

§ 73.1a Notice of quarantine.

(b) Notice is hereby given that cattle in certain portions of the State of Nebraska are affected with scabies, a contagious infectious, and communicable disease; and, therefore, the following areas in such State are hereby quarantined because of said disease:

(1) That portion of Garden County comprised of sec. 13, T. 17 N., R. 45 W., School District 43.

(2) That portion of Kearney County comprised of sec. 12, T. 7 N., R. 16 W. in Blaine Precinct.

(Secs. 4-7, 23 Stat. 32, as amended; secs. 1 and 2, 32 Stat. 791-792, as amended; secs. 1-4, 33 Stat. 1264, 1265, as amended; secs. 3 and 11, 76 Stat. 130, 132; (21 U.S.C. 111-113, 115, 117, 120, 121, 123-126; 134b, 134f); 37 FR 28464, 28477; 38 FR 19141.)

Effective date. The foregoing amendment shall become effective May 14, 1976.

The amendment relieves restrictions no longer deemed necessary to prevent the spread of cattle scabies and should be made effective promptly in order to be of maximum benefit to affected persons. It does not appear that public participation in this rulemaking proceeding would make additional relevant information available to the Department.

Accordingly, under the administrative procedure provisions in 5 U.S.C. 553, it is found upon good cause that notice and other public procedure with respect to the amendment are impracticable and unnecessary, and good cause is found for making the amendment effective less than 30 days after publication in the *FEDERAL REGISTER*.

Done at Washington, D.C., this 14th day of May 1976.

PIERRE A. CHALOUX,
Acting Deputy Administrator,
Veterinary Services.

[FR Doc. 76-14705 Filed 5-20-76; 8:45 am]

Title 12—Banks and Banking
CHAPTER V—FEDERAL HOME LOAN
BANK BOARD
SUBCHAPTER C—FEDERAL SAVINGS AND
LOAN SYSTEM
[No. 76-353]
PART 545—OPERATIONS
Amendment Relating to Mortgage-Futures
Transactions

SUMMARY

MAY 18, 1976.

The following summary of the amendment adopted by this Resolution is included for the reader's convenience and is subject to the full explanation in the preamble and to the specific provisions in the regulations.

I. PROPOSED REGULATIONS

A. Would authorize Federals to engage in transactions in the GNMA futures market operated by the Chicago Board of Trade.

B. Federals could only engage in such transactions for hedging purposes and in compliance with certain other restrictions.

C. Speculative transactions would be prohibited.

II. FINAL REGULATIONS

A. New eligibility requirements.

B. Limited anticipatory hedging authorized; must be matched against firm commitments or anticipated reinvestments of expected mortgage repayments (including principal and interest but excluding prepayments and penalties) over forthcoming 12-month period.

1. The term "firm commitments" expanded to include FHLMC Mortgage Participation Certificates and similar obligations secured by mortgages in which Federal associations are authorized to invest.

C. Dollar amount of gross mortgage-futures contracts limited to association's net worth; proposal would have allowed dollar amount of net mortgage-futures contracts to equal net worth.

D. New notification and record-keeping requirements, including justification of anticipated commitments.

E. Deletion of 12-month limit on firm commitments to be matched against futures contracts.

F. New definitions.

III. REASONS FOR MODIFICATIONS

More flexibility for association planning of future mortgage lending; greater safeguards and lower dollar amount of futures commitments in a new area of association activity.

Pursuant to the Commodity Futures Trading Commission Act of 1975 (P.L. 94-16), the Commodity Futures Trading Commission recently authorized the Chicago Board of Trade to begin operation of a futures market for mortgage-backed securities guaranteed by the Government National Mortgage Association (GNMAS).

By Resolution No. 75-865 of September 30, 1975, the Federal Home Loan Bank Board proposed to amend Part 545 of the Rules and Regulations for the Federal Savings and Loan System (12 CFR Part 545) by amending § 545.9 thereof and adding new § 545.29 thereto in order to enable Federal associations to engage in futures transactions with respect to GNMA for the limited purpose of obtaining protection against market interest rate fluctuations.

Notice of such proposed rulemaking was duly published in the *FEDERAL REGISTER* on October 8, 1975 (40 F.R. 47149-47150), with an invitation for interested persons to submit comments by November 10, 1975. On the basis of all relevant material presented by interested persons and otherwise available, the Board hereby adopts proposed new § 545.29 with modifications as discussed below. The substance of the proposed amendment to § 545.9 is incorporated in this amendment.

The proposal would have permitted a Federal association to engage in mortgage-futures transactions involving

GNMAs subject to three conditions. First, the association would have been required to take a "hedged" position, with its net futures market position matched against its net cash market position in firm commitments to buy (or otherwise acquire) or sell mortgages and GNMA's (without regard to the maturities of the contracts and commitments constituting these positions). Second, an association would have been permitted to take a hedged position in the mortgage-futures market only with respect to firm commitments. As used in proposed § 545.29, the term "firm commitment" referred to a binding written commitment to make, purchase, issue, or deliver mortgage loans or GNMA's at fixed interest rates or yields on or prior to a date specified in the contract and not later than one year from the date of commitment. Third, the amount of an association's total outstanding net mortgage-futures positions would not have been authorized to exceed its net worth at any time.

The final regulations adopted by the Board today continue to emphasize the importance of limiting mortgage-futures market trading to hedged positions, that is, obtaining protection against market interest rate fluctuations affecting cash market positions, but modifications have been made in a number of respects to broaden associations' hedging flexibility while adding new safeguards and reducing the dollar amount of trading authority. The Board believes that these changes will result in better and more detailed forecasting and planning for future mortgage lending activities and will dampen the amplitudes of variations in fund flows into the housing markets.

New paragraph (a) sets forth the basic authorization for Federal associations to engage in certain mortgage-futures transactions.

New paragraph (b) establishes threshold eligibility requirements for Federal associations engaging in mortgage-futures transactions. Associations must meet their net-worth requirements under § 563.13(b) of the Rules and Regulations for Insurance of Accounts (12 CFR 563.13(b)), have scheduled items not in excess of 2.5% of specified assets, and have appraised losses offset by specified loss reserves as required under § 563.17-2 of the Rules and Regulations for Insurance of Accounts (12 CFR 563.17-2). The threshold eligibility requirements may be waived by the Board upon specific written request.

New paragraph (c) sets out investment limitations for associations engaged in mortgage-futures transactions. Subparagraph (c) (2) provides that such transactions must be matched against either an association's firm commitments, or against anticipated reinvestments in mortgages and mortgage-related securities of its expected mortgage repayments over the next 12-month period (without regard to matching of maturities); as noted above, the proposal would only have allowed matching against firm commitments. The Board is persuaded that it is desirable to permit

more trading flexibility by allowing this limited type of anticipatory hedging, i.e., matching futures transactions against anticipated cash transactions which are based on expected future mortgage repayments. Under the recording requirements in new subparagraph (d)(2), an association is required to show justification for its expectations regarding future mortgage repayments.

The proposal employed the concept of "net" mortgage-futures positions with regard to the dollar limit of an association's transactions (net mortgage-futures position not to exceed an association's net worth). Upon reconsideration, the Board believes it significant, that a "net" mortgage-futures position does not reflect number and dollar amounts of outstanding mortgage-futures contracts, and that "netted" contracts may have widely-separated due dates resulting in possible loss to the association on both. The Board believes that the "net mortgage-futures position" concept could permit speculative trading situations rather than the hedged positions which are the focus of the Board's regulations. The Board therefore adopts the concept of "outstanding gross mortgage-futures position" and provides in new subparagraph (c) (1) that total outstanding gross mortgage-futures transactions may not exceed an association's net worth.

New paragraph (d) establishes record-keeping requirements for associations engaging in mortgage-futures transactions, requiring them to maintain: (1) a register of all outstanding futures contracts prepared in such a way as to show present totals; (2) records kept of matched futures transactions and cash market transactions, along with a justification of expected mortgage repayments upon which anticipated cash market transactions are based; (3) a record of all transactions in due bills by the associations; and (4) a list of association personnel authorized to engage in mortgage-futures trading.

New paragraph (e) requires a Federal association to notify the District Director-Examinations at its Federal Home Loan Bank District at the inception of its mortgage-futures trading activity, and report thereafter on a quarterly basis.

The proposal would have amended § 545.9 of the Rules and Regulations for the Federal Savings and Loan System (12 CFR 545.9), captioned Securities and other investments, to authorize a Federal association "to issue or purchase due bills in connection with § 545.29". Due bills are the equivalent of depository collateral receipts for GNMA securities and are issued only in those infrequent instances when there is delivery on a mortgage-futures contract. The proposed amendment to § 545.9 did not authorize associations to trade in a secondary market in due bills. The final amendment includes the proposed provision in paragraph (f) of new § 545.29; the provision is clarified to provide that an association may originate, deliver, receive, or redeem due bills in connection with its mortgage-futures transactions. Trading

in a secondary market for due bills continues to be unauthorized for Federal associations.

New paragraph (g) of new § 545.29 defines the terms "firm commitment", "mortgage-futures transactions", "mortgage-futures contract", "due bill", "mortgage repayment", and "mortgage-related security". The first of these terms was defined in paragraph (a) of the proposal; the other definitions are new. The definition of "firm commitment" differs in two respects from the proposal: (1) the 1-year limitation on the firm commitments is deleted in order to provide greater flexibility to associations in planning future mortgage lending activities; and (2) the definition is expanded to include Mortgage Participation Certificates of the Federal Home Loan Mortgage Corporation and similar obligations secured by mortgages in which Federal associations are authorized to invest.

The Board emphasizes that, while futures transactions which are conducted in a prudent and knowledgeable manner can provide an association with protection against market interest rate fluctuations, engaging in such transactions without sufficient understanding of the function and operation of the futures market is likely to result in loss to the association.

Accordingly, the Board hereby amends Part 545 by adding a new § 545.29 thereto, effective June 22, 1976.

§ 545.29 Mortgage-futures transactions.

(a) *General rule.* A Federal association may only engage in mortgage-futures transactions subject to the requirements and limitations set forth in this section.

(b) *Eligibility requirements.* An association engaging in a mortgage-futures transaction must meet the following eligibility requirements at the time of such transaction, unless one or more of such requirements are waived by the Board upon specific written request:

(1) Its net worth meets the requirements of § 563.13(b) of this chapter (associations insured for less than 2 years must meet the net-worth requirements for those insured for 2 years);

(2) Its scheduled items do not exceed 2.5 percent of its specified assets; and

(3) All its appraised losses have been offset by specified loss reserves to the extent required by the Board under § 563.17-2 of this chapter.

(c) *Investment limitations.* (1) An association may only engage in a mortgage-futures transaction if the amount of its total outstanding gross mortgage-futures position (the arithmetic sum of its short and long positions in the futures market) do not exceed the amount of its net worth or would not exceed it as a result of such transaction; and

(2) Mortgage-futures transactions must be directly matched against an association's firm commitments, or against anticipated reinvestments in mortgages and mortgage-related securities of its expected mortgage repayments over the forthcoming 12-month period: *provided*, that such matching need not include matching of maturities.

(d) *Record-keeping requirements.* An association engaging in mortgage-futures transactions shall maintain the following:

(1) A register of all its outstanding futures contracts, including brokers' confirmations as received, prepared in a manner sufficient to enable the Board to determine at any time the association's total outstanding gross mortgage-futures position;

(2) A record of specific futures contracts, the present or anticipated cash market transaction or transactions against which they are matched, and in the case of an anticipated transaction a statement of facts adequately justifying such anticipated transaction;

(3) A record of all transactions by the association in due bills;

(4) A list of all association personnel authorized to engage in mortgage-futures transactions in the association's behalf, and the duties, responsibilities, and limits of authority of each of them.

