015A	15-JUL-1999	99-08-329A	02
08	ND	BISMARCK, CITY OF	3801490025A	19-OCT-1999	99-08-413A	01
08	ND	BRANDENBURG, TOWNSHIP OF	3806220001B	27-JUL-1999	99-08-341A	02
08	ND	CENTER,TOWNSHIP OF	3806480005B	29-JUL-1999	99-08-355A	02
08	ND	DICKINSON, CITY OF	3801170005D	22-DEC-1999	00-08-061A	02
08	ND	HAZEN, CITY OF	3800670005D	15-DEC-1999	00-08-050A	02
08	ND	MANDAN, CITY OF	3800720020D	26-JUL-1999	99-08-336A	01
08	ND	MAPLETON, TOWNSHIP OF	3802620001B	10-SEP-1999	99-08-385A	01
08	ND	PARK RIVER, CITY OF	3801390002B	15-DEC-1999	99-08-448A	17
08	ND	PLEASANT, TOWNSHIP OF	3802630025A	26-JUL-1999	99-08-353A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
08	ND	STANLEY, TOWNSHIP OF	3802580005B	20-SEP-1999	99-08-403A	02
08	ND	WALSH COUNTY	3801350008B	15-JUL-1999	99-08-175A	02
08	SD	BOX ELDER, CITY OF	4600890002B	13-SEP-1999	99-08-405A	01
08	SD	BROWN COUNTY	46013C0265C	26-OCT-1999	99-08-246A	01
08	SD	CLARK, CITY OF	460013B	29-JUL-1999	99-08-308A	02
08	SD	CUSTER COUNTY	4600180225B	24-SEP-1999	99-08-417A	02
08	SD	LAKE COUNTY	4602760150B	13-OCT-1999	00-08-010A	02
08	SD	LEAD, CITY OF	4600940125B	26-OCT-1999	99-08-442A	02
08	SD	LINCOLN COUNTY	4602770001B	13-AUG-1999	99-08-375A	02
08	SD	LINCOLN COUNTY	4602770001B	29-OCT-1999	99-08-449A	02
08	SD	PHILIP, CITY OF	460033B	22-JUL-1999	99-08-335A	02
08	SD	RAPID CITY, CITY OF	4654200008F	13-DEC-1999	00-08-036A	01
08	SD	SIOUX FALLS, CITY OF	4600570110B	09-AUG-1999	99-08-328A	01
08	SD	SIOUX FALLS, CITY OF	4600600015C	15-NOV-1999	99-08-414A	01
08	SD	SPEARFISH, CITY OF	4600460001D	15-JUL-1999	99-08-271A	01
08	SD	SPEARFISH, CITY OF	4600460005D	25-OCT-1999	99-08-360A	02
08	SD	SPEARFISH, CITY OF	4600460001D	03-AUG-1999	99-08-383A	01
08	SD	WATERTOWN, CITY OF	4600160010B	26-AUG-1999	99-08-358A	02
08	SD	WATERTOWN, CITY OF	4600160010B	03-NOV-1999	99-08-429A	02
08	SD	YANKTON COUNTY	4600880006C	13-DEC-1999	99-08-282A	02
08	UT	DAVIS COUNTY	4900380070B	26-OCT-1999	98-08-447P	05
08	UT	GARFIELD COUNTY	4900650450B	01-SEP-1999	99-08-354A	02
08	UT	GARFIELD COUNTY	4900650450B	01-SEP-1999	99-08-400A	02
08	UT	KAYSVILLE, CITY OF	4900460001B	26-OCT-1999	98-08-447P	05
08	UT	KAYSVILLE, CITY OF	4900460002B	26-OCT-1999	98-08-447P	05
08	UT	MORGAN COUNTY	4900920085B	24-SEP-1999	99-08-420A	02
08	UT	RICHMOND, CITY OF	4900270005A	06-AUG-1999	99-08-313A	02
08	UT	SALT LAKE CITY, CITY OF	4901050031A	29-NOV-1999	99-08-447A	02
08	UT	SALT LAKE COUNTY	4901020431C	19-JUL-1999	98-08-220P	05
08	UT	SALT LAKE COUNTY	4901020450B	19-JUL-1999	98-08-220P	05
08	UT	SALT LAKE COUNTY	4901020425B	09-JUL-1999	99-08-276A	02
08	UT	SANDY CITY, CITY OF	4901060012C	08-DEC-1999	00-08-002A	02
08	UT	SOUTH JORDAN, CITY OF	4901070006C	19-JUL-1999	98-08-220P	05
08	UT	TOQUERVILLE, CITY OF	4901800005A	09-DEC-1999	99-08-357A	02
08	UT	UINTAH COUNTY	4901470010C	24-AUG-1999	99-08-255A	02
08	UT	WASATCH COUNTY	490164D	24-AUG-1999	99-08-392A	02
08	UT	WASHINGTON,CITY OF	4901820015C	26-JUL-1999	99-08-345A	02
08	UT	WELLSVILLE, CITY OF	4900310001B	03-AUG-1999	99-08-364A	02
08	UT	WEST JORDAN, CITY OF	4901080005D	19-JUL-1999	98-08-220P	05
08	UT	WEST JORDAN, CITY OF	4901080006D	19-JUL-1999	98-08-220P	05
08	UT	WEST JORDAN, CITY OF	4901080008D	19-JUL-1999	98-08-220P	05
08	UT	WEST JORDAN, CITY OF	4901080005D	22-DEC-1999	99-08-116P	06
08	UT	WEST JORDAN, CITY OF	4901080006D	24-SEP-1999	99-08-418A	02
08	WY	CHEYENNE, CITY OF	5600300005E	10-AUG-1999	99-08-348A	02
08	WY	GREEN RIVER, TOWN OF	5600500005B	22-SEP-1999	99-08-411A	01
08	WY	LARAMIE COUNTY	5600290515E	17-DEC-1999	00-08-034A	02
08	WY	PARK COUNTY	5600850022B	22-JUL-1999	99-08-342A	02
08	WY	ROCK SPRINGS, CITY OF	5600510005E	19-OCT-1999	99-08-439A	02
08	WY	UINTA COUNTY	5600530150B	03-NOV-1999	99-08-311A	02
08	WY	UINTA COUNTY	5600530475B	25-OCT-1999	99-08-390A	02
09	AZ	APACHE JUNCTION, CITY OF	0400770125D	29-NOV-1999	99-09-1029A	01
09	AZ	CAMP VERDE, TOWN OF	0401311085E	24-SEP-1999	99-09-1218A	02
09	AZ	CLIFTON, TOWN OF	0400350001B	23-AUG-1999	99-09-361P	05
09	AZ	CLIFTON, TOWN OF	0400350002B	23-AUG-1999	99-09-361P	05
09	AZ	GILA COUNTY	0400280280B	27-SEP-1999	99-09-1148A	02
09	AZ	GILBERT, TOWN OF	04013C2660E	22-SEP-1999	99-09-1163A	01
09	AZ	GILBERT, TOWN OF	04013C2690F	28-SEP-1999	99-09-509P	05
09	AZ	GILBERT, TOWN OF	04013C2695F	28-SEP-1999	99-09-509P	05
09	AZ	GLENDALE, CITY OF	04013C1640D	26-OCT-1999	00-09-006A	01
09	AZ	GLENDALE, CITY OF	04013C1640D	20-DEC-1999	00-09-183A	01
09	AZ	GLENDALE, CITY OF	04013C1640D	11-AUG-1999	99-09-1042A	01
09	AZ	GOODYEAR, CITY OF	04013C2080G	22-SEP-1999	99-09-1180A	01
09	AZ	GOODYEAR, CITY OF	04013C2080G	14-JUL-1999	99-09-940A	01
09	AZ	MARANA, TOWN OF	04019C0980K	16-NOV-1999	00-09-047A	02
09	AZ	MARANA, TOWN OF	04019C1605K	31-AUG-1999	98-09-353P	05
09	AZ	MARICOPA COUNTY	04013C0395F	16-AUG-1999	99-09-1019A	02
09	AZ	MARICOPA COUNTY	04013C2695F	28-OCT-1999	99-09-1296P	05
09	AZ	MARICOPA COUNTY	04013C2715E	28-OCT-1999	99-09-1296P	05
09	AZ	MARICOPA COUNTY	04013C3080F	28-OCT-1999	99-09-1296P	05
09	AZ	MARICOPA COUNTY	04013C2695F	28-SEP-1999	99-09-509P	05
09	AZ	MARICOPA COUNTY	04013C2715F	28-SEP-1999	99-09-509P	05
09	AZ	MARICOPA COUNTY	04013C3080F	28-SEP-1999	99-09-509P	05
09	AZ	MARICOPA COUNTY	04013C0815G	13-JUL-1999	99-09-765A	01

Region	State	Community	Map panel	Determination date	Case No.	Type
09	AZ	MESA, CITY OF	04013C2185E	22-SEP-1999	99-09-1034A	02
09	AZ	MESA, CITY OF	04013C2195E	03-AUG-1999	99-09-1050A	02
09	AZ	MESA, CITY OF	04013C2215F	01-SEP-1999	99-09-1132A	02
09	AZ	MESA, CITY OF	04013C2195E	08-DEC-1999	99-09-1219A	01
09	AZ	MESA, CITY OF	04013C2695F	28-SEP-1999	99-09-509P	05
09	AZ	MESA, CITY OF	04013C2195E	15-JUL-1999	99-09-945A	02
09	AZ	MOHAVE COUNTY	0400583110B	14-JUL-1999	99-09-980A	02
09	AZ	NAVAJO COUNTY	0400662467C	10-DEC-1999	00-09-129A	02
09	AZ	ORO VALLEY, TOWN OF	04019C1020K	14-JUL-1999	99-09-783P	06
09	AZ	ORO VALLEY, TOWN OF	04019C1020K	13-AUG-1999	99-09-822P	06
09	AZ	ORO VALLEY, TOWN OF	04019C1040K	13-AUG-1999	99-09-822P	06
09	AZ	ORO VALLEY, TOWN OF	04019C1020K	09-JUL-1999	99-09-870A	01
09	AZ	PEORIA, CITY OF	04013C1630F	06-JUL-1999	99-09-522P	05
09	AZ	PHOENIX, CITY OF	04013C1655H	08-NOV-1999	00-09-028A	02
09	AZ	PHOENIX, CITY OF	04013C1655H	08-NOV-1999	00-09-030A	02
09	AZ	PHOENIX, CITY OF	04013C1655H	10-NOV-1999	00-09-040A	02
09	AZ	PHOENIX, CITY OF	04013C1655H	29-NOV-1999	00-09-105A	02
09	AZ	PHOENIX, CITY OF	04013C1195D	22-JUL-1999	99-09-1044A	01
09	AZ	PHOENIX, CITY OF	04013C1215H	22-JUL-1999	99-09-1044A	01
09	AZ	PHOENIX, CITY OF	04013C1195D	26-JUL-1999	99-09-1045A	01
09	AZ	PHOENIX, CITY OF	04013C1215H	26-JUL-1999	99-09-1045A	01
09	AZ	PHOENIX, CITY OF	04013C1655H	11-AUG-1999	99-09-1083A	02
09	AZ	PHOENIX, CITY OF	04013C2610D	15-SEP-1999	99-09-1085A	01
09	AZ	PHOENIX, CITY OF	04013C1665G	07-OCT-1999	99-09-1169A	02
09	AZ	PHOENIX, CITY OF	04013C1195D	12-OCT-1999	99-09-1176A	01
09	AZ	PHOENIX, CITY OF	04013C1215H	12-OCT-1999	99-09-1176A	01
09	AZ	PHOENIX, CITY OF	04013C1210F	30-DEC-1999	99-09-1266A	01
09	AZ	PIMA COUNTY	04019C1605K	01-DEC-1999	00-09-023A	02
09	AZ	PIMA COUNTY	04019C1605K	31-AUG-1999	98-09-353P	05
09	AZ	PIMA COUNTY	04019C3905K	01-OCT-1999	98-09-442P	05
09	AZ	PIMA COUNTY	04019C1645K	27-JUL-1999	99-09-1001A	02
09	AZ	PIMA COUNTY	04019C1615K	02-SEP-1999	99-09-1138A	02
09	AZ	PIMA COUNTY	04019C1645K	07-SEP-1999	99-09-1157A	02
09	AZ	PIMA COUNTY	04019C1610K	05-OCT-1999	99-09-1225A	02
09	AZ	PIMA COUNTY	04019C1645K	05-OCT-1999	99-09-1235A	02
09	AZ	PIMA COUNTY	04019C1655K	19-AUG-1999	99-09-690A	02
09	AZ	PIMA COUNTY	04019C1020K	14-JUL-1999	99-09-783P	06
09	AZ	PIMA COUNTY	04019C1015K	15-JUL-1999	99-09-847A	02
09	AZ	QUEEN CREEK, TOWN OF	04013C2695F	28-OCT-1999	99-09-1296P	05
09	AZ	QUEEN CREEK, TOWN OF	04013C2715E	28-OCT-1999	99-09-1296P	05
09	AZ	QUEEN CREEK, TOWN OF	04013C3080F	28-OCT-1999	99-09-1296P	05
09	AZ	QUEEN CREEK, TOWN OF	04013C2695F	28-SEP-1999	99-09-509P	05
09	AZ	QUEEN CREEK, TOWN OF	04013C2715F	28-SEP-1999	99-09-509P	05
09	AZ	QUEEN CREEK, TOWN OF	04013C3080F	28-SEP-1999	99-09-509P	05
09	AZ	SAHUARITA, TOWN OF	04019C3415K	01-OCT-1999	98-09-442P	05
09	AZ	SAHUARITA, TOWN OF	04019C3905K	01-OCT-1999	98-09-442P	05
09	AZ	SANTA CRUZ COUNTY	0400900145A	21-SEP-1999	98-09-010P	05
09	AZ	SCOTTSDALE, CITY OF	04013C0820E	19-JUL-1999	99-09-1018A	01
09	AZ	SCOTTSDALE, CITY OF	04013C1695F	13-OCT-1999	99-09-1253A	02
09	AZ	TEMPE, CITY OF	04013C2165F	12-OCT-1999	99-09-1229A	02
09	AZ	TUCSON, CITY OF	04019C2253K	22-OCT-1999	00-09-014A	02
09	AZ	TUCSON, CITY OF	04019C2253K	19-OCT-1999	00-09-018A	02
09	AZ	TUCSON, CITY OF	04019C2253K	10-NOV-1999	00-09-039A	02
09	AZ	TUCSON, CITY OF	04019C1639K	15-NOV-1999	00-09-053A	02
09	AZ	TUCSON, CITY OF	04019C2256K	30-JUL-1999	99-09-1011A	17
09	AZ	TUCSON, CITY OF	04019C2232K	24-AUG-1999	99-09-1112A	02
09	AZ	TUCSON, CITY OF	04019C2232K	13-SEP-1999	99-09-1160A	02
09	AZ	TUCSON, CITY OF	04019C2232K	24-SEP-1999	99-09-1185A	02
09	AZ	TUCSON, CITY OF	04019C2232K	28-SEP-1999	99-09-1221A	02
09	AZ	TUCSON, CITY OF	04019C1670K	05-OCT-1999	99-09-1227A	02
09	AZ	TUCSON, CITY OF	04019C2251K	19-OCT-1999	99-09-1264A	02
09	AZ	TUCSON, CITY OF	04019C1619K	05-OCT-1999	99-09-1277A	02
09	AZ	TUCSON, CITY OF	04019C2251K	08-DEC-1999	99-09-1285A	02
09	AZ	TUCSON, CITY OF	04019C2258K	02-SEP-1999	99-09-314P	05
09	AZ	TUCSON, CITY OF	04019C2252K	10-SEP-1999	99-09-700P	05
09	AZ	TUCSON, CITY OF	04019C2256K	10-SEP-1999	99-09-700P	05
09	AZ	TUCSON, CITY OF	04019C2227K	13-AUG-1999	99-09-733A	02
09	AZ	TUCSON, CITY OF	04019C1644K	02-AUG-1999	99-09-894A	02
09	AZ	TUCSON, CITY OF	04019C2232K	17-AUG-1999	99-09-946A	02
09	AZ	TUCSON, CITY OF	04019C1639K	13-AUG-1999	99-09-952A	02
09	AZ	TUCSON, CITY OF	04019C2227K	19-JUL-1999	99-09-991A	02
09	AZ	WICKENBURG, TOWN OF	04013C0235E	08-DEC-1999	00-09-035A	02
09	CA	ALAMEDA COUNTY	0600010095B	09-AUG-1999	99-09-766A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
09	CA	ANAHEIM, CITY OF	06059C0021F	22-DEC-1999	00-09-081P	05
09	CA	ANDERSON, CITY OF	0603590001C	22-OCT-1999	99-09-1098A	01
09	CA	APPLE VALLEY, CITY OF	06071C5845F	15-SEP-1999	99-09-1105A	01
09	CA	BAKERSFIELD, CITY OF	0600751000B	05-OCT-1999	99-09-1120P	06
09	CA	BAKERSFIELD, CITY OF	0600751015B	05-OCT-1999	99-09-1120P	06
09	CA	BAKERSFIELD, CITY OF	0600770022B	05-OCT-1999	99-09-1120P	06
09	CA	BELMONT, CITY OF	0650160005B	15-JUL-1999	99-09-247P	06
09	CA	BENICIA, CITY OF	0603680002C	24-SEP-1999	99-09-1209A	02
09	CA	BRENTWOOD, CITY OF	0600250355B	29-NOV-1999	00-09-058A	01
09	CA	BRENTWOOD, CITY OF	0600250365B	10-SEP-1999	99-09-990A	02
09	CA	BUTTE COUNTY	06007C0985C	29-NOV-1999	00-09-100A	02
09	CA	BUTTE COUNTY	06007C0505C	10-AUG-1999	99-09-1069A	02
09	CA	BUTTE COUNTY	06007C0485C	15-SEP-1999	99-09-965A	02
09	CA	CALABASAS, CITY OF	0650430613B	02-SEP-1999	99-09-334P	05
09	CA	CALAVERAS COUNTY	0606330133B	20-DEC-1999	00-09-041A	02
09	CA	CALIFORNIA CITY, CITY OF	0604400068C	26-OCT-1999	99-09-1293A	02
09	CA	CALISTOGA, CITY OF	0602060005B	08-SEP-1999	99-09-1147A	02
09	CA	CAMARILLO, CITY OF	0650200006B	22-NOV-1999	99-09-1122A	01
09	CA	CANYON LAKE, CITY OF	0602452090C	17-SEP-1999	99-09-1139A	01
09	CA	CARSON, CITY OF	0601070005A	08-SEP-1999	99-09-903A	02
09	CA	CARSON, CITY OF	0601070005A	09-JUL-1999	99-09-910A	02
09	CA	CHICO, CITY OF	06007C0505C	09-DEC-1999	00-09-013A	02
09	CA	CHULA VISTA, CITY OF	06073C1917F	15-NOV-1999	00-09-043A	02
09	CA	CITRUS HEIGHTS, CITY OF	0602620095E	25-OCT-1999	00-09-022A	02
09	CA	CITRUS HEIGHTS, CITY OF	0602620090E	16-NOV-1999	00-09-026A	02
09	CA	CITRUS HEIGHTS, CITY OF	0602620085E	10-DEC-1999	00-09-107A	01
09	CA	CITRUS HEIGHTS, CITY OF	0602620085E	13-DEC-1999	00-09-161A	02
09	CA	CITRUS HEIGHTS, CITY OF	0602620085E	22-OCT-1999	99-09-1267A	02
09	CA	COLUSA COUNTY	060022D	29-NOV-1999	00-09-101A	02
09	CA	CONTRA COSTA COUNTY	0600250435C	15-DEC-1999	00-09-173A	17
09	CA	CONTRA COSTA COUNTY	0600250230B	07-SEP-1999	99-09-1146A	02
09	CA	CONTRA COSTA COUNTY	0600250435C	15-SEP-1999	99-09-1174A	02
09	CA	CONTRA COSTA COUNTY	0600250350B	25-OCT-1999	99-09-1282A	02
09	CA	CORONA, CITY OF	0602500005F	05-AUG-1999	99-09-435P	05
09	CA	CORONADO, CITY OF	06073C2132F	09-DEC-1999	99-09-662P	06
09	CA	COSTA MESA, CITY OF	06059C0037F	29-NOV-1999	00-09-082A	02
09	CA	DAVIS, CITY OF	0604230575C	08-DEC-1999	00-09-086A	01
09	CA	DAVIS, CITY OF	0604230575C	02-SEP-1999	99-09-1137A	01
09	CA	DAVIS, CITY OF	0604230560C	23-SEP-1999	99-09-1251A	01
09	CA	DAVIS, CITY OF	0604230575C	17-AUG-1999	99-09-985A	01
09	CA	DINUBA, CITY OF	0650660280B	08-DEC-1999	00-09-116A	01
09	CA	DINUBA, CITY OF	0604030001B	09-AUG-1999	99-09-1061A	01
09	CA	DINUBA, CITY OF	0604030001B	03-NOV-1999	99-09-1257A	01
09	CA	EL DORADO COUNTY	0600400450B	22-SEP-1999	99-09-1206A	02
09	CA	ESCONDIDO, CITY OF	06073C1081F	03-NOV-1999	99-09-1279A	02
09	CA	ESCONDIDO, CITY OF	06073C1083F	22-JUL-1999	99-09-927A	02
09	CA	EUREKA, CITY OF	0600620005C	22-JUL-1999	99-09-652A	02
09	CA	FAIRFIELD, CITY OF	0603700002C	15-NOV-1999	99-09-1273A	02
09	CA	FREMONT, CITY OF	0650280045C	13-AUG-1999	99-09-1094A	01
09	CA	FREMONT, CITY OF	0650280046C	13-AUG-1999	99-09-1094A	01
09	CA	FRESNO COUNTY	0650290920B	25-OCT-1999	00-09-011A	02
09	CA	FRESNO COUNTY	0650290895C	17-SEP-1999	99-09-1121A	02
09	CA	FRESNO COUNTY	0650290915B	22-NOV-1999	99-09-1269A	02
09	CA	FRESNO COUNTY	0650291400B	13-SEP-1999	99-09-879A	02
09	CA	FRESNO, CITY OF	0650290590C	29-OCT-1999	00-09-015A	01
09	CA	FRESNO, CITY OF	0650290590C	26-AUG-1999	99-09-1110A	01
09	CA	FRESNO, CITY OF	0600480035D	25-OCT-1999	99-09-1280A	02
09	CA	GLENN COUNTY	0600570400C	05-OCT-1999	99-09-1099A	01
09	CA	HEMET, CITY OF	0602530005D	17-DEC-1999	00-09-163A	01
09	CA	HEMET, CITY OF	0602530005D	01-SEP-1999	99-09-1156A	01
09	CA	HEMET, CITY OF	0602530005D	01-SEP-1999	99-09-1178A	01
09	CA	HUMBOLDT COUNTY	0600600785C	15-JUL-1999	99-09-823A	02
09	CA	HUMBOLDT COUNTY	0600601725B	09-JUL-1999	99-09-915A	02
09	CA	INDIAN WELLS, CITY OF	0602540005D	24-AUG-1999	99-09-465P	05
09	CA	IRVINE, CITY OF	06059C0049G	01-SEP-1999	99-09-1006A	02
09	CA	IRVINE, CITY OF	06059C0049G	18-AUG-1999	99-09-1014P	06
09	CA	IRVINE, CITY OF	06059C0057E	18-AUG-1999	99-09-1014P	06
09	CA	IRVINE, CITY OF	06059C0030E	29-DEC-1999	99-09-1031P	05
09	CA	IRVINE, CITY OF	06059C0031E	29-DEC-1999	99-09-1031P	05
09	CA	IRVINE, CITY OF	06059C0039E	29-DEC-1999	99-09-1031P	05
09	CA	IRVINE, CITY OF	06059C0040E	29-DEC-1999	99-09-1031P	05
09	CA	IRVINE, CITY OF	06059C0056E	02-AUG-1999	99-09-1066A	02
09	CA	IRVINE, CITY OF	06059C0039E	13-SEP-1999	99-09-382P	05

