806.309(j)(5)(B), 806.309(j)(6)(A), 806.309(j)(6)(B), 806.309(j)(6)(C), 806.309(j)(6)(D), 806.309(j)(6)(E), 806.309(j)(7) and 806.309(j)(8).

[FR Doc. 89-28830 Filed 12-8-89; 8:45 am]
BILLING CODE 4310-05-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 60

[FRL-3695-8]

Standards of Performance for New Stationary Sources Supplementary Delegation of Authority to Alabama

AGENCY: Environmental Protection Agency.

ACTION: Notice of delegation.

SUMMARY: On September 11, 1989, the State of Alabama requested that EPA delegate authority for implementation and enforcement of additional categories of Standards of Performance for New Stationary Sources (NSPS). Since EPA's review of pertinent State laws, rules and regulations showed them to be adequate for the implementation and enforcement of these federal standards, the Agency has made the delegations as requested.

EFFECTIVE DATE: The effective date of the delegation of authority is October 30, 1989.

ADDRESSES: Copies of the requests for delegation of authority and EPA's letter of delegation are available for public inspection at EPA's Region IV Office, 345 Courtland Street, NE, Atlanta, Georgia 30365.

All reports required pursuant to the newly delegated standards (listed below) should be submitted to the following address: Mr. Richard E. Grunsnick, Chief, Air Division, Alabama Department of Environmental, 1752 Congressman William L. Dickinson Drive, Montgomery, Alabama 36130.

FOR FURTHER INFORMATION CONTACT: Beverly T. Hudson, at the EPA Region IV address listed above and phone (404) 347-2864 or FTS 257-2864.

SUPPLEMENTARY INFORMATION: Section 301, in conjunction with sections 101 and 111(c)(1) of the Clean Air Act, authorizes EPA to delegate authority to implement and enforce the standards set out in 40 CFR part 60, NSPS.

On August 5, 1976, EPA initially delegated the authority for implementation and enforcement of the NSPS programs to the State of Alabama. On September 11, 1989, Alabama requested a delegation of authority for implementation and enforcement of the following recently promulgated or revised (denoted by R) NSPS categories found in 40 CFR part 60:

Subpart D	Fossil Fuel-Fired Steam Generators constructed after August 17, 1971 (R)
Subpart Da	Electric Utility Steam generating Units constructed after September 18, 1978 (R)
Subpart E	Incinerators (R)
Subpart F	Portland Cement Plants (R)
Subpart G	Nitric Acid Plants (R)
Subpart H	Sulfuric Acid Plants (R)
Subpart I	Hot Mix Asphalt Facilities (R)
Subpart J	Petroleum Refineries (R)
Subpart L	Secondary Lead Smelters (R)
Subpart M	Secondary Emissions from Basic Oxygen Process Steelmaking Facilities constructed after January 20, 1983 (R)
Subpart N	Iron and Steel Plants (R)
Subpart Na	Secondary Emissions from Basic Oxygen Process Steelmaking Facilities constructed after January 20, 1983 (R)
Subpart O	Sewage Treatment Plants (R)
Subpart P	Primary Copper Smelters (R)
Subpart Q	Primary Zinc Smelters (R)
Subpart R	Primary Lead Smelters (R)
Subpart S	Primary Aluminum Reduction Plants (R)
Subpart T	Wet Process Phosphoric Acid Plants (R)
Subpart U	Superphosphoric Acid Plants (R)
Subpart V	Diammonium Phosphate Plants (R)
Subpart W	Triple Superphosphate Plants (R)
Subpart X	Granular Triple Superphosphate Storage Facilities (R)
Subpart Y	Coal Preparation Plants (R)
Subpart Z	Ferroalloy Production Facilities (R)
Subpart AA	Steel Plants: Electric arc furnaces and dust-handling equipment (R)
Subpart AAa	Steel Plants: Electric Arc Furnaces and Argon-Oxygen Decarburization Vessels (R)
Subpart BB	Kraft Pulp Mills (R)
Subpart CC	Glass Manufacturing Plants (R)
Subpart DD	Grain Elevators (R)
Subpart GG	Stationary Gas Turbines (R)
Subpart HH	Lime Manufacturing Plants (R)
Subpart KK	Lead-Acid Battery Manufacture (R)
Subpart LL	Metallic Mineral Processing Plants (R)
Subpart NN	Phosphate Rock Plants (R)
Subpart PP	Ammonium Sulfate Manufacturing (R)
Subpart UU	Asphalt Processing and Asphalt Roofing Manufacture (R)
Subpart VV	Equipment Leaks of VOC in the Synthetic Organic Chemical Manufacturing Industry (R)
Subpart XX	Bulk Gasoline Terminals (R)
Subpart LLL	Onshore Natural Gas Processing SO_2 Emissions (R)
Subpart OOO	Nonmetallic Mineral Processing Plants (R)
Subpart PPP	Wool Fiberglass Insulation Manufacturing Plants (R)
Subpart QQQ	VOC Emissions from Petroleum Refinery Wastewater Systems
Subpart SSS	Magnetic Tape Manufacturing Industry
Subpart TTT	Industrial Surface Coating: Plastic Parts for Business Machines

After a thorough review of the request, the Regional Administrator determined that such a delegation was appropriate for these source categories with the conditions set forth in the original delegation letter of August 5, 1976. Alabama sources subject to the requirements of subparts D, Da, E, F, G, H, I, J, L, M, N, Na, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, AAa, BB, CC, DD, GG, HH, KK, LL, NN, PP, UU, VV, XX, LLL, OOO, PPP, QQQ, SSS, and TTT will now be under the jurisdiction of the State of Alabama.

Action: Since review of the pertinent Alabama laws, rules, and regulations showed them to be adequate for the implementation and enforcement of the aforementioned categories of NSPS, I delegated to the State of Alabama my authority for the source categories listed above on October 30, 1989.

The Office of Management and Budget has exempted this regulation from the requirements of section 3 of Executive Order 12291.

This notice is issued under the authority of section 101, 111, and 301 of the Clean Air Act, as amended (42 U.S.C. 7401, 7411, and 7601).

Dated: December 1, 1989.

Lee A. DeHihns III,

Acting Regional Administrator.