(e) *Notification.* Each association engaging in mortgage-futures transactions shall notify the District Director-Examinations at the Federal Home Loan Bank of which it is a member at the inception of such activity and thereafter on a quarterly basis shall notify said Director of its total outstanding gross mortgage-futures position on the date of such notification.

(f) *Due bills.* A Federal association may originate, deliver, receive, or redeem due bills in connection with its mortgage-futures transactions.

(g) *Definitions.* (1) The term "firm commitment" means a written commitment to make, purchase, issue, or deliver mortgage loans or mortgage-related securities at fixed interest rates on or prior to the date specified in the commitment contract.

(2) The term "mortgage-futures transaction" means the purchase or sale of a mortgage-futures contract under terms and conditions approved by the Commodity Futures Trading Commission.

(3) The term "mortgage-futures contract" means a transferable agreement to receive or deliver due bills under terms and conditions approved by the Commodity Futures Trading Commission.

(4) The term "due bill" means an instrument redeemable for GNMA-guaranteed mortgage-backed securities which is a valid delivery instrument under a mortgage-futures contract.

(5) The term "mortgage repayment" includes principal and interest, but excludes expected prepayments and penalties.

(6) The term "mortgage-related securities" includes GNMA-guaranteed mortgage-backed securities (as referred to in § 545.24-1), Mortgage Participation Certificates of the Federal Home Loan Mortgage Corporation, and similar obligations secured by mortgages in which the association is authorized to invest.

(Sec. 5, 48 Stat. 132, as amended; 12 U.S.C. § 1464. Reorg. Plan No. 3 of 1947, 12 F.R. 4981, 3 CFR, 1943-48 Comp., p. 1071.)

By the Federal Home Loan Bank Board.

J. J. FINN,
Secretary.

[FR Doc. 76-14975 Filed 5-20-76; 8:45 am]

[No. 76-346]

PART 571—STATEMENTS OF POLICY

Amendment Relating to Auditors of Insured Institutions

SUMMARY

MAY 14, 1976.

The following summary of the amendment adopted by this resolution is provided for the reader's convenience and is subject to the full explanation in the following preamble and to the specific provisions of the regulations.

I. *Existing Regulations*—specify certain types of loans that an insured institution, or its affiliate or subsidiary, may make to a public accountant or internal auditor without preventing him from being considered independent.

II. *Amendment*—specifies additional such loans.

III. *Purpose of Amendment*—prescribe criteria for determining the independence of public accountants and internal auditors that reflect the present lending authority of insured institutions and their subsidiaries and affiliates.

The Federal Home Loan Bank Board considers it desirable to amend § 571.2 of the Rules and Regulations for Insurance of Accounts (12 CFR 571.2) for the purpose of prescribing criteria for determining the independence of a public accountant or internal auditor that reflect the present lending authority of insured institutions and their subsidiaries and affiliates.

Section 571.2(c)(3)(ii) presently specifies certain types of loans that an insured institution, or its affiliate or subsidiary, may make to a public accountant or internal auditor without preventing him from being considered independent. This amendment adds thereto consumer loans which are unsecured or secured by goods used or bought primarily for personal, family, or household purposes.

The Board finds that notice and public procedure are unnecessary under 12 CFR 508.11 and 5 U.S.C. § 553(b), since the amendment relieves restriction, and that publication of said amendment for the 30-day period specified in 12 CFR 508.14 and 5 U.S.C. § 553(d) prior to effective date is unnecessary for the same reason.

Accordingly, the Board hereby amends § 571.2 of the Rules and Regulations for Insurance of Accounts, by deleting after paragraph (c)(3)(ii)(d)(2) and adding after paragraph (c)(3)(ii)(d)(3) thereof the word "or", and by adding new paragraph (c)(3)(ii)(d)(4) thereto, to

read as set forth below, effective May 21, 1976.

§ 571.2 Audits of insured institutions.

(c) *Audits by public accountants or internal auditors.*

(3) *Independence of public accountant or internal auditor.*

(ii) A public accountant will not be considered to be independent if he:

(d) is a borrower from the institution or any of its subsidiaries or affiliates except with respect to:

(2) a loan to make alterations, repairs, or improvements to his residence;

(3) a loan secured solely by his savings credits in the institution; or

(4) a consumer loan either unsecured or secured by goods used or bought primarily for personal, family, or household purposes.

(Sec. 402, 403, 407, 48 Stat. 1256, 1257, 1260, as amended; 12 U.S.C. 1725, 1726, 1730. Reorg. Plan No. 3 of 1947, 12 F.R. 4981, 3 CFR, 1943-48 Comp., p. 1071.)

By the Federal Home Loan Bank Board.

J. J. FINN,
Secretary.

[FR Doc. 76-14938 Filed 5-20-76; 8:45 am]

[No. 76-354]

PART 571—STATEMENTS OF POLICY

Amendments Relating to Mortgage-Futures Transactions

SUMMARY

MAY 18, 1976.

The following summary of the amendments adopted by this Resolution is provided for the reader's convenience and is subject to the full explanation in the following preamble and to the specific provisions of the amendments.

I. The authority of State-chartered insured institutions to engage in transactions in the GNMA futures market to be operated by the Chicago Board of Trade is primarily a matter of State law.

II. The Board strongly urges such institutions to only engage in such transactions in accordance with § 545.29.

Pursuant to the Commodity Futures Trading Commission Act of 1975 (P.L. 94-16), the Commodity Futures Trading Commission recently authorized the Chicago Board of Trade to begin operation of a futures market for mortgage-backed securities guaranteed by the Government National Mortgage Association (GNMA).

By Resolution No. 75-923 of October 3, 1975, the Federal Home Loan Bank Board proposed to amend Part 571 of the Rules

and Regulations for Insurance of Accounts (12 CFR Part 571) to add a new Statement of Policy at § 571.12 to be captioned Mortgage futures transactions, urging State-chartered insured institutions to only engage in mortgage-futures transactions in accordance with the then-proposed § 545.29 of the Rules and Regulations for the Federal Savings and Loan System. Section 545.29, adopted by the Board today in companion Resolution 76-353, provides that Federal associations may only engage in mortgage-futures transactions under certain conditions, which conditions should, in the Board's view, also be complied with by any insured institution engaging in such transactions.

Notice of such proposed rulemaking was duly published in the FEDERAL REGISTER on October 8, 1975 (40 F.R. 47151-47152), with an invitation to interested persons to submit comments by November 10, 1975. On the basis of all relevant material presented by interested persons and otherwise available, the Board hereby adopts § 571.12 substantially as proposed.

Accordingly, the Board hereby amends Part 571 by adding a new § 571.12 thereto, effective June 22, 1976.

§ 571.12 Mortgage-futures transactions.

The authority of State-chartered insured institutions to engage in mortgage-futures transactions is primarily a matter of State law. However, the Board believes that engaging in such transactions for speculative purposes, or as a hedge against market interest rate fluctuations of other than mortgage loans and mortgage-related securities as defined in § 545.29(g)(6) of this chapter may be an unsafe or unsound practice or otherwise inconsistent with the purposes of Title IV of the National Housing Act, as amended. State-chartered insured institutions are therefore strongly urged not to engage in mortgage-futures transactions other than in accordance with said § 545.29. The Board's examinations staff may take supervisory objection to mortgage-futures transactions by insured institutions not in accordance with said § 545.29. In addition, the Board emphasizes that, while mortgage-futures transactions in accordance with said § 545.29 which are conducted in a prudent and knowledgeable manner can protect an institution against market fluctuations of interest rates of mortgages and mortgage-related securities, engaging in such transactions without sufficient understanding of the function and operation of the mortgage-futures market is likely to result in loss to the institution.

(Secs. 402, 403, 407, 48 Stat. 1256, 1257, 1260, as amended; 12 U.S.C. 1725, 1726, 1730. Reorg. Plan No. 3 of 1947, 12 F.R. 4981, 3 CFR, 1943-48 Comp., p. 1071.)

By the Federal Home Loan Bank Board.

J. J. FINN,
Secretary.

[FR Doc. 76-14976 Filed 5-20-76; 8:45 am]

Title 17—Commodity and Securities
Exchanges

CHAPTER II—SECURITIES AND
EXCHANGE COMMISSION

[Release No. 33-5708]

PART 200—ORGANIZATION; CONDUCT
AND ETHICS; AND INFORMATION AND
REQUESTS

Oil and Gas Rights

The Commission today announced the amendment, effective immediately, of its regulations governing delegation of authority to the Director of the Division of Corporation Finance with respect to the Securities Act of 1933 and Regulation B (Rules 300-348) (17 CFR 230.300-230.348) thereunder.

The availability of the exemption to the registration provisions of the Securities Act of 1933 (the "Act") provided by Regulation B, pursuant to Section 3(b) of the Act, is dependent upon compliance with certain terms and conditions. One of those terms and conditions is provided by Rule 316(a) (17 CFR 230.316(a)), which requires that one copy of a Form 1-G (17 CFR 239.101(b)(1)) report be filed with the Commission. The form calls for a listing of the names and addresses of all purchasers of fractional undivided interests in oil and gas rights offered pursuant to the Regulation B exemption. Rule 316(a)(3) requires these reports to be kept confidential "unless the Commission shall order otherwise."

As noted in Securities Exchange Act Release No. 11992 (January 8, 1976), various abuses in the marketing of these interests have become apparent. In an effort to determine compliance with state securities laws, several state authorities have requested access to certain Form 1-G reports. The Commission has granted all such requests, subject to certain conditions designed to maintain the confidentiality of the reports. It is expected that more such requests will be received in the future. Inasmuch as these requests are of a routine nature and do not involve any policy considerations or novel questions, it is not necessary for the Commission to consider each request on an individual basis. The delegation of authority to respond to these requests to the Director of the Division of Corporation Finance, by eliminating any delay caused by seeking Commission approval for release of the information, will also aid in the enforcement effort necessary to end abuse of the Regulation B exemption, and thus is in the public interest and for the protection of investors.

It should be noted that, pursuant to 17 CFR 200.30-1, the Chairman of the Commission on October 23, 1975, designated the Associate Director of the Division of Corporation Finance to perform, under direction of the Director of the Division, the functions delegated to the Director pursuant to 17 CFR 200.30-1. That designation by its own terms would also apply to the delegation of authority announced today.

To accomplish this delegation of authority, the Commission hereby amends

17 CFR 200-30-1 (by revising paragraph (b)(6) and (7) and by adding paragraph (b)(8)).

§ 200.30-1 Delegation of authority to
Director of Division of Corporation
Finance.

(b) * * *

(6) To authorize the issuance of orders declaring offering sheets effective, as amended, filed in accordance with the provisions in Rule 340 thereunder (§ 230.340 of this chapter) and Rule 342(c) thereunder (§ 230.342(c) of this chapter);

(7) To authorize the issuance of orders terminating the effectiveness of offering sheets upon applications of persons filing them in compliance with the provisions of Rule 346 thereunder (§ 230.346 of this chapter); and

(8) To authorize the granting of applications for release of reports filed with the Commission on Form 1-G (§ 239.101(b)(1) of this chapter) pursuant to Rule 316(a) thereunder (§ 230.316(a) of this chapter).

The Commission finds that the foregoing action relates solely to agency management and personnel and that notice and prior publication under 5 U.S.C. 553 are not necessary. Accordingly, the foregoing action, which was taken pursuant to Pub. L. 87-592, 76 Stat. 394 (15 U.S.C. 78d-1, 78d-2) becomes effective immediately.

