Assistant to the Board; (202) 452-3204. You may call (202) 452-3207, beginning at approximately 5 p.m. two business days before this meeting, for a recorded announcement of bank and bank holding company applications scheduled for the meeting.

Dated: May 31, 1991.

Jennifer J. Johnson,

Associate Secretary of the Board.

[FR Doc. 91-13288 Filed 5-31-91; 3:58 pm]

BILLING CODE 6210-01-M

NATIONAL TRANSPORTATION SAFETY BOARD

TIME AND DATE: 9:30 a.m., Tuesday, June 11, 1991.

PLACE: Board Room, Eighth Floor, 800 Independence Avenue, SW., Washington, DC 20594.

STATUS: Open.

MATTERS TO BE CONSIDERED:

5319A—Pipeline Accident Report: Propane Pipeline Rupture and Fire, Texas Eastern Products Pipeline Company, North Blenheim, New York, March 13, 1990.

NEWS MEDIA CONTACT: Brent Bahler Telephone (202) 382-6600.

FOR MORE INFORMATION CONTACT: Bea Hardesty, (202) 382-6525.

Dated: May 31, 1991.

Bea Hardesty,

Federal Register Liaison Officer.

[FR Doc. 91-13227 Filed 5-31-91; 3:38 pm]

BILLING CODE 7533-01-M

NUCLEAR REGULATORY COMMISSION

DATES: Weeks of June 3, 10, 17, and 24, 1991.

PLACE: Commissioners' Conference Room, 11555 Rockville Pike, Rockville, Maryland.

STATUS: Open and Closed.

MATTERS TO BE CONSIDERED:

Week of June 3

Friday, June 7

1:30 p.m.
Periodic Meeting with the Advisory Committee on Reactor Safeguards (ACRS) (Public Meeting)

3:00 p.m.
Affirmation/Discussion and Vote (Public Meeting)
a. Final Rulemaking, "Procedures for Direct Commission Review of Decisions of Presiding Officers," and Establishment of Office of Opinion Writing

Week of June 10—Tentative

Monday, June 10

2:00 p.m.
Briefing on Proposed Rule on Training and Qualification of Nuclear Power Plant Personnel (Public Meeting)

Tuesday, June 11

10:00 a.m.
Briefing by Agreement States on Compatibility Issues (Public Meeting)

Wednesday, June 12

10:00 a.m.
Briefing on Progress of Design Certification Review and Implementation (Public Meeting)

11:30 a.m.
Affirmation/Discussion and Vote (Public Meeting) (if needed)

Week of June 17—Tentative

Wednesday, June 19

1:30 p.m.
Briefing on Shutdown Risk Status (Public Meeting)

Thursday, June 20

9:30 a.m.
Periodic Briefing on Operating Reactors and Fuel Facilities (Public Meeting)

11:30 a.m.
Affirmation/Discussion and Vote (Public Meeting) (if needed)

Week of June 24—Tentative

Friday, June 28

8:30 a.m.
Affirmation/Discussion and Vote (Public Meeting) (if needed)

Note: Affirmation sessions are initially scheduled and announced to the public on a time-reserved basis. Supplementary notice is provided in accordance with the Sunshine Act as specific items are identified and added to the meeting agenda. If there is no specific subject listed for affirmation, this means that no item has as yet been identified as requiring any Commission vote on this date.

To Verify the Status of Meetings Call (Recording)—(301) 492-0292.

CONTACT PERSON FOR MORE INFORMATION: William Hill (301) 492-1661.

Dated: May 30, 1991.

William M. Hill, Jr.,

Office of the Secretary.

[FR Doc. 91-13263 Filed 5-31-91; 2:59 p.m.]

BILLING CODE 7590-01-M

POSTAL SERVICE BOARD OF GOVERNORS

Amendment to Meeting

"FEDERAL REGISTER" CITATION OF PREVIOUS ANNOUNCEMENT: 56 FR 24117, May 28, 1991.

PREVIOUSLY ANNOUNCED DATE OF MEETING: June 4, 1991.

CHANGE: Delete the following item from the open meeting agenda:

4. Report on the Mailgram Program.

Change the following item on the closed meeting agenda to read:

1. Consideration of a Filing with the Postal Rate Commission for Barcode Discounts on Flats.

CONTACT PERSON FOR MORE INFORMATION: David F. Harris, (202) 268-4800.

David F. Harris,

Secretary.

Neva R. Watson,

Alternate Certifying Officer.