[FR Doc. 89-28872 Field 12-8-89; 8:45 am]

BILLING CODE 6560-50-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 435 and 436

[BERC-348-F]

RIN 0938-AC31

Medicaid Program; Eligibility Determinations Based on Disability

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule specifies HCFA's policy concerning the relationship between State Medicaid eligibility determinations based on disability and disability determinations made by the Social Security Administration (SSA) under the Supplemental Security Income (SSI) program. The rule clarifies the controlling nature of SSA determinations of disability, specifies when the State Medicaid agency must make independent disability determinations, clarifies the terminology used to describe the composition of the review team and the information considered under Medicaid in making disability determinations, and extends the Medicaid time limit for making eligibility determinations based on disability from 60 days to 90 days to ensure maximum uniformity in the disability determination process used by SSA and the State Medicaid agencies. These changes will enhance the effective and efficient administration of the Medicaid program.

EFFECTIVE DATE: January 10, 1990.

FOR FURTHER INFORMATION CONTACT: Robert Tomlinson, 301-966-4463.

SUPPLEMENTARY INFORMATION:

Background

Under the provisions of sections 1902(a)(10) and 1905(a) of the Social Security Act (the Act), individuals who meet certain income and resource requirements and other general eligibility requirements and who are disabled, as defined under the Act, are eligible for Medicaid. These individuals include those who are receiving cash assistance payments under the Supplemental Security Income (SSI) program, those who are eligible to receive such payments but are not receiving them, and those who, at a minimum, meet the SSI definition of disability but are not eligible for a cash assistance payment because they have income and/or resources that exceed allowable levels. The law requires that the SSI definition of disability set forth in section 1614 of the Act must be satisfied, at a minimum, in order for an individual to be eligible for Medicaid based upon disability. The SSI definition governs eligibility, except in those States that elect to use a more restrictive definition than used under SSI (although no more restrictive than under the State's 1972 approved Medicaid plan) under the provisions of section 1902(f) of the Act. The Medicaid regulations implementing the requirement that the SSI disability definition generally must be used are located in 42 CFR 435.540. In implementing this requirement, HCFA requires that the related SSI criteria, standards, presumptions, and factors required to reach SSI decisions on disability also apply to Medicaid eligibility determinations based on disability.

This document concerns only the definition of disability, which is one factor in eligibility. It does not concern any other factors of Medicaid eligibility.

Most State Medicaid agencies have agreements with SSA under the authority of section 1634 of the Act to determine Medicaid eligibility for individuals who are recipients of SSI and federally administered State supplements. The Federal regulations that govern these agreements are located in 42 CFR 435.909 and 20 CFR 416.2101 through 416.2176.

In cases in which a State has a section 1634 agreement with SSA, and the individual files an application only with SSA for SSI, the State Medicaid agency is not required to make a Medicaid disability determination for the period starting on the effective filing date of the SSI application. This is because an application for SSI is also an application for Medicaid in such States. An applicant is required to wait until SSA makes an SSI eligibility determination. An SSA determination is to provide SSI benefits confers Medicaid eligibility in section 1634 States (if certain statutory Medicaid requirements are met) and usually confers Medicaid eligibility in other States where a separate Medicaid application is required. (An SSA determination includes disability determinations made by State agencies on behalf of SSA.) There may be instances in section 1634 States where an applicant for SSI does not intend to apply for Medicaid and limits the application or the applicant may not be aware of the link between SSI and Medicaid. In these circumstances, the individual may apply separately for Medicaid and a State may not refuse to accept the application. As discussed in detail later in this preamble, the basic rule is that any SSA decision as to disability remains controlling as to the same set of facts, unless it is changed by SSA. However, if an individual files an application with the State Medicaid agency alleging that he or she is eligible for Medicaid on the basis of disability, the State agency responsible for Medicaid determinations must make a disability determination on certain circumstances.

The circumstances under which the State Medicaid agency is required to make an independent determination of disability are as follows:

1. An individual applies for Mediaid as a noncash recipient and has not applied to SSA for SSI cash benefits, or an individual applies for Medicaid and has applied for SSI benefits and is found ineligible for SSI for a reason other than disability.

2. The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State Medicaid agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within the Medicaid time limit for making a prompt determination on an individual's applications for Medicaid. (Section 1902(a)(8) of the Act provides that Medicaid must be furnished to eligible individuals with reasonable promptness. Regulations implementing this requirement, § 435.911, currently specify that the State Medicaid agency must make an eligibility determination based on disability within 60 days from the date a written application is submitted to the agency (the time limit is expanded in this final rule to 90 days).)

3. The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria for determining disability than SSI or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination within the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

4. The individual applies for Medicaid as a noncash recipient and alleges a disabling condition that is different from or in addition to that considered by SSA.

5. The individual applies for Medicaid as a noncash recipient more than 12

months after SSA last made a final determination that the individual was not disabled, and alleges that his or her condition has changed or deteriorated since that final determination and the individual has not reapplied for SSI on the basis of these allegations. (Any allegation of a deterioration of the condition for which SSA made a determination that is filed less than 12 months after the most recent final SSI determination must be submitted to SSA for reconsideration or reopening.)

On December 14, 1987 (52 FR 47414), we published in the **Federal Register** a proposed rule to incorporate in the Medicaid regulations HCFA's policy on the controlling nature of SSA disability determinations, the effect of new and material evidence on a prior SSA determination and other related matters. The proposed rule was issued (1) in response to numerous questions that we had received on the effects of SSI eligibility determinations based on disability on Medicaid eligibility disability determinations and (2) to clarify policy to help prevent or curtail disruptive court challenges to the policy's validity. We received correspondence from 26 respondents on the proposed rule. The specific public comments on the proposed rule and our responses are presented later in this document.

A discussion of the specific regulation changes that were proposed in the December 14, 1987 document, and that are being adopted in this final rule follows.

Effects of SSA Disability Determinations

The statute is clear that the SSI disability definition under section 1614 of the Act must be used in determining disability under Medicaid, except in those States that elect to apply a more restrictive definition, as noted above. It is clear also that, in States that have section 1634 agreements, if SSA awards SSI benefits to an individual on the basis of disability, the State also must provide Medicaid (if the individual agrees to assign any rights to third party payments, agrees to provide third party information, and does not have a Medicaid qualifying trust) and is bound by the SSA determination of disability.