Region	State	Community	Map panel	Determination date	Case No.	Type
09	CA	KERN COUNTY	0600751275B	15-JUL-1999	99-09-1008A	01
09	CA	LA QUINTA, CITY OF	0607090005B	17-DEC-1999	99-09-1073A	01
09	CA	LA QUINTA, CITY OF	0607090005B	09-AUG-1999	99-09-494A	01
09	CA	LAGUNA BEACH, CITY OF	06059C0069E	09-JUL-1999	99-09-651A	02
09	CA	LAGUNA HILLS, CITY OF	06059C0064E	08-DEC-1999	00-09-102A	02
09	CA	LAKE FOREST, CITY OF	06059C0049G	18-AUG-1999	99-09-1014P	06
09	CA	LAKEWOOD, CITY OF	0601300005A	07-JUL-1999	99-09-977A	02
09	CA	LAKEWOOD, CITY OF	0601300005A	07-JUL-1999	99-09-986A	02
09	CA	LIVERMORE, CITY OF	0600080005B	15-SEP-1999	99-09-1165A	02
09	CA	LODI, CITY OF	0603000001E	22-SEP-1999	99-09-1188A	02
09	CA	LONG BEACH, CITY OF	0601360025C	06-AUG-1999	99-09-1007A	01
09	CA	LONG BEACH, CITY OF	0601360015C	02-AUG-1999	99-09-1038A	02
09	CA	LONG BEACH, CITY OF	0601360015C	23-AUG-1999	99-09-1106A	02
09	CA	LONG BEACH, CITY OF	0601360015C	07-OCT-1999	99-09-1238A	02
09	CA	LONG BEACH, CITY OF	0601360025C	17-AUG-1999	99-09-996A	01
09	CA	LOS ANGELES COUNTY	0650430395B	11-AUG-1999	99-09-752A	02
09	CA	LOS ANGELES COUNTY	0650430757B	15-JUL-1999	99-09-892A	02
09	CA	LOS ANGELES, CITY OF	0601370056C	08-DEC-1999	00-09-020A	02
09	CA	LOS ANGELES, CITY OF	0601370071C	22-NOV-1999	00-09-034A	02
09	CA	LOS ANGELES, CITY OF	0601370071C	02-AUG-1999	99-09-1039A	02
09	CA	MARIN COUNTY	0601730250A	22-DEC-1999	00-09-181A	02
09	CA	MARIN COUNTY	0601730216A	01-DEC-1999	99-09-1292A	02
09	CA	MENDOCINO COUNTY	0601830794B	12-JUL-1999	99-09-795A	02
09	CA	MENLO PARK, CITY OF	0603210007D	16-AUG-1999	99-09-1037A	02
09	CA	MENLO PARK, CITY OF	0603210008D	07-JUL-1999	99-09-968A	02
09	CA	MENLO PARK, CITY OF	0603210007D	22-JUL-1999	99-09-993A	02
09	CA	MENLO PARK, CITY OF	0603210008D	27-JUL-1999	99-09-997A	02
09	CA	MERCED, CITY OF	06047C0440E	30-DEC-1999	00-09-008A	01
09	CA	MILPITAS, CITY OF	0603440003G	02-NOV-1999	99-09-1200P	05
09	CA	MILPITAS, CITY OF	0603440003G	28-SEP-1999	99-09-1212A	01
09	CA	MODESTO, CITY OF	0603870015C	15-DEC-1999	99-09-740P	05
09	CA	MODESTO, CITY OF	0603870020C	15-DEC-1999	99-09-740P	05
09	CA	MONTEREY COUNTY	0601950215D	27-JUL-1999	99-09-963A	02
09	CA	MORRO BAY, CITY OF	0603070005C	22-NOV-1999	00-09-072A	02
09	CA	MORRO BAY, CITY OF	0603070005C	27-AUG-1999	99-09-912A	02
09	CA	MURRIETA, CITY OF	0607512730A	29-OCT-1999	00-09-007A	01
09	CA	MURRIETA, CITY OF	0607512745A	15-DEC-1999	00-09-157A	01
09	CA	MURRIETA, CITY OF	0607512740A	19-OCT-1999	99-09-1070P	05
09	CA	MURRIETA, CITY OF	0607512740A	22-JUL-1999	99-09-792A	01
09	CA	MURRIETA, CITY OF	0607512730A	07-JUL-1999	99-09-876A	01
09	CA	NAPA, CITY OF	0602070005C	08-DEC-1999	00-09-134A	02
09	CA	NAPA, CITY OF	0602070005C	15-DEC-1999	00-09-174A	02
09	CA	NAPA, CITY OF	0602070005C	19-AUG-1999	99-09-1058A	01
09	CA	NAPA, CITY OF	0602070010C	24-AUG-1999	99-09-1107A	02
09	CA	NAPA, CITY OF	0602070005C	01-SEP-1999	99-09-1134A	02
09	CA	NAPA, CITY OF	0602070005C	10-SEP-1999	99-09-1145A	02
09	CA	NAPA, CITY OF	0602070005C	04-NOV-1999	99-09-1155A	02
09	CA	NAPA, CITY OF	0602070005C	15-SEP-1999	99-09-1167A	02
09	CA	NAPA, CITY OF	0602070010C	15-JUL-1999	99-09-961A	02
09	CA	NATIONAL CITY, CITY OF	06073C1912F	08-NOV-1999	99-09-1205A	02
09	CA	NORCO, CITY OF	0602560003B	05-AUG-1999	99-09-435P	05
09	CA	NOVATO, CITY OF	0601780004C	29-OCT-1999	99-09-1216A	02
09	CA	OCEANSIDE, CITY OF	06073C0468F	24-NOV-1999	00-09-019P	06
09	CA	OCEANSIDE, CITY OF	06073C0734F	24-NOV-1999	00-09-019P	06
09	CA	OCEANSIDE, CITY OF	06073C0751F	24-NOV-1999	00-09-019P	06
09	CA	OCEANSIDE, CITY OF	06073C0752F	24-NOV-1999	00-09-019P	06
09	CA	OCEANSIDE, CITY OF	06073C0753F	24-NOV-1999	00-09-019P	06
09	CA	OCEANSIDE, CITY OF	06073C0754F	24-NOV-1999	00-09-019P	06
09	CA	OCEANSIDE, CITY OF	06073C0756F	24-NOV-1999	00-09-019P	06
09	CA	OCEANSIDE, CITY OF	06073C0464F	28-JUL-1999	99-09-1048A	02
09	CA	OCEANSIDE, CITY OF	06073C0752F	26-AUG-1999	99-09-845A	01
09	CA	OCEANSIDE, CITY OF	06073C0752F	12-JUL-1999	99-09-955A	01
09	CA	ORANGE COUNTY	06059C0031E	29-DEC-1999	99-09-1031P	06
09	CA	ORANGE COUNTY	06059C0040E	29-DEC-1999	99-09-1031P	06
09	CA	ORANGE COUNTY	06059C0070E	09-AUG-1999	99-09-798A	02
09	CA	PALM SPRINGS, CITY OF	0602570006D	08-JUL-1999	98-09-737V	19
09	CA	PALM SPRINGS, CITY OF	0602570009D	08-JUL-1999	98-09-737V	19
09	CA	PALM SPRINGS, CITY OF	0602570006D	03-NOV-1999	99-09-1201A	01
09	CA	PALO ALTO, CITY OF	0603480002E	12-JUL-1999	99-09-1010A	02
09	CA	PALO ALTO, CITY OF	0603480003D	29-JUL-1999	99-09-1046A	02
09	CA	PALO ALTO, CITY OF	0603480002E	22-SEP-1999	99-09-1101A	02
09	CA	PALO ALTO, CITY OF	0603480003E	17-SEP-1999	99-09-1173A	02
09	CA	PALO ALTO, CITY OF	0603480003E	07-JUL-1999	99-09-905A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
09	CA	PALO ALTO, CITY OF	0603480003D	03-AUG-1999	99-09-994A	02
09	CA	PARAMOUNT, CITY OF	0650490002C	27-AUG-1999	99-09-988A	02
09	CA	PERRIS, CITY OF	0602580010D	26-AUG-1999	99-09-1118A	01
09	CA	PERRIS, CITY OF	0602580010D	27-OCT-1999	99-09-1250A	01
09	CA	PERRIS, CITY OF	0602580010D	26-JUL-1999	99-09-875A	01
09	CA	PITTSBURG,CITY OF	0600330001D	10-SEP-1999	99-09-1104A	02
09	CA	PLACER COUNTY	06061C0477F	16-NOV-1999	00-09-064A	02
09	CA	PLACER COUNTY	06061C0477F	22-NOV-1999	00-09-076A	02
09	CA	PLEASANTON, CITY OF	0600120001E	15-SEP-1999	99-09-1170A	02
09	CA	PLEASANTON, CITY OF	0600120002D	03-NOV-1999	99-09-1189A	01
09	CA	PLEASANTON, CITY OF	0600120001E	02-JUL-1999	99-09-974A	02
09	CA	PLEASANTON, CITY OF	0600120003D	02-JUL-1999	99-09-974A	02
09	CA	PLUMAS COUNTY	060244B	17-AUG-1999	99-09-1089A	02
09	CA	PLUMAS COUNTY	060244B	09-JUL-1999	99-09-851A	02
09	CA	POWAY, CITY OF	06073C1358F	16-AUG-1999	99-09-1072A	02
09	CA	POWAY, CITY OF	06073C1358F	16-AUG-1999	99-09-1093A	02
09	CA	POWAY, CITY OF	06073C1358F	13-OCT-1999	99-09-1131A	02
09	CA	RANCHO CUCAMONGA, CITY OF	06071C7890F	08-DEC-1999	00-09-119A	02
09	CA	RANCHO CUCAMONGA, CITY OF	06071C7890F	13-DEC-1999	00-09-155A	02
09	CA	RANCHO CUCAMONGA, CITY OF	06071C7890F	09-DEC-1999	99-09-1194A	02
09	CA	RED BLUFF, CITY OF	0650530001F	01-SEP-1999	99-09-1133A	02
09	CA	RED BLUFF, CITY OF	0650530001F	24-SEP-1999	99-09-1214A	02
09	CA	REDDING, CITY OF	0603600030D	15-JUL-1999	99-09-983A	02
09	CA	REDLANDS, CITY OF	06071C8717F	13-DEC-1999	99-09-1054A	01
09	CA	RIVERSIDE COUNTY	0602450685B	15-NOV-1999	99-09-1005A	01
09	CA	RIVERSIDE COUNTY	0602450705A	06-OCT-1999	99-09-1096P	05
09	CA	RIVERSIDE COUNTY	0602452710C	10-DEC-1999	99-09-1256P	06
09	CA	RIVERSIDE COUNTY	0602451490C	08-DEC-1999	99-09-1260A	02
09	CA	RIVERSIDE COUNTY	0602452265B	24-AUG-1999	99-09-465P	05
09	CA	RIVERSIDE, CITY OF	0602600030B	02-SEP-1999	99-09-1136A	02
09	CA	ROSEVILLE, CITY OF	06061C0478F	19-AUG-1999	99-09-933A	02
09	CA	SACRAMENTO COUNTY	0602620090E	30-DEC-1999	00-09-159A	02
09	CA	SACRAMENTO COUNTY	0602620345C	22-DEC-1999	00-09-160A	02
09	CA	SACRAMENTO COUNTY	0602620070D	24-NOV-1999	98-09-553P	05
09	CA	SACRAMENTO COUNTY	0602620090E	24-NOV-1999	98-09-553P	05
09	CA	SACRAMENTO COUNTY	0602620090E	17-SEP-1999	99-09-1179A	02
09	CA	SACRAMENTO COUNTY	0602620330D	30-DEC-1999	99-09-1268A	01
09	CA	SACRAMENTO COUNTY	0602620250C	12-OCT-1999	99-09-464P	05
09	CA	SACRAMENTO COUNTY	0602620335D	12-OCT-1999	99-09-464P	05
09	CA	SACRAMENTO COUNTY	0602620340D	12-OCT-1999	99-09-464P	05
09	CA	SACRAMENTO COUNTY	0602620345C	12-OCT-1999	99-09-464P	05
09	CA	SACRAMENTO COUNTY	0602620375C	12-OCT-1999	99-09-464P	05
09	CA	SACRAMENTO COUNTY	0602620475E	12-OCT-1999	99-09-464P	05
09	CA	SACRAMENTO COUNTY	0602620085E	06-AUG-1999	99-09-603A	02
09	CA	SACRAMENTO COUNTY	0602620185F	02-JUL-1999	99-09-962A	02
09	CA	SACRAMENTO, CITY OF	0602660005F	15-NOV-1999	00-09-062A	02
09	CA	SACRAMENTO, CITY OF	0602660015F	15-NOV-1999	00-09-062A	02
09	CA	SACRAMENTO, CITY OF	0602660020F	15-NOV-1999	00-09-062A	02
09	CA	SACRAMENTO, CITY OF	0602660005F	24-NOV-1999	98-09-553P	05
09	CA	SACRAMENTO, CITY OF	0602660030F	06-AUG-1999	99-09-1030A	02
09	CA	SACRAMENTO, CITY OF	0602660005F	22-SEP-1999	99-09-1207A	02
09	CA	SACRAMENTO, CITY OF	0602660005F	21-DEC-1999	99-09-890A	01
09	CA	SALINAS, CITY OF	0602020003D	28-DEC-1999	00-09-037P	06
09	CA	SALINAS, CITY OF	0602020005D	11-AUG-1999	99-09-1091A	02
09	CA	SAN BERNARDINO COUNTY	06071C8615F	22-SEP-1999	99-09-1193A	02
09	CA	SAN BERNARDINO COUNTY	06071C7155F	01-OCT-1999	99-09-1241A	02
09	CA	SAN BERNARDINO COUNTY	06071C8717F	12-JUL-1999	99-09-810A	02
09	CA	SAN BERNARDINO COUNTY	06071C3915F	27-JUL-1999	99-09-878A	02
09	CA	SAN BERNARDINO COUNTY	06071C4526F	27-JUL-1999	99-09-878A	02
09	CA	SAN BERNARDINO, CITY OF	06071C7930F	15-NOV-1999	99-09-1291A	02
09	CA	SAN BUENAVENTURA, CITY OF	0604190010C	26-JUL-1999	98-09-383P	05
09	CA	SAN CARLOS, CITY OF	0603270001C	29-NOV-1999	00-09-038A	02
09	CA	SAN CARLOS, CITY OF	0603270001C	13-DEC-1999	00-09-162A	02
09	CA	SAN CARLOS, CITY OF	0603270001C	10-AUG-1999	99-09-1043A	02
09	CA	SAN CARLOS, CITY OF	0603270001C	12-NOV-1999	99-09-1161A	01
09	CA	SAN DIEGO COUNTY	06073C1735F	22-NOV-1999	00-09-074A	02
09	CA	SAN DIEGO COUNTY	06073C1652F	08-DEC-1999	00-09-125A	02
09	CA	SAN DIEGO COUNTY	06073C1679F	07-JUL-1999	98-09-1071P	06
09	CA	SAN DIEGO COUNTY	06073C0487F	07-OCT-1999	99-09-1249A	02
09	CA	SAN DIEGO COUNTY	06073C1917F	13-OCT-1999	99-09-1261A	02
09	CA	SAN DIEGO, CITY OF	06073C1878F	08-DEC-1999	00-09-077A	02
09	CA	SAN DIEGO, CITY OF	06073C2154F	27-DEC-1999	00-09-186A	02
09	CA	SAN DIEGO, CITY OF	06073C1594F	06-AUG-1999	99-09-1068A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
09	CA	SAN DIEGO, CITY OF	06073C1903F	23-AUG-1999	99-09-1086A	01
09	CA	SAN DIEGO, CITY OF	06073C1908F	22-NOV-1999	99-09-1090A	02
09	CA	SAN DIEGO, CITY OF	06073C1594F	16-AUG-1999	99-09-1100A	02
09	CA	SAN DIEGO, CITY OF	06073C1594F	20-SEP-1999	99-09-1192A	02
09	CA	SAN DIEGO, CITY OF	06073C1344F	22-NOV-1999	99-09-1220A	02
09	CA	SAN DIEGO, CITY OF	06073C1363F	08-SEP-1999	99-09-975A	02
09	CA	SAN JACINTO, CITY OF	0650560005D	19-OCT-1999	99-09-1232A	01
09	CA	SAN JOSE, CITY OF	0603490020F	25-OCT-1999	00-09-017A	02
09	CA	SAN JOSE, CITY OF	0603490037D	19-OCT-1999	99-09-1263A	02
09	CA	SAN LEANDRO, CITY OF	0600130003B	29-OCT-1999	99-09-1144A	01
09	CA	SAN LUIS OBISPO, CITY OF	0603100005C	30-SEP-1999	99-09-989A	01
09	CA	SAN MARCOS, CITY OF	06073C0793F	17-SEP-1999	99-09-1115A	01
09	CA	SAN RAFAEL, CITY OF	0650580015B	08-DEC-1999	00-09-092A	02
09	CA	SAN RAFAEL, CITY OF	0650580015B	22-JUL-1999	99-09-867A	01
09	CA	SANTA BARBARA COUNTY	0603310556C	06-DEC-1999	99-09-1025A	01
09	CA	SANTA BARBARA COUNTY	0603310740D	18-AUG-1999	99-09-767A	17
09	CA	SANTA BARBARA COUNTY	0603310709C	14-JUL-1999	99-09-884A	02
09	CA	SANTA BARBARA, CITY OF	0603350004D	09-AUG-1999	99-09-1067A	02
09	CA	SANTA BARBARA, CITY OF	0603350005D	15-SEP-1999	99-09-600P	06
09	CA	SANTA CLARA COUNTY	0603370645E	08-DEC-1999	00-09-111A	02
09	CA	SANTA CLARA COUNTY	0603370255E	08-DEC-1999	99-09-1065A	02
09	CA	SANTA CLARA, CITY OF	0603500001D	22-OCT-1999	00-09-003A	02
09	CA	SANTA CLARA, CITY OF	0603500005D	08-NOV-1999	00-09-029A	02
09	CA	SANTA CLARA, CITY OF	0603500005D	15-NOV-1999	00-09-042A	02
09	CA	SANTA CLARA, CITY OF	0603500005D	15-JUL-1999	99-09-978A	02
09	CA	SANTA CRUZ, CITY OF	0603550004C	09-DEC-1999	00-09-005A	02
09	CA	SANTA PAULA, CITY OF	0604200003D	22-NOV-1999	00-09-024A	02
09	CA	SANTEE, CITY OF	06073C1653F	19-AUG-1999	99-09-757A	02
09	CA	SHASTA COUNTY	0603580405B	10-SEP-1999	99-09-1024A	02
09	CA	SHASTA LAKE, CITY OF	0607580005A	09-AUG-1999	99-09-1062A	02
09	CA	SIERRA COUNTY	06091C0215A	30-NOV-1999	99-09-835P	06
09	CA	SIMI VALLEY, CITY OF	0604210008B	15-NOV-1999	00-09-046A	02
09	CA	SIMI VALLEY, CITY OF	0604210009B	17-DEC-1999	00-09-114A	02
09	CA	SIMI VALLEY, CITY OF	0604210002B	30-JUL-1999	99-09-1000A	01
09	CA	SIMI VALLEY, CITY OF	0604210004B	30-JUL-1999	99-09-1000A	01
09	CA	SIMI VALLEY, CITY OF	0604210008B	26-JUL-1999	99-09-1022A	02
09	CA	SIMI VALLEY, CITY OF	0604210002B	15-SEP-1999	99-09-1080A	02
09	CA	SIMI VALLEY, CITY OF	0604210002B	12-NOV-1999	99-09-1199A	01
09	CA	SIMI VALLEY, CITY OF	0604210004B	12-NOV-1999	99-09-1199A	01
09	CA	SIMI VALLEY, CITY OF	0604210004B	07-JUL-1999	99-09-931A	02
09	CA	SIMI VALLEY, CITY OF	0604210008B	07-JUL-1999	99-09-931A	02
09	CA	SOLANO COUNTY	0606310406B	13-AUG-1999	99-09-1102A	02
09	CA	SONOMA COUNTY	0603750785C	21-DEC-1999	00-09-189A	02
09	CA	SONOMA COUNTY	0603750515B	21-DEC-1999	99-09-1149A	02
09	CA	SOUTH LAKE TAHOE, CITY OF	0650600010B	12-JUL-1999	99-09-726A	02
09	CA	SOUTH SAN FRANCISCO, CITY OF	0650620001B	19-OCT-1999	99-09-1262A	01
09	CA	SOUTH SAN FRANCISCO, CITY OF	0650620007B	19-OCT-1999	99-09-1262A	01
09	CA	STANISLAUS COUNTY	0603840290A	15-DEC-1999	99-09-740P	05
09	CA	STANISLAUS COUNTY	0603840295A	15-DEC-1999	99-09-740P	05
09	CA	STANISLAUS COUNTY	0603840480A	15-DEC-1999	99-09-740P	05
09	CA	STANISLAUS COUNTY	0603840485A	15-DEC-1999	99-09-740P	05
09	CA	STANISLAUS COUNTY	0603840505A	15-DEC-1999	99-09-740P	05
09	CA	STANISLAUS COUNTY	0603840510A	15-DEC-1999	99-09-740P	05
09	CA	SUISUN CITY, CITY OF	0603720001B	16-NOV-1999	00-09-056A	02
09	CA	SUNNYVALE, CITY OF	0603520001D	17-AUG-1999	99-09-1092A	02
09	CA	TEHAMA COUNTY	0650640475B	03-NOV-1999	00-09-012A	02
09	CA	TEMECULA, CITY OF	0607420005B	22-NOV-1999	99-09-1222A	02
09	CA	THOUSAND OAKS, CITY OF	0604220020A	28-SEP-1999	99-09-1223A	02
09	CA	THOUSAND OAKS, CITY OF	0604220015B	30-JUL-1999	99-09-953A	02
09	CA	TUSTIN, CITY OF	06059C0030E	29-DEC-1999	99-09-1031P	05
09	CA	TUSTIN, CITY OF	06059C0039E	29-DEC-1999	99-09-1031P	05
09	CA	TUSTIN, CITY OF	06059C0038F	13-SEP-1999	99-09-382P	05
09	CA	TUSTIN, CITY OF	06059C0039E	13-SEP-1999	99-09-382P	05
09	CA	TWENTYNINE PALMS, CITY OF	06071C8935F	20-DEC-1999	00-09-176A	02
09	CA	TWENTYNINE PALMS, CITY OF	06071C8190F	08-DEC-1999	99-09-1259A	02
09	CA	UNION CITY, CITY OF	0600140010B	03-NOV-1999	00-09-016A	01
09	CA	UNION CITY, CITY OF	0600140010B	10-AUG-1999	99-09-1021A	01
09	CA	UNION CITY, CITY OF	0600140010B	23-AUG-1999	99-09-1095A	01
09	CA	UNION CITY, CITY OF	0600140010B	08-OCT-1999	99-09-1247A	01
09	CA	VALLEJO, CITY OF	0603740010C	22-OCT-1999	99-09-1271A	02
09	CA	VENTURA COUNTY	0604130745B	26-JUL-1999	98-09-383P	05
09	CA	VENTURA COUNTY	0604130645B	01-SEP-1999	99-09-964A	01
09	CA	VISALIA, CITY OF	0604090010C	22-NOV-1999	00-09-079A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
09	CA	VISALIA, CITY OF	0604090010C	08-DEC-1999	00-09-133A	02
09	CA	VISALIA, CITY OF	0604090005D	13-SEP-1999	99-09-1142A	01
09	CA	WALNUT CREEK, CITY OF	0650700003C	22-DEC-1999	00-09-175A	02
09	CA	WALNUT CREEK, CITY OF	0650700001C	10-SEP-1999	99-09-1143A	02
09	CA	WALNUT CREEK, CITY OF	0650700001C	07-SEP-1999	99-09-1158A	02
09	CA	WALNUT CREEK, CITY OF	0650700001C	08-OCT-1999	99-09-1231A	02
09	CA	WOODLAND, CITY OF	0604230450E	21-SEP-1999	99-09-1079P	08
09	CA	YOLO COUNTY	0604230555C	15-JUL-1999	99-09-1013A	01
09	CA	YOLO COUNTY	0604230560C	15-SEP-1999	99-09-1164A	01
09	CA	YOLO COUNTY	0604230565C	24-SEP-1999	99-09-1187A	02
09	CA	YOLO COUNTY	0604230575C	22-OCT-1999	99-09-1276A	02
09	CA	YUBA COUNTY	0604270225B	22-OCT-1999	00-09-002A	02
09	CA	YUBA COUNTY	0604270360B	27-JUL-1999	99-09-995A	02
09	CA	YUCCA VALLEY, TOWN OF	06071C8120F	18-AUG-1999	99-09-873P	06
09	HI	HAWAII COUNTY	1551660890C	17-SEP-1999	99-09-1183A	02
09	HI	HAWAII COUNTY	1551660890C	22-OCT-1999	99-09-1202A	02
09	HI	HONOLULU COUNTY	1500010044B	22-OCT-1999	99-09-692A	02
09	HI	KAUAI COUNTY	1500020130D	15-DEC-1999	00-09-067A	02
09	NV	CLARK COUNTY	32003C2553D	27-DEC-1999	00-09-179A	01
09	NV	CLARK COUNTY	32003C2554D	27-DEC-1999	00-09-179A	01
09	NV	CLARK COUNTY	32003C2590D	27-DEC-1999	99-09-1211P	06
09	NV	CLARK COUNTY	32003C2554D	28-SEP-1999	99-09-814A	02
09	NV	CLARK COUNTY	32003C2569D	02-JUL-1999	99-09-841A	01
09	NV	CLARK COUNTY	32003C1735D	17-SEP-1999	99-09-936P	05
09	NV	CLARK COUNTY	32003C1755D	17-SEP-1999	99-09-936P	05
09	NV	CLARK COUNTY	32003C1790D	17-SEP-1999	99-09-936P	05
09	NV	CLARK COUNTY	32003C2178D	17-SEP-1999	99-09-936P	05
09	NV	CLARK COUNTY	32003C2180D	17-SEP-1999	99-09-936P	05
09	NV	CLARK COUNTY	32003C2200D	17-SEP-1999	99-09-936P	05
09	NV	CLARK COUNTY	32003C2535D	14-JUL-1999	99-09-944A	02
09	NV	CLARK COUNTY	32003C2562D	29-JUL-1999	99-09-969A	02
09	NV	DOUGLAS COUNTY	32005C0030F	09-NOV-1999	99-09-1297V	19
09	NV	DOUGLAS COUNTY	32005C0040F	09-NOV-1999	99-09-1297V	19
09	NV	DOUGLAS COUNTY	32005C0210F	09-NOV-1999	99-09-1297V	19
09	NV	DOUGLAS COUNTY	32005C0235F	09-NOV-1999	99-09-1297V	19
09	NV	DOUGLAS COUNTY	32005C0255F	09-NOV-1999	99-09-1297V	19
09	NV	DOUGLAS COUNTY	32005C0267F	09-NOV-1999	99-09-1297V	19
09	NV	DOUGLAS COUNTY	32005C0268F	09-NOV-1999	99-09-1297V	19
09	NV	DOUGLAS COUNTY	32005C0030F	15-NOV-1999	99-09-1304V	19
09	NV	DOUGLAS COUNTY	32005C0040F	15-NOV-1999	99-09-1304V	19
09	NV	DOUGLAS COUNTY	32005C0210F	15-NOV-1999	99-09-1304V	19
09	NV	DOUGLAS COUNTY	32005C0235F	15-NOV-1999	99-09-1304V	19
09	NV	DOUGLAS COUNTY	32005C0255F	15-NOV-1999	99-09-1304V	19
09	NV	DOUGLAS COUNTY	32005C0267F	15-NOV-1999	99-09-1304V	19
09	NV	DOUGLAS COUNTY	32005C0268F	15-NOV-1999	99-09-1304V	19
09	NV	FALLON, CITY OF	3200020001A	13-DEC-1999	00-09-166A	02
09	NV	HENDERSON, CITY OF	32003C2590D	28-DEC-1999	99-09-1041P	06
09	NV	HENDERSON, CITY OF	32003C2930D	28-DEC-1999	99-09-1041P	06
09	NV	HENDERSON, CITY OF	32003C2595D	12-JUL-1999	99-09-627A	01
09	NV	HENDERSON, CITY OF	32003C2595D	02-JUL-1999	99-09-907A	01
09	NV	HENDERSON, CITY OF	32003C2595D	23-JUL-1999	99-09-908P	06
09	NV	HENDERSON, CITY OF	32003C2590D	15-JUL-1999	99-09-960A	02
09	NV	HENDERSON, CITY OF	32003C2590D	22-OCT-1999	99-09-998A	01
09	NV	LAS VEGAS, CITY OF	32003C1745D	02-NOV-1999	99-09-025P	05
09	NV	LAS VEGAS, CITY OF	32003C1765D	02-NOV-1999	99-09-025P	05
09	NV	LAS VEGAS, CITY OF	32003C2155D	02-NOV-1999	99-09-025P	05
09	NV	LAS VEGAS, CITY OF	32003C1735D	17-SEP-1999	99-09-936P	06
09	NV	LAS VEGAS, CITY OF	32003C1755D	17-SEP-1999	99-09-936P	06
09	NV	LAS VEGAS, CITY OF	32003C1770D	17-SEP-1999	99-09-936P	06
09	NV	LAS VEGAS, CITY OF	32003C2180D	17-SEP-1999	99-09-936P	06
09	NV	LAS VEGAS, CITY OF	32003C2187D	17-SEP-1999	99-09-936P	06
09	NV	LAS VEGAS, CITY OF	32003C2200D	17-SEP-1999	99-09-936P	06
09	NV	NORTH LAS VEGAS, CITY OF	32003C1769D	30-NOV-1999	00-09-144P	06
09	NV	NORTH LAS VEGAS, CITY OF	32003C2160D	02-DEC-1999	99-09-1190P	06
09	NV	NORTH LAS VEGAS, CITY OF	32003C1770D	01-JUL-1999	99-09-861A	01
09	NV	NORTH LAS VEGAS, CITY OF	32003C1755D	17-SEP-1999	99-09-936P	06
09	NV	NORTH LAS VEGAS, CITY OF	32003C1760D	17-SEP-1999	99-09-936P	06
09	NV	NORTH LAS VEGAS, CITY OF	32003C1765D	17-SEP-1999	99-09-936P	06
09	NV	NORTH LAS VEGAS, CITY OF	32003C1770D	17-SEP-1999	99-09-936P	06
09	NV	NORTH LAS VEGAS, CITY OF	32003C1790D	17-SEP-1999	99-09-936P	06
09	NV	NORTH LAS VEGAS, CITY OF	32003C2176D	17-SEP-1999	99-09-936P	06
09	NV	NORTH LAS VEGAS, CITY OF	32003C2178D	17-SEP-1999	99-09-936P	06
09	NV	NORTH LAS VEGAS, CITY OF	32003C2180D	17-SEP-1999	99-09-936P	06