[FR Doc. 91-13288 Filed 5-31-91; 3:00 pm]

BILLING CODE 7710-12-M

Corrections

Federal Register
Vol. 56, No. 107
Tuesday, June 4, 1991

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

48 CFR Part 52

[FAC 90-4]

RIN 9000-AC43, 9000-AE12, 9000-AD85, 9000-AE00, 9000-AD32, 9000-AE01, 9000-AD66, 9000-AD21, 9000-AD57, 9000-AD08, 9000-AE05, 9000-AD73, 9000-AD02, 9000-AD78, 9000-AD81, 9000-AD77, and 9000-AD33

Federal Acquisition Regulation (FAR); Miscellaneous Amendments

Correction

In rule document 91-8647 beginning on page 15142, in the issue of Monday, April 15, 1991, make the following corrections:

1. On page 15142, in the first column, under DATES:, in the third line, "and 25-225-11 (a)" should read "and 52.225-11 (a)".

2. On page 15156, in the third column, the heading that reads "52.224-1 [Amended]" should read "52.244-1 [Amended]".

BILLING CODE 1505-01-D

DEPARTMENT OF DEFENSE

48 CFR Parts 232 and 252

Department of Defense Federal Acquisition Regulation Supplement; Contract Financing

Correction

In proposed rule document 91-9618 beginning on page 18800 in the issue of Wednesday, April 24, 1991, make the following correction:

On page 18801, in the third column, Section 252.232-7009 was omitted and should read as follows:

252.232-7009 DoD Progress Payment Rates for Small Businesses.

As prescribed in 232.502-4 (S-73) and (S-74) insert the following clause:

DOD PROGRESS PAYMENT RATES FOR SMALL BUSINESSES (XXX 1991)

The progress payment rate and liquidation rate specified in Federal Acquisition Regulation clause 52.232-16, Progress Payments, shall be 90 percent for this contract, excepting paragraph (k),*Limitations on Undefinitized Contract Actions.* (End of Clause)

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES DEPARTMENT

Food and Drug Administration

21 CFR Part 177

[Docket No. 90F-0204]

Indirect Food Additives: Polymers

Correction

In rule document 91-11047 beginning on page 21446 in the issue of Thursday, May 9, 1991, make the following correction:

1. On page 21447, in the first column, under SUPPLEMENTARY INFORMATION, in the tenth line, "poly(vinyulidene fluoride)" should read "poly(vinylidene fluoride)".

2. On page 21448, in the first column, in the fourth line,"100-1" should read "100^{-1}".

3. On the same page, in the same paragraph, in the second line from the bottom, "S St." should read "L St.".

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

45 CFR Part 57

RIN 0905-AD07

Health Professions Student Loan Program

Correction

In rule document 91-9751 beginning on page 19290 in the issue of Friday, April 26, 1991, make the following correction:

§ 57.202 [Corrected]

On page 19293, in the first column, amendatory instruction 2 should read as follows:

"2. In 57.202, the definition of "grace period" is amended by removing the term "podiatry" and adding the term "podiatric medicine", and the definitions of "health professions school", "National of the United States", and "State" are revised to read as follows:"

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Social Security Administration

20 CFR Part 416

[Regulation No. 16]

RIN 0960-AC51

Supplemental Security Income for the Aged, Blind, and Disabled; Interim Assistance Provisions

Correction

In rule document 91-9951 beginning on page 19260 in the issue of Friday, April 26, 1991, make the following corrections:

§ 416.1902 [Corrected]

1. On page 19262, in the first column, in § 416.1902, in the first paragraph, in the fourth line "use" should read "us".

2. On the same page, in the same column, in the second paragraph, in the fourth line, after "meet" insert "your".

BILLING CODE 1505-01-D

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[ID-942-01-4730-12]

Idaho; Filing of Plats of Survey

Correction

In notice document 91-7271 appearing on page 12950 in the issue of Thursday, March 28, 1991, in the first column, in the second paragraph, in the third line, "substantial" should read "subdivisional".

BILLING CODE 1505-01-D

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 23

RIN 1018-AB30

Export of American Ginseng Harvested in 1991-93 Seasons

Correction

In proposed rule document 91-8922 beginning on page 15318 in the issue of Tuesday, April 16, 1991, make the following correction:

On page 15321, in the third column, in the first paragraph, beginning in the seventh line, remove the sentence, "Once the convention export documentation and contents of the shipment".

BILLING CODE 1505-01-D

OFFICE OF MANAGEMENT AND BUDGET

Office of Federal Procurement Policy

Government-wide Small Business and Small Disadvantaged Business Goals for Procurement Contracts; Policy Letter

Correction

In notice document 91-6564 beginning on page 11796 in the issue of Wednesday, March 20, 1991, make the following corrections:

1. On page 11798, in the second column, under paragraph 5(d), in the second line, "nd" should read "and".

2. On the same page, in the same column, under paragragh 6, in the ninth line, "and" should read "an".

BILLING CODE 1505-01-D

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 23

RIN 1018-AG10

Import of American Ginseng Harvested in 1999-2000 Seasons

Correction

In proposed rule document 01-[illegible] beginning on page [illegible] in the issue of [illegible] April [illegible], 2001, make the following correction:

On page [illegible], in the third column, in the first paragraph, [illegible] line, remove the semicolon.