Under section 1902(a)(10) of the Act, States have the option of providing Medicaid coverage to persons who are eligible for payment under specified cash assistance programs (including the SSI program), but are not receiving such payments, and to persons who are ineligible for cash payments under one of these programs solely as a result of excess income or resources (that is, they would be eligible for such payments if they met income and resource requirements). If a cash assistance program (in this case, SSI) determines or previously has determined that an individual is ineligible for cash assistance because he or she does not satisfy the categorical requirements for eligibility (in this case, disability), the individual, by definition, is not eligible for such cash assistance, and would not be eligible if income and resource standards were satisfied. Such an individual accordingly is not eligible for Medicaid under these State options. Therefore, a finding by SSA that an individual is not disabled controls for purposes of any applications for Medicaid based upon an allegation of disability for essentially the same condition and time periods.

Our basic rule is that any SSA determination as to an individual claimed disability remains controlling as to that claimed condition until it is changed by SSA. In the event a different conclusion was reached by the State Medicaid agency prior to the individual's application for SSI or because the SSA determination was not made promptly as required under 42 CFR 435.911, the State Medicaid agency's determination is superseded by the SSA determination.

It is only in those cases in which SSA has not decided disability (e.g., individuals who simply choose not to apply for SSI, or who do not apply because they are not financially eligible for SSI or who are found ineligible for SSI payments for a reason other than disability) that States must apply to SSI eligibility criteria and determine whether an applicant would be eligible for SSI if he or she applied, and were financially eligible. When the SSI program has determined that an individual is not disabled, that determination settles the question of whether the individual "would be eligible for SSI." The option of providing Medicaid to individuals who are eligible for SSI but have not applied for cash payments, or who would be eligible for SSI if they met financial requirements, was not intended to grant individuals a second chance at Medicaid after they have been found not disabled by the SSI program.

As SSA disability decision has a binding prospective effect on Medicaid eligibility. If SSA makes a determination of disability that is different from one already made by a State Medicaid agency, the SSI decision controls Medicaid eligibility based upon disability under one of the State options just described, and Federal financial participation (FFP) in Medicaid expenditures for these individuals accordingly is limited in accordance with §§ 435.1001–1003. In case in which SSA denies disability after the State agency has made a determination of eligibility, FFP is available only for the period of eligibility in which the State made a reasonable application of SSI policies, definitions, standards, and criteria until SSA reached the different determination. At that point, FFP is available only as provided in § 435.1003. In other words, States that have made a good faith effort to apply the SSA rules on disability (or more restrictive rules under section 1902(f)) will not be penalized because they made a determination that ultimately proves to be contrary to the SSA determination. For purposes of FFP and quality control guidelines, the date an SSA disability determination becomes binding on a State Medicaid agency is the date the State receives State data exchange information from SSA. The binding prospective effect of an SSI determination is subject to the administrative period permitted by 42 CFR 435.1003. State that do not take necessary action, including notice to the applicant, concerning such a determination within the period allowed under § 435.1003 will be subject to quality control errors.

We have adopted as final the proposed regulations to amend § 435.541 to incorporate the conditions under which the State Medicaid agency must make independent determinations of disability, and the effect of any SSA determinations on Medicaid eligibility.

Court Challenges

Medicaid eligibility under the State's option of providing Medicaid to individuals who would be eligible for SSI but have not applied for, or are not financially eligible for, SSI generally involves individuals who would not have received a disability determination from SSA. For this reason, the existing Medicaid regulations do not expressly address the situation in which SSA has determined that an applicant for SSI is not disabled, and that individual subsequently applies to the State for Medicaid based on disability. This has not only caused confusion, but, we believe, gave rise to the decision by certain Medicaid applicants in the State of Rhode Island to bring a Federal court challenge to HCFA's policy that SSI disability determinations control for purposes of State Medicaid applications based upon disability (*Rousseau* v. *Bordeleau* v. *Heckler*, 624 F. Supp. 355 (D.R.I. 1985)). The plaintiffs in *Rousseau* alleged that even if SSI has found an individual not disabled, and thus by

definition not eligible under the SSI categorical standard, States should still make an "independent" determination as to whether the individual "would be" eligible for SSI if he or she applies for Medicaid based upon disability.

In ruling for the plaintiffs, in a decision we believe to be erroneous, the District Court in *Rousseau* held that the existing regulations governing Medicaid applications to States based upon disability support the view that States should in such cases make independent disability determinations (624 F. Supp. at 360). We do not agree with this decision for two reasons. First, the decision in the *Rousseau* case was in part the result of a lack of clarity in the regulations which these final regulations will correct. Once these final regulations are in effect, the regulations relied upon by the court in support of its decision will have been changed and a reevaluation of the *Rousseau* decision would be in order. Secondly, we believe the statutory analysis in the *Rousseau* decision is weak because the court failed to distinguish between determining eligibility and determining disability. It is only the determination of disability that is affected by this regulation. The court incorrectly associated the authority to make the determination of "Medicaid eligibility" which the State did indeed contract out to SSA, with the authority to make determinations as to whether an applicant for SSI benefits is disabled under the SSI disability standard. This latter determination is solely the SSI program's to make in the case of an individual applying for SSD. Once SSI has made a disability determination, this determination is only a component of the ultimate determination of Medicaid eligibility, along with such other components as financial eligibility, eligibility groups contained in the State's Medicaid plan, and State residency. (Of course, a negative SSI determination on disability will end the inquiry.) The court's conclusion that Rhode Island has plenary authority to make disability determinations, and that it somehow "contracted" this authority away to SSA in the case of SSI applicants, necessarily assumes that in the absence of a section 1634 agreement, the State could make independent disability determinations even in the case of individuals who have actually been found not disabled by SSI. Rather than possessing plenary authority to determine whether individuals are disabled under the SSI disability standard, we believe that States that do not apply more restrictive disability criteria than SSI under section 1902(f) have this authority only in those cases in which there is no disability decision for purposes of the SSI program, i.e., in the case of applicants who have not applied (certain optional categorically needy) or are not financially eligible (certain optional categorically needy or medically needy) for actual SSI benefits. Finally, the argument contained in the *Rousseau* case is that favorable disability determinations should be binding on the States but not unfavorable ones.