(Secs. 1, 2, Pub. L. 87-592, 76 Stat. 394, 395; (15 U.S.C. 78d-1, 78d-2))

By the Commission.

GEORGE A. FITZSIMMONS,

Secretary.

MAY 18, 1976.

[FR Doc.76-15054 Filed 5-20-76; 8:45 am]

Title 20—Employees' Benefits

CHAPTER III—SOCIAL SECURITY ADMINISTRATION,
DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE

[Regulations No. 5, further amended]

PART 405—FEDERAL HEALTH INSURANCE
FOR THE AGED AND DISABLED

Social Security Amendments of 1972

On June 19, 1975, there was published in the FEDERAL REGISTER (40 FR 25938) a Notice of Proposed Rule Making which set forth proposed amendments to regulations relating to conditions of participation for clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy services. (A correction was published on September 3, 1975 (40 FR 40537).) Those changes were proposed to implement the amendments to section 1861(p) of the Social Security Act (42 U.S.C. 1395x(p)), which were enacted by section 251(a)(1) of Pub. L. 92-603, which covers physical therapy services furnished by physical therapists in independent practice; and Section 283 of Pub. L. 92-603, which provides for the inclusion of the outpatient speech pathology benefit. Interested parties

were given the opportunity to submit in writing on or before July 21, 1975, data, views, or arguments with regard to the proposed amendments. Comments and suggestions received after that date have also been considered.

Comments were received from a number of sources, including representatives of national, State, and local organizations. Following is a summary of the comments and suggestions with regard to the Notice of Proposed Rulemaking, responses thereto, and changes in the proposed regulations:

1. Although a variety of concerns were reflected, the majority of the comments dealt with certain conditions and standards related to the outpatient speech pathology benefit. A large number of respondents objected to the parallelism drawn between physical therapy and speech pathology and indicated that speech pathology is unique and distinct from physical therapy and that, traditionally, speech pathologists are not, as contrasted with physical therapists, dependent upon a physician's prescription. Section 405.1717 of the proposed regulations required that the patient be treated under a plan of care established, and periodically reviewed, by a physician, and was based on section 1861(p) of the Social Security Act, as amended (42 U.S.C. 1395x(p)), which reads in part as follows:

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) Who is under the care of a physician (as defined in section 1861(r)(1)), and

(2) With respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established, and is periodically reviewed, by a physician (as so defined);

The term "outpatient physical therapy services" also includes speech pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection.

Since the Social Security Act provides for the similarity in requirements between the outpatient physical therapy and speech pathology benefits, § 405.1717 is felt to be consistent with the Act. It should be noted that § 405.1717(b) of the proposed regulation did provide for input by the speech pathologist as to the substantive plan of care through consultation with the physician, and this has been retained (while a duplicative sentence on the physician's role was deleted).

2. The proposed Medicare definition of "clinic" (§ 405.1702(b)) does not, in our opinion, create extreme hardship for speech pathology clinics, as has been

suggested by some respondents, since the term does not apply to them. Those facilities primarily providing speech pathology services, and which are commonly referred to as speech pathology clinics, are considered rehabilitation agencies (§ 405.1702(h)) for purposes of the health insurance program and are expected to have little difficulty meeting that definition and complying with the regulations for such agencies. The term "rehabilitation agency" refers to an agency which provides social or vocational adjustment services in addition to speech pathology or physical therapy services. The term "clinic" is generally applied to outpatient facilities in which medicine is taught by examination and treatment of patients in the presence of students, or where patients are treated by physicians who practice as a group. Speech and hearing organizations that identify themselves as speech pathology clinics are not expected to change that identity. Speech and hearing organizations, for Medicare purposes, are identified by the services they provide and not by name. These definitions of "clinic" and "rehabilitation agency" reflect those which are currently in effect and have been in effect since the promulgation of regulations implementing the outpatient physical therapy benefit included in the Social Security Amendments of 1967.

3. Comments received also questioned the justification for requiring a rehabilitation agency (§ 405.1702(h)) to provide either social or vocational adjustment services in addition to physical therapy or speech pathology. This requirement is already in effect under regulations implementing the 1967 Social Security Amendments at 20 CFR 405.1701(c)(1). These amendments included clinics, rehabilitation agencies, and public health agencies among organizations and institutions permitted to provide covered outpatient physical therapy services. Only after consultation with representatives of organizations of rehabilitation facilities, and other professional consultants, was the term "rehabilitation agency" defined as it presently appears in regulations. The authority to require that rehabilitation agencies furnish social or vocational adjustment services to clients is based on section 1861(p)(4)(A)(v) of the Social Security Act, as amended (42 U.S.C. 1395x(p)(4)(A)(v)). In addition to the differentiation evident in the statutory language with regard to a rehabilitation agency and a clinic, the Secretary, in the interest of beneficiary health and safety, has determined that since the term "rehabilitation agency" implies an agency with a rehabilitation program which offers more than one restorative service to improve the mental or physical status of its clients in the pursuit of an objective of social or vocational adjustment, such an agency, by its very nature, must also provide social or vocational adjustment services. It is felt that these services are essential to complement other services provided by a rehabilitation agency. Since a clinic, however, provides pri-

marily medical services and its function does not parallel that of a rehabilitation agency, regulations requiring a clinic to render social or vocational adjustment services are not appropriate.

4. As proposed, the definition of the physical therapist assistant (§ 405.1702(e)) would have enabled individuals to be recognized for Medicare purposes by accumulating two years of appropriate experience as a physical therapist assistant in addition to achieving a satisfactory grade on a proficiency examination approved by the Secretary. In view of the lack of interest shown in a proficiency examination (to date an insignificant number of inquiries requesting proficiency examination information has been received), the Secretary has determined that this alternative means of qualification for physical therapist assistants is not warranted. Therefore, the proficiency examination has been deleted from Subpart Q (§ 405.1702(e)(2)), (which is adopted and set forth below) and will subsequently be deleted from Subpart K (§ 405.1101(r)), and Subpart L (§ 405.1202(j)).

5. Suggestions were made to increase the frequency of the physical therapist supervisory visits to as often as once every 7 days in contrast to once every 30 days as stated in § 405.1718(a), when physical therapy services are provided off the premises of the organization by a physical therapist assistant. One of the concerns expressed was that an increase in supervision of the physical therapist assistant was necessary in order to ensure quality patient care. Although patient well-being is of primary importance, strict adherence to a timetable as suggested by some respondents would nullify, to a great degree, effective utilization of the physical therapist assistant. The Department has considered potential difficulties that may arise from supervision that is either too frequent or too infrequent, and believes that health insurance program experience to date with similar services furnished by other providers of services justifies the requirement for onsite supervisory visits at least once every 30 days.

6. Continuation of the handrail requirement in § 405.1723(a)(4) of the proposed amendments was questioned, and regarded as unnecessary in an outpatient institution. It was contended that the needs and abilities of resident, as opposed to non-resident, patients are different, and handrails, while being of value in a residential institution, are not essential in an outpatient institution where patients are more independent. The suggestion for deletion of the handrail requirement was considered, and it was concluded that adequate substitutions could be made for handrails where they were used to facilitate the movement of disabled persons. Therefore, the suggestion was adopted.

7. With respect to the conditions for coverage for outpatient physical therapy services furnished by physical therapists in independent practice, objection was

expressed concerning the requirement that the physical therapist must maintain, at his own expense, an office and the necessary equipment to provide an adequate program of physical therapy (see § 405.1731(b) and § 405.1737). The report of the Committee on Ways and Means indicates that one of the purposes for this change in the law was to make outpatient physical therapy services, furnished by a physical therapist in his office, more readily available to the beneficiary in cases where the therapist's office might be more accessible than a provider's facility and that the Secretary, in establishing the health and safety conditions under which the services of such practitioner must be furnished, would be expected to assure the availability of an adequate program of physical therapy services in the therapist's office. Section 405.232(e)(2)(ii), effective August 9, 1974, requires that a physical therapist in independent practice maintain at his own expense an office or office space and the necessary equipment to provide an adequate program of physical therapy. Therefore, conforming provisions in § 405.1731(b) as proposed, have been retained.

8. Sections 405.1230 and 405.232 are being published at this time to correct the cross-references to various sections in Subpart Q. Since these are only technical amendments, notice and public procedure thereon are unnecessary, and therefore good cause exists for dispensing with Notice of Proposed Rule Making with respect to §§ 405.1230 and 405.232.

9. Conformance to Subpart K (§ 405.1101(t)(1)) has been brought about by changes being made in § 405.1702(j). Subsequently, Subpart K will be revised to delete "the publication of this provision" and insert "January 17, 1974".

10. Various editorial and cross-reference changes have also been made in the interest of clarity.

Accordingly, with these changes and additions, the proposed amendments are adopted as set forth below.

(Secs. 1102, 1861(p), and 1871 of the Social Security Act, 49 Stat. 647, as amended, 79 Stat. 321, as amended, 79 Stat. 331; 42 U.S.C. 1302, 1395x(p), 1395hh.)

Effective date. These amendments shall be effective June 21, 1976.

(Catalog of Federal Domestic Assistance Program No. 13.801, Health Insurance for the Aged and Disabled Program—Supplementary Medical Insurance.)

Dated: March 1, 1976.

J. B. CARDWELL,
Commissioner of Social Security.

Approved: May 12, 1976.

MARJORIE LYNCH,
Acting Secretary of Health,
Education, and Welfare.

Regulations No. 5 of the Social Security Administration, as amended (20 CFR Part 405) are further amended as follows:

1. Subpart Q is revised to read as follows:

Subpart Q—Conditions of Participation: Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and/or Speech Pathology Services; and Conditions for Coverage: Outpatient Physical Therapy Services Furnished by Physical Therapists in Independent Practice

CONDITIONS OF PARTICIPATION: CLINICS, REHABILITATION AGENCIES, AND PUBLIC HEALTH AGENCIES AS PROVIDERS OF OUTPATIENT PHYSICAL THERAPY AND/OR SPEECH PATHOLOGY SERVICES

- Sec.
- 405.1701 Conditions of participation—general.
- 405.1702 Definitions relating to clinics, rehabilitation agencies, and public health agencies.
- 405.1715 Condition of participation—compliance with Federal, State, and local laws.
- 405.1716 Condition of participation—administrative management.
- 405.1717 Condition of participation—physician's direction and plan of care.
- 405.1718 Condition of participation—physical therapy services.
- 405.1719 Condition of participation—speech pathology services.
- 405.1720 Condition of participation—rehabilitation program.
- 405.1721 Condition of participation—arrangements for physical therapy and speech pathology services to be performed by other than salaried organization personnel.
- 405.1722 Condition of participation—clinical records.
- 405.1723 Condition of participation—physical environment.
- 405.1724 Condition of participation—infection control.
- 405.1725 Condition of participation—disaster preparedness.
- 405.1726 Condition of participation—program evaluation.

CONDITIONS FOR COVERAGE: OUTPATIENT PHYSICAL THERAPY SERVICES FURNISHED BY PHYSICAL THERAPISTS IN INDEPENDENT PRACTICE

- 405.1730 Conditions for coverage—services furnished by physical therapists in independent practice—general.
- 405.1731 Definitions relating to physical therapists in independent practice.
- 405.1732 Condition for coverage—compliance with Federal, State, and local laws.
- 405.1733 Condition for coverage—physician's direction and plan of care.
- 405.1734 Condition for coverage—physical therapy services.
- 405.1735 Condition for coverage—coordination of services with other organizations, agencies, or individuals.
- 405.1736 Condition for coverage—clinical records.
- 405.1737 Condition for coverage—physical environment.