[FR Doc. C1-[illegible] Filed [illegible]; 8:45 am]

BILLING CODE 1505-01-D

Correction

1. On page [illegible], in the second column, under paragraph [illegible], in the second line, "[illegible]" should read "[illegible]".

2. On the same page, in the same column, [illegible] paragraph [illegible], in the [illegible] line, "[illegible]" should read "[illegible]".

BILLING CODE 1505-01-D

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

48 CFR Part 52

[illegible]

Federal Acquisition Regulation (FAR); [illegible]

Correction

[illegible]

DEPARTMENT OF DEFENSE

[illegible]

Department of Defense [illegible]

Correction

[illegible]

OFFICE OF MANAGEMENT AND BUDGET

Office of Federal Procurement Policy

Government-wide Small Business and Small Disadvantaged Business Goals for Procurement Contracts; Policy Letter

Correction

[illegible]

BILLING CODE 1505-01-D

DEPARTMENT OF TRANSPORTATION

[illegible]

[illegible]

Correction

[illegible]

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

42 CFR Part [illegible]

RIN [illegible]

[illegible]

Correction

[illegible]

DEPARTMENT OF THE TREASURY

[illegible]

[illegible]

Correction

[illegible]

BILLING CODE 1505-01-D

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[illegible]

Correction

[illegible]

BILLING CODE 1505-01-D

federal register

Tuesday,
June 4, 1991

Part II

Department of Transportation

Federal Aviation Administration

14 CFR Parts 121, 125, 127, 129, and 135

Special Federal Aviation Regulation No. 38; Certification and Operating Requirements; Final Rule; Request for Comments

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Parts 121, 125, 127, 129, and 135

[Docket No. 18510; SFAR No. 38-7]

Special Federal Aviation Regulation No. 38; Certification and Operating Requirements

AGENCY: Federal Aviation Administration [FAA], DOT.

ACTION: Final Rule; request for comments.

SUMMARY: This amendment establishes a new termination date for Special Federal Aviation Regulation [SFAR] No. 38-2 (50 FR 23941; June 7, 1985), which contains the certification and operating requirements for persons conducting commercial passenger or cargo operations. The FAA stated in previous extensions of SFAR 38-2 that it was necessary to establish a new termination date for SFAR 38-2 to allow time for the FAA to complete the rulemaking process that will consolidate the rules regarding certification and operating requirements and incorporate SFAR 38-2 into the Federal Aviation Regulations (FAR). The current termination date for SFAR 38-2 is June 1, 1991. Because the FAA has not completed that rulemaking process, a 1-year extension of the termination date is necessary. SFAR 38-2 is extended to ensure that the FAA has adequate time to complete the consolidation of the rules regarding certification and operating requirements. However, if a final rule, which consolidates those rules, is issued before the new termination date, the FAA intends to publish a notice rescinding SFAR 38-2 concurrently with the publication of the final rule in the **Federal Register.**

DATES: Effective date May 28, 1991. Comments must be received on or before August 5, 1991.

ADDRESSES: Send comments on the rule in triplicate to: Federal Aviation Administration, Office of the Chief Counsel, Attn: Rules Docket (AGC-10), Docket No. 18518, 800 Independence Avenue, SW., Washington, DC 10591, or deliver comments in triplicate to: Federal Aviation Administration, Rules Docket, room 916, 800 Independence Avenue, SW., Washington, DC. Comments may be examined in the Rules Dockets weekdays, except Federal holidays, between 8:30 a.m. and 5 p.m.

FOR FURTHER INFORMATION CONTACT: Ms. Donell Pollard, Project Development Branch, AFS-240, Air Transportation Division, Flight Standards Service, Federal Aviation Administration, 800 Independence Avenue, SW., Washington, DC 20591; Telephone (202) 267-3750.

SUPPLEMENTAL INFORMATION:

Background

On December 12, 1978, the FAA issued SFAR 38 (43 FR 58366; December 14, 1978) as a consequence of the Airline Deregulation Act of 1978 (ADA or Act) (Pub. L. 95-504, 92 Stat. 1705). That Act expresses the Congressional intent that the Federal Government diminish its involvement in regulating the economic aspects of the airline industry. To accomplish this, Congress directed that the CAB be abolished on December 31, 1984, and that certain of its functions cease before that date. Anticipating its sunset, the CAB itself curtailed or suspended much of its regulatory activity during the period 1979-1984. On October 4, 1984, additional legislation was enacted further defining the process of CAB sunset. On January 1, 1985, the remaining CAB functions were transferred to the Department of Transportation (DOT).