By clearly spelling out HCFA's policy in the Medicaid regulations, we believe that such a ruling can be avoided in the future. Because the *Rousseau* decision relied in part on the court's misreading of the statute, unless and until the court's ruling is vacated or overruled, the policy set out in these regulations does not apply in the State of Rhode Island. Rhode Island and HCFA are subject to a court order requiring the State to make independent disability determinations even if SSA has found an applicant not disabled.

Another recent court decision in New Jersey supports the policy set forth in these regulations. In the case of *Fratone et. al.* v. *Department of Public Welfare et. al.* (D.N.J. Nos. 87–2569, 87–2570, February 8, 1988), the District Court upheld HCFA's policy that SSA disability determinations control prospectively for purposes of Medicaid eligibility under one of the State options and expressly rejected the court's analysis in *Rousseau*. The *Fratone* court found HCFA's policy, as implemented by New Jersey, resulted in uniform State treatment of Federal disability findings, and saw no reason why Congress would wish findings of disability to be binding on the States and findings of no disability to be meaningless for the States.

The *Fratone* court held that the Social Security Act does not require State Medicaid agencies to make their own disability determinations where SSA determined within the year preceding the application (or thereafter) that an individual was not disabled, and that neither the statute nor the regulations establish State authority to make independent disability determinations when SSA has spoken.

The court rejected the *Rousseau* court's view that the provisions of § 435.541(d) provided a basis for inferring State authority to make independent disability determinations, and found that § 435.541(d) is nothing more than a reiteration of section 1902(a)(10)(A)(i)(I) of the Act. This provision requires States to provide Medicaid to applicants who are already receiving SSI on the basis of disability. If SSA has already determined disability in favor of the applicant, the statute itself directs that a State may not deny Medicaid on the grounds of disability. It is only logical then that the procedures for State disability hearings should be inoperative in those cases.

The court concluded that there was no support in the statute, the regulations, or New Jersey's section 1634 agreement for the proposition that the State agency had an inherent authority to decide the appellant's disability claim on its merits once SSA found the individual not disabled.

Consideration of New and Material Evidence

Since SSA determinations are controlling, HCFA has determined that new and material evidence or allegations by individuals regarding previous SSA determinations of disability must be presented to SSA for reconsideration in accordance with SSA's rules. SSA is in the best position to reconsider or reopen its prior determinations. SSA has an ongoing process for making disability determinations and has a high level of expertise in this area. It is not in the interest of program efficiency or in the best interests of recipients for States to perform duplicate tasks which might arrive at different or conflicting determinations of eligibility. To do so would be wasteful of Federal tax dollars and would subject recipients unnecessarily to application of two separate processes.

Under SSA's rules, the individual may request a reconsideration within 60 days of receipt of the notice denying disability eligibility under the SSI program. If the individual does not appeal the determination within the stated time, he may still request reopening of the determination within 1 year for any reason and within 2 years for good cause. Good cause is defined as new and material evidence, clerical error, or error on the fact of the evidence (20 CFR 416.1489). If the individual's request is not made within the stated times, the time may be extended if the individual establishes good cause for the late filing of an appeal request. However, HCFA believes that a separate State Medicaid agency decision is warranted where the individual applies for Medicaid as a noncash recipient and alleges changed circumstances from those present at the time of the SSI determination which would make it unreasonable to consider the SSI determination controlling. This would occur, for example, if the applicant alleges (1) a new and different

disabling condition, or (2) a deterioration of his or her condition since SSA made its original determination, occurring at least 12 months after the date of the most recent final SSA determination, and the applicant has not applied for SSI with respect to these allegations. SSA thus has never made a determination with respect to these conditions.

We have adopted as final the proposed regulations under § 435.541 that specify that States must refer to SSA all applicants that allege new or material evidence (as opposed to a subsequent change in their condition) that affect previous SSA determinations.

Time Limits for Making Medicaid Disability Determinations

As stated earlier, under existing regulations a State is required to make eligibility determinations based on disability within 60 days of the date the individual files a written application for Medicaid with the State. In States that have section 1634 agreements with SSA, this time limit causes SSA and the State Medicaid agency to duplicate the eligibility determination process when an individual applies separately for Medicaid and SSI. Frequently, SSA does not reach its decision by the end of the 60-day period following application for Medicaid. Therefore, in order to comply with the Medicaid time limit, the State Medicaid agency is forced to make an independent disability determination. In some cases, the Medicaid agency may make a determination that later is contrary to that made by SSA. Under HCFA's existing policy, if a prior and different conclusion was reached earlier by the State Medicaid agency, the State agency's determination is superseded by the SSI determination. However, FFP is available to the State for Medicaid expenditures for the period during which the State made a reasonable application of SSI policies, definitions, standards and criteria. This system wastes both State and Federal funds. We have adopted as final the proposed Medicaid regulations that recognize the typical length of time required by SSA to process most disability determinations. These regulations extend the Medicaid time standard for making eligibility determinations based on disability from 60 days to 90 days from the date of application (§ 435.911).

Most disability claims are processed by SSA within 90 days. While some claims will remain undecided by SSA on the 90th day, extending the time limit for Medicaid State disability determinations from 60 to 90 days will substantially reduce the number of applications for Medicaid based on disability for which the State must make a determination without the benefit of an SSA disability determination. For example, in the month of April 1987, 50.3 percent of SSI claims were processed by the 60th day, and 73.4 percent of the claims were processed by the 90th day. Thus, the number of Medicaid applications for which a State Medicaid agency determination would have to be made without benefit of an SSA determination on the issue of disability will be reduced by nearly one half of the number of claims that the State would have had to process given the 60-day limit. This change will substantially remove the risk that a determination of eligibility based on disability by the State will be reversed later because of an SSA determination of ineligibility based on disability. This also will save Medicaid program funds expended for services for individuals who, in fact, are not eligible. We do not find that this change will adversely affect recipients because Medicaid eligibility is effective with the date of application and retroactive Medicaid eligibility for the period of up to 3 months before the month of application under § 435.914 must be provided if certain conditions are met.