Region	State	Community	Map panel	Determination date	Case No.	Type
09	NV	RENO, CITY OF	32031C3156E	24-NOV-1999	00-09-078A	02
09	NV	RENO, CITY OF	32031C3176E	08-DEC-1999	00-09-120A	01
09	NV	RENO, CITY OF	32031C3176E	24-AUG-1999	99-09-1117A	01
09	NV	RENO, CITY OF	32031C3176E	15-JUL-1999	99-09-954A	01
10	AK	ANCHORAGE, MUNICIPALITY OF	0200050230B	06-DEC-1999	00-10-030A	02
10	AK	ANCHORAGE, MUNICIPALITY OF	0200050230B	06-DEC-1999	00-10-054A	02
10	AK	HOMER, CITY OF	0201070004A	25-AUG-1999	99-10-205P	05
10	ID	ADA COUNTY	16001C0258G	08-DEC-1999	00-10-062A	01
10	ID	ADA COUNTY	1600010155C	26-OCT-1999	99-10-481P	05
10	ID	ADA COUNTY	1600010254C	01-SEP-1999	99-10-525A	02
10	ID	ADA COUNTY	1600010315C	13-AUG-1999	99-10-527A	02
10	ID	ADA COUNTY	16001C0254G	24-SEP-1999	99-10-577A	02
10	ID	ADA COUNTY	16001C0254G	24-SEP-1999	99-10-591A	02
10	ID	ADA COUNTY	16001C0152G	12-NOV-1999	99-10-619V	19
10	ID	ADA COUNTY	16001C0167G	12-NOV-1999	99-10-619V	19
10	ID	ADA COUNTY	16001C0186G	12-NOV-1999	99-10-619V	19
10	ID	ADA COUNTY	16001C0254G	12-NOV-1999	99-10-619V	19
10	ID	ADA COUNTY	16001C0258G	12-NOV-1999	99-10-619V	19
10	ID	ADA COUNTY	16001C0283G	12-NOV-1999	99-10-619V	19
10	ID	ADA COUNTY	16001C0315G	12-NOV-1999	99-10-619V	19
10	ID	ADA COUNTY	16001C0152G	15-NOV-1999	99-10-623V	19
10	ID	ADA COUNTY	16001C0167G	15-NOV-1999	99-10-623V	19
10	ID	ADA COUNTY	16001C0169G	15-NOV-1999	99-10-623V	19
10	ID	ADA COUNTY	16001C0186G	15-NOV-1999	99-10-623V	19
10	ID	ADA COUNTY	16001C0254G	15-NOV-1999	99-10-623V	19
10	ID	ADA COUNTY	16001C0258G	15-NOV-1999	99-10-623V	19
10	ID	ADA COUNTY	16001C0283G	15-NOV-1999	99-10-623V	19
10	ID	ADA COUNTY	16001C0315G	15-NOV-1999	99-10-623V	19
10	ID	BINGHAM COUNTY	1600180435C	15-JUL-1999	99-10-475A	02
10	ID	BINGHAM COUNTY	1600180260B	19-OCT-1999	99-10-618A	02
10	ID	BLACKFOOT, CITY OF	1600190002C	12-JUL-1999	99-10-473A	02
10	ID	BLAINE COUNTY	1651670461B	08-NOV-1999	99-10-470A	02
10	ID	BOISE, CITY OF	1600020014C	10-SEP-1999	99-10-560A	02
10	ID	BOISE, CITY OF	16001C0169G	12-NOV-1999	99-10-619V	19
10	ID	BOISE, CITY OF	16001C0277G	12-NOV-1999	99-10-619V	19
10	ID	BOISE, CITY OF	16001C0281G	12-NOV-1999	99-10-619V	19
10	ID	BOISE, CITY OF	16001C0283G	12-NOV-1999	99-10-619V	19
10	ID	BOISE, CITY OF	16001C0284G	12-NOV-1999	99-10-619V	19
10	ID	BOISE, CITY OF	16001C0169G	15-NOV-1999	99-10-623V	19
10	ID	BOISE, CITY OF	16001C0277G	15-NOV-1999	99-10-623V	19
10	ID	BOISE, CITY OF	16001C0281G	15-NOV-1999	99-10-623V	19
10	ID	BOISE, CITY OF	16001C0283G	15-NOV-1999	99-10-623V	19
10	ID	BOISE, CITY OF	16001C0284G	15-NOV-1999	99-10-623V	19
10	ID	BONNER COUNTY	1602060325B	08-NOV-1999	00-10-013A	02
10	ID	BONNER COUNTY	1602060400C	09-DEC-1999	00-10-028A	02
10	ID	BONNER COUNTY	1602060300C	09-DEC-1999	00-10-067A	02
10	ID	BONNER COUNTY	1602060050B	10-AUG-1999	99-10-519A	02
10	ID	BONNER COUNTY	1602060300C	05-OCT-1999	99-10-594A	02
10	ID	BONNER COUNTY	1602060360C	29-OCT-1999	99-10-599A	02
10	ID	CASSIA COUNTY	1600410100B	22-DEC-1999	00-10-049A	02
10	ID	EAGLE, CITY OF	1600030001C	26-OCT-1999	99-10-481P	05
10	ID	EAGLE, CITY OF	1600010165C	02-AUG-1999	99-10-506A	01
10	ID	EAGLE, CITY OF	16001C0153G	12-NOV-1999	99-10-619V	19
10	ID	EAGLE, CITY OF	16001C0161G	12-NOV-1999	99-10-619V	19
10	ID	EAGLE, CITY OF	16001C0153G	15-NOV-1999	99-10-623V	19
10	ID	EAGLE, CITY OF	16001C0161G	15-NOV-1999	99-10-623V	19
10	ID	FREMONT COUNTY	1600610225B	22-NOV-1999	00-10-021A	02
10	ID	GARDEN CITY, CITY OF	1600040002E	24-AUG-1999	99-10-539A	02
10	ID	GARDEN CITY, CITY OF	16001C0169G	27-OCT-1999	99-10-603A	02
10	ID	GARDEN CITY, CITY OF	16001C0169G	27-OCT-1999	99-10-606A	02
10	ID	GARDEN CITY, CITY OF	16001C0166G	12-NOV-1999	99-10-619V	19
10	ID	GARDEN CITY, CITY OF	16001C0167G	12-NOV-1999	99-10-619V	19
10	ID	GARDEN CITY, CITY OF	16001C0169G	12-NOV-1999	99-10-619V	19
10	ID	GARDEN CITY, CITY OF	16001C0166G	15-NOV-1999	99-10-623V	19
10	ID	GARDEN CITY, CITY OF	16001C0167G	15-NOV-1999	99-10-623V	19
10	ID	GARDEN CITY, CITY OF	16001C0169G	15-NOV-1999	99-10-623V	19
10	ID	JEFFERSON COUNTY	16051C0400B	03-AUG-1999	99-10-505A	02
10	ID	JEFFERSON COUNTY	16051C0125B	25-AUG-1999	99-10-514A	02
10	ID	KOOTENAI COUNTY	1600760155C	02-AUG-1999	99-10-529A	02
10	ID	KOOTENAI COUNTY	1600760170D	17-SEP-1999	99-10-573A	02
10	ID	KOOTENAI COUNTY	1600760170D	19-OCT-1999	99-10-616A	02
10	ID	MERIDIAN, CITY OF	16001C0232G	08-DEC-1999	99-10-614A	02
10	ID	MERIDIAN, CITY OF	16001C0143G	12-NOV-1999	99-10-619V	19

Region	State	Community	Map panel	Determination date	Case No.	Type
10	ID	MERIDIAN, CITY OF	16001C0144G	12-NOV-1999	99-10-619V	19
10	ID	MERIDIAN, CITY OF	16001C0231G	12-NOV-1999	99-10-619V	19
10	ID	MERIDIAN, CITY OF	16001C0232G	12-NOV-1999	99-10-619V	19
10	ID	MERIDIAN, CITY OF	16001C0143G	15-NOV-1999	99-10-623V	19
10	ID	MERIDIAN, CITY OF	16001C0144G	15-NOV-1999	99-10-623V	19
10	ID	MERIDIAN, CITY OF	16001C0231G	15-NOV-1999	99-10-623V	19
10	ID	MERIDIAN, CITY OF	16001C0232G	15-NOV-1999	99-10-623V	19
10	ID	MERIDIAN, CITY OF	16001C0232G	15-NOV-1999	99-10-623V	19
10	ID	MIDDLETON, CITY OF	1600370001E	19-OCT-1999	00-10-002A	01
10	ID	MIDDLETON, CITY OF	1600370001E	17-SEP-1999	99-10-538A	01
10	ID	SPIRIT LAKE, CITY OF	1600840001A	22-JUL-1999	99-10-486A	02
10	ID	VALLEY COUNTY	1602200175A	08-NOV-1999	00-10-014A	02
10	ID	VALLEY COUNTY	1602200325A	12-NOV-1999	00-10-018A	02
10	ID	WASHINGTON COUNTY	1602210200B	22-JUL-1999	99-10-468A	02
10	ID	WEISER,CITY OF	1601240005B	06-AUG-1999	99-10-377A	02
10	OR	ALBANY, CITY OF	4101370001F	08-JUL-1999	98-10-264V	19
10	OR	ALBANY, CITY OF	4101370002F	08-JUL-1999	98-10-264V	19
10	OR	ALBANY, CITY OF	4101370003F	08-JUL-1999	98-10-264V	19
10	OR	ALBANY, CITY OF	4101370004F	08-JUL-1999	98-10-264V	19
10	OR	ALBANY, CITY OF	4101370004F	14-JUL-1999	99-10-247A	01
10	OR	ALBANY, CITY OF	4101370002F	15-JUL-1999	99-10-488A	02
10	OR	ALBANY, CITY OF	4101370001F	15-JUL-1999	99-10-489A	02
10	OR	ALBANY, CITY OF	4101370003F	15-JUL-1999	99-10-490A	02
10	OR	ALBANY, CITY OF	4101370001F	15-JUL-1999	99-10-491A	02
10	OR	ALBANY, CITY OF	4101370001F	15-JUL-1999	99-10-492A	02
10	OR	ALBANY, CITY OF	4101370001F	19-AUG-1999	99-10-530A	02
10	OR	BENTON COUNTY	4100080050C	09-DEC-1999	99-10-593A	02
10	OR	CLACKAMAS COUNTY	4155880020A	22-JUL-1999	99-10-454A	02
10	OR	CLACKAMAS COUNTY	4155880145A	13-SEP-1999	99-10-572A	02
10	OR	COLUMBIA COUNTY	41009C0463C	13-SEP-1999	99-10-548A	02
10	OR	COOS BAY, CITY OF	4100440006B	06-DEC-1999	00-10-043A	02
10	OR	COOS BAY, CITY OF	4100440008B	30-JUL-1999	99-10-503A	02
10	OR	CORVALLIS, CITY OF	4100090005E	22-JUL-1999	99-10-445A	02
10	OR	CORVALLIS, CITY OF	4100090002E	08-OCT-1999	99-10-605A	02
10	OR	CRESWELL, CITY OF	41039C1661F	29-NOV-1999	00-10-031A	02
10	OR	CRESWELL, CITY OF	41039C1661F	06-DEC-1999	00-10-051A	02
10	OR	CRESWELL, CITY OF	41039C1661F	08-DEC-1999	00-10-057A	02
10	OR	DEPOE BAY, CITY OF	4102830001B	02-AUG-1999	99-10-533A	02
10	OR	DESCHUTES COUNTY	41017C0460D	03-AUG-1999	99-10-463A	02
10	OR	DESCHUTES COUNTY	41017C0465D	14-DEC-1999	99-10-621P	06
10	OR	DESCHUTES COUNTY	41017C0655C	14-DEC-1999	99-10-621P	06
10	OR	DESCHUTES COUNTY	41017C0675C	14-DEC-1999	99-10-621P	06
10	OR	DOUGLAS COUNTY	4100590930A	30-DEC-1999	00-10-044A	02
10	OR	DOUGLAS COUNTY	4100590930A	27-JUL-1999	99-10-462A	02
10	OR	DOUGLAS COUNTY	4100590395A	02-AUG-1999	99-10-512A	02
10	OR	DOUGLAS COUNTY	4100591140B	16-NOV-1999	99-10-612A	02
10	OR	ELGIN, CITY OF	4102180005B	26-JUL-1999	99-10-408A	02
10	OR	ELGIN, CITY OF	4102180005B	08-OCT-1999	99-10-600A	02
10	OR	ELGIN, CITY OF	4102180005B	04-NOV-1999	99-10-611A	02
10	OR	EUGENE, CITY OF	41039C1136F	10-NOV-1999	00-10-019A	02
10	OR	EUGENE, CITY OF	41039C1106F	08-DEC-1999	00-10-061A	01
10	OR	EUGENE, CITY OF	41039C1107F	30-DEC-1999	00-10-076A	02
10	OR	EUGENE, CITY OF	41039C1107F	12-JUL-1999	99-10-158A	01
10	OR	EUGENE, CITY OF	41039C1106F	08-SEP-1999	99-10-562A	02
10	OR	EUGENE, CITY OF	41039C1107F	08-SEP-1999	99-10-562A	02
10	OR	EUGENE, CITY OF	41039C1129F	30-SEP-1999	99-10-578A	02
10	OR	EUGENE, CITY OF	41039C1106F	13-OCT-1999	99-10-608A	02
10	OR	FAIRVIEW, CITY OF	4101800001D	10-AUG-1999	99-10-502A	01
10	OR	GLENDALE, CITY OF	4100630005C	23-AUG-1999	99-10-479A	02
10	OR	GRANTS PASS, CITY OF	4101080003C	15-DEC-1999	00-10-056A	02
10	OR	JACKSON COUNTY	4155890314B	22-OCT-1999	00-10-003A	02
10	OR	JOSEPHINE COUNTY	4155900241C	10-SEP-1999	99-10-532A	02
10	OR	KEIZER, CITY OF	4102880005B	19-OCT-1999	99-10-586A	02
10	OR	LANE COUNTY	41039C1107F	30-DEC-1999	00-10-052A	02
10	OR	LANE COUNTY	41039C2087F	15-DEC-1999	00-10-070A	02
10	OR	LANE COUNTY	41039C0450F	22-JUL-1999	99-10-285A	02
10	OR	LANE COUNTY	41039C1107F	14-JUL-1999	99-10-448A	02
10	OR	LANE COUNTY	41039C1128F	30-JUL-1999	99-10-500A	02
10	OR	LANE COUNTY	41039C0790F	01-SEP-1999	99-10-547A	02
10	OR	LANE COUNTY	41039C1107F	07-SEP-1999	99-10-563A	02
10	OR	LANE COUNTY	41039C0619F	27-OCT-1999	99-10-569A	02
10	OR	LANE COUNTY	41039C1107F	27-OCT-1999	99-10-569A	02
10	OR	LANE COUNTY	41039C1107F	30-SEP-1999	99-10-592A	02