AUTHORITY: Secs. 1102, 1861(p), 1871, 49 Stat. 647, as amended, 79 Stat. 321, as amended, 79 Stat. 331, (42 U.S.C. 1302, 1395x(p), 1395hh).

CONDITIONS OF PARTICIPATION: CLINICS, REHABILITATION AGENCIES, AND PUBLIC HEALTH AGENCIES AS PROVIDERS OF OUTPATIENT PHYSICAL THERAPY AND/OR SPEECH PATHOLOGY SERVICES

§ 405.1701 Conditions of participation—general.

(a) In order to participate in the program of health insurance for the aged

and disabled as a provider of outpatient physical therapy and/or speech pathology services, a clinic, rehabilitation agency, or public health agency (other than a provider of services as defined in section 1861(u) of the Social Security Act, 42 U.S.C. 1395x(u)) must meet the requirements set forth in section 1861(p)(4) thereof, 42 U.S.C. 1395x(p)(4). This section of the law states a number of specific requirements which must be met by such participating providers and authorizes the Secretary of Health, Education, and Welfare to prescribe by regulation other requirements relating to the health and safety of beneficiaries as may be found necessary.

(b) Section 1861(p) provides in pertinent part as follows:

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, a rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

excluding, however—

(3) Any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital; and

(4) Any such service—

(A) If furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

(i) Provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such program, in accordance with such requirements as the Secretary may specify.

(ii) Has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (i)) it provides.

(iii) Maintains clinical records on all patients.

(iv) If such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(v) Meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, or

(B) If furnished by a public health agency, unless such agency meets such other conditions relating to health and safety of individuals who are furnished services by such agency on an outpatient basis, as the Secretary may find necessary.

The term "outpatient physical therapy services" also includes speech pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection.

(c) The specific requirements included in the statute and the additional health

and safety requirements prescribed by the Secretary are set forth in the following Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and/or Speech Pathology Services.

§ 405.1702 Definitions relating to clinics, rehabilitation agencies, and public health agencies.

As used in §§ 405.1715–405.1726, the following definitions apply:

(a) *Administrator.* A person who has a bachelor's degree and:

(1) Has experience or specialized training in the administration of health institutions or agencies; or

(2) Is qualified and has experience in one of the professional health disciplines.

(b) *Clinic.* A facility established primarily for the provision of outpatient physicians' services. To meet this definition, an organization must meet the following test of physician participation:

(1) The medical services of the clinic are provided by a group of physicians (i.e., more than two) practicing medicine together; and

(2) A physician is present in the clinic at all times during hours of operation to perform medical services (rather than only administrative services).

(c) *Organization.* A clinic, rehabilitation agency, or public health agency.

(d) *Physical therapist.* A person who is licensed as a physical therapist by the State in which he is practicing if the State licenses physical therapists, and

(1) Has graduated from a physical therapy curriculum approved by the American Physical Therapy Association, or by the Council on Medical Education and Hospitals of the American Medical Association, or jointly by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association; or

(2) Prior to January 1, 1966:

(i) Was admitted to membership by the American Physical Therapy Association; or

(ii) Was admitted to registration by the American Registry of Physical Therapists; or

(iii) Has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education; or

(3) Has 2 years of appropriate experience as a physical therapist and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State after December 31, 1977, or seeking qualification as a physical therapist after such date; or

(4) (i) Was licensed or registered prior to January 1, 1966, and (ii) Prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or

(5) If trained outside the United States:

(i) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy.

(ii) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

(iii) Has 1 year of experience under the supervision of an active member of the American Physical Therapy Association, and

(iv) Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

(e) *Physical therapist assistant.* A person who is licensed as a physical therapist assistant by the State in which he is practicing, if the State licenses such assistants, and has graduated from a 2-year college-level program approved by the American Physical Therapy Association.

(f) *Psychologist.* A person who:

(1) Holds a doctoral degree in psychology from a training program approved by the American Psychological Association; or

(2) Has attained certification or licensing by the State, or non-statutory certification by the State psychological association.

(g) *Public health agency.* An official agency established by a State or local government, the primary function of which is to maintain the health of the population served by performing environmental health services, preventive medical services, and in certain cases, therapeutic services.

(h) *Rehabilitation agency.* An agency which provides an integrated multidisciplinary program designed to upgrade the physical function of handicapped, disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, a rehabilitation agency must provide physical therapy or speech pathology services, and a rehabilitation program which in addition to physical therapy or speech pathology services, includes social or vocational adjustment services.

(i) *Social worker.* A person who is licensed by the State in which he is practicing if the State licenses social workers, is a graduate of a school of social work accredited or approved by the Council on Social Work Education, and has 1 year of social work experience in a health-care setting.

(j) *Speech pathologist.* A person who is licensed by the State in which he is practicing, if the State licenses speech pathologists, and

(1) Is eligible for a certificate of clinical competence in speech pathology granted by the American Speech and Hearing Association under its requirements in effect on January 17, 1974; or

(2) Meets the educational requirements for certification, and is in the process of accumulating the supervised clinical experience required for certification.

(k) *Supervision.* Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within such person's sphere of competence, with initial direction and periodic inspection of the actual act of accomplishing the function or activity. Unless otherwise stated in this Part 405, such qualified person must be on the premises if the person performing the function or activity does not meet assistant-level qualifications specified in this section.

(1) *Vocational specialist.* A person who has a baccalaureate degree and:

(1) Two years experience in vocational counseling in a rehabilitation setting such as a sheltered workshop, State employment service agency, etc.; or

(2) At least 18 semester hours in vocational rehabilitation, educational or vocational guidance, psychology, social work, special education or personnel administration, and 1 year of experience in vocational counseling in a rehabilitation setting; or

(3) A master's degree in vocational counseling.

§ 405.1715 Condition of participation—compliance with Federal, State, and local laws.

The clinic, rehabilitation agency, or public health agency and its staff are in compliance with all applicable Federal, State, and local laws and regulations.

(a) *Standard: Licensure of organization.* In any State in which State or applicable local law provides for the licensing of clinics, rehabilitation agencies, or public health agencies, a clinic, rehabilitation agency, or public health agency is licensed pursuant to such law.

(b) *Standard: Licensure or registration of personnel.* Staff of the organization are licensed or registered in accordance with applicable laws.

§ 405.1716 Condition of participation—administrative management.

The clinic or rehabilitation agency has an effective governing body that is legally responsible for the conduct of the clinic or rehabilitation agency. The governing body designates an administrator, and establishes administrative policies.

(a) *Standard: Governing body.* There is a governing body (or designated person(s) so functioning) which assumes full legal responsibility for the overall conduct of the clinic or rehabilitation agency and for compliance with applicable laws and regulations. The name of the owner(s) of the clinic or rehabilitation agency is fully disclosed to the State agency. In the case of corporations, the names of the corporate officers are made known.

(b) *Standard: Administrator.* The governing body appoints a qualified full-time administrator and delegates to the administrator the internal operation of the clinic or rehabilitation agency in accordance with established written policies. The administrator's responsibilities for procurement and direction of per-

sonnel are clearly defined. A competent individual is authorized to act in the temporary absence of the administrator.

(c) *Standard: Personnel policies.* Personnel practices are supported by appropriate written personnel policies. Personnel records include job descriptions, qualifications, licensure, performance evaluations, and health examinations, and are kept current.

(d) *Standard: Patient care policies.* Patient care practices and procedures are supported by written policies established by a group of professional personnel including one or more physicians associated with the clinic or rehabilitation agency and one or more qualified physical therapists (if physical therapy services are provided) and one or more qualified speech pathologists (if speech pathology services are provided) to govern the outpatient physical therapy and/or speech pathology services and related services which are provided. These policies cover scope of services offered, admission and discharge policies, physician services, patient care plans and methods of implementation, care of patients in an emergency, clinical records, administrative records, use and maintenance of the plant and equipment, and program evaluation. The policies are reviewed at least annually by such group of professional personnel, and revised as necessary based upon this review.

§ 405.1717 Condition of participation—physician's direction and plan of care.

Patients in need of outpatient physical therapy or speech pathology services are accepted for treatment only on the order of a physician who indicates anticipated goals and is responsible for the general medical direction of such services as part of the total care of the patient. For each patient, there is a written plan of care established and periodically reviewed by the physician. The organization has a physician available to furnish necessary medical care in case of emergency.

(a) *Standard: Medical findings and physician's orders.* The following is made available to the organization prior to or at the time of initiation of treatment: (1) The patient's significant past history, (2) Current medical findings, (3) Diagnosis(es), (4) Physician's orders, (5) Rehabilitation goals, if determined, (6) Contraindications, if any, (7) The extent to which the patient is aware of the diagnosis(es) and prognosis, and (8) Where appropriate, the summary of treatment rendered and results achieved during previous periods of physical therapy or speech pathology services or institutionalization.

(b) *Standard: Plan of care.* For each patient there is a written plan of care established by the physician which indicates anticipated goals and specifies the type, amount, frequency, and duration of physical therapy or speech pathology services. Where appropriate, the plan is developed in consultation between the physical therapist(s) or speech pathologist(s) and such attending or other physician. The plan of care and results of

treatment are reviewed once every 30 days, or more often if required, by the attending or other physician and appropriate professional staff, and the indicated action is taken.

(c) *Standard: General medical direction.* The organization requires that the health care of every patient is under the general medical direction of a physician. The patient in need of physical therapy and/or speech pathology services is seen by the physician at least once every 30 days. The organization is responsible for contacting the physician if the patient has not been seen by the physician within a 30-day period. There is evidence in the clinical record of the physician's services at appropriate intervals.

(d) *Standard: Notification of physician.* The attending physician, or where applicable, another responsible physician, is promptly notified of any changes in the patient's condition. If changes are required in the plan of care, such changes are approved by such physician and noted in the clinical record.

(e) *Standard: Availability of physicians for emergency.* The organization provides for one or more physicians to be available on call to furnish necessary medical care in case of emergency. A schedule listing the names and telephone numbers of these physicians and the specific days each is on call is posted. There are established procedures to be followed by personnel in an emergency which cover immediate care of the patient, persons to be notified and reports to be prepared.

§ 405.1718 Condition of participation—physical therapy services.

If physical therapy services are offered, the organization provides an adequate program of physical therapy and has an adequate number of qualified personnel and the equipment necessary to carry out its program and to fulfill its objectives.

(a) *Standard: Adequate program.* (1) The organization will be considered to have an adequate outpatient physical therapy program if it can: (i) Provide services utilizing therapeutic exercise and the modalities of heat, cold, water, and electricity; (ii) Conduct patient evaluations; and (iii) Administer tests and measurements of strength, balance, endurance, range of motion, and activities of daily living. (2) A qualified physical therapist is present or readily available to offer needed supervision to the physical therapist assistant when physical therapy services are provided on or off the organization's premises. Where a qualified physical therapist is not on the premises during all hours of operation, patients are scheduled in such a manner as to ensure the physical therapist's presence when specific skills are needed (e.g., the evaluation and re-evaluation and to provide appropriate and needed supervision to the physical therapist assistant when providing services. When physical therapy services are provided off the premises of the organization by a qualified physical therapist

assistant, such services are provided under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days.

(b) *Standard: Facilities and equipment.* The organization has the equipment and facilities required to provide the range of services necessary in the treatment of the types of disabilities accepted for service.

(c) *Standard: Personnel qualified to provide physical therapy services.* Physical therapy services are provided by, or under the supervision of, a qualified physical therapist. The number of qualified physical therapists and qualified physical therapist assistants is adequate for the volume and diversity of physical therapy services offered. A qualified physical therapist is on the premises or readily available during the operating hours of the organization.