Composition of Disability Review Teams

The Medicaid regulations under § 435.541 address the composition of the State disability review teams for making disability decisions, and the information that must be obtained and reviewed by the team. The State disability review team must, under those regulations, include a physician and a social worker "qualified by professional training and experience." The agency must obtain, for review by the team, a medical report that includes a diagnosis that is based on medical evidence and a "social history." SSI regulations (20 CFR 416.1015) provide that the disability determination must be made by a medical or psychological consultant, and a disability examiner who is qualified to interpret and evaluate medical reports and other evidence relating to the individual's physical or mental impairments, and, as necessary, to determine the capacities of the individual to perform substantial gainful activity. SSI regulations (20 CFR part 416, subpart I) do not employ the term "social history." However, SSA does consider, in addition to the required medical reports and medical assessment, information from other sources such as public and private social welfare agencies, observations by nonmedical sources, and other practitioners that will help the agency to understand how an individual's impairment affects his or her ability to work. Although the Medicaid regulations thus call for essentially the same process as that used in the SSI program, we believe that the regulations for both programs should employ the same terminology. This will help ensure a more uniform application of the definition of disability under section 1614 of the Act.

Questions have been raised as to whether the differences between the terminology used to describe the composition of the review team and the information considered under Medicaid and the terminology used by SSA reflect any substantive difference in the process used to determine disability under the two programs. Although we do not believe that the differences in the specific terminology used to describe the requirements of the Medicaid and SSI review teams reflect any substantive differences in procedures used, we recognize that these terminology differences have been, and likely may continue to be, a source of confusion. Thus, we have adopted as final the proposed revised § 435.541 that requires that the review team be composed of individuals with the same level of skill as required by SSA under 20 CFR part 416, subpart J. This revision also requires States to use the same type of medical evidence and other nonmedical information and the methodology for obtaining and evaluating this evidence and information that is used for making disability determinations by SSA under 20 CFR part 416, subpart I. These changes serve to achieve the goal of maximum uniformity in the disability determination process.

Application of Changes to Territories

Except in one instance, we have not changed the regulations governing the categorical and application requirements for Medicaid eligibility in Guam, Puerto Rico, and the Virgin Islands under 42 CFR part 436. These Territories provide Medicaid to disabled individuals on the basis of receipt of or eligibility for assistance under the program of aid to the aged, blind, and disabled under title XVI in existence before the SSI program was created. They also are not subject to the provisions for optional use of more restrictive eligibility requirements than SSI under section 1902(f) of the Act. Persons who do not reside in, or who leave, the 50 States, the District of Columbia, or the Northern Mariana Islands are not eligible for SSI payments. Thus anyone who lives in or who moves to Guam, Puerto Rico, or the

Virgin Islands is not eligible to receive SSI payments even if that person would be eligible if he or she lived in one of the 50 States, the District of Columbia, or the Northern Mariana Islands. The precedence of an SSI determination of disability in these Territories therefore is not an issue. In addition, because the Territories continue by law to use disability standards under title XVI that have been superseded by SSI in the States and are not eligible to participate in SSI, we have decided that it is not reasonable to require the Territories to follow the review team, information, and evidence requirements applied to SSA in making SSI disability determinations. However, we have adopted as final the proposed revised § 436.541 concerning the composition of the medical review teams and the information considered in making a determination of disability to make the existing requirements in the Medicaid regulations minimum requirements. If the Territories use a more rigorous set of review team, information, and evidence requirements in determining disability under their programs of aid to the aged, blind, and disabled, they also are required to follow those requirements for Medicaid disability determinations.

We believe, however, that the Territories should have the same time standard for making determinations on applications based on disability as the States. Therefore, we are maintaining in the regulations under § 436.901 application of the requirements governing the States relating to the time limit for acting on applications. As discussed earlier, we have changed the time standard from 60 to 90 days. Thus, both States and Territories are allowed 90 days to complete determinations based on disability. Because the Territories generally must use off-island facilities for consultative examinations, the additional time permits the Territories to conduct more thorough determinations of eligibility. This change also retains HCFA's policy that all States and Territories meet the same timeliness standards for action on applications.

Public Comments and Departmental Responses

Comment: One commenter alleged that under the proposed rules Medicaid applicants would have to wait up to 2 years before Medicaid could be granted.

Response: We believe the commenter has inaccurately interpreted the proposed rules. States are required by the regulations to make determinations within 90 days of the Medicaid application. If SSA has made an initial or final determination within that time, the State must follow the SSA disability determination in making its Medicaid eligibility determination. If SSA has not made an initial or final disability determination in sufficient time for the State to comply with the 90-day requirement, the State must make its own disability determination within the 90-day limit. FFP is available until SSA acts on the SSI application. The State then has the time set forth in existing regulations at § 435.1003 to determine Medicaid eligibility on some other basis if the SSA determination denies disability eligibility.

Comment: One commenter suggested that States should pend disability applications for 90 days and then have 60 days to make a decision. This could result in a period of 150 days before a decision is made on a Medicaid application.

Response: We believe a 150-day period in which to make a decision does not meet the promptness standard in section 1902(a)(8) of the Act. Section 1902(a)(8) requires assistance be furnished with reasonable promptness. We believe that a total of 90 days is a reasonable limit. In part, we have based this limit on the experience of SSA in administering the social security disability program. In 1986, the most recent year for which we have data, the average processing time from application to initial decision was 78 days. Therefore, we believe it is reasonable to expect States to be able to process disability claims within the 90-day period. We also extended the time from 60 to 90 days to encourage and provide some additional time for greater coordination and cooperation between the States and SSA. This coordination and cooperation, we believe, should be achievable because in many States the State Disability Determination Service processes both SSA disability applications and Medicaid disability determinations. It also helps prevent the uncertainty and disruption in an applicant's life that is the result of two approximately concurrent but different decisions, one of which must yield to the other.