Region	State	Community	Map panel	Determination date	Case No.	Type
10	OR	LANE COUNTY	41039C0945F	25-OCT-1999	99-10-615A	02
10	OR	LINCOLN CITY, CITY OF	4101300001C	06-AUG-1999	99-10-457A	02
10	OR	LINCOLN CITY, CITY OF	4101300001C	07-SEP-1999	99-10-528A	02
10	OR	LINCOLN CITY, CITY OF	4101300001C	16-AUG-1999	99-10-537A	02
10	OR	LINN COUNTY	4101360190B	14-JUL-1999	99-10-465A	02
10	OR	MARION COUNTY	4101540175D	05-NOV-1999	00-10-038A	02
10	OR	MARION COUNTY	4101540175D	09-NOV-1999	99-10-389P	05
10	OR	MCMINNVILLE, CITY OF	4102490303C	10-DEC-1999	00-10-071A	02
10	OR	MULTNOMAH COUNTY	4101790215B	08-SEP-1999	99-10-561A	02
10	OR	NORTH BEND, CITY OF	4100420155B	29-NOV-1999	99-10-582A	02
10	OR	POLK COUNTY	41053C0225C	06-DEC-1999	00-10-046A	02
10	OR	PORTLAND, CITY OF	4101830020D	08-SEP-1999	99-10-545A	02
10	OR	ROSEBURG, CITY OF	4100670005E	29-OCT-1999	00-10-011A	02
10	OR	ROSEBURG, CITY OF	4100670005E	13-SEP-1999	99-10-565A	02
10	OR	SALEM, CITY OF	4101670004E	28-OCT-1999	99-10-580A	02
10	OR	SCAPPOOSE, CITY OF	41009C0444C	10-SEP-1999	99-10-496A	02
10	OR	SHERIDAN, CITY OF	4102570002C	09-JUL-1999	99-10-428A	01
10	OR	SHERIDAN, CITY OF	4102570001C	13-AUG-1999	99-10-526A	02
10	OR	SPRINGFIELD, CITY OF	41039C1134F	12-JUL-1999	99-10-353A	01
10	OR	STANFIELD, CITY OF	4102130001C	15-SEP-1999	99-10-571A	02
10	OR	TILLAMOOK COUNTY	4101960170B	26-AUG-1999	99-10-471A	02
10	OR	WASHINGTON COUNTY	4102380200B	26-OCT-1999	00-10-006A	02
10	OR	WASHINGTON COUNTY	4102380502C	26-JUL-1999	99-10-484A	02
10	WA	ABERDEEN, CITY OF	5300580004B	02-NOV-1999	99-10-598P	06
10	WA	BENTON COUNTY	5302370440B	29-OCT-1999	00-10-010A	02
10	WA	BENTON COUNTY	5302370636D	08-NOV-1999	00-10-016A	02
10	WA	BENTON COUNTY	5302370440B	29-OCT-1999	99-10-541A	02
10	WA	BRIER, CITY OF	53061C1317E	09-NOV-1999	99-10-166V	19
10	WA	BRIER, CITY OF	5302760005A	06-AUG-1999	99-10-510A	02
10	WA	BRIER, CITY OF	53061C1317E	15-NOV-1999	99-10-622V	19
10	WA	BURIEN, CITY OF	53033C0953F	01-JUL-1999	99-10-358A	02
10	WA	CHEHALIS, CITY OF	5301040001B	06-DEC-1999	00-10-033A	02
10	WA	CHELAN COUNTY	5300150600A	03-AUG-1999	99-10-474A	02
10	WA	CLARK COUNTY	5300240340C	06-DEC-1999	00-10-041A	02
10	WA	CLARK COUNTY	5300240187B	22-NOV-1999	99-10-509A	01
10	WA	CLARK COUNTY	5300240189B	22-NOV-1999	99-10-509A	01
10	WA	CLARK COUNTY	5300240191B	22-NOV-1999	99-10-509A	01
10	WA	CLARK COUNTY	5300240193B	22-NOV-1999	99-10-509A	01
10	WA	CLARK COUNTY	5300240340C	11-AUG-1999	99-10-511A	02
10	WA	CLARK COUNTY	5300240340C	07-SEP-1999	99-10-564A	02
10	WA	EDMONDS, CITY OF	53061C1315E	09-NOV-1999	99-10-166V	19
10	WA	EDMONDS, CITY OF	53061C1315E	15-NOV-1999	99-10-622V	19
10	WA	FERNDALE, TOWN OF	5302010005B	10-SEP-1999	99-10-552A	01
10	WA	FERNDALE, TOWN OF	5302010005B	22-NOV-1999	99-10-601A	01
10	WA	GOLD BAR, TOWN OF	53061C1427E	09-NOV-1999	99-10-166V	19
10	WA	GOLD BAR, TOWN OF	53061C1427E	15-NOV-1999	99-10-622V	19
10	WA	GRAYS HARBOR COUNTY	5300570400B	30-JUL-1999	99-10-504A	02
10	WA	KING COUNTY	53033C0687F	15-DEC-1999	00-10-039A	02
10	WA	KING COUNTY	53033C1235F	13-DEC-1999	99-10-568A	02
10	WA	KING COUNTY	53033C0925F	29-NOV-1999	99-10-581A	02
10	WA	KITSAP COUNTY	5300920310B	22-NOV-1999	00-10-024A	02
10	WA	KITSAP COUNTY	5300920380B	06-DEC-1999	00-10-047A	02
10	WA	KITSAP COUNTY	5300920310B	15-JUL-1999	99-10-469A	02
10	WA	KITSAP COUNTY	5300920105B	26-AUG-1999	99-10-485A	02
10	WA	KITSAP COUNTY	5300920205B	23-AUG-1999	99-10-536A	02
10	WA	KITTITAS COUNTY	5300950241B	11-AUG-1999	99-10-397A	02
10	WA	KITTITAS COUNTY	5300950241B	11-AUG-1999	99-10-404A	02
10	WA	LAKE STEVENS, CITY OF	53061C0743E	09-NOV-1999	99-10-166V	19
10	WA	LAKE STEVENS, CITY OF	53061C0743E	15-NOV-1999	99-10-622V	19
10	WA	LEWIS COUNTY	5301020243B	22-JUL-1999	99-10-483A	02
10	WA	MASON COUNTY	5301150185C	10-AUG-1999	99-10-515A	02
10	WA	MONROE, CITY OF	53061C1357E	09-NOV-1999	99-10-166V	19
10	WA	MONROE, CITY OF	53061C1376E	09-NOV-1999	99-10-166V	19
10	WA	MONROE, CITY OF	53061C1357E	15-NOV-1999	99-10-622V	19
10	WA	MONROE, CITY OF	53061C1376E	15-NOV-1999	99-10-622V	19
10	WA	MORTON, CITY OF	5301050001C	12-JUL-1999	99-10-453A	02
10	WA	MOUNTLAKE TERRACE, CITY OF	53061C1320E	09-NOV-1999	99-10-166V	19
10	WA	MOUNTLAKE TERRACE, CITY OF	53061C1320E	15-NOV-1999	99-10-622V	19
10	WA	OLYMPIA, CITY OF	5301910007B	07-OCT-1999	99-10-596A	02
10	WA	PEND OREILLE COUNTY	530131B	27-JUL-1999	99-10-493A	02
10	WA	PIERCE COUNTY	5301381150C	01-SEP-1999	99-10-385A	02
10	WA	PIERCE COUNTY	5301380213C	29-OCT-1999	99-10-535A	01
10	WA	RAYMOND, CITY OF	5301290005B	10-AUG-1999	99-10-522A	02

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10	WA	SAN JUAN COUNTY	5301490003B	22-OCT-1999	00-10-005A	02
10	WA	SAN JUAN COUNTY	5301490003B	09-DEC-1999	99-10-607A	02
10	WA	SKAGIT COUNTY	5301510260C	08-NOV-1999	00-10-015A	02
10	WA	SKAGIT COUNTY	5301510250C	22-NOV-1999	00-10-026A	02
10	WA	SKAGIT COUNTY	5301510225C	09-DEC-1999	00-10-069A	02
10	WA	SKAGIT COUNTY	5301510285C	10-AUG-1999	99-10-405A	02
10	WA	SKAGIT COUNTY	5301510250C	28-JUL-1999	99-10-459A	02
10	WA	SKAGIT COUNTY	5301510235D	30-JUL-1999	99-10-501A	02
10	WA	SKAGIT COUNTY	5301510250C	24-AUG-1999	99-10-540A	02
10	WA	SKAGIT COUNTY	5301510235D	10-SEP-1999	99-10-557A	02
10	WA	SKAMANIA COUNTY	5301600400B	17-SEP-1999	99-10-553A	02
10	WA	SNOHOMISH COUNTY	53061C0120E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C0165E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C0390E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C0420E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C0735E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C0739E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C0745E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C0755E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C0760E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C1055E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C1060E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C1100E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C1114E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C1309E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C1310E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C1315E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C1317E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C1345E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C1377E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C1385E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C1405E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	53061C1435E	09-NOV-1999	99-10-166V	19
10	WA	SNOHOMISH COUNTY	5355340510B	19-AUG-1999	99-10-370A	01
10	WA	SNOHOMISH COUNTY	5355340510B	12-JUL-1999	99-10-382A	02
10	WA	SNOHOMISH COUNTY	5355340205B	10-AUG-1999	99-10-497A	02
10	WA	SNOHOMISH COUNTY	5355340467C	27-AUG-1999	99-10-499A	02
10	WA	SNOHOMISH COUNTY	53061C0120E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C0165E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C0390E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C0420E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C0735E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C0739E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C0745E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C0755E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C0760E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C1055E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C1060E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C1100E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C1114E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C1309E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C1310E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C1315E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C1317E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C1345E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C1377E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C1385E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C1405E	07-NOV-1999	99-10-622V	19
10	WA	SNOHOMISH COUNTY	53061C1435E	07-NOV-1999	99-10-622V	19
10	WA	SPOKANE COUNTY	5301740277B	22-NOV-1999	00-10-029A	02
10	WA	SPOKANE COUNTY	5301740401C	01-DEC-1999	00-10-045A	02
10	WA	SPOKANE COUNTY	5301740025B	22-JUL-1999	99-10-300A	02
10	WA	SPOKANE COUNTY	5301740277B	13-SEP-1999	99-10-327P	05
10	WA	SPOKANE COUNTY	5301740310C	14-JUL-1999	99-10-472P	06
10	WA	SPOKANE COUNTY	5301740225B	24-SEP-1999	99-10-551A	02
10	WA	SPOKANE COUNTY	5301740225B	08-OCT-1999	99-10-602A	02
10	WA	STANWOOD, CITY OF	53061C0351E	09-NOV-1999	99-10-166V	19
10	WA	STANWOOD, CITY OF	53061C0351E	15-NOV-1999	99-10-622V	19
10	WA	SULTAN, TOWN OF	53061C1402E	09-NOV-1999	99-10-166V	19
10	WA	SULTAN, TOWN OF	53061C1406E	09-NOV-1999	99-10-166V	19
10	WA	SULTAN, TOWN OF	5301730001B	15-JUL-1999	99-10-476A	01
10	WA	SULTAN, TOWN OF	53061C1402E	15-NOV-1999	99-10-622V	19
10	WA	SULTAN, TOWN OF	53061C1406E	15-NOV-1999	99-10-622V	19

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10	WA	THURSTON COUNTY	5301880350C	15-NOV-1999	00-10-036A	02
10	WA	THURSTON COUNTY	5301880475C	01-JUL-1999	99-10-312A	02
10	WA	THURSTON COUNTY	5301880180C	08-SEP-1999	99-10-534A	02
10	WA	VANCOUVER, CITY OF	5300240410B	16-DEC-1999	98-10-460P	06
10	WA	WHATCOM COUNTY	530198B	15-DEC-1999	00-10-035P	06
10	WA	WHATCOM COUNTY	530198B	24-SEP-1999	99-10-401A	02
10	WA	WHATCOM COUNTY	530198B	22-JUL-1999	99-10-478A	02
10	WA	WHITMAN COUNTY	5302050685B	10-NOV-1999	00-10-020A	02

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01	CONNECTICUT	MILFORD, CITY OF	0900820005E	07-SEP-1999
01	CONNECTICUT	RIDGEFIELD, TOWN OF	0900130001C	23-AUG-1999
01	CONNECTICUT	RIDGEFIELD, TOWN OF	0900130002C	23-AUG-1999
01	CONNECTICUT	RIDGEFIELD, TOWN OF	0900130003C	23-AUG-1999
01	CONNECTICUT	RIDGEFIELD, TOWN OF	0900130004C	23-AUG-1999
01	CONNECTICUT	RIDGEFIELD, TOWN OF	0900130005C	23-AUG-1999
01	CONNECTICUT	RIDGEFIELD, TOWN OF	0900130006C	23-AUG-1999
01	CONNECTICUT	RIDGEFIELD, TOWN OF	0900130007C	23-AUG-1999
01	CONNECTICUT	RIDGEFIELD, TOWN OF	0900130008C	23-AUG-1999
01	CONNECTICUT	RIDGEFIELD, TOWN OF	0900130009C	23-AUG-1999
01	CONNECTICUT	RIDGEFIELD, TOWN OF	900130000	23-AUG-1999
01	CONNECTICUT	VERNON, TOWN OF	0901310005C	09-AUG-1999
01	MAINE	RANGELEY, TOWN OF	2303520000	08-SEP-1999
01	MAINE	RANGELEY, TOWN OF	2303520001B	08-SEP-1999
01	MAINE	RANGELEY, TOWN OF	2303520002B	08-SEP-1999
01	MAINE	RANGELEY, TOWN OF	2303520004B	08-SEP-1999
01	MAINE	RANGELEY, TOWN OF	2303520005B	08-SEP-1999
01	MAINE	RANGELEY, TOWN OF	2303520010B	08-SEP-1999
01	MASSACHUSETTS	BOURNE, TOWN OF	2552100000	09-AUG-1999
01	MASSACHUSETTS	BOURNE, TOWN OF	2552100001E	09-AUG-1999
01	MASSACHUSETTS	BOURNE, TOWN OF	2552100002E	09-AUG-1999
01	MASSACHUSETTS	BOURNE, TOWN OF	2552100003E	09-AUG-1999
01	MASSACHUSETTS	BOURNE, TOWN OF	2552100004E	09-AUG-1999
01	MASSACHUSETTS	BOURNE, TOWN OF	2552100005E	09-AUG-1999
01	MASSACHUSETTS	BOURNE, TOWN OF	2552100007F	09-AUG-1999
01	MASSACHUSETTS	BOURNE, TOWN OF	2552100008F	09-AUG-1999
01	MASSACHUSETTS	BOURNE, TOWN OF	2552100010F	09-AUG-1999
01	MASSACHUSETTS	BOURNE, TOWN OF	2552100011F	09-AUG-1999
01	MASSACHUSETTS	BOURNE, TOWN OF	2552100013E	09-AUG-1999
01	MASSACHUSETTS	BOURNE, TOWN OF	2552100014F	09-AUG-1999
01	MASSACHUSETTS	BOXBOROUGH, TOWN OF	2501840000	08-SEP-1999
01	MASSACHUSETTS	BOXBOROUGH, TOWN OF	2501840001C	08-SEP-1999
01	MASSACHUSETTS	BOXBOROUGH, TOWN OF	2501840002C	08-SEP-1999
01	MASSACHUSETTS	BOXBOROUGH, TOWN OF	2501840003C	08-SEP-1999
01	MASSACHUSETTS	BOXBOROUGH, TOWN OF	2501840004C	08-SEP-1999
01	MASSACHUSETTS	BRIDGEWATER, TOWN OF	2502600000	08-SEP-1999
01	MASSACHUSETTS	BRIDGEWATER, TOWN OF	2502600002C	08-SEP-1999
01	MASSACHUSETTS	BRIDGEWATER, TOWN OF	2502600005C	08-SEP-1999
01	MASSACHUSETTS	BRIDGEWATER, TOWN OF	2502600010C	08-SEP-1999
01	MASSACHUSETTS	BRIDGEWATER, TOWN OF	2502600015C	08-SEP-1999
01	NEW HAMPSHIRE	CONCORD, CITY OF	3301100000	23-AUG-1999
01	NEW HAMPSHIRE	CONCORD, CITY OF	3301100005B	23-AUG-1999
01	NEW HAMPSHIRE	CONCORD, CITY OF	3301100010B	23-AUG-1999
01	NEW HAMPSHIRE	CONCORD, CITY OF	3301100015B	23-AUG-1999
01	NEW HAMPSHIRE	CONCORD, CITY OF	3301100020B	23-AUG-1999
01	NEW HAMPSHIRE	CONCORD, CITY OF	3301100025B	23-AUG-1999
01	NEW HAMPSHIRE	CONCORD, CITY OF	3301100030B	23-AUG-1999
01	RHODE ISLAND	NORTH PROVIDENCE, TOWN OF	4400200000	06-DEC-1999
01	RHODE ISLAND	NORTH PROVIDENCE, TOWN OF	4400200001C	06-DEC-1999
01	RHODE ISLAND	NORTH PROVIDENCE, TOWN OF	4400200002C**	06-DEC-1999
01	RHODE ISLAND	NORTH PROVIDENCE, TOWN OF	4400200003C	06-DEC-1999
01	VERMONT	BELLOWS FALLS, VILLAGE OF	5001250001C**	20-DEC-1999
01	VERMONT	NEWBURY, TOWN OF	5002370000	21-JUL-1999
01	VERMONT	NEWBURY, TOWN OF	5002370005C	21-JUL-1999
01	VERMONT	NEWBURY, TOWN OF	5002370010C	21-JUL-1999
01	VERMONT	NEWBURY, TOWN OF	5002370015C	21-JUL-1999
01	VERMONT	NEWBURY, TOWN OF	5002370020C	21-JUL-1999
01	VERMONT	NEWBURY, TOWN OF	5002370025C	21-JUL-1999
01	VERMONT	NEWBURY, TOWN OF	5002370030C	21-JUL-1999
01	VERMONT	ROCKINGHAM, TOWN OF	5001350000	20-DEC-1999
01	VERMONT	ROCKINGHAM, TOWN OF	5001350005C**	20-DEC-1999

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01	VERMONT	ROCKINGHAM, TOWN OF	5001350010C**	20-DEC-1999
01	VERMONT	ROCKINGHAM, TOWN OF	5001350015C**	20-DEC-1999
01	VERMONT	ROCKINGHAM, TOWN OF	5001350020C**	20-DEC-1999
01	VERMONT	ROYALTON, TOWN OF	5001530000	20-OCT-1999
01	VERMONT	ROYALTON, TOWN OF	5001530001D	20-OCT-1999
01	VERMONT	ROYALTON, TOWN OF	5001530002D	20-OCT-1999
01	VERMONT	ROYALTON, TOWN OF	5001530004D	20-OCT-1999
01	VERMONT	ROYALTON, TOWN OF	5001530005D	20-OCT-1999
01	VERMONT	ROYALTON, TOWN OF	5001530006D**	20-OCT-1999
01	VERMONT	ROYALTON, TOWN OF	5001530008D**	20-OCT-1999
01	VERMONT	SPRINGFIELD, TOWN OF	5001540000	20-DEC-1999
01	VERMONT	SPRINGFIELD, TOWN OF	5001540015C**	20-DEC-1999
01	VERMONT	SPRINGFIELD, TOWN OF	5001540017C**	20-DEC-1999
01	VERMONT	SPRINGFIELD, TOWN OF	5001540025C**	20-DEC-1999
01	VERMONT	THETFORD, TOWN OF	5000750000	20-DEC-1999
01	VERMONT	THETFORD, TOWN OF	5000750010C**	20-DEC-1999
01	VERMONT	THETFORD, TOWN OF	5000750015C**	20-DEC-1999
01	VERMONT	THETFORD, TOWN OF	5000750020C**	20-DEC-1999
02	NEW JERSEY	ABSECON, CITY OF	3400010000	23-AUG-1999
02	NEW JERSEY	ABSECON, CITY OF	3400010001C	23-AUG-1999
02	NEW JERSEY	ABSECON, CITY OF	3400010002C	23-AUG-1999
02	NEW JERSEY	ABSECON, CITY OF	3400010003C	23-AUG-1999
02	NEW JERSEY	LAVALLETTE, BOROUGH OF	3403790001E	22-NOV-1999
02	NEW JERSEY	MOUNT LAUREL, TOWNSHIP OF	3401070000	22-SEP-1999
02	NEW JERSEY	MOUNT LAUREL, TOWNSHIP OF	3401070005E	22-SEP-1999
02	NEW JERSEY	MOUNT LAUREL, TOWNSHIP OF	3401070010E	22-SEP-1999
02	NEW JERSEY	MOUNT LAUREL, TOWNSHIP OF	3401070015E	22-SEP-1999
02	NEW YORK	BUFFALO, CITY OF	3602300000	23-AUG-1999
02	NEW YORK	BUFFALO, CITY OF	3602300010C	23-AUG-1999
02	NEW YORK	BUFFALO, CITY OF	3602300015C**	23-AUG-1999
02	NEW YORK	BUFFALO, CITY OF	3602300020C	23-AUG-1999
02	NEW YORK	CHAUMONT, VILLAGE OF	3603290001D	08-SEP-1999
02	NEW YORK	DEER PARK, TOWN OF	3606120000	20-OCT-1999
02	NEW YORK	DEER PARK, TOWN OF	3606120016D	20-OCT-1999
02	NEW YORK	DEER PARK, TOWN OF	3606120017D	20-OCT-1999
02	NEW YORK	ILION, VILLAGE OF	3603080001C	08-SEP-1999
02	NEW YORK	LAGRANGE, TOWN OF	3610110000	08-SEP-1999
02	NEW YORK	LAGRANGE, TOWN OF	3610110005D	08-SEP-1999
02	NEW YORK	LAGRANGE, TOWN OF	3610110010D	08-SEP-1999
02	NEW YORK	LAGRANGE, TOWN OF	3610110015D	08-SEP-1999
02	NEW YORK	MOHAWK, VILLAGE OF	3603140001C	08-SEP-1999
02	NEW YORK	OSWEGO, CITY OF	3606560000	22-NOV-1999
02	NEW YORK	OSWEGO, CITY OF	3606560001D	22-NOV-1999
02	NEW YORK	OSWEGO, CITY OF	3606560002D	22-NOV-1999
02	NEW YORK	OSWEGO, CITY OF	3606560003D	22-NOV-1999
02	NEW YORK	OSWEGO, CITY OF	3606560004D	22-NOV-1999
02	NEW YORK	OSWEGO, TOWN OF	3606570000	20-OCT-1999
02	NEW YORK	OSWEGO, TOWN OF	3606570005E	20-OCT-1999
02	NEW YORK	OSWEGO, TOWN OF	3606570010E	20-OCT-1999
02	NEW YORK	POUGHKEEPSIE, TOWN OF	3611420000	08-SEP-1999
02	NEW YORK	POUGHKEEPSIE, TOWN OF	3611420001C	08-SEP-1999
02	NEW YORK	POUGHKEEPSIE, TOWN OF	3611420002C	08-SEP-1999
02	NEW YORK	POUGHKEEPSIE, TOWN OF	3611420003C	08-SEP-1999
02	NEW YORK	POUGHKEEPSIE, TOWN OF	3611420004C	08-SEP-1999
02	NEW YORK	POUGHKEEPSIE, TOWN OF	3611420005C	08-SEP-1999
02	NEW YORK	POUGHKEEPSIE, TOWN OF	3611420006C	08-SEP-1999
02	NEW YORK	POUGHKEEPSIE, TOWN OF	3611420007C	08-SEP-1999
02	NEW YORK	POUGHKEEPSIE, TOWN OF	3611420008C	08-SEP-1999
02	NEW YORK	POUGHKEEPSIE, TOWN OF	3611420009C	08-SEP-1999
02	NEW YORK	VERONA, TOWN OF	3605610000	20-OCT-1999
02	NEW YORK	VERONA, TOWN OF	3605610014C	20-OCT-1999
02	NEW YORK	VERONA, TOWN OF	3605610027C	20-OCT-1999
02	NEW YORK	VIENNA, TOWN OF	3605620000	20-OCT-1999
02	NEW YORK	VIENNA, TOWN OF	3605620025C	20-OCT-1999
02	NEW YORK	VIENNA, TOWN OF	3605620030C	20-OCT-1999
02	NEW YORK	WAPPINGER, TOWN OF	3613870000	22-SEP-1999
02	NEW YORK	WAPPINGER, TOWN OF	3613870001B	22-SEP-1999
02	NEW YORK	WAPPINGER, TOWN OF	3613870002B**	22-SEP-1999
02	NEW YORK	WAPPINGER, TOWN OF	3613870003B	22-SEP-1999
02	NEW YORK	WAPPINGER, TOWN OF	3613870004B**	22-SEP-1999
02	NEW YORK	WAPPINGER, TOWN OF	3613870005B**	22-SEP-1999
02	NEW YORK	WAPPINGER, TOWN OF	3613870006B**	22-SEP-1999
02	NEW YORK	WAPPINGER, TOWN OF	3613870007B**	22-SEP-1999
02	NEW YORK	WAPPINGERS FALLS, VILLAGE OF	3602230001C	22-SEP-1999

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03	PENNSYLVANIA	BRIDGEPORT, BOROUGH OF	4209480352F	09-AUG-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170000	22-SEP-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170001B	22-SEP-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170002B	22-SEP-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170003B	22-SEP-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170004B	22-SEP-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170005B	22-SEP-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170006B	22-SEP-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170007B	22-SEP-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170008B	22-SEP-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170009B	22-SEP-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170010B	22-SEP-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170011B	22-SEP-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170012B	22-SEP-1999
03	PENNSYLVANIA	CHANCEFORD, TOWNSHIP OF	4222170013B	22-SEP-1999
03	PENNSYLVANIA	COLUMBIA, BOROUGH OF	4205430001C	22-SEP-1999
03	PENNSYLVANIA	CONSHOHOCKEN, BOROUGH OF	4209490000	09-AUG-1999
03	PENNSYLVANIA	CONSHOHOCKEN, BOROUGH OF	4209490354F	09-AUG-1999
03	PENNSYLVANIA	HELLAM, TOWNSHIP OF	4209270000	22-SEP-1999
03	PENNSYLVANIA	HELLAM, TOWNSHIP OF	4209270001D	22-SEP-1999
03	PENNSYLVANIA	HELLAM, TOWNSHIP OF	4209270002D	22-SEP-1999
03	PENNSYLVANIA	HELLAM, TOWNSHIP OF	4209270003D	22-SEP-1999
03	PENNSYLVANIA	HELLAM, TOWNSHIP OF	4209270004D	22-SEP-1999
03	PENNSYLVANIA	HELLAM, TOWNSHIP OF	4209270005D	22-SEP-1999
03	PENNSYLVANIA	HELLAM, TOWNSHIP OF	4209270006D	22-SEP-1999
03	PENNSYLVANIA	HELLAM, TOWNSHIP OF	4209270007D	22-SEP-1999
03	PENNSYLVANIA	LOWER MERION, TOWNSHIP OF	4207010000	09-AUG-1999
03	PENNSYLVANIA	LOWER MERION, TOWNSHIP OF	4207010354F	09-AUG-1999
03	PENNSYLVANIA	LOWER WINDSOR, TOWNSHIP OF	4211870000	22-SEP-1999
03	PENNSYLVANIA	LOWER WINDSOR, TOWNSHIP OF	4211870001C	22-SEP-1999
03	PENNSYLVANIA	LOWER WINDSOR, TOWNSHIP OF	4211870002C	22-SEP-1999
03	PENNSYLVANIA	LOWER WINDSOR, TOWNSHIP OF	4211870003C	22-SEP-1999
03	PENNSYLVANIA	LOWER WINDSOR, TOWNSHIP OF	4211870004C	22-SEP-1999
03	PENNSYLVANIA	LOWER WINDSOR, TOWNSHIP OF	4211870005C	22-SEP-1999
03	PENNSYLVANIA	LOWER WINDSOR, TOWNSHIP OF	4211870006C	22-SEP-1999
03	PENNSYLVANIA	LOWER WINDSOR, TOWNSHIP OF	4211870007C	22-SEP-1999
03	PENNSYLVANIA	LOWER WINDSOR, TOWNSHIP OF	4211870008C	22-SEP-1999
03	PENNSYLVANIA	LOWER WINDSOR, TOWNSHIP OF	4211870009C	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570000	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570001C	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570002C	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570003C	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570004C	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570005C	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570006C	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570007C	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570008C	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570009C	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570010C	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570011C	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570012C	22-SEP-1999
03	PENNSYLVANIA	MANOR, TOWNSHIP OF	4205570013C	22-SEP-1999
03	PENNSYLVANIA	NORRISTOWN, BOROUGH OF	4253860000	09-AUG-1999
03	PENNSYLVANIA	NORRISTOWN, BOROUGH OF	4253860351F	09-AUG-1999
03	PENNSYLVANIA	NORRISTOWN, BOROUGH OF	4253860352F	09-AUG-1999
03	PENNSYLVANIA	PLYMOUTH, TOWNSHIP OF	4209550000	09-AUG-1999
03	PENNSYLVANIA	PLYMOUTH, TOWNSHIP OF	4209550352F	09-AUG-1999
03	PENNSYLVANIA	PLYMOUTH, TOWNSHIP OF	4209550354F	09-AUG-1999
03	PENNSYLVANIA	SMITHFIELD, TOWNSHIP OF	4218960000	06-DEC-1999
03	PENNSYLVANIA	SMITHFIELD, TOWNSHIP OF	4218960001B	06-DEC-1999
03	PENNSYLVANIA	SMITHFIELD, TOWNSHIP OF	4218960002B	06-DEC-1999
03	PENNSYLVANIA	SMITHFIELD, TOWNSHIP OF	4218960004B	06-DEC-1999
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03	PENNSYLVANIA	SMITHFIELD, TOWNSHIP OF	4218960006B	06-DEC-1999
03	PENNSYLVANIA	SMITHFIELD, TOWNSHIP OF	4218960007B	06-DEC-1999
03	PENNSYLVANIA	SMITHFIELD, TOWNSHIP OF	4218960008B	06-DEC-1999
03	PENNSYLVANIA	TUNKHANNOCK, BOROUGH OF	4209170001C	23-AUG-1999
03	PENNSYLVANIA	TUNKHANNOCK, TOWNSHIP OF	4222060000	23-AUG-1999
03	PENNSYLVANIA	TUNKHANNOCK, TOWNSHIP OF	4222060004C	23-AUG-1999
03	PENNSYLVANIA	TUNKHANNOCK, TOWNSHIP OF	4222060005C	23-AUG-1999
03	PENNSYLVANIA	UPPER MERION, TOWNSHIP OF	4209570000	09-AUG-1999
03	PENNSYLVANIA	UPPER MERION, TOWNSHIP OF	4209570332F	09-AUG-1999