(d) *Standard: Supportive personnel.* If personnel are available to assist qualified physical therapists by performing services incident to physical therapy that do not require professional knowledge and skill, such personnel are instructed in appropriate patient care services by qualified physical therapists who retain responsibility for the treatment prescribed by the attending physician.

§ 405.1719 Condition of participation—speech pathology services.

If speech pathology services are offered, the organization provides an adequate program of speech pathology and has an adequate number of qualified personnel and the equipment necessary to carry out its program and to fulfill its objectives.

(a) *Standard: Adequate program.* The organization will be considered to have an adequate outpatient speech pathology program if it can provide the diagnostic and treatment services to effectively treat speech disorders.

(b) *Standard: Facilities and equipment.* The organization has the equipment and facilities required to provide the range of services necessary in the treatment of the types of speech disorders accepted for service.

(c) *Standard: Personnel qualified to provide speech pathology services.* Speech pathology services are given or supervised by a qualified speech pathologist and the number of qualified speech pathologists is adequate for the volume and diversity of speech pathology services offered. At least one qualified speech pathologist is present at all times when speech pathology services are rendered.

§ 405.1720 Condition of participation—rehabilitation program.

At a minimum, a rehabilitation agency provides physical therapy or speech pathology services, and a rehabilitation program which, in addition to physical therapy or speech pathology services, includes social or vocational adjustment services to all patients in need of such services by making provision for special, qualified staff to evaluate the social or vocational factors involved in a patient's rehabilitation, to counsel and advise on

social or vocational problems arising from the patient's illness or injury, and to make appropriate referrals for required services.

(a) *Standard: Qualification of staff.* The agency's social or vocational adjustment services are rendered, as applicable, by qualified psychologists, qualified social workers, or qualified vocational specialists. Social or vocational adjustment services may be performed by a qualified psychologist or qualified social worker. Vocational adjustment services may be furnished by a qualified vocational specialist.

(b) *Standard: Arrangements for social or vocational services.* If a rehabilitation agency does not provide social or vocational adjustment services through salaried employees, it may provide such adjustment services by means of a written contract with others which provides for retention by the agency of responsibility for, and control and supervision of, such services. The terms of the contract:

(1) Provide that the regimen of social or vocational adjustment services to be furnished is developed in consultation between appropriate professional staff members and the patient's attending physician;

(2) Specify the geographical areas in which the services are to be furnished;

(3) Provide that such services are furnished by personnel meeting the qualifications in § 405.1702;

(4) Provide that personnel under contract will participate as needed in conferences required to coordinate patient care;

(5) Provide for the preparation of treatment records and notes, and for the prompt incorporation of such into the clinical records of the agency;

(6) Specify the period of time the contract is to be in effect and the manner of termination or renewal.

§ 405.1721 Condition of participation—arrangements for physical therapy and speech pathology services to be performed by other than salaried organization personnel.

When an organization provides outpatient physical therapy and/or speech pathology services under an arrangement with others, such services are to be furnished in accordance with the terms of a written contract, which provides for retention by the organization of professional and administrative responsibility for, and control and supervision of, such services.

(a) *Standard: Contract provisions.* The terms of the contract:

(1) Provide that physical therapy and/or speech pathology services are to be furnished in accordance with the plan of care established by the physician responsible for the patient's care and may not be altered in type, amount, frequency, or duration by the physical therapist or speech pathologist (except in the case of an adverse reaction to a specific treatment);

(2) Specify the geographical areas in which the services are to be furnished;

(3) Provide that personnel and services contracted for meet the same requirements as those which would be applicable if the personnel and services were furnished directly by the clinic, rehabilitation agency, or public health agency;

(4) Provide that as needed the physical therapist or speech pathologist (as appropriate) will participate in conferences required to coordinate the care of an individual patient;

(5) Provide for the preparation of treatment records, with progress notes and observations, and for the prompt incorporation of such into the clinical records of the clinic, rehabilitation agency, or public health agency;

(6) Specify the financial arrangements which provide that the contracting outside resource may not bill the patient or the health insurance program for covered services, since pursuant to section 1861(w) of the Act (42 U.S.C. 1395x(w)), covered services furnished under arrangements must be billed through the provider exclusively and receipt of payment by the provider for such services on behalf of an entitled individual discharges the liability of such individual or any other person to pay for such services;

(7) Specify the period of time the contract is to be in effect and the manner of termination or renewal;

(8) Except as provided in paragraph (a) (9) of this section, provide that the services shall be performed in the patient's home, on the premises of the clinic, rehabilitation agency, or public health agency making the arrangements, or on the premises of an institution which meets the requirements of section 1861(e) (1) or section 1861(j) (1) of the Act; and

(9) In the case of a public health agency (including a public health agency which is certified by the health insurance program as a home health agency), may provide that physical therapy and/or speech pathology services may also be performed on the premises of the supplier of such services but only under the following circumstances:

(i) The public health agency does not have the capacity to provide on its premises all of the (A) Modalities of treatment, tests, and measurements as specified in § 405.1718(a) (in the case of outpatient physical therapy services), or (B) Diagnostic and treatment services as specified in § 405.1719(a) (in the case of outpatient speech pathology services);

(ii) The services provided on the premises of the supplier include those as defined in § 405.1718(a) or § 405.1719(a), as appropriate, which the public health agency cannot provide on its premises, and these services are not provided on an outpatient basis in another accessible participating provider of services;

(iii) Services are provided on the premises of the supplier only in those instances in which the patient's treatment requires the use of a modality or regimen which is not available on the premises of the public health agency;

(iv) The public health agency is responsible for advising the State agency of the name of each supplier with whom it contracts for the provision of services and makes the arrangements necessary in order for the State agency to survey the premises and organization of each supplier of services to determine compliance with applicable regulations; and

(v) A physician, qualified physical therapist, qualified speech pathologist, or supervising nurse employed by the public health agency reviews at least every 2 weeks all records of the patients of the public health agency who have been treated on the premises of the supplier.

§ 405.1722 Condition of participation—clinical records.

The organization maintains clinical records on all patients in accordance with accepted professional standards, and practices. The clinical records are completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.

(a) *Standard: Protection of clinical record information.* The organization recognizes the confidentiality of clinical record information and provides safeguards against loss, destruction, or unauthorized use. Written procedures govern the use and removal of records and the conditions for release of information. The patient's written consent is required for release of information not authorized by law.

(b) *Standard: Content.* The clinical record contains sufficient information to identify the patient clearly, to justify the diagnosis(es) and treatment, and to document the results accurately. All clinical records contain the following general categories of data:

(1) Documented evidence of the assessment of the needs of the patient, of an appropriate plan of care, and of the care and services provided;

(2) Identification data and consent forms;

(3) Medical history;

(4) Report of physical examinations, if any;

(5) Observations and progress notes;

(6) Reports of treatments and clinical findings; and

(7) Discharge summary including final diagnosis(es) and prognosis.

(c) *Standard: Completion of records and centralization of reports.* Current clinical records and those of discharged patients are completed promptly. All clinical information pertaining to a patient is centralized in the patient's clinical record. Each physician's entries into the clinical record are signed by the appropriate physician.

(d) *Standard: Retention and preservation.* Clinical records are retained for a period of time not less than:

(1) That determined by the respective State statute, or the statute of limitations in the State; or

(2) In the absence of a State statute:

(i) Five years after the date of discharge, or (ii) In the case of a minor,

3 years after the patient becomes of age under State law or 5 years after the date of discharge, whichever is longer.

(e) *Standard: Indexes.* Clinical records are indexed at least according to name of patient to facilitate acquisition of statistical medical information and retrieval of records for research or administrative action.

(f) *Standard: Location and facilities.* The organization maintains adequate facilities and equipment, conveniently located, to provide efficient processing of clinical records (reviewing, indexing, filing, and prompt retrieval).

§ 405.1723 Condition of participation—physical environment.

The building housing the organization is constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public and provides a functional, sanitary, and comfortable environment.

(a) *Standard: Safety of patients.* The organization satisfies the following requirements:

(1) It complies with all applicable State and local building, fire, and safety codes.

(2) Permanently attached automatic fire-extinguishing systems of adequate capacity are installed in all areas of the organization considered to have special fire hazards. Fire extinguishers are conveniently located on each floor of the organization. Fire regulations are prominently posted.

(3) Doorways, passageways and stairwells negotiated by patients are: (i) Of adequate width to allow for easy movement of all patients (including those on stretchers or in wheelchairs), (ii) free from obstruction at all times, and (iii) in the case of stairwells, equipped with firmly attached handrails on at least one side.

(4) Lights are placed at exits and in corridors used by patients and are supported by an emergency power source.

(5) A fire alarm system with local alarm capability and, where applicable, an emergency power source, is functional.

(6) At least two persons are on duty on the premises of the organization whenever a patient is being treated.

(7) No occupancies or activities undesirable or injurious to the health and safety of patients are located in the building.

(b) *Standard: Maintenance of equipment, building, and grounds.* The organization establishes a written preventive-maintenance program to ensure:

(1) That equipment is operative, and is properly calibrated, and

(2) That the interior and exterior of the building are clean and orderly and maintained free of any defects which are a potential hazard to patients, personnel, and the public.

(c) *Standard: Other environmental considerations.* The organization provides a functional, sanitary, and comfortable environment for patients, personnel, and the public.

(1) Provision is made for adequate and comfortable lighting levels in all areas; limitation of sounds at comfort levels; a comfortable room temperature; and adequate ventilation through windows, mechanical means, or a combination of both.

(2) Toilet rooms, toilet stalls, and lavatories are accessible and constructed so as to allow utilization by nonambulatory and semiambulatory individuals.

(3) Whatever the size of the building, there is an adequate amount of space for the services provided and disabilities treated, including reception area, staff space, examining room, treatment areas, and storage.

**§ 405.1724 Condition of participation—
infection control.**

The organization that provides outpatient physical therapy services establishes an infection-control committee of representative professional staff with responsibility for overall infection control. All necessary housekeeping and maintenance services are provided to maintain a sanitary and comfortable environment and to help prevent the development and transmission of infection.

(a) *Standard: Infection-control committee.* The infection-control committee establishes policies and procedures for investigating, controlling, and preventing infections in the organization and monitors staff performance to ensure that the policies and procedures are executed.

(b) *Standard: Aseptic and isolation techniques.* Written effective procedures in aseptic techniques are followed by all personnel. Procedures are reviewed and revised annually for effectiveness and improvement.

(c) *Standard: Housekeeping.* The organization employs sufficient housekeeping personnel and provides all necessary equipment to maintain a safe, clean, and orderly interior. A full-time employee is designated as the one responsible for the housekeeping services and for supervision and training of such personnel. An organization that has a contract with an outside resource for housekeeping services may be found to be in compliance with this standard provided the organization and/or outside resource meets the requirements of the standard.

(d) *Standard: Linen.* The organization has available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection.

(e) *Standard: Pest control.* The organization is maintained free from insects and rodents through operation of a pest-control program.

**§ 405.1725 Condition of participation—
disaster preparedness.**

The organization has a written plan, periodically rehearsed, with procedures to be followed in the event of an internal or external disaster and for the care of casualties (patients and personnel) arising from such disasters.

(a) *Standard: Disaster plan.* The organization has an acceptable written plan in operation, with procedures to be followed in the event of fire, explosion, or other disaster. The plan is developed and maintained with the assistance of qualified fire, safety, and other appropriate experts, and includes:

(1) Procedures for prompt transfer of casualties and records.

(2) Instructions regarding the location and use of alarm systems and signals and of firefighting equipment.

(3) Information regarding methods of containing fire.

(4) Procedures for notification of appropriate persons, and

(5) Specifications of evacuation routes and procedures.