We have made a conforming change to § 435.541(c)(3) to ensure that Medicaid disability determinations are made timely even when SSA has not made its disability determination within the time period established for the Medicaid determinations. SSA is not bound by time periods such as those used in the Medicaid program. Even though the time remaining in the 90-day time limit after a State concludes SSA will not render a determination may be short, we expect that States will take steps to do any preliminary work without waiting for SSA to act (for example, securing evidence from the applicant).

Comment: One commenter suggested that Medicaid disability determinations that are later invalidated by an SSA disability determination should not be overturned unless the determination is reviewed under the Disability Benefits Reform Act of 1984 (DEBRA). The commenter reasoned that the invalidation was a termination of disability and that DEBRA applies.

Response: DEBRA does not apply in this situation because the two determinations (the earlier State determination and the later SSA determination) are both initial determinations employing the same facts, time period, and allegations of disability. Further, the medical improvement standard in DEBRA found in section 1614(a)(4) of the Act applies to a recipient of disability-based benefits under title XVI. Therefore, the medical improvement standard in DEBRA only applies to someone actually receiving SSI payments, who SSA determines is no longer disabled. SSA decisions to terminate disability benefits previously approved by SSA occur either when SSA receives evidence that the beneficiary is no longer disabled within the meaning of the Act (for example, the beneficiary is engaged in substantial gainful activity) or a scheduled medical reexamination reveals that the individual is no longer disabled within the meaning of the Act. In these cases the medical improvement standard in DEBRA is applied in deciding whether the beneficiary is still disabled. The proposed rule does not address the issue of terminating disability because an individual is no longer disabled but rather the issue of whether and when SSA disability determinations must be followed by States in Medicaid eligibility decisions.

Comment: One commenter suggested that the requirement that applicants be referred to SSA during the 12 months after SSA made a determination denying disability then alleging a worsening of their disability, or new evidence to support an allowance, unfairly penalizes the applicant.

Response: We do not believe the applicant is penalized by the requirement. Since both Medicaid and SSI utilize the same definition of disability (unless the State elects the option to use a more restrictive definition), if the new evidence or worsened condition meets this definition, it can be to the applicant's advantage to go back to SSA since the

applicant may end up not only receiving Medicaid but SSI as well. Furthermore, the appropriate appeal forum to reconsider a determination made by SSA is SSA.

Comment: One commenter asked for an explanation of the eligibility procedures when an individual, who within 12 months of the SSA decision, became more disabled than when he or she was when SSA denied disability, but that person's income or resources have increased above the SSI thresholds.

Response: During the first 12 months after SSA has made a decision denying disability, an applicant may seek reconsideration or reopening of that decision from SSA. Whether SSA will reopen its disability determination depends on a number of factors; for example, whether the applicant submits new evidence, or whether the applicant alleges a new onset date. Ordinarily, if an applicant's income or resources are clearly above the SSI limits, SSA will deny an application on the financial basis without making a determination concerning the applicant's disability claim. Although this situation would occur only rarely, we are revising the regulation to provide an additional exception to cover cases in which a deterioration or change in condition is alleged less than 12 months after the SSA determination denying disability, SSA refuses to consider whether the new allegations would change the disability determination, and the individual no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

We also have clarified § 435.541 with respect to the period of time the State must use an existing SSA disability determination, and may not make a disability determination independent of the SSA determination. States must use the most recent SSA disability determination for a period of 12 months after the determination is made.

Comment: Several commenters suggested that SSA's relatively high reversal rate at the administrative law judge (ALJ) hearing level argues against HCFA's position as to the controlling nature of SSA disability determinations.

Response: We disagree with the commenters for two reasons. Most importantly, as explained in the preamble of the proposed rule, we believe that the applicable statutory provisions compel the interpretation that SSA disability determinations control where there is an actual or potential conflict between the SSA determination and a State disability determination. Second, reliance on the reversal rate at the ALJ level is misleading since available figures indicate that less than 20 percent of the total number of denied claims are reversed as a result of the introduction of new evidence substantiating the applicant's claim. Reversal also may occur where a claimant's condition deteriorates subsequent to the initial or reconsidered determination.

Comment: One commenter stated that § 435.541(c)(4)(ii) of the proposed regulation text seems inconsistent with the background material in the preamble to the NPRM regarding the description of circumstances under which the State Medicaid agency is required to make an independent determination of disability. The commenter read the regulatory provision as requiring that only the individual's condition must have changed or deteriorated "or" the period of disability is at least 12 months after the most recent final SSA determination before an initial determination is made. The preamble requires that both circumstances exist.

Response: Our intent for the regulatory provision as stated in the preamble is correct—that is, the individual needs to allege both a change or deterioration in his or her condition and a new period of disability. We have corrected the text of the final regulation to require that both circumstances exist.

Comment: One commenter suggested that the proposed regulations would prohibit an individual from applying for Medicaid if, within the previous 12 months, SSA had denied disability. In this context, some commenters also stated that they believed the regulations would deprive the States of the right to make eligibility determinations.

Response: The regulations do not prohibit an individual from applying for Medicaid for circumstances other than disability once a determination of SSA disability is denied. An individual may apply for Medicaid on grounds other than disability, in which case the disability determination by SSA would have no effect on eligibility. The regulation only concerns the binding effect of SSA disability determinations. The disability determination is only one part of an eligibility determination. The preamble to these final regulations and the preamble to the proposed rule explain why we require that the State use the SSA disability decision when determining the eligibility of an applicant for Medicaid as disabled. We do not consider this policy clarification to preempt in any way State authority to determine eligibility.

Comment: One commenter expressed concern that the regulation would not be cost effective because of duplication of effort if States must make disability determinations before SSA has acted in order to meet the Medicaid time limit. The commenter believes this would be especially true of States that do not have section 1634 agreements, of which there are 19. The commenter also observed that if a State does not cover the optional groups of persons who would be eligible for SSI if they applied (§ 435.210), that is, those persons not receiving SSI and not living in an institution, hence not eligible for Medicaid under the State plan, these regulations would cause duplication of effort.

Response: While duplication of effort and the costs of a duplicate decision would certainly be avoided if a State waits until SSA acts on an SSI disability application, the statutory requirement in section 1902(a)(8) of the Act mandates that a State act promptly to determine eligibility. If the State waited beyond the time limit established in the regulations at § 435.911, it would violate this statutory requirement.