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03	PENNSYLVANIA	UPPER MERION, TOWNSHIP OF	4209570352F	09-AUG-1999
03	PENNSYLVANIA	UPPER MERION, TOWNSHIP OF	4209570353F	09-AUG-1999
03	PENNSYLVANIA	UPPER MERION, TOWNSHIP OF	4209570354F	09-AUG-1999
03	PENNSYLVANIA	WEST CONSHOHOCKEN, BOROUGH OF	4207100000	09-AUG-1999
03	PENNSYLVANIA	WEST CONSHOHOCKEN, BOROUGH OF	4207100354F	09-AUG-1999
03	PENNSYLVANIA	WEST HEMPFIELD, TOWNSHIP OF	4217890000	22-SEP-1999
03	PENNSYLVANIA	WEST HEMPFIELD, TOWNSHIP OF	4217890001D	22-SEP-1999
03	PENNSYLVANIA	WEST HEMPFIELD, TOWNSHIP OF	4217890002D	22-SEP-1999
03	PENNSYLVANIA	WEST HEMPFIELD, TOWNSHIP OF	4217890003D	22-SEP-1999
03	PENNSYLVANIA	WEST HEMPFIELD, TOWNSHIP OF	4217890005D	22-SEP-1999
03	PENNSYLVANIA	WEST HEMPFIELD, TOWNSHIP OF	4217890006D	22-SEP-1999
03	PENNSYLVANIA	WEST HEMPFIELD, TOWNSHIP OF	4217890007D	22-SEP-1999
03	PENNSYLVANIA	WEST NORRITON, TOWNSHIP OF	4207110000	09-AUG-1999
03	PENNSYLVANIA	WEST NORRITON, TOWNSHIP OF	4207110332F	09-AUG-1999
03	PENNSYLVANIA	WEST NORRITON, TOWNSHIP OF	4207110351F	09-AUG-1999
03	PENNSYLVANIA	WRIGHTSVILLE, BOROUGH OF	4209430001C	22-SEP-1999
03	VIRGINIA	LURAY, TOWN OF	5101100002C	23-AUG-1999
03	VIRGINIA	ROCKY MOUNT, TOWN OF	5102910005B	08-NOV-1999
03	WEST VIRGINIA	MINERAL COUNTY *	5401290000	20-OCT-1999
03	WEST VIRGINIA	MINERAL COUNTY *	5401290105C	20-OCT-1999
03	WEST VIRGINIA	MINERAL COUNTY *	5401290110C	20-OCT-1999
04	GEORGIA	BIBB COUNTY*	130011IND0	22-SEP-1999
04	GEORGIA	COWETA COUNTY *	1302980000	08-SEP-1999
04	GEORGIA	COWETA COUNTY *	1302980140B	08-SEP-1999
04	GEORGIA	COWETA COUNTY *	1302980230B	08-SEP-1999
04	GEORGIA	COWETA COUNTY *	1302980240B	08-SEP-1999
04	GEORGIA	COWETA COUNTY *	1302980250B	08-SEP-1999
04	GEORGIA	DALLAS, CITY OF	13223C0000	08-NOV-1999
04	GEORGIA	DALLAS, CITY OF	13223C0136B	08-NOV-1999
04	GEORGIA	DALLAS, CITY OF	13223C0137B	08-NOV-1999
04	GEORGIA	DALLAS, CITY OF	13223C0139B	08-NOV-1999
04	GEORGIA	DALLAS, CITY OF	13223C0141B	08-NOV-1999
04	GEORGIA	DALLAS, CITY OF	13223C0143B	08-NOV-1999
04	GEORGIA	GILMER COUNTY*	13123C0000	23-AUG-1999
04	GEORGIA	GILMER COUNTY*	13123C0060C	23-AUG-1999
04	GEORGIA	GILMER COUNTY*	13123C0070C	23-AUG-1999
04	GEORGIA	GILMER COUNTY*	13123C0075C	23-AUG-1999
04	GEORGIA	HIRAM, CITY OF	13223C0000	08-NOV-1999
04	GEORGIA	HIRAM, CITY OF	13223C0141B	08-NOV-1999
04	GEORGIA	HIRAM, CITY OF	13223C0142B	08-NOV-1999
04	GEORGIA	HIRAM, CITY OF	13223C0143B	08-NOV-1999
04	GEORGIA	HIRAM, CITY OF	13223C0144B	08-NOV-1999
04	GEORGIA	HIRAM, CITY OF	13223C0163B	08-NOV-1999
04	GEORGIA	HIRAM, CITY OF	13223C0227B	08-NOV-1999
04	GEORGIA	HIRAM, CITY OF	13223C0229B	08-NOV-1999
04	GEORGIA	HIRAM, CITY OF	13223C0231B	08-NOV-1999
04	GEORGIA	HIRAM, CITY OF	13223C0232B	08-NOV-1999
04	GEORGIA	HIRAM, CITY OF	13223C0233B	08-NOV-1999
04	GEORGIA	LOWNDES COUNTY	1304690000	08-NOV-1999
04	GEORGIA	LOWNDES COUNTY	1304690085C	08-NOV-1999
04	GEORGIA	MACON, CITY OF	1300110000	22-SEP-1999
04	GEORGIA	MACON, CITY OF	1300110041E	22-SEP-1999
04	GEORGIA	MACON, CITY OF	1300110042E	22-SEP-1999
04	GEORGIA	MACON, CITY OF	1300110043E	22-SEP-1999
04	GEORGIA	PAULDING COUNTY *	13223C0000	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0025B**	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0033B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0034B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0037B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0039B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0041B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0042B	08-NOV-1999
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04	GEORGIA	PAULDING COUNTY *	13223C0044B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0110B**	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0117B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0118B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0119B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0126B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0127B	08-NOV-1999
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04	GEORGIA	PAULDING COUNTY *	13223C0134B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0136B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0137B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0138B	08-NOV-1999
04	GEORGIA	PAULDING COUNTY *	13223C0139B	08-NOV-1999
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04	GEORGIA	PAULDING COUNTY *	13223C0184B	08-NOV-1999
04	KENTUCKY	OWEN COUNTY*	210186 01***	01-JUL-1999
04	KENTUCKY	OWEN COUNTY*	210186 02***	01-JUL-1999
04	KENTUCKY	OWEN COUNTY*	210186 03***	01-JUL-1999
04	KENTUCKY	OWEN COUNTY*	210186 04***	01-JUL-1999
04	KENTUCKY	OWEN COUNTY*	210186 05***	01-JUL-1999
04	KENTUCKY	OWEN COUNTY*	210186 06***	01-JUL-1999
04	MISSISSIPPI	BALDWYN, CITY OF	28081C0000	20-OCT-1999
04	MISSISSIPPI	BALDWYN, CITY OF	28081C0025D	20-OCT-1999
04	MISSISSIPPI	BALDWYN, CITY OF	28081C0050D	20-OCT-1999
04	MISSISSIPPI	BALDWYN, CITY OF	28081C0085D	20-OCT-1999
04	MISSISSIPPI	BALDWYN, CITY OF	28081C0125D	20-OCT-1999
04	MISSISSIPPI	GUNTOWN, TOWN OF	28081C0000	20-OCT-1999
04	MISSISSIPPI	GUNTOWN, TOWN OF	28081C0085D	20-OCT-1999
04	MISSISSIPPI	GUNTOWN, TOWN OF	28081C0095D	20-OCT-1999
04	MISSISSIPPI	HOLMES COUNTY *	2802110000	22-SEP-1999
04	MISSISSIPPI	HOLMES COUNTY *	2802110095D	22-SEP-1999
04	MISSISSIPPI	HOLMES COUNTY *	2802110100D	22-SEP-1999
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04	MISSISSIPPI	LEE COUNTY *	28081C0025D	20-OCT-1999
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04	MISSISSIPPI	LEE COUNTY *	28081C0100D	20-OCT-1999
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04	MISSISSIPPI	LEE COUNTY *	28081C0161D	20-OCT-1999
04	MISSISSIPPI	LEE COUNTY *	28081C0162D	20-OCT-1999
04	MISSISSIPPI	LEE COUNTY *	28081C0166D	20-OCT-1999
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04	MISSISSIPPI	LEE COUNTY *	28081C0205D	20-OCT-1999
04	MISSISSIPPI	LEE COUNTY *	28081C0207D	20-OCT-1999
04	MISSISSIPPI	LEE COUNTY *	28081C0209D	20-OCT-1999
04	MISSISSIPPI	LEE COUNTY *	28081C0210D	20-OCT-1999
04	MISSISSIPPI	LEE COUNTY *	28081C0215D	20-OCT-1999
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04	MISSISSIPPI	LEE COUNTY *	28081C0310D	20-OCT-1999
04	MISSISSIPPI	NETTLETON, TOWN OF	28081C0000	20-OCT-1999
04	MISSISSIPPI	NETTLETON, TOWN OF	28081C0310D	20-OCT-1999
04	MISSISSIPPI	NETTLETON, TOWN OF	28081C0350D	20-OCT-1999
04	MISSISSIPPI	PLANTERSVILLE, VILLAGE OF	28081C0000	20-OCT-1999
04	MISSISSIPPI	PLANTERSVILLE, VILLAGE OF	28081C0231D	20-OCT-1999
04	MISSISSIPPI	PLANTERSVILLE, VILLAGE OF	28081C0233D	20-OCT-1999
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04	MISSISSIPPI	SALTILLO, TOWN OF	28081C0100D	20-OCT-1999
04	MISSISSIPPI	SALTILLO, TOWN OF	28081C0155D	20-OCT-1999
04	MISSISSIPPI	SALTILLO, TOWN OF	28081C0160D	20-OCT-1999
04	MISSISSIPPI	SHANNON, TOWN OF	28081C0000	20-OCT-1999
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04	MISSISSIPPI	SHANNON, TOWN OF	28081C0305D	20-OCT-1999
04	MISSISSIPPI	SHANNON, TOWN OF	28081C0310D	20-OCT-1999
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04	MISSISSIPPI	TUPELO, CITY OF	28081C0143D	20-OCT-1999
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04	MISSISSIPPI	TUPELO, CITY OF	28081C0154D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0155D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0161D	20-OCT-1999
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04	MISSISSIPPI	TUPELO, CITY OF	28081C0163D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0164D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0166D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0167D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0168D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0169D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0207D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0209D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0210D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0226D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0227D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0228D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0229D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0231D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0232D	20-OCT-1999
04	MISSISSIPPI	TUPELO, CITY OF	28081C0233D	20-OCT-1999
04	MISSISSIPPI	VERONA,TOWN OF	28081C0000	20-OCT-1999
04	MISSISSIPPI	VERONA,TOWN OF	28081C0228D	20-OCT-1999
04	MISSISSIPPI	VERONA,TOWN OF	28081C0229D	20-OCT-1999
04	MISSISSIPPI	VERONA,TOWN OF	28081C0240D	20-OCT-1999
04	NORTH CAROLINA	ASHE COUNTY *	37009C0000	20-OCT-1999
04	NORTH CAROLINA	ASHE COUNTY *	37009C0132F	20-OCT-1999
04	NORTH CAROLINA	ASHE COUNTY *	37009C0153F	20-OCT-1999
04	NORTH CAROLINA	HERTFORD COUNTY *	3703770001A**	01-NOV-1999
04	NORTH CAROLINA	HERTFORD COUNTY *	3703770002A**	01-NOV-1999
04	NORTH CAROLINA	HERTFORD COUNTY *	3703770003A**	01-NOV-1999
04	NORTH CAROLINA	HERTFORD COUNTY *	3703770005A**	01-NOV-1999
04	NORTH CAROLINA	HERTFORD COUNTY *	3703770006A**	01-NOV-1999
04	NORTH CAROLINA	LEGGETT, TOWN OF	3703170005B	
04	NORTH CAROLINA	TRENT WOODS, TOWNSHIP OF	3704340000	08-SEP-1999
04	NORTH CAROLINA	TRENT WOODS, TOWNSHIP OF	3704340001B	08-SEP-1999
04	NORTH CAROLINA	TRENT WOODS, TOWNSHIP OF	3704340002B	08-SEP-1999
04	NORTH CAROLINA	WILKES COUNTY *	3702560175D	09-AUG-1999
04	NORTH CAROLINA	WILKES COUNTY *	370256C0000	09-AUG-1999
04	NORTH CAROLINA	WILKESBORO, TOWN OF	3702590005E	09-AUG-1999
04	SOUTH CAROLINA	ATLANTIC BEACH, TOWN OF	45051C0000	23-AUG-1999
04	SOUTH CAROLINA	ATLANTIC BEACH, TOWN OF	45051C0586H	23-AUG-1999
04	SOUTH CAROLINA	ATLANTIC BEACH, TOWN OF	45051C0587H	23-AUG-1999
04	SOUTH CAROLINA	AYNOR, TOWN OF	45051C0000	23-AUG-1999
04	SOUTH CAROLINA	AYNOR, TOWN OF	45051C0175H	23-AUG-1999
04	SOUTH CAROLINA	AYNOR, TOWN OF	45051C0325H	23-AUG-1999
04	SOUTH CAROLINA	BRIARCLIFF ACRES, TOWN OF	45051C0000	23-AUG-1999
04	SOUTH CAROLINA	BRIARCLIFF ACRES, TOWN OF	45051C0567H	23-AUG-1999
04	SOUTH CAROLINA	BRIARCLIFF ACRES, TOWN OF	45051C0587H	23-AUG-1999
04	SOUTH CAROLINA	CONWAY, TOWN OF	45051C0000	23-AUG-1999

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04	SOUTH CAROLINA	CONWAY, TOWN OF	45051C0502H	23-AUG-1999
04	SOUTH CAROLINA	CONWAY, TOWN OF	45051C0503H	23-AUG-1999
04	SOUTH CAROLINA	CONWAY, TOWN OF	45051C0504H	23-AUG-1999
04	SOUTH CAROLINA	CONWAY, TOWN OF	45051C0506H	23-AUG-1999
04	SOUTH CAROLINA	CONWAY, TOWN OF	45051C0508H	23-AUG-1999
04	SOUTH CAROLINA	CONWAY, TOWN OF	45051C0512H	23-AUG-1999
04	SOUTH CAROLINA	CONWAY, TOWN OF	45051C0516H	23-AUG-1999
04	SOUTH CAROLINA	HOLLYWOOD, TOWN OF	4500370000	20-DEC-1999
04	SOUTH CAROLINA	HOLLYWOOD, TOWN OF	4500370005C	20-DEC-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0000	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0025H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0050H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0075H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0100H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0150H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0175H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0200H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0225H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0250H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0275H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0300H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0325H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0340H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0345H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0350H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0355H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0360H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0365H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0370H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0380H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0385H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0390H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0395H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0405H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0410H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0415H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0420H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0438H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0439H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0475H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0500H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0501H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0502H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0503H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0504H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0506H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0507H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0508H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0509H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0511H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0512H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0513H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0514H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0516H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0517H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0518H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0519H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0530H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0535H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0540H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0545H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0555H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0560H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0561H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0563H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0564H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0566H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0567H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0568H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0569H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0578H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0579H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0580H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0581H	23-AUG-1999

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04	SOUTH CAROLINA	HORRY COUNTY *	45051C0582H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0583H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0584H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0586H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0587H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0591H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0601H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0602H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0603H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0604H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0606H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0630H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0635H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0645H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0652H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0655H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0660H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0665H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0670H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0679H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0680H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0681H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0682H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0683H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0684H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0691H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0694H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0694H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0694H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0696H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0697H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0698H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0701H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0702H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0703H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0706H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0730H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0731H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0732H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0734H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0751H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0752H	23-AUG-1999
04	SOUTH CAROLINA	HORRY COUNTY *	45051C0753H	23-AUG-1999
04	SOUTH CAROLINA	LORIS, TOWN OF	45051C0000	23-AUG-1999
04	SOUTH CAROLINA	LORIS, TOWN OF	45051C0225H	23-AUG-1999
04	SOUTH CAROLINA	LORIS, TOWN OF	45051C0250H	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0000	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0564H	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0568H	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0679H	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0683H	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0684H	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0694H	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0696H	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0697H	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0698H	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0701H	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0702H	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0703H	23-AUG-1999
04	SOUTH CAROLINA	MYRTLE BEACH, CITY OF	45051C0706H	23-AUG-1999
04	SOUTH CAROLINA	NORTH MYRTLE BEACH, TOWN OF	45051C0000	23-AUG-1999
04	SOUTH CAROLINA	NORTH MYRTLE BEACH, TOWN OF	45051C0578H	23-AUG-1999
04	SOUTH CAROLINA	NORTH MYRTLE BEACH, TOWN OF	45051C0579H	23-AUG-1999
04	SOUTH CAROLINA	NORTH MYRTLE BEACH, TOWN OF	45051C0581H	23-AUG-1999
04	SOUTH CAROLINA	NORTH MYRTLE BEACH, TOWN OF	45051C0582H	23-AUG-1999
04	SOUTH CAROLINA	NORTH MYRTLE BEACH, TOWN OF	45051C0583H	23-AUG-1999
04	SOUTH CAROLINA	NORTH MYRTLE BEACH, TOWN OF	45051C0584H	23-AUG-1999
04	SOUTH CAROLINA	NORTH MYRTLE BEACH, TOWN OF	45051C0585H	23-AUG-1999
04	SOUTH CAROLINA	NORTH MYRTLE BEACH, TOWN OF	45051C0586H	23-AUG-1999
04	SOUTH CAROLINA	NORTH MYRTLE BEACH, TOWN OF	45051C0587H	23-AUG-1999
04	SOUTH CAROLINA	NORTH MYRTLE BEACH, TOWN OF	45051C0591H	23-AUG-1999
04	SOUTH CAROLINA	NORTH MYRTLE BEACH, TOWN OF	45051C0601H	23-AUG-1999
04	SOUTH CAROLINA	NORTH MYRTLE BEACH, TOWN OF	45051C0603H	23-AUG-1999
04	SOUTH CAROLINA	RAVENEL, TOWN OF	4500430005C	20-DEC-1999

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04	SOUTH CAROLINA	SUMTER COUNTY *	4501820090B	23-AUG-1999
04	SOUTH CAROLINA	SURFSIDE BEACH, TOWN OF	45051C0000	23-AUG-1999
04	SOUTH CAROLINA	SURFSIDE BEACH, TOWN OF	45051C0694H	23-AUG-1999
04	SOUTH CAROLINA	SURFSIDE BEACH, TOWN OF	45051C0751H	23-AUG-1999
04	SOUTH CAROLINA	SURFSIDE BEACH, TOWN OF	45051C0752H	23-AUG-1999
04	SOUTH CAROLINA	SURFSIDE BEACH, TOWN OF	45051C0753H	23-AUG-1999
04	TENNESSEE	ASHLANDCITY, TOWN OF	47021C0000	06-DEC-1999
04	TENNESSEE	ASHLANDCITY, TOWN OF	47021C0140C	06-DEC-1999
04	TENNESSEE	ASHLANDCITY, TOWN OF	47021C0145C	06-DEC-1999
04	TENNESSEE	ASHLANDCITY, TOWN OF	47021C0205C	06-DEC-1999
04	TENNESSEE	ASHLANDCITY, TOWN OF	47021C0209C	06-DEC-1999
04	TENNESSEE	ASHLANDCITY, TOWN OF	47021C0210C	06-DEC-1999
04	TENNESSEE	ASHLANDCITY, TOWN OF	47021C0226C	06-DEC-1999
04	TENNESSEE	ASHLANDCITY, TOWN OF	47021C0228C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0000	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0025C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0050C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0075C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0085C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0105C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0110C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0120C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0130C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0135C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0140C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0145C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0155C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0175C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0185C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0195C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0205C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0208C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0209C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0210C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0215C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0216C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0217C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0220C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0226C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0228C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0236C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0238C	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0260C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0280C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0285C**	06-DEC-1999
04	TENNESSEE	CHEATHAM COUNTY *	47021C0290C**	06-DEC-1999
04	TENNESSEE	FAYETTEVILLE, CITY OF	47103C0000	20-DEC-1999
04	TENNESSEE	FAYETTEVILLE, CITY OF	47103C0161C	20-DEC-1999
04	TENNESSEE	FAYETTEVILLE, CITY OF	47103C0162C	20-DEC-1999
04	TENNESSEE	FAYETTEVILLE, CITY OF	47103C0163C	20-DEC-1999
04	TENNESSEE	FAYETTEVILLE, CITY OF	47103C0164C	20-DEC-1999
04	TENNESSEE	FAYETTEVILLE, CITY OF	47103C0166C	20-DEC-1999
04	TENNESSEE	FAYETTEVILLE, CITY OF	47103C0167C	20-DEC-1999
04	TENNESSEE	FAYETTEVILLE, CITY OF	47103C0168C	20-DEC-1999
04	TENNESSEE	FAYETTEVILLE, CITY OF	47103C0169C	20-DEC-1999
04	TENNESSEE	FAYETTEVILLE, CITY OF	47103C0277C	20-DEC-1999
04	TENNESSEE	FAYETTEVILLE, CITY OF	47103C0281C	20-DEC-1999
04	TENNESSEE	GORDONSVILLE, TOWN OF	4703950000	07-JUL-1999
04	TENNESSEE	GORDONSVILLE, TOWN OF	4703950001A	07-JUL-1999
04	TENNESSEE	GORDONSVILLE, TOWN OF	4703950002A	07-JUL-1999
04	TENNESSEE	KINGSTON SPRINGS, CITY OF	47021C0000	06-DEC-1999
04	TENNESSEE	KINGSTON SPRINGS, CITY OF	47021C0260C	06-DEC-1999
04	TENNESSEE	KINGSTON SPRINGS, CITY OF	47021C0280C	06-DEC-1999
04	TENNESSEE	LA VERGNE, CITY OF	47149C0000	08-NOV-1999
04	TENNESSEE	LA VERGNE, CITY OF	47149C0014F**	08-NOV-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0000	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0050C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0075C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0100C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0125C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0150C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0161C	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0162C	20-DEC-1999