(b) *Standard: Staff training and drills.* All employees are trained, as part of their employment orientation, in all aspects of preparedness for any disaster. The disaster program includes orientation and ongoing training and drills for all personnel in all procedures so that each employee promptly and correctly carries out his assigned role in case of a disaster.

**§ 405.1726 Condition of participation—
program evaluation.**

The organization has procedures which provide for a systematic evaluation of its total program to assure appropriate utilization of services and to determine whether the organization's policies are followed in providing services to patients through employees or under arrangements with others.

(a) *Standard: Clinical-record review.* A sample of active and closed clinical records is reviewed quarterly by the appropriate health professionals to assure that established policies are followed in providing services.

(b) *Standard: Annual statistical evaluation.* An evaluation is conducted annually of such statistical data as number of different patients treated, number of patient visits, condition on admission and discharge, number of new patients, number of patients by diagnosis(es), sources of referral, number and cost of units of service by treatment given, and total staff days or work hours by discipline.

**CONDITIONS FOR COVERAGE: OUTPATIENT
PHYSICAL THERAPY SERVICES FURNISHED
BY PHYSICAL THERAPISTS IN INDEPENDENT
PRACTICE**

**§ 405.1730 Conditions for coverage—
services furnished by physical therapists
in independent practice—general.**

(a) In order to be covered under the program of health insurance for the aged and disabled as a supplier of outpatient physical therapy services, a physical therapist in independent practice must meet State licensure and requirements set forth in section 1861(p)(4) of the Act, 42 U.S.C. 1395x(p)(4), and other requirements established pursuant to this provision. This section of the law states specific requirements which must be met by such suppliers and authorizes the

Secretary of Health, Education, and Welfare to prescribe by regulation other requirements relating to the health and safety of beneficiaries as may be found necessary.

(b) Section 1861(p) provides in pertinent part as follows:

(p) The term 'outpatient physical therapy services' means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

The term 'outpatient physical therapy services' also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary * * *

(c) The requirements included in the statute and the additional health and safety requirements prescribed by the Secretary are set forth in the Conditions for Coverage for Outpatient Physical Therapy Services Furnished By Physical Therapists in Independent Practice (see §§ 405.1732-405.1737).

§ 405.1731 Definitions relating to physical therapists in independent practice.

As used in §§ 405.1732-405.1737, the following definitions apply:

(a) *Physical therapist.* A person who is licensed as a physical therapist by the State in which he is practicing if the State licenses physical therapists, and

(1) Has graduated from a physical therapy curriculum approved by the American Physical Therapy Association, or by the Council on Medical Education and Hospitals of the American Medical Association, or jointly by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association; or

(2) Prior to January 1, 1966:

(i) Was admitted to membership by the American Physical Therapy Association, or

(ii) Was admitted to registration by the American Registry of Physical Therapists, or

(iii) Has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education; or

(3) Has 2 years of appropriate experience as a physical therapist and has achieved a satisfactory grade on a proficiency examination approved by the Secretary except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State after December 31, 1977, or seeking qualification as a physical therapist after such date; or

(4) (i) Was licensed or registered prior to January 1, 1966, and

(ii) Prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or

(5) If trained outside the United States:

(i) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy;

(ii) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy;

(iii) Has 1 year of experience under the supervision of an active member of the American Physical Therapy Association, and

(iv) Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

(b) *Physical therapist in independent practice:* A person who is licensed as a physical therapist by the State in which he is practicing, meets one of the qualification requirements in paragraph (a) of this section, and furnishes services under the circumstances described in § 405.232(e) (2) (ii).

(c) *Supervision:* The presence, at all times, of a qualified physical therapist when physical therapy services are rendered in the physical therapist's office or in the patient's place of residence.

§ 405.1732 Condition for coverage—compliance with Federal, State, and local laws.

The physical therapist in independent practice and staff, if any, are in compliance with all applicable Federal, State, and local laws and regulations.

(a) *Standard: Licensure of facility.* In any State in which State or applicable local law provides for the licensing of the facility of a physical therapist, such facility is:

(1) Licensed pursuant to such law; or
(2) If not subject to licensure, is approved (by the agency of such State or locality responsible for licensing) as meeting the standards established for such licensing.

(b) *Standard: Licensure or registration of personnel.* The physical therapist in independent practice and staff, if any, are licensed or registered in accordance with applicable laws.

§ 405.1733 Condition for coverage—physician's direction and plan of care.

Patients in need of outpatient physical therapy services are accepted for treatment by the physical therapist in independent practice only on the order of a physician who indicates anticipated goals and is responsible for the general medical direction of such services as part of the total care of the patient. For each patient, there is a written plan of care established and periodically reviewed by the physician.

(a) *Standard: Medical findings and physician's orders.* The following is made available to the physical therapist, prior to or at the time of initiation of treatment:

- (1) The patient's significant past history,
- (2) Diagnosis(es),
- (3) Physician's orders,
- (4) Rehabilitation goals and potential for their achievement,
- (5) Contraindications, if any,
- (6) The extent to which the patient is aware of the diagnosis(es) and prognosis, and

(7) Where appropriate, the summary of treatment rendered and results achieved during previous periods of physical therapy services or institutionalization.

(b) *Standard: Plan of care.* For each patient there is a written plan of care established by the physician which indicates anticipated goals and specifies the type, amount, frequency, and duration of physical therapy services. Where appropriate, the plan is developed in consultation between the physical therapist and the patient's attending physician. The plan of care and results of treatment are reviewed once every 30 days, or more often if required, by the attending physician and the physical therapist; and the indicated action is taken.

(c) *Standard: General medical direction.* Patients are seen by a physician at least once every 30 days. General medical direction at appropriate intervals is evident from the clinical record.

(d) *Standard: Notification of physician.* The attending physician is promptly notified of any changes in the patient's condition. If changes are required in the plan of care, such changes are approved by such physician and noted in the clinical record.

§ 405.1734 Condition for coverage—physical therapy services.

The physical therapist in independent practice provides an adequate program of physical therapy services and has the facilities and equipment necessary to carry out the services offered.

(a) *Standard: Adequate program.* The physical therapist will be considered to have an adequate physical therapy program when services can be provided, utilizing therapeutic exercise and the modalities of heat, cold, water, and electricity; patient evaluations are conducted; and tests and measurements of strength, balance, endurance, range of motion, and activities of daily living are administered.

(b) *Standard: Supervision of physical therapy services.* Physical therapy services are provided by, or under the supervision of, a qualified physical therapist.

§ 405.1735 Condition for coverage—coordination of services with other organizations, agencies, or individuals.

The physical therapy services provided by the physical therapist in independent practice are coordinated with the health and medical services provided to the patient by organizations, agencies, or individuals.

(a) *Standard: Exchange of clinical records and reports.* When a patient is receiving or has recently received health and medical services from providers, organizations, physicians, or others that are related to and that may involve the physical therapy program, the physical therapist shall, on a regular basis, exchange with such providers, organizations, physicians, or others in accordance with § 405.1736(a) documented information which has a bearing on the patient's health and welfare so as to ensure that services effectively complement one another.

§ 405.1736 Condition for coverage—clinical records.

The physical therapist in independent practice maintains clinical records on all patients in accordance with accepted professional standards and practices. The clinical records are completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.

(a) *Standard: Protection of clinical record information.* Clinical-record information is recognized as confidential and is safeguarded against loss, destruction, or unauthorized use. Written procedures govern use and removal of records and include conditions for release of information. A patient's written consent is required for release of information not authorized by law.

(b) *Standard: Content.* The clinical record information. Clinical record information contains sufficient information to identify the patient clearly, to justify the diagnosis(es) and treatment, and to document the results accurately. All clinical records contain the following general categories of data:

- (1) Documented evidence of the assessment of the needs of the patient, of an appropriate plan of care, and of the care and services provided,
- (2) Identification data and consent forms,
- (3) Medical history,
- (4) Report of physical examination(s), if any,
- (5) Observations and progress notes,
- (6) Reports of treatments and clinical findings, and
- (7) Discharge summary including final diagnosis(es) and prognosis.

(c) *Standard: Completion of records and centralization of reports.* Current clinical records and those of discharged patients are completed promptly. All clinical information pertaining to a patient is centralized in the patient's clinical record.

(d) *Standard: Retention and preservation.* Clinical records are retained for a period of time not less than:

(1) That determined by the respective State statute or the statute of limitations in the State, or

(2) In the absence of a State statute: (i) 5 years after the date of discharge or, (ii) in the case of a minor, 3 years after the patient becomes of age under State law, or 5 years after the date of discharge, whichever is longer.

(e) *Standard: Indexes.* Clinical records are indexed at least according to name of patient to facilitate acquisition of statistical clinical information and retrieval of records for administrative action.

§ 405.1737 Condition for coverage—physical environment.

The physical environment of the office and/or facility of the physical therapist in independent practice affords a functional, sanitary, safe, and comfortable surrounding for patients, personnel, and the public.

(a) *Standard: Building construction.* The construction of the building housing the physical therapy office meets all applicable State and local building, fire, and safety codes.

(b) *Standard: Maintenance of the physical therapy office and equipment.* There is established a written preventive-maintenance program to ensure that equipment is operative and that the physical therapy office is clean and orderly. All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition, and is properly calibrated.

(c) *Standard: Other environmental considerations.* The building housing the physical therapy office is accessible to, and functional for, patients, personnel, and the public. Written effective procedures in aseptic techniques are followed by all personnel and such procedures are reviewed annually, and when necessary, revised.

(d) *Standard: Emergency procedures.* The physical therapist is aware of the possibility of the occurrence of fire and other non-medical emergencies and has documented: (1) A means of providing for safe patient egress from the physical therapy office and the building housing the office, such means being demonstrated by fire exit signs, etc., and (2) Other such provisions necessary to ensure the safety of patients.

2. Section 405.1230 is revised to read as follows:

§ 405.1230 Condition of participation: Qualifying to provide outpatient physical therapy or speech pathology services.

(a) Section 1861(p) of the Social Security Act provides in pertinent part as follows:

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, a rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

The term "outpatient physical therapy services" also includes speech pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection.

(b) As a provider of services, a home health agency may qualify to provide outpatient physical therapy or speech pathology services if such agency meets the statutory requirements of section 1861(o) of the Act and complies with other health and safety requirements prescribed by the Secretary for home health agencies, and, additionally, is in compliance with applicable health and safety requirements pertaining to rendition of outpatient physical therapy or speech pathology services. The applicable health and safety requirements pertaining to outpatient physical therapy or speech pathology services are included in the conditions of participation in Subpart Q of this part. (See §§ 405.1717, 405.1718, 405.1719, 405.1721, 405.1723, and 405.1725.)

3. Section 405.232(e) (2) (iii) is revised to read as follows:

§ 405.232 Medical and other health services: conditions, limitations, and exclusions.

(e) * * *

(2) The outpatient physical therapy services described in § 405.231(1) (2) shall include only those items and services:

(iii) Furnished by a physical therapist licensed by the State in which the items and services were furnished and who meets the other qualifications set out in § 405.1702(d).

[FR Doc.76-14707 Filed 5-20-76-8:45 am]

[Regulations No. 16]

PART 416—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

Reimbursement to States for Interim Assistance Payments, Cost-of-Living Adjustments in Benefits

On November 12, 1975, there was published in the FEDERAL REGISTER (40 FR 52742) a Notice of Proposed Rule Making with proposed amendments to Subparts D and E and the establishment of a new Subpart S, Regulations No. 16. The amendments to Part 416 implement the interim assistance and cost-of-living provisions of Pub. L. 93-368, enacted August 7, 1974. Section 5 of Pub. L. 93-368 amends Section 1631 of the Social Security Act to permit the Social Security Administration to enter into an agreement with a State whereby such State would be reimbursed for interim assistance payments made to or on behalf of an individual (subsequently determined to be eligible) during the period such individual's application for supplemental security income benefits is pending. Section 6 of Pub. L. 93-368 provides for cost-of-living adjustments in the supplemental security income benefit standards in conjunction with and by the same percentage as benefits under Title II of the Act are increased in accordance with section 215(i) of the Act. Interested persons were given the opportunity to sub-

mit, within 30 days, data, views or arguments with regard to the proposed changes.