With regard to the comment applicable to States without optional categorical needy programs, the State would not have to make a disability determination because the State only covers persons receiving SSI. Thus the State could deny the application without addressing the issue of disability. If the individual is found by SSA to be disabled and eligible for SSI retroactive to a month covered by the Medicaid application, the State could reopen its determination denying eligibility. In States with section 1634 agreements, reopening would be necessary since an SSI application also is an application for Medicaid. Under Medicaid the first month for which an SSI recipient could have received a check is considered the first month of receipt, even if the money is not actually received until months later. Consequently, we consider any duplication of effort to be minimal.

Comment: Several commenters expressed opposition to the proposed regulations because the regulations do not follow the *Rousseau* decision (explained earlier) and do not implement an explicit statutory provision. The commenters believe that the *Rousseau* decision correctly interprets the statute.

Response: Under the Medicaid statute, the determination of eligibility for medical assistance must be made by the State or local agency (42 U.S.C. 1396a(a)(5)). As we have explained earlier, the *Rousseau* court focused on an exception to this general principle which exists in the case of States like Rhode Island that have agreements with

SSA under which SSA performs the function of determining Medicaid eligibility in the case of individuals it finds eligible for SSI. These agreements are authorized by section 1634 of the Act and are expressly limited under the regulations to individuals found eligible for SSI, i.e., "mandatory categorically needy" individuals. As Rhode Island is required to provide Medicaid to State residents who are receiving SSI, Medicaid eligibility under its agreement with the State generally involves only SSA's notification to the State of those applicants who are eligible for SSI.

It is the authority to perform this function on behalf of the State, involving individuals who, by law, must be Medicaid eligible if they are State residents, that Rhode Island delegated to SSA under its section 1634 agreement. The court construed this agreement as "contracting away the powers to make disability determinations to the federal government" and concluded that this means "that the State has that authority in the first place" (624 F. Supp. at 359).

We have already discussed earlier in this preamble under the section on "Court Challenges" the reasons why we do not agree with the commenters that the decision correctly interprets the statute. Also, as discussed earlier in this preamble, in a recent New Jersey court decision in *Fratone* v. *Department of Public Welfare*, the court supported our position and affirmed the State's denial of applications for Medicaid-only benefits when those denials were based on SSA determinations that the applicants were not disabled.

Comment: One commenter suggested that the proposed regulations would deny applicants a meaningful hearing of the Medicaid denial because the State is required to adhere to an SSA denial of disability.

Response: We do not accept this analysis. The effect on Medicaid appeals of the change we proposed to § 435.541 should be minimal. When SSA makes a disability determination that is binding on a State, the applicant is not denied a meaningful hearing on the basis for the Medicaid denial because the SSA denial of disability upon which the Medicaid denial is based is appealable through SSA's appeals process. It is not appropriate to challenge an SSA determination through the Medicaid appeals process because although the State has adopted the SSA determination the State did not make the determination. In this instance § 435.541, as revised, would prevent an appeal through the State agency as set forth in § 431.220. However, when the State makes an independent determination of disability, that is, where a binding SSA disability determination does not exist, a denial of disability is appealable through the State agency. The change in § 435.541 does not, however, affect in any way the appealability of other determinations by State agencies.

Comment: A number of comments concerned issues on how the regulations would be implemented and operational issues arising from implementation.

Response: We will address operating issues in instructions provided to States.

Additional Change

In addition to the changes made in response to comments, and discussed above, we have revised the wording of § 435.541(a) to avoid the inaccurate impression that the provisions in § 435.541(b) are limited in their application to States with section 1634 agreements. We believe that this revision has no substantive effect, and merely clarifies the intent set forth in the preamble to the NPRM.

Regulatory Analysis

Executive Order 12291 requires us to prepare and publish an initial regulatory impact analysis for any regulations that are likely to meet the criteria for a "major rule." A major rule is one that would result in: (1) An annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individuals, industries, Federal, State, or local government agencies, or any geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation or on the ability of United States-based enterprises in domestic or export markets. In addition, we prepare and publish an initial regulatory flexibility analysis consistent with the Regulatory Flexibility Act (RFA), 5 U.S.C. 601 through 612, for regulations unless the Secretary certifies that the regulations will not have a significant impact on a substantial number of small entities. For purposes of the RFA, neither States not individuals are considered small entities.

These regulations will impact on Medicaid disability determinations in a significant way. State Medicaid agencies are currently compelled to determine Medicaid disability eligibility within 60 days of application for Medicaid. SSI, which is not so obligated, may decide contrary to the State's ruling after the 60-day State limit. We estimate that, by extending the time limit imposed on the State Medicaid agencies to 90 days, duplication of effort by section 1634 States and SSI in the determination of disability will be eliminated for a number of applications. As a result, the Medicaid program will save funds expended for benefits to individuals determined not to be eligible because a Medicaid agency's positive eligibility determination is overruled by SSA in the 60- to 90-day window.

We estimate that total annual Medicaid savings will be about $5 million, shared approximately equally by the Federal Government and the States. Therefore, we have determined, and the Secretary certifies, that these regulations are not a major rule and will not have a significant economic impact on a substantial number of small entities. Neither a regulatory impact analysis nor an initial regulatory flexibility analysis has been prepared.

Paperwork Reduction Act

These regulations do not impose any new information collection or reporting requirements that are subject to approval of the Executive Office of Management and Budget under the Paperwork Reduction Act.

List of Subjects

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs—health, Medicaid, Supplemental Security Income (SSI).

42 CFR Part 436

Aid to Families with Dependent Children, Grant programs—health, Guam, Medicaid, Puerto Rico, Supplemental Security Income (SSI), Virgin Islands.

For the reasons set out in the preamble, 42 CFR chapter IV, subchapter C, is amended as follows:

PART 435—ELIGIBILITY IN THE STATES, THE DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

A. Part 435 is amended as follows:

1. The authority citation for part 435 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 435.541 is revised to read as follows:

§ 435.541 Determinations of disability.

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of

disability when the only application is filed with SSA.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under § 435.909.