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04	TENNESSEE	LINCOLN COUNTY*	47103C0164C	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0166C	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0167C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0168C	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0169C	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0175C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0200C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0225C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0250C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0275C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0277C	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0281C	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0300C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0325C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0350C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0425C**	20-DEC-1999
04	TENNESSEE	LINCOLN COUNTY*	47103C0450C**	20-DEC-1999
04	TENNESSEE	MURFREESBORO, CITY OF	47149C0000	08-NOV-1999
04	TENNESSEE	MURFREESBORO, CITY OF	47149C0141F	08-NOV-1999
04	TENNESSEE	MURFREESBORO, CITY OF	47149C0143F	08-NOV-1999
04	TENNESSEE	MURFREESBORO, CITY OF	47149C0144F	08-NOV-1999
04	TENNESSEE	MURFREESBORO, CITY OF	47149C0161F	08-NOV-1999
04	TENNESSEE	MURFREESBORO, CITY OF	47149C0163F	08-NOV-1999
04	TENNESSEE	MURFREESBORO, CITY OF	47149C0255F	08-NOV-1999
04	TENNESSEE	MURFREESBORO, CITY OF	47149C0257F	08-NOV-1999
04	TENNESSEE	MURFREESBORO, CITY OF	47149C0259F	08-NOV-1999
04	TENNESSEE	MURFREESBORO, CITY OF	47149C0260F	08-NOV-1999
04	TENNESSEE	MURFREESBORO, CITY OF	47149C0276F	08-NOV-1999
04	TENNESSEE	PEGRAM, TOWNSHIP OF	47021C0000	06-DEC-1999
04	TENNESSEE	PEGRAM, TOWNSHIP OF	47021C0215C	06-DEC-1999
04	TENNESSEE	PEGRAM, TOWNSHIP OF	47021C0220C	06-DEC-1999
04	TENNESSEE	PEGRAM, TOWNSHIP OF	47021C0280C	06-DEC-1999
04	TENNESSEE	PEGRAM, TOWNSHIP OF	47021C0285C	06-DEC-1999
04	TENNESSEE	PETERSBURG, CITY OF	47103C0000	20-DEC-1999
04	TENNESSEE	PETERSBURG, CITY OF	47103C0050C	20-DEC-1999
04	TENNESSEE	RUTHERFORD COUNTY *	47149C0000	08-NOV-1999
04	TENNESSEE	RUTHERFORD COUNTY *	47149C0141F	08-NOV-1999
04	TENNESSEE	RUTHERFORD COUNTY *	47149C0143F	08-NOV-1999
04	TENNESSEE	RUTHERFORD COUNTY *	47149C0144F	08-NOV-1999
04	TENNESSEE	RUTHERFORD COUNTY *	47149C0161F	08-NOV-1999
04	TENNESSEE	RUTHERFORD COUNTY *	47149C0163F	08-NOV-1999
04	TENNESSEE	RUTHERFORD COUNTY *	47149C0255F	08-NOV-1999
04	TENNESSEE	RUTHERFORD COUNTY *	47149C0259F	08-NOV-1999
04	TENNESSEE	RUTHERFORD COUNTY *	47149C0260F	08-NOV-1999
04	TENNESSEE	RUTHERFORD COUNTY *	47149C0276F	08-NOV-1999
04	TENNESSEE	SMITH COUNTY *	4702830000	07-JUL-1999
04	TENNESSEE	SMITH COUNTY *	4702830069C	07-JUL-1999
04	TENNESSEE	SMITH COUNTY *	4702830088C	07-JUL-1999
04	TENNESSEE	SMITH COUNTY *	4702830100C**	07-JUL-1999
04	TENNESSEE	SMITH COUNTY *	4702830107C	07-JUL-1999
04	TENNESSEE	SMITH COUNTY *	4702830125C**	07-JUL-1999
05	ILLINOIS	ROMEOVILLE, VILLAGE OF	17197C0000	22-SEP-1999
05	ILLINOIS	ROMEOVILLE, VILLAGE OF	17197C0045F	22-SEP-1999
05	ILLINOIS	ROMEOVILLE, VILLAGE OF	17197C0065F	22-SEP-1999
05	ILLINOIS	WILL COUNTY *	17197C0000	22-SEP-1999
05	ILLINOIS	WILL COUNTY *	17197C0033F	22-SEP-1999
05	ILLINOIS	WILL COUNTY *	17197C0045F	22-SEP-1999
05	ILLINOIS	WILL COUNTY *	17197C0065F	22-SEP-1999
05	ILLINOIS	WILL COUNTY *	17197C0135F	22-SEP-1999
05	MICHIGAN	FARMINGTON HILLS, CITY OF	2601720000	08-NOV-1999
05	MICHIGAN	FARMINGTON HILLS, CITY OF	2601720001C	08-NOV-1999
05	MICHIGAN	FARMINGTON HILLS, CITY OF	2601720002C	08-NOV-1999
05	MICHIGAN	FARMINGTON HILLS, CITY OF	2601720003C	08-NOV-1999
05	MICHIGAN	FARMINGTON HILLS, CITY OF	2601720004C	08-NOV-1999
05	MICHIGAN	FARMINGTON HILLS, CITY OF	2601720005C	08-NOV-1999
05	MICHIGAN	FARMINGTON HILLS, CITY OF	2601720006C	08-NOV-1999
05	MICHIGAN	FARMINGTON HILLS, CITY OF	2601720007C	08-NOV-1999
05	MICHIGAN	FARMINGTON HILLS, CITY OF	2601720008C	08-NOV-1999
05	MICHIGAN	FARMINGTON HILLS, CITY OF	2601720009C	08-NOV-1999
05	MICHIGAN	FARMINGTON HILLS, CITY OF	2601720010C	08-NOV-1999
05	MICHIGAN	FARMINGTON HILLS, CITY OF	2601720011C	08-NOV-1999
05	MICHIGAN	FARMINGTON HILLS, CITY OF	2601720012C	08-NOV-1999
05	MICHIGAN	HAY, TOWNSHIP OF	2609840001A	22-SEP-1999

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05	MICHIGAN	NASHVILLE, CITY OF	2609020001A	06-DEC-1999
05	MICHIGAN	NORTHVILLE, CITY OF	2602350001B	06-DEC-1999
05	MICHIGAN	OWOSSO, TOWNSHIP OF	2608090000	20-OCT-1999
05	MICHIGAN	OWOSSO, TOWNSHIP OF	2608090005A	20-OCT-1999
05	MICHIGAN	OWOSSO, TOWNSHIP OF	2608090010A	20-OCT-1999
05	MINNESOTA	BLUE EARTH COUNTY *	2752310000	21-JUL-1999
05	MINNESOTA	BLUE EARTH COUNTY *	2752310025E	21-JUL-1999
05	MINNESOTA	BLUE EARTH COUNTY *	2752310040E	21-JUL-1999
05	MINNESOTA	BLUE EARTH COUNTY *	2752310050E	21-JUL-1999
05	MINNESOTA	CLEVELAND, CITY OF	27079C0000	21-JUL-1999
05	MINNESOTA	CLEVELAND, CITY OF	27079C0255D	21-JUL-1999
05	MINNESOTA	COURTLAND, CITY OF	27103C0000	21-JUL-1999
05	MINNESOTA	COURTLAND, CITY OF	27103C0265G	21-JUL-1999
05	MINNESOTA	ELYSIAN, CITY OF	27079C0000	21-JUL-1999
05	MINNESOTA	ELYSIAN, CITY OF	27079C0425D**	21-JUL-1999
05	MINNESOTA	HEIDELBERG, CITY OF	27079C0000	21-JUL-1999
05	MINNESOTA	HEIDELBERG, CITY OF	27079C0075D**	21-JUL-1999
05	MINNESOTA	HEIDELBERG, CITY OF	27079C0088D**	21-JUL-1999
05	MINNESOTA	HEIDELBERG, CITY OF	27079C0175D	21-JUL-1999
05	MINNESOTA	HEIDELBERG, CITY OF	27079C0200D	21-JUL-1999
05	MINNESOTA	KASOTA, CITY OF	27079C0236D	21-JUL-1999
05	MINNESOTA	KASOTA, CITY OF	27079C0237D	21-JUL-1999
05	MINNESOTA	KASOTA, CITY OF	27079CIND0	21-JUL-1999
05	MINNESOTA	KILKENNY, CITY OF	27079C0000	21-JUL-1999
05	MINNESOTA	KILKENNY, CITY OF	27079C0325D	21-JUL-1999
05	MINNESOTA	LAFAYETTE, CITY OF	27103C0000	21-JUL-1999
05	MINNESOTA	LE CENTER, CITY OF	27079C0000	21-JUL-1999
05	MINNESOTA	LE CENTER, CITY OF	27079C0175D**	21-JUL-1999
05	MINNESOTA	LE SUEUR COUNTY *	27079C0000	21-JUL-1999
05	MINNESOTA	LE SUEUR COUNTY *	27079C0020D	21-JUL-1999
05	MINNESOTA	LE SUEUR COUNTY *	27079C0040D**	21-JUL-1999
05	MINNESOTA	LE SUEUR COUNTY *	27079C0045D**	21-JUL-1999
05	MINNESOTA	LE SUEUR COUNTY *	27079C0075D**	21-JUL-1999
05	MINNESOTA	LE SUEUR, CITY OF	27079C0000	21-JUL-1999
05	MINNESOTA	LE SUEUR, CITY OF	27079C0020D	21-JUL-1999
05	MINNESOTA	LE SUEUR, CITY OF	27079C0110D	21-JUL-1999
05	MINNESOTA	LE SUEUR, CITY OF	27079C0120D	21-JUL-1999
05	MINNESOTA	MONTGOMERY, CITY OF	27079C0200	21-JUL-1999
05	MINNESOTA	MONTOGOMERY, CITY OF	27079C0000	21-JUL-1999
05	MINNESOTA	NEW PRAGUE, CITY OF	27079C0000	21-JUL-1999
05	MINNESOTA	NEW PRAGUE, CITY OF	27079C0087D	21-JUL-1999
05	MINNESOTA	NEW PRAGUE, CITY OF	27079C0088D**	21-JUL-1999
05	MINNESOTA	NEW PRAGUE, CITY OF	27079C0089D**	21-JUL-1999
05	MINNESOTA	NEW PRAGUE, CITY OF	27079C0091D	21-JUL-1999
05	MINNESOTA	NEW PRAGUE, CITY OF	27079C0093D	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0000	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0010G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0030G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0035G**	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0040G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0045G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0065G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0070G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0180G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0185G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0190G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0195G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0205G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0210G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0230G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0235G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0240G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0245G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0265G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0320G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0325G**	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0330G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0340G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0355G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0360G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0380G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0385G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0395G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0405G	21-JUL-1999

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05	MINNESOTA	NICOLLET COUNTY *	27103C0410G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0415G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0416G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0417G	21-JUL-1999
05	MINNESOTA	NICOLLET COUNTY *	27103C0420G	21-JUL-1999
05	MINNESOTA	NICOLLET, CITY OF	27103C0000	21-JUL-1999
05	MINNESOTA	NORTH MANKATO, CITY OF	27103C0000	21-JUL-1999
05	MINNESOTA	NORTH MANKATO, CITY OF	27103C0410G	21-JUL-1999
05	MINNESOTA	NORTH MANKATO, CITY OF	27103C0415G	21-JUL-1999
05	MINNESOTA	NORTH MANKATO, CITY OF	27103C0416G	21-JUL-1999
05	MINNESOTA	NORTH MANKATO, CITY OF	27103C0417G	21-JUL-1999
05	MINNESOTA	SAUK RAPIDS, CITY OF	2700230000	20-DEC-1999
05	MINNESOTA	SAUK RAPIDS, CITY OF	2700230001D**	20-DEC-1999
05	MINNESOTA	SAUK RAPIDS, CITY OF	2700230002D**	20-DEC-1999
05	MINNESOTA	ST. PETER, CITY OF	27103C0000	21-JUL-1999
05	MINNESOTA	ST. PETER, CITY OF	27103C0330G	21-JUL-1999
05	MINNESOTA	ST. PETER, CITY OF	27103C0340G	21-JUL-1999
05	MINNESOTA	WATERVILLE, CITY OF	27079C0000	21-JUL-1999
05	MINNESOTA	WATERVILLE, CITY OF	27079C0427D**	21-JUL-1999
05	MINNESOTA	WATERVILLE, CITY OF	27079C0429D**	21-JUL-1999
05	MINNESOTA	WATERVILLE, CITY OF	27079C0431D**	21-JUL-1999
05	MINNESOTA	WATERVILLE, CITY OF	27079C0433D	21-JUL-1999
05	OHIO	ASHVILLE, VILLAGE OF	39129C0000	30-SEP-1999
05	OHIO	ASHVILLE, VILLAGE OF	39129C0180H	30-SEP-1999
05	OHIO	BAY VILLAGE, CITY OF	3900930000	06-DEC-1999
05	OHIO	BAY VILLAGE, CITY OF	3900930002C	06-DEC-1999
05	OHIO	CIRCLEVILLE, CITY OF	39129C0000	30-SEP-1999
05	OHIO	CIRCLEVILLE, CITY OF	39129C0200H**	30-SEP-1999
05	OHIO	CIRCLEVILLE, CITY OF	39129C0302H	30-SEP-1999
05	OHIO	CIRCLEVILLE, CITY OF	39129C0306H	30-SEP-1999
05	OHIO	CIRCLEVILLE, CITY OF	39129C0307H	30-SEP-1999
05	OHIO	CIRCLEVILLE, CITY OF	39129C0308H	30-SEP-1999
05	OHIO	CIRCLEVILLE, CITY OF	39129C0309H	30-SEP-1999
05	OHIO	CIRCLEVILLE, CITY OF	39129C0325H	30-SEP-1999
05	OHIO	COMMERCIAL POINT, VILLAGE OF	39129C0000	30-SEP-1999
05	OHIO	COMMERCIAL POINT, VILLAGE OF	39129C0050H	30-SEP-1999
05	OHIO	DARBYVILLE, VILLAGE OF	39129C0000	30-SEP-1999
05	OHIO	DARBYVILLE, VILLAGE OF	39129C0155H**	30-SEP-1999
05	OHIO	HARRISBURG, VILLAGE OF	39129C0000	30-SEP-1999
05	OHIO	HARRISBURG, VILLAGE OF	39129C0025H**	30-SEP-1999
05	OHIO	NEW HOLLAND, VILLAGE OF	39129C0000	30-SEP-1999
05	OHIO	NEW HOLLAND, VILLAGE OF	39129C0250H**	30-SEP-1999
05	OHIO	NEW HOLLAND, VILLAGE OF	39129C0275H	30-SEP-1999
05	OHIO	ORIENT, VILLAGE OF	39129C0000	30-SEP-1999
05	OHIO	ORIENT, VILLAGE OF	39129C0025H**	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0000	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0025H**	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0050H	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0075H	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0087H	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0125H**	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0150H**	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0155H**	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0175H	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0180H	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0200H**	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0225H**	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0250H**	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0275H	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0300H**	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0302H	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0306H	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0307H	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0308H	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0309H	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0325H	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0350H**	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0375H**	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0400H**	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0425H**	30-SEP-1999
05	OHIO	PICKAWAY COUNTY *	39129C0450H**	30-SEP-1999
05	OHIO	SOLON, CITY OF	3901300000**	21-JUL-1999
05	OHIO	SOLON, CITY OF	3901300007C**	21-JUL-1999
05	OHIO	SOUTH BLOOMFIELD, VILLAGE OF	39129C0000	30-SEP-1999

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05	OHIO	SOUTH BLOOMFIELD, VILLAGE OF	39129C0180H	30-SEP-1999
05	OHIO	TARLTON, VILLAGE OF	39129C0000	30-SEP-1999
05	OHIO	TARLTON, VILLAGE OF	39129C0350H**	30-SEP-1999
05	OHIO	WILLIAMSPORT, VILLAGE OF	39129C0000	30-SEP-1999
05	OHIO	WILLIAMSPORT, VILLAGE OF	39129C0275H	30-SEP-1999
05	OHIO	WILLIAMSPORT, VILLAGE OF	39129C0300H**	30-SEP-1999
05	WISCONSIN	BLUE RIVER, VILLAGE OF	5501470001B	09-AUG-1999
05	WISCONSIN	GRANT COUNTY *	5555570000	20-DEC-1999
05	WISCONSIN	GRANT COUNTY *	5555570025C	20-DEC-1999
05	WISCONSIN	GRANT COUNTY *	5555570050C	20-DEC-1999
05	WISCONSIN	GRANT COUNTY *	5555570075C**	20-DEC-1999
05	WISCONSIN	GRANT COUNTY *	5555570150C	20-DEC-1999
05	WISCONSIN	GRANT COUNTY *	5555570175C**	20-DEC-1999
05	WISCONSIN	MUSCODA, VILLAGE OF	5501530001B	08-SEP-1999
05	WISCONSIN	OZAUKEE COUNTY *	55089C0000	06-DEC-1999
05	WISCONSIN	OZAUKEE COUNTY *	55089C0050E	06-DEC-1999
05	WISCONSIN	OZAUKEE COUNTY *	55089C0056E**	06-DEC-1999
05	WISCONSIN	PORT WASHINGTON, CITY OF	55089C0000	06-DEC-1999
05	WISCONSIN	PORT WASHINGTON, CITY OF	55089C0050E	06-DEC-1999
05	WISCONSIN	PORT WASHINGTON, CITY OF	55089C0056E	06-DEC-1999
05	WISCONSIN	SAUKVILLE, VILLAGE OF	55089C0000	06-DEC-1999
05	WISCONSIN	SAUKVILLE, VILLAGE OF	55089C0056E**	06-DEC-1999
06	AR	ALMA, CITY OF	05033CIND0 **	23-AUG-1999
06	AR	CHESTER, TOWN OF	05033CIND0 **	23-AUG-1999
06	AR	CRAWFORD COUNTY *	05033C0170G	23-AUG-1999
06	AR	CRAWFORD COUNTY *	05033CIND0 **	23-AUG-1999
06	AR	CRITTENDEN COUNTY	0504290025C	23-AUG-1999
06	AR	CRITTENDEN COUNTY	0504290100C	23-AUG-1999
06	AR	CRITTENDEN COUNTY	050429IND0 **	23-AUG-1999
06	AR	DYER, TOWN OF	05033CIND0 **	23-AUG-1999
06	AR	EARLE, CITY OF	0500540005D	23-AUG-1999
06	AR	ELKINS, CITY OF	05143CIND0 **	21-JUL-1999
06	AR	ELM SPRINGS, TOWN OF	05143CIND0 **	21-JUL-1999
06	AR	FARMINGTON, CITY OF	05143C0090D	21-JUL-1999
06	AR	FARMINGTON, CITY OF	05143C0095D	21-JUL-1999
06	AR	FARMINGTON, CITY OF	05143CIND0 **	21-JUL-1999
06	AR	FAYETTEVILLE, CITY OF	05143C0082D	21-JUL-1999
06	AR	FAYETTEVILLE, CITY OF	05143C0084D	21-JUL-1999
06	AR	FAYETTEVILLE, CITY OF	05143C0085D	21-JUL-1999
06	AR	FAYETTEVILLE, CITY OF	05143C0092D	21-JUL-1999
06	AR	FAYETTEVILLE, CITY OF	05143C0094D	21-JUL-1999
06	AR	FAYETTEVILLE, CITY OF	05143C0095D	21-JUL-1999
06	AR	FAYETTEVILLE, CITY OF	05143C0101E	21-JUL-1999
06	AR	FAYETTEVILLE, CITY OF	05143CIND0 **	21-JUL-1999
06	AR	GOSHEN, TOWN OF	05143CIND0 **	21-JUL-1999
06	AR	GREENLAND, CITY OF	05143C0094D	21-JUL-1999
06	AR	GREENLAND, CITY OF	05143CIND0 **	21-JUL-1999
06	AR	HOLLY GROVE, CITY OF	0501570001C	21-JUL-1999
06	AR	JOHNSON, CITY OF	05143C0082D	21-JUL-1999
06	AR	JOHNSON, CITY OF	05143CIND0 **	21-JUL-1999
06	AR	KIBLER, CITY OF	05033CIND0 **	23-AUG-1999
06	AR	LINCOLN, CITY OF	05143CIND0 **	21-JUL-1999
06	AR	MONROE COUNTY	050154 C	21-JUL-1999
06	AR	MOUNTAINBURG, CITY OF	05033CIND0 **	23-AUG-1999
06	AR	MULBERRY, CITY OF	05033CIND0 **	23-AUG-1999
06	AR	PRAIIE GROVE, CITY OF	05143CIND0 **	21-JUL-1999
06	AR	RUDY, TOWN OF	05033CIND0 **	23-AUG-1999
06	AR	SPRINGDALE, CITY OF	05143C0082D	21-JUL-1999
06	AR	SPRINGDALE, CITY OF	05143C0085D	21-JUL-1999
06	AR	SPRINGDALE, CITY OF	05143C0101E	21-JUL-1999
06	AR	TONTITOWN, TOWN OF	05143CIND0 **	21-JUL-1999
06	AR	VAN BUREN, CITY OF	05033C0170G	23-AUG-1999
06	AR	VAN BUREN, CITY OF	05033CIND0 **	23-AUG-1999
06	AR	WASHINGTON COUNTY	05143C0079D	21-JUL-1999
06	AR	WASHINGTON COUNTY	05143C0080D**	21-JUL-1999
06	AR	WASHINGTON COUNTY	05143C0082D	21-JUL-1999
06	AR	WASHINGTON COUNTY	05143C0083D	21-JUL-1999
06	AR	WASHINGTON COUNTY	05143C0084D	21-JUL-1999
06	AR	WASHINGTON COUNTY	05143C0085D**	21-JUL-1999
06	AR	WASHINGTON COUNTY	05143C0087D	21-JUL-1999
06	AR	WASHINGTON COUNTY	05143C0090D**	21-JUL-1999
06	AR	WASHINGTON COUNTY	05143C0091D	21-JUL-1999
06	AR	WASHINGTON COUNTY	05143C0092D	21-JUL-1999

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06	AR	WASHINGTON COUNTY	05143C0095D**	21-JUL-1999
06	AR	WASHINGTON COUNTY	05143C0101E	21-JUL-1999
06	AR	WASHINGTON COUNTY	05143C0103D	21-JUL-1999
06	AR	WASHINGTON COUNTY	05143CIND0 **	21-JUL-1999
06	AR	WEST FORK, CITY OF	05143CIND0 **	21-JUL-1999
06	AR	WINSLOW, CITY OF	05143CIND0 **	21-JUL-1999
06	LA	BALL, TOWN OF	2203730005D	22-NOV-1999
06	LA	FARMERVILLE, TOWN OF	2203250005C	22-NOV-1999
06	LA	HAMMOND, CITY OF	2202080001D	21-JUL-1999
06	LA	HAMMOND, CITY OF	2202080002D	21-JUL-1999
06	LA	HAMMOND, CITY OF	2202080003C	21-JUL-1999
06	LA	HAMMOND, CITY OF	2202080004C**	21-JUL-1999
06	LA	HAMMOND, CITY OF	2202080006C	21-JUL-1999
06	LA	HAMMOND, CITY OF	220208IND0 **	21-JUL-1999
06	LA	LINCOLN PARISH*	2203660002C	22-NOV-1999
06	LA	LINCOLN PARISH*	220366IND0 **	22-NOV-1999
06	LA	PONCHATOULA, TOWN OF	2202110005D	21-JUL-1999
06	LA	UNION PARISH*	2203590025C	22-NOV-1999
06	LA	UNION PARISH*	2203590050C	22-NOV-1999
06	LA	UNION PARISH*	2203590075C**	22-NOV-1999
06	LA	UNION PARISH*	2203590100C**	22-NOV-1999
06	LA	UNION PARISH*	2203590125C	22-NOV-1999
06	LA	UNION PARISH*	2203590150C	22-NOV-1999
06	LA	UNION PARISH*	2203590175C	22-NOV-1999
06	LA	UNION PARISH*	2203590200C**	22-NOV-1999
06	LA	UNION PARISH*	2203590225C	22-NOV-1999
06	LA	UNION PARISH*	2203590250C	22-NOV-1999
06	LA	UNION PARISH*	2203590275C	22-NOV-1999
06	LA	UNION PARISH*	2203590300C**	22-NOV-1999
06	LA	UNION PARISH*	220359IND0 **	22-NOV-1999
06	NM	CLOVIS, CITY OF	3500100033C	23-AUG-1999
06	NM	CLOVIS, CITY OF	3500100036C	23-AUG-1999
06	NM	CLOVIS, CITY OF	3500100037C	23-AUG-1999
06	NM	CLOVIS, CITY OF	3500100038C	23-AUG-1999
06	NM	CLOVIS, CITY OF	3500100039C	23-AUG-1999
06	NM	CLOVIS, CITY OF	3500100041C	23-AUG-1999
06	NM	CLOVIS, CITY OF	3500100043C	23-AUG-1999
06	NM	CLOVIS, CITY OF	3500100044C	23-AUG-1999
06	NM	CLOVIS, CITY OF	350010IND0 **	23-AUG-1999
06	OK	BIXBY, TOWN OF	40143C0520H	22-SEP-1999
06	OK	BIXBY, TOWN OF	40143C0540H	22-SEP-1999
06	OK	BIXBY, TOWN OF	40143C0603H	22-SEP-1999
06	OK	BIXBY, TOWN OF	40143C0605H	22-SEP-1999
06	OK	BIXBY, TOWN OF	40143C0610H	22-SEP-1999
06	OK	BIXBY, TOWN OF	40143C0620H	22-SEP-1999
06	OK	BIXBY, TOWN OF	40143C0630H	22-SEP-1999
06	OK	BIXBY, TOWN OF	40143C0635H	22-SEP-1999
06	OK	BIXBY, TOWN OF	40143C0640H	22-SEP-1999
06	OK	BIXBY, TOWN OF	40143C0645H	22-SEP-1999
06	OK	BIXBY, TOWN OF	40143C0680H	22-SEP-1999
06	OK	BIXBY, TOWN OF	40143C0685H	22-SEP-1999
06	OK	BIXBY, TOWN OF	40143C0705H	22-SEP-1999
06	OK	BIXBY, TOWN OF	40143CIND0 **	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0530H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0534H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0535H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0540H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0541H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0542H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0543H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0544H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0554H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0558H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0561H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0562H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0564H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0566H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0568H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0630H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0631H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0632H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0635H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143C0640H	22-SEP-1999