The only comments received during the comment period concerned the new Subpart S. The following comments were made regarding the new Subpart:

1. One recommendation was for an addition to Subpart S authorizing the Social Security Administration to provide information to State and local governments on the status of supplemental security income cases where the applicant has applied for interim assistance. Furnishing interim status reports would not be administratively feasible, and the delays it would cause in processing time would only hinder the Social Security Administration's ability to respond promptly to the needs of the individual. Also, a comment was made in response to § 416.1906(c), which provides that an applicant's written authorization to withhold benefits due him for purposes of reimbursing the State of the interim assistance furnished him is in effect until the Social Security Administration has made a final determination on his claim. The commenter stated that if an application is denied, no provision is made for informing the local social service districts of this fact on a timely basis. However, current operating instructions provide for the notification of State and local governments whether a claim for supplemental security income has been allowed or denied. A sentence has been included in § 416.1906(c) to reflect this policy.

2. Two commenters recommended that the provisions of the interim assistance legislation be applied to all State or local funded assistance (e.g., AFDC) regardless of whether federal funding is also involved. However, section 1631(g) (3) of the Social Security Act and the related legislative history indicate that the term "interim assistance" with respect to any individual refers only to assistance financed totally from State or local funds. Therefore, no change has been made.

3. Section 416.1911(b) (1) provides that if payment to the State by the Social Security Administration in reimbursement for interim assistance for an individual is greater than the amount of the interim assistance granted, the State is required to pay the excess amount to the individual no later than ten working days from receipt of the payment. Two comments were made that in order to comply with this requirement, the award letter needs to accompany the payment. Administrative problems in this area are recognized and work is being done to assist the State to resolve them. Nevertheless, section 1631(g) (4) (A) of the Social Security Act expressly requires the State to pay the excess amount to the individual within ten working days.

4. A comment was made questioning the provision in § 416.1911(b) (2) which requires the State to refund the excess amount to the Social Security Administration if the State is unable to pay the excess to the individual. In the case of a deceased individual, the commenter

felt that the excess should be paid to the decedent's estate. Section 1631(b) of the Act provides that the Social Security Administration can only pay on underpayments involving supplemental security income underpayments to the individual or his eligible spouse. There is no provision in the statute for paying supplemental security income benefits to an individual's estate. Accordingly, § 416.542 (b) of the regulations provides that no underpayment may be paid to the estate of any underpaid recipient or to any survivor other than the living-with eligible spouse. Therefore, § 416.1911(b)(2) provides that if payment cannot be made to the individual the excess should be returned to the Social Security Administration so that it may be handled under the generally applicable rules.

5. One comment indicated that the States do not always receive reimbursement when the Social Security Administration erroneously sends the initial benefit check to the individual instead of the State Agency. It was recommended that the Social Security Administration have the responsibility to ensure that reimbursement is made to the State, regardless of whether the Social Security Administration can recoup those funds erroneously sent to the individual. Section 1631(g) of the Social Security Act only authorizes the Secretary, under certain conditions and if the applicant so elects to make the first payment of supplemental security income benefits, which he has determined to be due, to a State or to a political subdivision. Even if the Social Security Administration makes a mistake and sends the first payment of supplemental security income benefits to the individual rather than to the State, there is no liability provided for in the agreements between the Secretary and the State, nor does any such Federal liability seem to have been intended by Congress when it enacted the interim assistance provisions.

After due consideration of the comments received, the amendments are hereby adopted as so revised and are set forth below.

(Secs. 1102, 1611(b), 1617, 1631(d), and 1631 (g) of the Social Security Act, 49 Stat. 647, as amended, 86 Stat. 1466, as amended, 88 Stat. 422, 88 Stat. 1475, 88 Stat. 420; 42 U.S.C. 1302, 1382(b), 1382(f), 1383(d), and 1383 (g).)

Effective date. The amendments shall be effective May 21, 1976.

(Catalog of Federal Domestic Assistance Programs No. 13.807, Supplemental Security Income Program.)

Dated: April 5, 1976.

J. B. CARDWELL,
Commissioner of Social Security.

Approved: May 12, 1976.

MARJORIE LYNCH,
Acting Secretary of Health,
Education, and Welfare.

Part 416 of Chapter III of Title 20 of the Code of Federal Regulations is amended as follows:

1. A new § 416.405 is added to read as follows:

§ 416.405 Cost-of-living adjustments in benefits.

Whenever benefit amounts under title II of the Act (Part 404 of this Chapter) are increased by any percentage effective with any month as a result of a determination made under section 215(i) of the Act, each of the dollar amounts in effect for such month under §§ 416.410, 416.412, 416.413, 416.432(c) and 416.531, as specified in such sections or as previously increased under this section, shall be increased by the same percentage (and rounded on an annual basis, when not a multiple of \$1.20 to the next higher multiple of \$1.20), effective with respect to benefits for months after such month.

2. Section 416.410 is revised to read as follows:

§ 416.410 Amount of benefits; eligible individual.

The benefit under this part for an eligible individual who does not have an eligible spouse, who is not in an institution (see § 416.231), who is not living in the household of another under the conditions set forth in § 416.1125, and who is not a qualified individual (as defined in § 416.242), shall be payable at the rate of \$1,680 per year (\$420 per quarter, \$140 per month) for the period ending June 30, 1974, at the rate of \$1,752 per year (\$438 per quarter, \$146 per month) for the period beginning July 1, 1974, and ending June 30, 1975, and at the rate of \$1,892.40 per year (\$473.10 per quarter, \$157.70 per month) for the remainder of 1975 and any calendar year thereafter (however, see § 416.405 with respect to cost-of-living increases) reduced by the amount of such individual's income not excluded pursuant to Subpart K of this part.

3. Section 416.412 is revised to read as follows:

§ 416.412 Amount of benefits; eligible couple.

The benefit under this part for an eligible couple neither of whom is in an institution (see § 416.231) nor is living in the household of another under the conditions set forth in § 416.1125, nor is a qualified individual (as defined in § 416.242), shall be payable at the rate of \$2,520 per year (\$630 per quarter, \$210 per month) for the period ending June 30, 1974, at the rate of \$2,628 per year (\$657 per quarter, \$219 per month) for the period beginning July 1, 1974, and ending June 30, 1975, and at the rate of \$2,839.20 per year (\$709.80 per quarter, \$236.60 per month) for the remainder of 1975 and any calendar year thereafter (however, see § 416.405 with respect to cost-of-living increases) reduced by the amount of income not excluded pursuant to Subpart K of this part, of such individual and spouse. (See § 416.502.)

4. Section 416.413 is revised to read as follows:

§ 416.413 Amount of benefits; qualified individual.

A qualified individual (as defined in § 416.242) will receive in addition to the

amount specified in § 416.410 or § 416.412, as applicable, \$70 per month for the period ending June 30, 1974, \$73 per month for the period beginning July 1, 1974, and ending June 30, 1975, and \$78.90 per month for the remainder of 1975 and any calendar year thereafter (however, see § 416.405 with respect to cost-of-living increases) for each essential person (as defined in § 416.243) living in his household. (See §§ 416.531 and 416.532.)

5. In § 416.432 paragraph (c) is revised to read as follows:

§ 416.432 Change in eligibility status within a quarter involving a couple; eligibility exists in all months of the quarter.

(c) When one member of a couple is in an institution and subject to payment reduction for Medicaid (§ 416.231), and the other member of the couple is living in the household of another and receiving support and maintenance from that person, the rate of payment for such couple shall be \$1,420 per year (\$355 per quarter, \$118.34 per month) for the period ending June 30, 1974, at the rate of \$1,468 per year (\$367 per quarter, \$122.34 per month) for the period beginning July 1, 1974, and ending June 30, 1975, and at the rate of \$1,561.60 per year (\$390.40 per quarter, \$130.14 per month) for the remainder of 1975 and any calendar year thereafter (however, see § 416.405 with respect to cost-of-living increases). These amounts are based on the sum of \$25 and the reduction of the rate of payment for an individual by one-third ($\frac{1}{3}$). This rate of payment shall then be reduced by the amount of income not excluded pursuant to Subpart K of this part, of such individual and spouse and paid in accordance with § 416.502. As in paragraph (b) of this section, no more than \$25 shall be paid to the institutionalized member of the couple.

6. A new § 416.525 is added to read as follows:

§ 416.525 Reimbursement to States for interim assistance payments.

Notwithstanding § 416.542, the Social Security Administration may, in accordance with the provisions of Subpart S of this part, withhold supplemental security income benefits due with respect to an individual and may pay to a State (or political subdivision thereof, if agreed to by the Social Security Administration and the State) from the benefits withheld, an amount sufficient to reimburse the State (or political subdivision) for interim assistance furnished on behalf of the individual.

7. Section 416.531 is revised to read as follows:

§ 416.531 Standard of payment based on existence of an essential person.

In determining the amount of the supplemental security income standard of payment to any qualified individual (see § 416.242), for months after December

1973, such standard shall be increased to take into account the needs of an essential person (see § 416.243). The amount of such increase shall be at the rate of \$840 per year, in the case of any period prior to July 1974, at the rate of \$876 per year for the period beginning July 1, 1974, and ending June 30, 1975, and at the rate of \$946.80 per year (\$236.70 per quarter, \$78.90 per month) for the remainder of 1975 and any calendar year thereafter (however, see § 416.405 with respect to cost-of-living increases). The total amount due the qualified individual will be computed in accordance with section 1611 of the Act. The resulting monthly payment will be made to the qualified individual. If State records appropriately identify two or more essential persons for a qualified individual, an increment of \$70 per month for the period ending June 30, 1974, (\$73 for the period beginning July 1, 1974, and ending June 30, 1975, and \$78.90 for the remainder of 1975 and any calendar year thereafter) shall be added to the qualified individual's standard of payment for each such essential person (however, see § 416.405 with respect to cost-of-living increases).

8. Section 416.533 is revised to read as follows:

§ 416.533 Transfer or assignment of benefits.

Except as provided in § 416.525 and Subpart S of this part, the Social Security Administration shall not certify payment of supplemental security income benefits to a transferee or assignee of a person eligible for such benefits under the Act. The Social Security Administration shall not certify payment of supplemental security income benefits to any person claiming such payment by virtue of an execution, levy, attachment, garnishment, or other legal process or by virtue of any bankruptcy or insolvency proceeding against or affecting the person eligible for benefits under the Act.

9. A new Subpart S is added to read as follows:

Subpart S—Interim Assistance Provisions; Agreements; Payments

- Sec.
416.1901 Purpose and scope.
416.1906 General provisions and definitions.
416.1911 Interim assistance agreements.
416.1916 Effective period for reimbursement to States for interim assistance.
416.1921 Hearings and review.
416.1926 Term of the agreement.

AUTHORITY: Secs. 1102, 1611(b), 1617, 1631(d), 1631(g) of the Social Security Act, 49 Stat. 647, as amended, 86 Stat. 1466, as amended, 88 Stat. 422, 86 Stat. 1475, 88 Stat. 420; 42 U.S.C. 1302, 1382(b), 1382f, 1383(d), 1383(g).