(b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash recipient and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

(d) *Basis for determinations.* The agency must make a determination of disability as provided in paragraph (c) of this section—

(1) On the basis of the evidence required under paragraph (e) of this section; and

(2) In accordance with the requirements for evaluating that evidence under the SSI program specified in 20 CFR 416.901 through 416.998.

(e) *Medical and nonmedical evidence.* The agency must obtain a medical report and other nonmedical evidence for individuals applying for Medicaid on the basis of disability. The medical report and nonmedical evidence must include diagnosis and other information in accordance with the requirements for evidence applicable to disability determinations under the SSI program specified in 20 CFR part 416, subpart I.

(f) *Disability review teams*—(1) *Function.* A review team must review the medical report and other evidence required under paragraph (e) of this section and determine on behalf of the agency whether the individual's condition meets the definition of disability.

(2) *Composition.* The review team must be composed of a medical or psychological consultant and another individual who is qualified to interpret and evaluate medical reports and other evidence relating to the individual's physical or mental impairments and, as necessary, to determine the capacities of the individual to perform substantial gainful activity, as specified in 20 CFR part 416, subpart J.

(3) *Periodic reexaminations.* The review team must determine whether and when reexaminations will be necessary for periodic redeterminations of eligibility as required under § 435.916 of this part, using the principles set forth in 20 CFR 416.989 and 416.990. If a State uses the same definition of disability as SSA, as provided for under § 435.540, and a recipient is Medicaid eligible because he or she receives SSI, this paragraph (f)(3) does not apply. The reexamination will be conducted by SSA.

3. In § 435.911, paragraph (a) introductory text is republished and paragraph (a)(1) is revised to read as follows:

§ 435.911 Timely determination of eligibility.

(a) The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed—

(1) Ninety days for applicants who apply for Medicaid on the basis of disability; and

* * * * *

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

B. Part 436 is amended as set forth below:

1. The authority citation for part 436 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 436.541 is revised to read as follows:

§ 436.541 Determination of disability.

(a) *Basic requirements.* (1) At a minimum, the agency must use the review team, information, and evidence requirements specified in paragraph (b) through (d) of this section in making a determination of disability.

(2) If the requirements or determining disability under the State's APTD or AABD program are more restrictive than the minimum requirements specified in this section, the agency must use the requirements applied under the APTD or AABD program.

(b) The agency must obtain a medical report and a social history for individuals applying for Medicaid on the basis of disability. The medical report must include a diagnosis based on medical evidence. The social history

must contain enough information to enable the agency to determine disability.

(c) A physician and social worker, qualified by professional training and experience, must review the medical report and social history and determine on behalf of the agency whether the individual meets the definition of disability. The physician must determine whether and when reexaminations will be necessary for periodic redeterminations of eligibility as required under § 435.916 of this subchapter.

(d) In subsequently determining disability, the physician and social worker must review reexamination reports and the social history and determine whether the individual continues to meet the definition. Disability is considered to continue until this determination is made.

(Catalog of Federal Domestic Assistance Program No. 13.714—Medical Assistance)

Dated: April 21, 1989.

Louis B. Hays,

Acting Administrator, Health Care Financing Administration.

Approved: November 6, 1989.

Louis W. Sullivan,

Secretary.

[FR Doc. 89-28843 Filed 12-8-89; 8:45 am]

BILLING CODE 4120-01-M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 88-222; RM-6259]

Radio Broadcasting Services; Mexico Beach, FL

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document, at the request of Robert G. Kerrigan, substitutes Channel 257C2 for Channel 257A at Mexico Beach, Florida, and modifies the license for Station WMQA(FM) to specify operation on the higher powered channel. Channel 257C2 can be allotted to Mexico Beach in compliance with the Commission's minimum distance separation requirements with a site restriction of 2.6 kilometers (1.6 miles) east to avoid a short spacing to Station WKSM(FM), Channel 258C2, Fort Walton Beach, Florida. The coordinates for this allotment are North Latitude 29-56-32 and West Longitude 85-23-31. With this action, this proceeding is terminated.

EFFECTIVE DATES: January 19, 1989.

FOR FURTHER INFORMATION CONTACT: Nancy J. Walls, Mass Media, (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report and Order, MM Docket No. 88-222, adopted November 17, 1989, and released December 5, 1989. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW, Washington, D.C. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW, Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

1. The authority citation for part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments is amended under the entry for Mexico Beach, Florida, by removing Channel 257A and adding Channel 257C2.

Karl A. Kensinger,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 89-28751 Filed 12-8-89; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 88-321; RM-6270]

Radio Broadcasting Services; Volcano, HA

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Commission at the request of Timothy D. Martz allots Channel 299A to Volcano, Hawaii, as the community's first FM service. Channel 299A can be allotted to Volcano, Hawaii, in compliance with the Commission's minimum distance separation requirements. The coordinates for this allotment are 19-26-00 and 155-15-42. With this action, this proceeding is terminated.

DATES: Effective January 19, 1990; The window period for filing applications will open on January 22, 1990, and close on February 21, 1990.

FOR FURTHER INFORMATION CONTACT: Nancy J. Walls, Mass Media Bureau (202) 634-6530.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report and Order, MM Docket No. 88-321, adopted November 20, 1989, and released December 5, 1989. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street, NW, Suite 140, Washington, DC 20037.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

PART 73—[AMENDED]

1. The authority citation for part 73 continues to read as follows:

AUTHORITY: 47 U.S.C. 154, 303.

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments is amended under Hawaii by adding Volcano, Channel 299A.

Karl A. Kensinger,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 89-89-28752 Filed 12-8-89; 8:45 am]

BILLING CODE 6712-01-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 216

Taking and Importing of Marine Mammals

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

ACTION: Notice of Finding of Conformance.

SUMMARY: The Assistant Administrator for Fisheries, NMFS, announces that the Governments of Venezuela, the Republic of Panama, the Republic of Vanuatu, and the Republic of Ecuador have submitted information which demonstrates that these nations and the tuna purse seine fishing vessels under their control are in conformance with United States marine mammal regulations. As a result of this finding, yellowfin tuna from Venezuela, Panama, Vanuatu, and Ecuador may continue to be imported into the United States through 1990.

DATES: This finding is effective on December 11, 1989, and remains in effect