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06	OK	BROKEN ARROW, CITY OF	40143C0645H	22-SEP-1999
06	OK	BROKEN ARROW, CITY OF	40143CIND0 **	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143C0095H	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143C0113H	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143C0114H	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143C0115H	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143C0116H	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143C0118H	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143C0210H	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143C0226H	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143C0227H	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143C0228H	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143C0229H	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143C0231H	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143C0233H	22-SEP-1999
06	OK	COLLINSVILLE, CITY OF	40143CIND0 **	22-SEP-1999
06	OK	GLENPOOL, TOWN OF	40143C0582H	22-SEP-1999
06	OK	GLENPOOL, TOWN OF	40143C0584H	22-SEP-1999
06	OK	GLENPOOL, TOWN OF	40143C0595H	22-SEP-1999
06	OK	GLENPOOL, TOWN OF	40143C0601H	22-SEP-1999
06	OK	GLENPOOL, TOWN OF	40143C0603H	22-SEP-1999
06	OK	GLENPOOL, TOWN OF	40143C0605H	22-SEP-1999
06	OK	GLENPOOL, TOWN OF	40143C0660H	22-SEP-1999
06	OK	GLENPOOL, TOWN OF	40143C0680H	22-SEP-1999
06	OK	GLENPOOL, TOWN OF	40143CIND0 **	22-SEP-1999
06	OK	JENKS, CITY OF	40143C0492H	22-SEP-1999
06	OK	JENKS, CITY OF	40143C0494H	22-SEP-1999
06	OK	JENKS, CITY OF	40143C0511H	22-SEP-1999
06	OK	JENKS, CITY OF	40143C0512H	22-SEP-1999
06	OK	JENKS, CITY OF	40143C0513H	22-SEP-1999
06	OK	JENKS, CITY OF	40143C0514H	22-SEP-1999
06	OK	JENKS, CITY OF	40143C0582H	22-SEP-1999
06	OK	JENKS, CITY OF	40143C0601H	22-SEP-1999
06	OK	JENKS, CITY OF	40143C0603H	22-SEP-1999
06	OK	JENKS, CITY OF	40143C0605H	22-SEP-1999
06	OK	JENKS, CITY OF	40143C0610H	22-SEP-1999
06	OK	JENKS, CITY OF	40143CIND0 **	22-SEP-1999
06	OK	KAY COUNTY*	40143C0477H	22-SEP-1999
06	OK	LIBERTY, TOWN OF	40143C0660H	22-SEP-1999
06	OK	LIBERTY, TOWN OF	40143C0680H	22-SEP-1999
06	OK	LIBERTY, TOWN OF	40143C0685H	22-SEP-1999
06	OK	LIBERTY, TOWN OF	40143CIND0 **	22-SEP-1999
06	OK	LINCOLN COUNTY*	4004570165B	06-DEC-1999
06	OK	LINCOLN COUNTY*	4004570175B **	06-DEC-1999
06	OK	LINCOLN COUNTY*	400457IND0 **	06-DEC-1999
06	OK	LOTSEE, VILLAGE OF	40143C0315H	22-SEP-1999
06	OK	LOTSEE, VILLAGE OF	40143CIND0 **	22-SEP-1999
06	OK	NEWCASTLE, TOWN OF	4001030003F	22-NOV-1999
06	OK	NEWCASTLE, TOWN OF	4001030005E	22-NOV-1999
06	OK	NEWCASTLE, TOWN OF	4001030006E	22-NOV-1999
06	OK	NEWCASTLE, TOWN OF	4001030007F	22-NOV-1999
06	OK	NEWCASTLE, TOWN OF	4001030009E	22-NOV-1999
06	OK	NEWCASTLE, TOWN OF	400103IND0 **	22-NOV-1999
06	OK	OWASSO, CITY OF	40143C0210H	22-SEP-1999
06	OK	OWASSO, CITY OF	40143C0220H	22-SEP-1999
06	OK	OWASSO, CITY OF	40143C0228H	22-SEP-1999
06	OK	OWASSO, CITY OF	40143C0229H	22-SEP-1999
06	OK	OWASSO, CITY OF	40143C0233H	22-SEP-1999
06	OK	OWASSO, CITY OF	40143C0236H	22-SEP-1999
06	OK	OWASSO, CITY OF	40143C0237H	22-SEP-1999
06	OK	OWASSO, CITY OF	40143C0238H	22-SEP-1999
06	OK	OWASSO, CITY OF	40143C0239H	22-SEP-1999
06	OK	OWASSO, CITY OF	40143C0245H	22-SEP-1999
06	OK	OWASSO, CITY OF	40143C0360H	22-SEP-1999
06	OK	OWASSO, CITY OF	40143C0380H	22-SEP-1999
06	OK	OWASSO, CITY OF	40143CIND0 **	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143C0190H	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143C0295H	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143C0305H	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143C0310H	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143C0315H	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143C0320H	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143C0330H	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143C0336H	22-SEP-1999

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06	OK	SAND SPRINGS, CITY OF	40143C0455H	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143C0457H	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143C0459H	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143C0460H	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143C0476H	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143C0477H	22-SEP-1999
06	OK	SAND SPRINGS, CITY OF	40143CIND0 **	22-SEP-1999
06	OK	SKIATOOK, TOWN OF	40143C0070H	22-SEP-1999
06	OK	SKIATOOK, TOWN OF	40143C0090H	22-SEP-1999
06	OK	SKIATOOK, TOWN OF	40143C0095H	22-SEP-1999
06	OK	SKIATOOK, TOWN OF	40143C0180H	22-SEP-1999
06	OK	SKIATOOK, TOWN OF	40143C0182H	22-SEP-1999
06	OK	SKIATOOK, TOWN OF	40143C0184H	22-SEP-1999
06	OK	SKIATOOK, TOWN OF	40143C0190H	22-SEP-1999
06	OK	SKIATOOK, TOWN OF	40143C0201H	22-SEP-1999
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06	OK	SKIATOOK, TOWN OF	40143C0203H	22-SEP-1999
06	OK	SKIATOOK, TOWN OF	40143C0204H	22-SEP-1999
06	OK	SKIATOOK, TOWN OF	40143C0210H	22-SEP-1999
06	OK	SKIATOOK, TOWN OF	40143CIND0 **	22-SEP-1999
06	OK	SPERRY, TOWN OF	40143C0211H	22-SEP-1999
06	OK	SPERRY, TOWN OF	40143C0212H	22-SEP-1999
06	OK	SPERRY, TOWN OF	40143C0213H	22-SEP-1999
06	OK	SPERRY, TOWN OF	40143CIND0 **	22-SEP-1999
06	OK	TULSA COUNTY *	40143C0070H	22-SEP-1999
06	OK	TULSA COUNTY *	40143C0090H	22-SEP-1999
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06	OK	TULSA COUNTY *	40143C0116H	22-SEP-1999
06	OK	TULSA COUNTY *	40143C0118H	22-SEP-1999
06	OK	TULSA COUNTY *	40143C0180H	22-SEP-1999
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06	OK	TULSA COUNTY *	40143C0566H	22-SEP-1999
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06	OK	TULSA COUNTY *	40143C0705H	22-SEP-1999
06	OK	TULSA COUNTY *	40143CIND0 **	22-SEP-1999
06	OK	TULSA, CITY OF	40143C0204H	22-SEP-1999
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06	OK	TULSA, CITY OF	40143C0370H	22-SEP-1999
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06	OK	TULSA, CITY OF	40143C0512H	22-SEP-1999
06	OK	TULSA, CITY OF	40143C0520H	22-SEP-1999
06	OK	TULSA, CITY OF	40143C0530H	22-SEP-1999
06	OK	TULSA, CITY OF	40143C0534H	22-SEP-1999
06	OK	TULSA, CITY OF	40143C0535H	22-SEP-1999
06	OK	TULSA, CITY OF	40143C0540H	22-SEP-1999
06	OK	TULSA, CITY OF	40143C0605H	22-SEP-1999
06	OK	TULSA, CITY OF	40143C0610H	22-SEP-1999
06	OK	TULSA, CITY OF	40143CIND0 **	22-SEP-1999
06	TX	ALVIN, CITY OF	48039C0045J**	22-SEP-1999
06	TX	ALVIN, CITY OF	48039C0045J	22-SEP-1999
06	TX	ALVIN, CITY OF	48039C0065J	22-SEP-1999
06	TX	ALVIN, CITY OF	48039C0135I	22-SEP-1999
06	TX	ALVIN, CITY OF	48039C0175I	22-SEP-1999
06	TX	ALVIN, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	ANGLETON, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	BAILEYS PRAIRIE, VILLAGE OF	48039CIND0 **	22-SEP-1999
06	TX	BONNEY, TOWN OF	48039CIND0 **	22-SEP-1999
06	TX	BRAZORIA COUNTY *	48039C0010I**	22-SEP-1999
06	TX	BRAZORIA COUNTY *	48039C0030I	22-SEP-1999
06	TX	BRAZORIA COUNTY *	48039C0035I	22-SEP-1999
06	TX	BRAZORIA COUNTY *	48039C0040I	22-SEP-1999
06	TX	BRAZORIA COUNTY *	48039C0045J**	22-SEP-1999
06	TX	BRAZORIA COUNTY *	48039C0045J	22-SEP-1999
06	TX	BRAZORIA COUNTY *	48039C0065J	22-SEP-1999
06	TX	BRAZORIA COUNTY *	48039C0135I	22-SEP-1999
06	TX	BRAZORIA COUNTY *	48039C0175I	22-SEP-1999
06	TX	BRAZORIA COUNTY *	48039CIND0 **	22-SEP-1999
06	TX	BRAZORIA, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	BROOKSIDE VILLAGE, CITY OF	48039C0030I	22-SEP-1999
06	TX	BROOKSIDE VILLAGE, CITY OF	48039C0035I	22-SEP-1999
06	TX	BROOKSIDE VILLAGE, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	CALDWELL COUNTY*	4800940025C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940050C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940075C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940100C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940125C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940150C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940155D	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940160C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940165C	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940170C	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940180C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940200C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940210C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940225C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940230C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940250C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940275C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940285C	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940305C	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940310C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940315C	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940320C	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940340C	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940350C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	4800940375C**	21-JUL-1999
06	TX	CALDWELL COUNTY*	480094IND0 **	21-JUL-1999
06	TX	CHATEAU WOODS, CITY OF	48339C0537G	22-SEP-1999
06	TX	CHATEAU WOODS, CITY OF	48339CIND0 **	22-SEP-1999
06	TX	CLUTE, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	CONROE, CITY OF	48339CIND0 **	22-SEP-1999
06	TX	CUT 'N SHOOT, CITY OF	48339CIND0 **	22-SEP-1999
06	TX	DANBURY, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	FREEPORT, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	FRIENDSWOOD, CITY OF	4854680005E	22-SEP-1999
06	TX	HILLCREST VILLAGE, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	HOLIDAY LAKES, TOWN OF	48039CIND0 **	22-SEP-1999
06	TX	IOWA COLONY, TOWN OF	48039CIND0 **	22-SEP-1999
06	TX	JONES CREEK, VILLAGE OF	48039CIND0 **	22-SEP-1999

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06	TX	LAKE BARBARA, VILLAGE OF	48039CIND0 **	22-SEP-1999
06	TX	LAKE JACKSON, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	LEAGUE CITY, CITY OF	4854880005D	22-SEP-1999
06	TX	LEAGUE CITY, CITY OF	4854880010D	22-SEP-1999
06	TX	LEAGUE CITY, CITY OF	4854880011D	22-SEP-1999
06	TX	LEAGUE CITY, CITY OF	4854880013D**	22-SEP-1999
06	TX	LEAGUE CITY, CITY OF	4854880020D	22-SEP-1999
06	TX	LEAGUE CITY, CITY OF	4854880025D	22-SEP-1999
06	TX	LEAGUE CITY, CITY OF	4854880030E	22-SEP-1999
06	TX	LEAGUE CITY, CITY OF	485488IND0 **	22-SEP-1999
06	TX	LIVERPOOL, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	MAGNOLIA, TOWN OF	48339CIND0 **	22-SEP-1999
06	TX	MANVEL, TOWN OF	48039C0040I	22-SEP-1999
06	TX	MANVEL, TOWN OF	48039CIND0 **	22-SEP-1999
06	TX	MIDLAND COUNTY *	48329C0044E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0050E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0058E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0059E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0063E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0064E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0066E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0067E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0068E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0069E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0075E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0086E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0087E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0088E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0089E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0093E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0094E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0100E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0125E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0150E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0175E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0182E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0184E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0200E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0201E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0202E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0203E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0204E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0206E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0207E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0208E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0209E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0211E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0212E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0213E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0214E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0216E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0217E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0218E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0219E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0226E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0227E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0231E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0236E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0238E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0250E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0275E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0300E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0325E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0350E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0375E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0400E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0425E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0450E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0475E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0500E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329C0525E	06-DEC-1999
06	TX	MIDLAND COUNTY *	48329CIND0 **	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0050E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0058E	06-DEC-1999

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06	TX	MIDLAND, CITY OF	48329C0059E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0066E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0067E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0068E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0069E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0086E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0087E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0088E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0089E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0093E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0100E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0182E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0184E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0200E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0201E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0202E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0203E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0204E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329C0206E	06-DEC-1999
06	TX	MIDLAND, CITY OF	48329CIND0 **	06-DEC-1999
06	TX	MONTGOMERY COUNTY*	48339C0537G	22-SEP-1999
06	TX	MONTGOMERY COUNTY*	48339C0539G	22-SEP-1999
06	TX	MONTGOMERY COUNTY*	48339C0730G	22-SEP-1999
06	TX	MONTGOMERY COUNTY*	48339CIND0 **	22-SEP-1999
06	TX	MONTGOMERY, CITY OF	48339CIND0 **	22-SEP-1999
06	TX	OAK RIDGE NORTH, CITY OF	48339C0537G	22-SEP-1999
06	TX	OAK RIDGE NORTH, CITY OF	48339C0539G	22-SEP-1999
06	TX	OAK RIDGE NORTH, CITY OF	48339CIND0 **	22-SEP-1999
06	TX	ODESSA, CITY OF	48329C0100E	06-DEC-1999
06	TX	ODESSA, CITY OF	48329C0175E	06-DEC-1999
06	TX	ODESSA, CITY OF	48329C0200E	06-DEC-1999
06	TX	ODESSA, CITY OF	48329CIND0 **	06-DEC-1999
06	TX	OYSTER CREEK, VILLAGE OF	48039CIND0 **	22-SEP-1999
06	TX	PANORAMA VILLAGE, CITY OF	48339CIND0 **	22-SEP-1999
06	TX	PATTON VILLAGE, VILLAGE OF	48339CIND0 **	22-SEP-1999
06	TX	PEARLAND, CITY OF	48039C0010I**	22-SEP-1999
06	TX	PEARLAND, CITY OF	48039C0030I	22-SEP-1999
06	TX	PEARLAND, CITY OF	48039C0035I	22-SEP-1999
06	TX	PEARLAND, CITY OF	48039C0040I	22-SEP-1999
06	TX	PEARLAND, CITY OF	48039C0045J**	22-SEP-1999
06	TX	PEARLAND, CITY OF	48039C0045J	22-SEP-1999
06	TX	PEARLAND, CITY OF	48039C0065J	22-SEP-1999
06	TX	PEARLAND, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	QUINTANA, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	QUINTANA, VILLAGE OF	48039CIND0 **	22-SEP-1999
06	TX	RANGER, CITY OF	480205 B***	01-JUL-1999
06	TX	RANGER, CITY OF	4802059999 ***	01-JUL-1999
06	TX	RICHWOOD, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	ROMAN FOREST, TOWN OF	48339CIND0 **	22-SEP-1999
06	TX	SHENANDOAH, TOWN OF	48339C0537G	22-SEP-1999
06	TX	SHENANDOAH, TOWN OF	48339CIND0 **	22-SEP-1999
06	TX	SPLENDORA, CITY OF	48339CIND0 **	22-SEP-1999
06	TX	STAGECOACH, CITY OF	48339CIND0 **	22-SEP-1999
06	TX	SURFSIDE BEACH, VILLAGE OF	48039CIND0 **	22-SEP-1999
06	TX	SWEENY, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	VICTORIA, CITY OF	4806380005G	21-JUL-1999
06	TX	VICTORIA, CITY OF	480638IND0 **	21-JUL-1999
06	TX	WEST COLUMBIA, CITY OF	48039CIND0 **	22-SEP-1999
06	TX	WILLIS, CITY OF	48339CIND0 **	22-SEP-1999
06	TX	WOODBRANCH, VILLAGE OF	48339CIND0 **	22-SEP-1999
06	TX	WOODLOCH, VILLAGE OF	48339CIND0 **	22-SEP-1999
07	IA	ANKENY, CITY OF	1902260003C**	06-DEC-1999
07	IA	ANKENY, CITY OF	1902260004C	06-DEC-1999
07	IA	ANKENY, CITY OF	190226IND0 **	06-DEC-1999
07	IA	BUCHANAN COUNTY*	1908480025C	21-JUL-1999
07	IA	BUCHANAN COUNTY*	1908480050C**	21-JUL-1999
07	IA	BUCHANAN COUNTY*	1908480075C**	21-JUL-1999
07	IA	BUCHANAN COUNTY*	1908480100C	21-JUL-1999
07	IA	BUCHANAN COUNTY*	1908480125C	21-JUL-1999
07	IA	BUCHANAN COUNTY*	1908480150C**	21-JUL-1999
07	IA	BUCHANAN COUNTY*	1908480175C**	21-JUL-1999
07	IA	BUCHANAN COUNTY*	1908480200C	21-JUL-1999
07	IA	BUCHANAN COUNTY*	1908480225C	21-JUL-1999
07	IA	BUCHANAN COUNTY*	190848IND0 **	21-JUL-1999

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07	IA	QUASQUETON, TOWN OF	1903320001C	21-JUL-1999
07	IA	VAN BUREN COUNTY	1902650025B	22-SEP-1999
07	IA	VAN BUREN COUNTY	1902650100B	22-SEP-1999
07	IA	VAN BUREN COUNTY	190265IND0 **	22-SEP-1999
07	IA	WESTFIELD, CITY OF	190482 A	20-OCT-1999
07	KS	MORGANVILLE, CITY OF	200055 A	20-OCT-1999
07	MO	AUGUSTA, VILLAGE OF	29183CIND0 **	06-DEC-1999
07	MO	COTTLEVILLE, CITY OF	29183CIND0 **	06-DEC-1999
07	MO	DARDENNE PRAIRIE, TOWN OF	29183CIND0 **	06-DEC-1999
07	MO	FLINTHILL, VILLAGE OF	29183CIND0 **	06-DEC-1999
07	MO	FORISTELL, CITY OF	29183C0190F	06-DEC-1999
07	MO	FORISTELL, CITY OF	29183CIND0 **	06-DEC-1999
07	MO	JOSEPHVILLE, VILLAGE OF	29183CIND0 **	06-DEC-1999
07	MO	LAKE ST. LOUIS, CITY OF	29183CIND0 **	06-DEC-1999
07	MO	LEE'S SUMMIT, CITY OF	2901740014D	06-DEC-1999
07	MO	LEE'S SUMMIT, CITY OF	2901740022D	06-DEC-1999
07	MO	LEE'S SUMMIT, CITY OF	290174IND0 **	06-DEC-1999
07	MO	NEW MELLE, VILLAGE OF	29183CIND0 **	06-DEC-1999
07	MO	NIXA, CITY OF	2900780005B	22-SEP-1999
07	MO	O'FALLON, CITY OF	29183CIND0 **	06-DEC-1999
07	MO	PORTAGE DES SIOUX, CITY OF	29183CIND0 **	06-DEC-1999
07	MO	ST. CHARLES COUNTY *	29183C0190F	06-DEC-1999
07	MO	ST. CHARLES COUNTY *	29183CIND0 **	06-DEC-1999
07	MO	ST. CHARLES, CITY OF	29183CIND0 **	06-DEC-1999
07	MO	ST. PAUL, CITY OF	29183CIND0 **	06-DEC-1999
07	MO	ST. PETERS, CITY OF	29183CIND0 **	06-DEC-1999
07	MO	WELDON SPRING HEIGHTS, TOWN OF	29183CIND0 **	06-DEC-1999
07	MO	WELDON SPRING, CITY OF	29183CIND0 **	06-DEC-1999
07	MO	WENTZVILLE, CITY OF	29183C0190F	06-DEC-1999
07	MO	WENTZVILLE, CITY OF	29183CIND0 **	06-DEC-1999
07	MO	WEST ALTON, TOWN OF	29183CIND0 **	06-DEC-1999
07	NE	ALBION, CITY OF	31011C0309C	06-DEC-1999
07	NE	ALBION, CITY OF	31011C0325C	06-DEC-1999
07	NE	ALBION, CITY OF	31011C0328C	06-DEC-1999
07	NE	ALBION, CITY OF	31011C0350C	06-DEC-1999
07	NE	ALBION, CITY OF	31011CIND0 **	06-DEC-1999
07	NE	BOELUS, VILLAGE OF	3101170005B	08-NOV-1999
07	NE	BOONE COUNTY*	31011C0025C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0050C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0075C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0100C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0125C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0150C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0175C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0177C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0200C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0225C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0250C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0275C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0300C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0309C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0325C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0328C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0350C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0375C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0400C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0409C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0417C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0425C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0450C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0475C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0478C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0486C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0500C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0525C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0550C	06-DEC-1999
07	NE	BOONE COUNTY*	31011C0575C	06-DEC-1999
07	NE	BOONE COUNTY*	31011CIND0 **	06-DEC-1999
07	NE	CEDAR RAPIDS, VILLAGE OF	31011C0409C	06-DEC-1999
07	NE	CEDAR RAPIDS, VILLAGE OF	31011C0417C	06-DEC-1999
07	NE	CEDAR RAPIDS, VILLAGE OF	31011C0425C	06-DEC-1999
07	NE	CEDAR RAPIDS, VILLAGE OF	31011CIND0 **	06-DEC-1999
07	NE	HOWARD COUNTY *	3104460110B	08-NOV-1999
07	NE	HOWARD COUNTY *	3104460115B	08-NOV-1999