Subpart S—Interim Assistance Provisions; Agreements; Payments

§ 416.1901 Purpose and scope.

This subpart implements section 1631(g) of the Act (added by section 5 of Pub. L. 93-368) which permits the Social Security Administration to enter into an agreement with a State whereby

such State (or a political subdivision of the State) would be reimbursed for interim assistance payments furnished an applicant for supplemental security income benefits upon the written authorization of such applicant to withhold benefits due for the purpose of reimbursing the State (or political subdivision) for the interim assistance furnished.

§ 416.1906 General provisions and definitions.

(a) *General provisions.* Notwithstanding § 416.542, the Social Security Administration may, upon receipt of written authorization by an individual or a proper party executing an application on his behalf (see § 416.310), withhold supplemental security income benefits due with respect to that individual and may pay to a State (or political subdivision thereof) if agreed to by the Social Security Administration and the State) from the benefits withheld, an amount sufficient to reimburse the State (or political subdivision) for interim assistance furnished on behalf of the individual.

(b) *Definitions.* For purposes of this subpart:

(1) "Authorization" means an authorization which is written and is in a form which is acceptable to the Social Security Administration and legally acceptable in the State from which the individual received interim assistance;

(2) "Benefits" with respect to any individual means supplemental security income benefits under title XVI of the Act, and any State supplementary payments under section 1616 of the Act or section 212 of Pub. L. 93-66 which the Social Security Administration makes on behalf of a State (or political subdivision thereof), that the Social Security Administration has determined to be due with respect to the individual at the time the Social Security Administration makes the first payment of benefits. A cash advance made pursuant to § 416.520 shall not be considered as the first payment of benefits for purposes of the preceding sentence;

(3) "Interim assistance" with respect to any individual means assistance, including vendor payments, financed from State or local funds and furnished for meeting basic needs during the period beginning with the month in which the individual filed an application for benefits and for which such individual was eligible. Assistance payments financed in whole or in part from Federal funds (e.g., aid to families with dependent children) do not come within the meaning of interim assistance.

(c) *Effective life of authorization.* An authorization is in effect until the Social Security Administration has made a final determination on the applicant's claim. When an initial determination has been made, the Social Security Administration will notify the State (or political subdivision) whether the applicant's claim for supplemental security income benefits has been allowed or denied. If the individual's supplemental security income application is denied, the denial is the final determination unless the in-

dividual files a timely appeal. If the individual applies again at a later time, a new authorization must be obtained.

§ 416.1911 Interim assistance agreements.

In order for a State to receive reimbursement under the provisions of this subpart, the State shall have in effect an interim assistance agreement with the Social Security Administration which shall provide that:

(a) The Social Security Administration will make payments to the State (or political subdivision) pursuant to the provisions of this subpart and § 416.525; and

(b) If the Social Security Administration makes payment to the State (or political subdivision) in reimbursement for interim assistance for an individual in an amount greater than the amount of interim assistance reimbursable under this subpart,

(1) The State (or political subdivision) shall pay to the individual the excess amount as soon as feasible but not later than 10 working days (or a shorter period specified in the agreement) from the date the State (or political subdivision) receives the payment; or

(2) If the State is unable to pay the excess to the individual, the State shall refund the excess to the Social Security Administration; and

(c) The State will comply with such other rules as the Social Security Administration finds necessary to achieve efficient and effective administration of this subpart, and to carry out the provisions of this part, including the furnishing of a notice to the individual of action taken pursuant to paragraph (b) (1) of this section, and the protection of hearing rights (see § 416.1921) for any individual aggrieved by action taken by the State (or political subdivision) pursuant to this subpart.

§ 416.1916 Effective period for reimbursement to States for interim assistance.

The provisions for reimbursement to States for interim assistance to an individual in a State as set out in § 416.1911 shall be effective with respect to authorizations received by the Social Security Administration on or before the last day an agreement with such State under this subpart is in effect.

§ 416.1921 Hearings and review.

The provisions of Subpart N of this part shall not be applicable to any disagreement concerning payment by the Social Security Administration to a State (or political subdivision) pursuant to the provisions of this subpart nor the amount retained by the State (or political subdivision). The State shall provide an opportunity for a hearing to any individual aggrieved by action taken by the State (or political subdivision) pursuant to this subpart. However, provisions of Subpart N shall be applicable to any disagreement concerning the total amount of the payment made by the Social Security Administration.

§ 416.1926 Term of the agreement.

The Social Security Administration and the State shall mutually agree upon the term of agreement.

[FR Doc.76-14708 Filed 5-20-76;8:45 am]

Title 21—Food and Drugs

CHAPTER I—FOOD AND DRUG ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SUBCHAPTER B—FOOD AND FOOD PRODUCTS

[Docket No. 76F-0147]

PART 121—FOOD ADDITIVES

Heptylparaben; Food Additives Permitted in Food for Human Consumption

The Food and Drug Administration is amending the food additive regulations to provide for safe use of heptylparaben in noncarbonated soft drinks and fruit-based beverages to inhibit microbiological spoilage, effective May 21, 1976; objections by June 21, 1976.

Notice was given by publication in the FEDERAL REGISTER of October 28, 1972 (37 FR 23120), that a food additive petition (FAP 2H2805) had been filed by Mallinckrodt Chemical Works, Washine Division, Lodi, NJ 07644, proposing that § 121.1186 (21 CFR 121.1186) be amended to provide for safe use of *n*-heptyl *p*-hydroxybenzoate in nonstandardized soft drinks and fruit-based beverages.

The Commissioner of Food and Drugs issued, in the FEDERAL REGISTER of October 30, 1974 (39 FR 38224), a regulation establishing "heptylparaben" as the common or usual name for *n*-heptyl *p*-hydroxybenzoate.

The Commissioner, having evaluated the data in the food additive petition and other relevant material, concludes that § 121.1186 (21 CFR 121.1186) should be amended as set forth below to provide for safe use of heptylparaben in noncarbonated soft drinks and fruit-based beverages to inhibit microbiological spoilage.

Therefore, under the Federal Food, Drug, and Cosmetic Act (sec. 409(c) (1), 72 Stat. 1786 (21 U.S.C. 348(c) (1))) and under authority delegated to the Commissioner (21 CFR 2.120), § 121.1186 is revised to read as follows:

§ 121.1186 Heptylparaben.

(a) The food additive heptylparaben is the chemical *n*-heptyl *p*-hydroxybenzoate.

(b) It may be safely used to inhibit microbiological spoilage in accordance with the following prescribed conditions:

(1) In fermented malt beverages in amounts not to exceed 12 parts per million.

(2) In noncarbonated soft drinks and fruit-based beverages in amounts not to exceed 20 parts per million, when standards of identity established under section 401 of the act (21 U.S.C. 341) do not preclude such use.

Any person who will be adversely affected by the foregoing regulation may at any time on or before June 21, 1976, file with the Hearing Clerk, Food and Drug Administration, Rm. 4-65, 5600

Fishers Lane, Rockville MD 20852, written objections thereto. Objections shall show wherein the person filing will be adversely affected by the regulation, specify with particularity the provisions of the regulation deemed objectionable, and state the grounds for the objections. If a hearing is requested, the objections shall state the issues for the hearing, shall be supported by grounds factually and legally sufficient to justify the relief sought, and shall include a detailed description and analysis of the factual information intended to be presented in support of the objections in the event that a hearing is held. Six copies of all documents shall be filed and should be identified with the Hearing Clerk docket number found in brackets in the heading of this regulation. Received objections may be seen in the above office during working hours, Monday through Friday.

Effective date. This regulation shall become effective May 21, 1976.

(Sec. 409(c) (1), 72 Stat. 1786 (21 U.S.C. 348(c) (1)))

Dated: May 14, 1976.

SAM D. FINE,
Associate Commissioner
for Compliance.

[FR Doc.76-14879 Filed 5-20-76;8:45 am]

Title 24—Housing and Urban Development CHAPTER III—GOVERNMENT NATIONAL MORTGAGE ASSOCIATION

[Docket No. R-76-210]

PART 300—GENERAL

List of Attorneys-in-Fact

Section 300.11 is amended to add additional names to the list of attorneys-in-fact authorized to act on behalf of the Association and to remove two names from the current list.

Notice and public procedure on this amendment are unnecessary and impracticable because of the large volume of legal documents that must be executed on behalf of the Association in connection with its recent auctions of mortgages.

§ 300.11 [Amended]

1. Paragraph (c) of § 300.11 is amended by deleting the following names from the current list of attorneys-in-fact:

NAME AND REGION

Stephen C. Crabb, Dallas, Texas
W. J. Gerard, Los Angeles, California

2. Paragraph (c) of § 300.11 is further amended by adding the following names in alphabetical sequence to the current list of attorneys-in-fact:

NAME AND REGION

H. D. Banks, Atlanta, Georgia
Diane E. Cozad, Los Angeles, California
S. C. Crabb, Dallas, Texas
Helen M. Eitzeroth, Atlanta, Georgia
R. L. Shanteau, Atlanta, Georgia
Mary Simpson, Dallas, Texas
Samuel M. Smith, III, Atlanta, Georgia
E. A. Taylor, Atlanta, Georgia

Effective date: This amendment shall be effective on May 21, 1976.

It is hereby certified that the economic and inflationary impacts of this regulation have been carefully evaluated in accordance with OMB Circular A-107.

DAVID M. DEWILDE,
President, Government National
Mortgage Association.

[FR Doc.76-14895 Filed 5-20-76;8:45 am]

Title 26—Internal Revenue

CHAPTER I—INTERNAL REVENUE SERVICE, DEPARTMENT OF THE TREASURY

SUBCHAPTER A—INCOME TAX

[T.D. 7421]

PART 1—INCOME TAX; TAXABLE YEARS BEGINNING AFTER DECEMBER 31, 1953

SUBCHAPTER F—PROCEDURE AND ADMINISTRATION

PART 301—PROCEDURE AND ADMINISTRATION

Notification of Interested Parties Regarding Qualification of Certain Retirement Plans

Preamble. On June 4, 1975, a notice of proposed rule making with respect to the amendments of the Income Tax Regulations (26 CFR Part 1) relating to notification of interested parties regarding the qualification of certain retirement plans under section 7476 of the Internal Revenue Code of 1954, as added by section 1041(a) of the Employment Retirement Income Security Act of 1974 (88 Stat. 949), was published in the FEDERAL REGISTER (40 FR 24011). A correction notice was published in the FEDERAL REGISTER (40 FR 24527) on June 9, 1975. On July 14, 1975, a notice of proposed rule making with respect to the amendments of the Income Tax Regulations (26 CFR Part 1) relating to the notice of determination regarding qualification of certain retirement plans, also under section 7476 of the Internal Revenue Code of 1954, was published in the FEDERAL REGISTER (40 FR 29553).

Under section 3001(a) of the Employee Retirement Income Security Act of 1974 (88 Stat. 995), before the Internal Revenue Service may issue an advance determination whether a pension, profit-sharing or stock bonus plan, a trust which is a part of such a plan, an annuity plan, or bond purchase plan described in section 401(a), 403(a), or 405(a) of the Code is exempt from taxation, the applicant must provide the Internal Revenue Service with satisfactory evidence that such applicant has notified each employee qualifying as an interested party under the regulations prescribed under section 7476(b) (1) of the Code of the application for such determination.

Under section 7476(b) (2) of the Code, if the petitioner for a declaratory judgment concerning the status of certain retirement plans was the applicant for an advance determination by the Internal Revenue Service of such status, the Tax Court may hold the filing of a pleading for such declaratory judgment to be premature unless the petitioner establishes to the satisfaction of the Tax Court that such petitioner has notified all interested parties of such application for an advance determination.