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07	NE	HOWARD COUNTY *	310446IND0 **	08-NOV-1999
07	NE	O'NEILL, CITY OF	3101160001C	22-SEP-1999
07	NE	O'NEILL, CITY OF	3101160003C	22-SEP-1999
07	NE	O'NEILL, CITY OF	3101160004C	22-SEP-1999
07	NE	O'NEILL, CITY OF	310116IND0 **	22-SEP-1999
07	NE	PETERSBURG, VILLAGE OF	31011C0177C	06-DEC-1999
07	NE	PETERSBURG, VILLAGE OF	31011CIND0 **	06-DEC-1999
07	NE	ST. EDWARD, CITY OF	31011C0478C	06-DEC-1999
07	NE	ST. EDWARD, CITY OF	31011C0486C	06-DEC-1999
07	NE	ST. EDWARD, CITY OF	31011CIND0 **	06-DEC-1999
08	CO	CALHAN, TOWN OF	08041C0391G	23-AUG-1999
08	CO	CALHAN, TOWN OF	08041C0393G	23-AUG-1999
08	CO	CALHAN, TOWN OF	08041CIND0 **	23-AUG-1999
08	CO	COLORADO SPRINGS, CITY OF	08041CIND0 **	23-AUG-1999
08	CO	EL PASO COUNTY*	08041C0391G	23-AUG-1999
08	CO	EL PASO COUNTY*	08041C0393G	23-AUG-1999
08	CO	EL PASO COUNTY*	08041C0400G	23-AUG-1999
08	CO	EL PASO COUNTY*	08041CIND0 **	23-AUG-1999
08	CO	FOUNTAIN, CITY OF	08041CIND0 **	23-AUG-1999
08	CO	GREEN MOUNTAIN FALLS, TOWN OF	08041CIND0 **	23-AUG-1999
08	CO	MANITOU SPRINGS, CITY OF	08041CIND0 **	23-AUG-1999
08	CO	MONUMENT, TOWN OF	08041CIND0 **	23-AUG-1999
08	CO	PALMER LAKE, TOWN OF	08041CIND0 **	23-AUG-1999
08	CO	RAMAH, TOWN OF	08041CIND0 **	23-AUG-1999
08	CO	SEVERANCE, TOWN OF	0803170001A	22-SEP-1999
08	CO	WELD COUNTY *	0802660465D	22-SEP-1999
08	CO	WELD COUNTY *	0802660475D**	22-SEP-1999
08	CO	WELD COUNTY *	080266IND0 **	22-SEP-1999
08	MT	YELLOWSTONE COUNTY *	3001420865B	08-SEP-1999
08	MT	YELLOWSTONE COUNTY *	3001420870B	08-SEP-1999
08	UT	SANTA CLARA, TOWN OF	4901780005B	06-DEC-1999
08	WY	RIVERTON, CITY OF	560021 B***	01-SEP-1999
08	WY	RIVERTON, CITY OF	5600219999B***	01-SEP-1999
09	CA	AGUA CALIENTE BAND OF CAHUILLA INDIANS TRIBE.	0602570004D**	07-JUL-1999
09	CA	AGUA CALIENTE BAND OF CAHUILLA INDIANS TRIBE.	0602570004D	07-JUL-1999
09	CA	AGUA CALIENTE BAND OF CAHUILLA INDIANS TRIBE.	0602570006D**	07-JUL-1999
09	CA	AGUA CALIENTE BAND OF CAHUILLA INDIANS TRIBE.	0602570006D	07-JUL-1999
09	CA	AGUA CALIENTE BAND OF CAHUILLA INDIANS TRIBE.	0602570007D**	07-JUL-1999
09	CA	AGUA CALIENTE BAND OF CAHUILLA INDIANS TRIBE.	0602570007D	07-JUL-1999
09	CA	AGUA CALIENTE BAND OF CAHUILLA INDIANS TRIBE.	0602570009D**	07-JUL-1999
09	CA	AGUA CALIENTE BAND OF CAHUILLA INDIANS TRIBE.	0602570009D	07-JUL-1999
09	CA	AGUA CALIENTE BAND OF CAHUILLA INDIANS TRIBE.	060257IND0 **	07-JUL-1999
09	CA	ALTURAS, CITY OF	0601930005C	20-OCT-1999
09	CA	BUELLTON, CITY OF	060331IND0 **	07-JUL-1999
09	CA	CATHEDRAL CITY, CITY OF	0607040005D**	07-JUL-1999
09	CA	CATHEDRAL CITY, CITY OF	0607040010C**	07-JUL-1999
09	CA	CATHEDRAL CITY, CITY OF	060704IND0 **	07-JUL-1999
09	CA	EAST PALO ALTO, CITY OF	0607080001B	23-AUG-1999
09	CA	HILLSBOROUGH, TOWN OF	0603200002A	06-OCT-1999
09	CA	MODOC COUNTY *	0601920802C	20-OCT-1999
09	CA	MODOC COUNTY *	0601920804C	20-OCT-1999
09	CA	MODOC COUNTY *	0601920825C**	20-OCT-1999
09	CA	MODOC COUNTY *	060192IND0 **	20-OCT-1999
09	CA	PALM SPRINGS, CITY OF	0602570004D**	07-JUL-1999
09	CA	PALM SPRINGS, CITY OF	0602570004D	07-JUL-1999
09	CA	PALM SPRINGS, CITY OF	0602570006D**	07-JUL-1999
09	CA	PALM SPRINGS, CITY OF	0602570006D	07-JUL-1999
09	CA	PALM SPRINGS, CITY OF	0602570007D**	07-JUL-1999
09	CA	PALM SPRINGS, CITY OF	0602570007D	07-JUL-1999
09	CA	PALM SPRINGS, CITY OF	0602570009D**	07-JUL-1999
09	CA	PALM SPRINGS, CITY OF	0602570009D	07-JUL-1999
09	CA	PALM SPRINGS, CITY OF	060257IND0 **	07-JUL-1999
09	CA	SANTA BARBARA COUNTY *	0603310229D**	07-JUL-1999
09	CA	SANTA BARBARA COUNTY *	0603310233D**	07-JUL-1999
09	CA	SANTA BARBARA COUNTY *	0603310241D**	07-JUL-1999

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09	CA	SANTA BARBARA COUNTY *	060331IND0 **	07-JUL-1999
09	CA	SOLVANG, CITY OF	060331IND0 **	07-JUL-1999
09	NV	DOUGLAS COUNTY *	32005C0030F	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0035F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0040F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0055F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0060F	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0065F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0070F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0080F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0090F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0093F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0150F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0175F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0205F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0210F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0230F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0235F	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0240F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0245F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0252F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0254F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0255F	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0256F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0258F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0259F	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0265F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0266F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0267F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0268F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0286F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0325F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0350F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0360F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0400F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0425F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0450F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0500F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005C0525F**	08-NOV-1999
09	NV	DOUGLAS COUNTY *	32005CIND0 **	08-NOV-1999
10	AK	KENAI PENINSULA BOROUGH	0200122045C	06-DEC-1999
10	AK	KENAI PENINSULA BOROUGH	020012IND0 **	06-DEC-1999
10	AK	SEWARD, CITY OF	020012IND0 **	06-DEC-1999
10	ID	ADA COUNTY *	16001C0025G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0050G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0075G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0120G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0130G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0134G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0135G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0139G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0140G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0141G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0142G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0143G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0144G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0151G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0152G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0153G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0154G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0160G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0161G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0162G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0166G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0167G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0169G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0180G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0186G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0187G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0188G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0189G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0193G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0231G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0232G	22-SEP-1999

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10	ID	ADA COUNTY *	16001C0234G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0250G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0251G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0253G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0254G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0258G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0259G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0265G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0267G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0270G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0276G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0277G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0281G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0282G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0283G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0284G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0286G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0287G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0291G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0295G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0305G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0315G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0325G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0350G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0400G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0425G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0450G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0475G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0500G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0525G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0550G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0575G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0600G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0625G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0650G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0675G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0700G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0750G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0775G	22-SEP-1999
10	ID	ADA COUNTY *	16001C0800G	22-SEP-1999
10	ID	ADA COUNTY *	16001CIND0 **	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0161G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0162G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0166G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0167G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0169G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0186G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0187G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0188G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0189G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0193G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0258G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0259G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0267G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0276G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0277G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0281G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0282G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0283G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0284G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0286G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0287G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0291G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0295G	22-SEP-1999
10	ID	BOISE, CITY OF	16001C0315G	22-SEP-1999
10	ID	BOISE, CITY OF	16001CIND0 **	22-SEP-1999
10	ID	EAGLE, CITY OF	16001C0134G	22-SEP-1999
10	ID	EAGLE, CITY OF	16001C0142G	22-SEP-1999
10	ID	EAGLE, CITY OF	16001C0152G	22-SEP-1999
10	ID	EAGLE, CITY OF	16001C0153G	22-SEP-1999
10	ID	EAGLE, CITY OF	16001C0154G	22-SEP-1999
10	ID	EAGLE, CITY OF	16001C0161G	22-SEP-1999
10	ID	EAGLE, CITY OF	16001C0162G	22-SEP-1999
10	ID	EAGLE, CITY OF	16001CIND0 **	22-SEP-1999

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10	ID	GARDEN CITY, CITY OF	16001C0162G	22-SEP-1999
10	ID	GARDEN CITY, CITY OF	16001C0166G	22-SEP-1999
10	ID	GARDEN CITY, CITY OF	16001C0167G	22-SEP-1999
10	ID	GARDEN CITY, CITY OF	16001C0169G	22-SEP-1999
10	ID	GARDEN CITY, CITY OF	16001C0188G	22-SEP-1999
10	ID	GARDEN CITY, CITY OF	16001C0276G	22-SEP-1999
10	ID	GARDEN CITY, CITY OF	16001CIND0 **	22-SEP-1999
10	ID	KUNA, CITY OF	16001C0250G	22-SEP-1999
10	ID	KUNA, CITY OF	16001C0400G	22-SEP-1999
10	ID	KUNA, CITY OF	16001CIND0 **	22-SEP-1999
10	ID	MERIDIAN, CITY OF	16001C0139G	22-SEP-1999
10	ID	MERIDIAN, CITY OF	16001C0143G	22-SEP-1999
10	ID	MERIDIAN, CITY OF	16001C0144G	22-SEP-1999
10	ID	MERIDIAN, CITY OF	16001C0231G	22-SEP-1999
10	ID	MERIDIAN, CITY OF	16001C0232G	22-SEP-1999
10	ID	MERIDIAN, CITY OF	16001C0234G	22-SEP-1999
10	ID	MERIDIAN, CITY OF	16001C0250G	22-SEP-1999
10	ID	MERIDIAN, CITY OF	16001C0251G	22-SEP-1999
10	ID	MERIDIAN, CITY OF	16001CIND0 **	22-SEP-1999
10	ID	STAR, CITY OF	16001C0130G	22-SEP-1999
10	ID	STAR, CITY OF	16001C0140G	22-SEP-1999
10	ID	STAR, CITY OF	16001CIND0 **	22-SEP-1999
10	OR	ALBANY, CITY OF	4101370001F	07-JUL-1999
10	OR	ALBANY, CITY OF	4101370002F	07-JUL-1999
10	OR	ALBANY, CITY OF	4101370003F	07-JUL-1999
10	OR	ALBANY, CITY OF	4101370004F**	07-JUL-1999
10	OR	ALBANY, CITY OF	4101370005F	07-JUL-1999
10	OR	ALBANY, CITY OF	4101370006F	07-JUL-1999
10	OR	ALBANY, CITY OF	4101370007F**	07-JUL-1999
10	OR	ALBANY, CITY OF	410137IND0 **	07-JUL-1999
10	OR	ATHENA, CITY OF	4102060001D	08-SEP-1999
10	OR	UMATILLA COUNTY*	4102040280C	08-SEP-1999
10	OR	UMATILLA COUNTY*	4102040285C	08-SEP-1999
10	OR	UMATILLA COUNTY*	4102040520C	08-SEP-1999
10	OR	UMATILLA COUNTY*	4102040525C**	08-SEP-1999
10	OR	UMATILLA COUNTY*	4102040530C	08-SEP-1999
10	OR	UMATILLA COUNTY*	4102040540C	08-SEP-1999
10	OR	UMATILLA COUNTY*	410204IND0 **	08-SEP-1999
10	WA	ALGONA, CITY OF	53033CIND0 **	08-NOV-1999
10	WA	ARLINGTON, CITY OF	53061C0384E	08-NOV-1999
10	WA	ARLINGTON, CITY OF	53061C0391E	08-NOV-1999
10	WA	ARLINGTON, CITY OF	53061C0392E	08-NOV-1999
10	WA	ARLINGTON, CITY OF	53061C0405E	08-NOV-1999
10	WA	ARLINGTON, CITY OF	53061C0415E	08-NOV-1999
10	WA	ARLINGTON, CITY OF	53061CIND0 **	08-NOV-1999
10	WA	AUBURN, CITY OF	53033CIND0 **	08-NOV-1999
10	WA	BEAUX ARTS VILLAGE, TOWN OF	53033CIND0 **	08-NOV-1999
10	WA	BELLEVUE, CITY OF	53033CIND0 **	08-NOV-1999
10	WA	BLACK DIAMOND, TOWN OF	53033CIND0 **	08-NOV-1999
10	WA	BOTHELL, CITY OF	53033C0063G	08-NOV-1999
10	WA	BOTHELL, CITY OF	53033C0064G	08-NOV-1999
10	WA	BOTHELL, CITY OF	53033C0068G	08-NOV-1999
10	WA	BOTHELL, CITY OF	53033C0352G	08-NOV-1999
10	WA	BOTHELL, CITY OF	53033C0360G	08-NOV-1999
10	WA	BOTHELL, CITY OF	53033CIND0 **	08-NOV-1999
10	WA	BOTHELL, CITY OF	53061C1330E	08-NOV-1999
10	WA	BOTHELL, CITY OF	53061C1335E	08-NOV-1999
10	WA	BOTHELL, CITY OF	53061C1337E	08-NOV-1999
10	WA	BOTHELL, CITY OF	53061C1338E	08-NOV-1999
10	WA	BOTHELL, CITY OF	53061C1339E	08-NOV-1999
10	WA	BOTHELL, CITY OF	53061C1343E	08-NOV-1999
10	WA	BOTHELL, CITY OF	53061C1345E	08-NOV-1999
10	WA	BOTHELL, CITY OF	53061CIND0 **	08-NOV-1999
10	WA	BREWSTER, TOWN OF	5302750001B	09-AUG-1999
10	WA	BRIER, CITY OF	53061C1317E	08-NOV-1999
10	WA	BRIER, CITY OF	53061C1319E	08-NOV-1999
10	WA	BRIER, CITY OF	53061C1320E	08-NOV-1999
10	WA	BRIER, CITY OF	53061CIND0 **	08-NOV-1999
10	WA	BURIEN, CITY OF	53033CIND0 **	08-NOV-1999
10	WA	CARNATION, TOWN OF	53033CIND0 **	08-NOV-1999
10	WA	CLYDE HILL, TOWN OF	53033CIND0 **	08-NOV-1999
10	WA	COWLITZ COUNTY *	5300320035D	07-JUL-1999
10	WA	COWLITZ COUNTY *	5300320055C	07-JUL-1999
10	WA	COWLITZ COUNTY *	5300320065C	07-JUL-1999

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10	WA	COWLITZ COUNTY *	5300320075C	07-JUL-1999
10	WA	COWLITZ COUNTY *	530032IND0 **	07-JUL-1999
10	WA	DARRINGTON, TOWN OF	53061C0188E	08-NOV-1999
10	WA	DARRINGTON, TOWN OF	53061C0501E	08-NOV-1999
10	WA	DARRINGTON, TOWN OF	53061C0502E	08-NOV-1999
10	WA	DARRINGTON, TOWN OF	53061CIND0 **	08-NOV-1999
10	WA	DES MOINES, CITY OF	53033CIND0 **	08-NOV-1999
10	WA	DUVALL, TOWN OF	53033CIND0 **	08-NOV-1999
10	WA	EDMONDS, CITY OF	53061C1285E	08-NOV-1999
10	WA	EDMONDS, CITY OF	53061C1292E	08-NOV-1999
10	WA	EDMONDS, CITY OF	53061C1305E	08-NOV-1999
10	WA	EDMONDS, CITY OF	53061C1315E	08-NOV-1999
10	WA	EDMONDS, CITY OF	53061CIND0 **	08-NOV-1999
10	WA	ENUMCLAW, CITY OF	53033CIND0 **	08-NOV-1999
10	WA	EVERETT, CITY OF	53061C0695E	08-NOV-1999
10	WA	EVERETT, CITY OF	53061C0715E	08-NOV-1999
10	WA	EVERETT, CITY OF	53061C0720E	08-NOV-1999
10	WA	EVERETT, CITY OF	53061C1010E	08-NOV-1999
10	WA	EVERETT, CITY OF	53061C1020E	08-NOV-1999
10	WA	EVERETT, CITY OF	53061C1030E	08-NOV-1999
10	WA	EVERETT, CITY OF	53061C1035E	08-NOV-1999
10	WA	EVERETT, CITY OF	53061C1040E	08-NOV-1999
10	WA	EVERETT, CITY OF	53061C1045E	08-NOV-1999
10	WA	EVERETT, CITY OF	53061CIND0 **	08-NOV-1999
10	WA	FEDERAL WAY, CITY OF	53033CIND0 **	08-NOV-1999
10	WA	GOLD BAR, TOWN OF	53061C1427E	08-NOV-1999
10	WA	GOLD BAR, TOWN OF	53061C1431E	08-NOV-1999
10	WA	GOLD BAR, TOWN OF	53061CIND0 **	08-NOV-1999
10	WA	GRANITE FALLS, TOWN OF	53061C0755E	08-NOV-1999
10	WA	GRANITE FALLS, TOWN OF	53061CIND0 **	08-NOV-1999
10	WA	HUNTS POINT, TOWN OF	53033CIND0 **	08-NOV-1999
10	WA	INDEX, TOWN OF	53061C1454E	08-NOV-1999
10	WA	INDEX, TOWN OF	53061C1458E	08-NOV-1999
10	WA	INDEX, TOWN OF	53061CIND0 **	08-NOV-1999
10	WA	ISSAQUAH, CITY OF	53033CIND0 **	08-NOV-1999
10	WA	KENMORE, CITY OF	53033CIND0 **	08-NOV-1999
10	WA	KENT, CITY OF	53033CIND0 **	08-NOV-1999
10	WA	KING COUNTY*	53033C0063G**	08-NOV-1999
10	WA	KING COUNTY*	53033C0064G**	08-NOV-1999
10	WA	KING COUNTY*	53033C0068G	08-NOV-1999
10	WA	KING COUNTY*	53033C0352G**	08-NOV-1999
10	WA	KING COUNTY*	53033C0360G**	08-NOV-1999
10	WA	KING COUNTY*	53033CIND0 **	08-NOV-1999
10	WA	KIRKLAND, CITY OF	53033C0360G**	08-NOV-1999
10	WA	KIRKLAND, CITY OF	53033CIND0 **	08-NOV-1999
10	WA	KITTITAS COUNTY *	530095IND0 **	06-DEC-1999
10	WA	LAKE FOREST PARK, CITY OF	53033CIND0 **	08-NOV-1999
10	WA	LAKE STEVENS, CITY OF	53061C0739E	08-NOV-1999
10	WA	LAKE STEVENS, CITY OF	53061C0743E	08-NOV-1999
10	WA	LAKE STEVENS, CITY OF	53061CIND0 **	08-NOV-1999
10	WA	LYNNWOOD, CITY OF	53061C1305E	08-NOV-1999
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The items in this list were editorially compiled as an aid to Federal Register users. Inclusion or exclusion from this list has no legal significance.

RULES GOING INTO EFFECT JUNE 29, 2000

COMMERCE DEPARTMENT

National Oceanic and Atmospheric Administration

Marine mammals:

Dolphin-safe tuna labeling; official mark; published 5-30-00

OFFICE OF UNITED STATES TRADE REPRESENTATIVE

Trade Representative, Office of United States

Tariff-rate quota amount determinations:

Lamb meat; published 6-29-00

TRANSPORTATION DEPARTMENT

Coast Guard

Ports and waterways safety:

East River, Wards Island, NY; fireworks display; published 6-1-00

OPSAIL 2000/International Naval Review 2000; Port of New York/New Jersey; published 5-25-00

TRANSPORTATION DEPARTMENT

Federal Aviation Administration

Airports:

Passenger facility charges; published 5-30-00

Airworthiness directives:

Eurocopter France; published 5-25-00

TREASURY DEPARTMENT

Alcohol, Tobacco and Firearms Bureau

Alcohol, tobacco, and other excise taxes:

Tobacco produucts—

Roll-your-own tobacco; manufacturers and importers; package use-up rule extension; published 6-29-00

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Agricultural Marketing Service

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Idaho and Oregon; comments due by 7-3-00; published 5-3-00

AGRICULTURE DEPARTMENT

Animal and Plant Health Inspection Service

Plant-related quaratine, domestic:

Oriental fruit fly; comments due by 7-7-00; published 5-8-00

COMMERCE DEPARTMENT

National Oceanic and Atmospheric Administration

Endangered and threatened species:

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Fishery conservation and management:

Caribbean, Gulf, and South Atlantic fisheries—

Coastal migratory pelagic resources; comments due by 7-3-00; published 6-1-00

South Atlantic Fishery Management Council; hearings; comments due by 7-5-00; published 4-17-00

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South Atlantic snapper-grouper; comments due by 7-6-00; published 6-6-00

COMMODITY FUTURES TRADING COMMISSION

Commodity Exchange Act:

Futures commission merchants and introducing brokers; minimum financial requirements

Subordination agreements; net capital treatment; comments due by 7-3-00; published 6-2-00

DEFENSE DEPARTMENT

Federal Acquisition Regulation (FAR):

Advance payments for non-commercial items; comments due by 7-3-00; published 5-2-00

Cost accounting standards coverage; applicability, thresholds, and waiver; comments due by 7-6-00; published 6-6-00

EDUCATION DEPARTMENT

Civil Rights Restoration Act; implementation:

Nondiscrimination on basis of race, color, national origin, sex, disability, and age; conforming amendments to regulations; comments due by 7-5-00; published 5-5-00

ENVIRONMENTAL PROTECTION AGENCY

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Inspector General Office Hotline posters within contractor work areas; display requirements; comments due by 7-3-00; published 5-4-00

Air quality implementation plans; approval and promulgation; various States:

Arizona; comments due by 7-3-00; published 6-19-00

Pennsylvania; comments due by 7-6-00; published 6-6-00

Toxic substances:

Polychlorinated biphenyls (PCBs)—

Non-liquid PCBs; use authorization and distribution in commerce; comments due by 7-7-00; published 12-10-99

FEDERAL COMMUNICATIONS COMMISSION

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Individuals with hearing and speech disabilities; telecommunications relay services and speech-to-speech services; comments due by 7-5-00; published 6-21-00

Personal communications services—

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GENERAL SERVICES ADMINISTRATION

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Cost accounting standards coverage; applicability, thresholds, and waiver; comments due by 7-6-00; published 6-6-00

HEALTH AND HUMAN SERVICES DEPARTMENT

Food and Drug Administration

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HEALTH AND HUMAN SERVICES DEPARTMENT

Health Care Financing Administration

Medicare:

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Supplemental practice expense survey data; submission criteria; comments due by 7-3-00; published 5-3-00

HEALTH AND HUMAN SERVICES DEPARTMENT

Inspector General Office, Health and Human Services Department

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INTERIOR DEPARTMENT

Fish and Wildlife Service

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Migratory bird hunting:

Seasons, limits, and shooting hours; establishment, etc.

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INTERIOR DEPARTMENT

Surface Mining Reclamation and Enforcement Office

Permanent program and abandoned mine land reclamation plan submissions:

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New Mexico; comments due by 7-7-00; published 6-7-00

Surface coal mining and reclamation operations:

Ownership and control of mining operations; definitions, permit requirements, enforcement actions, etc.; comments due by 7-7-00; published 6-7-00

LABOR DEPARTMENT
Federal Contract Compliance Programs Office
Affirmative action and nondiscrimination obligations of contractors and subcontractors:
Affirmative action programs; requirements; comments due by 7-3-00; published 5-4-00

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION
Federal Acquisition Regulation (FAR):
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Nuclear waste shipments; advance notification to Native American Tribes; comments due by 7-5-00; published 4-6-00

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LIST OF PUBLIC LAWS

This is a continuing list of public bills from the current session of Congress which have become Federal laws. 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.

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H.R. 435/P.L. 106–36

Miscellaneous Trade and Technical Corrections Act of 1999 (June 25, 1999; 113 Stat. 127)

Last List June 17, 1999

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