Because some aspects of FAA safety regulations relied upon CAB definitions and authority, the FAA found it necessary in 1978 to adopt an interim measure to provide for an orderly transition to the change in economic regulatory activities. This action was consistent with the Congressional directive contained in section 107(a) of the Act that the deregulation of airline economics result in no diminution of the high standard of safety in air transportation that existed when the ADA was enacted. SFAR 38 set forth FAA certification and operating requirements applicable to all "air commerce" and "air transportation" operations for "compensation or hire." (SFAR 38 did not address part 133 External Load Operations, part 137 Agriculture Aircraft Operations, or part 91 training and other special purpose operations.)

On December 27, 1984, the FAA issued SFAR 38-1 (50 FR 450; January 4, 1985), which merely extended the termination date of the regulation and allowed the FAA time to propose and receive comments on revising SFAR 38.

On May 28, 1985, the FAA issued SFAR 38-2 (50 FR 23941; June 7, 1985), which updated SFAR 38 in light of changes since 1978 and clarified provisions stating which FAA regulations apply to each air carrier and each type of operation. This action was necessary because of the changes in the air transportation industry brought about by economic deregulation. Before deregulation, economic certificates were rigidly compartmentalized, and each air carrier typically was authorized to conduct only one type of operation (domestic, flag, or charter (i.e., supplemental)). The safety certificate issued to the air carrier by the FAA paralleled the authorization granted in the air carrier's economic certificate. Economic deregulation broke down the barriers between the various types of operations. The economic authority granted an air carrier by the DOT is no longer indicative of the safety regulations applicable to the type of operation authorized by the FAA. Thus, it was necessary for the FAA to establish guidelines to determine what safety standards were applicable to an air carrier's particular operation.

On April 30, 1986, the FAA issued SFAR 38-3, which extended the termination date of SFAR 38-2 to allow the FAA time to incorporate its contents into Notice No. 88-16. That notice proposes to consolidate the certification and operating requirements rules in parts 121 and 135, and to incorporate various provisions of SFAR 38-2 into new part 119 of the FAR.

On July 15, 1987, the FAA issued SFAR 38-4, which reinstated SFAR 38-2, because it was inadvertently allowed to expire, and extended its termination date to June 1, 1989. That extension allowed the FAA time to incorporate the contents of SFAR 38-2 into Notice No. 88-16.

On May 26, 1989, the FAA issued SFAR 38-5, which extended the expiration date of SFAR 38-2 to June 1, 1990, in order for the FAA to consider comments on Notice No. 88-16 and to issue a final rule which would consolidate the certification and operating requirements rules of SFAR 38-2, Part 121, and Part 135.

On April 11, 1990, the FAA reopened the comment period for Notice No. 88-16 (55 FR 14404; April 17, 1990) for comments on the definition of "scheduled operation" and the notification requirement for changes to operations specifications for a period of 30 days. The reopened comment period closed May 17, 1990.

To allow for additional time to consider comments received during the reopened comment period, the FAA extended the expiration date for SFAR 38-2 until June 1, 1991 (55 FR 23043).

Currently, the FAA is completing work on the final rule that would make SFAR 38-2 a permanent Federal Aviation Regulation; therefore it is necessary to extend the expiration date for SFAR 38-2 until June 1, 1992.

Good Cause Justification for Immediate Adoption

The reasons which justify the adoption, and the subsequent revision, of SFAR 38 still exist. Therefore, it is in the public interest to establish a new termination date for SFAR 38-2 of June 1, 1992. If the FAA publishes a final rule incorporating SFAR 38-2 into the FAR before the termination date, a notice rescinding SFAR 38-2 will be published concurrently. This action is necessary to permit continued operations under SFAR 38, as amended, and to avoid confusion in the administration of FAA regulations regarding operating certificates and operating requirements.

For this reason, and because this amendment continues in effect the provisions of a currently effective SFAR and imposes no additional burden on any person, I find that notice and public procedures are unnecessary, impracticable, and contrary to the public interest, and that the amendment should be made effective in less than 30 days after publication. However, interested persons are invited to submit such comments as they desire regarding this amendment. Communications should identify the docket number and be submitted in duplicate to the address above. All communications received on or before the close of the comment period will be considered by the Administrator, and this amendment may be changed in light of the comments received. All comments will be available, both before and after the closing date for comments, in the Rules Docket for examination by interested parties.

Regulatory Flexibility Determination

The Regulatory Flexibility Act of 1980 (RFA) was enacted to ensure that small entities are not unnecessarily and disproportionately burdened by Government regulations. The RFA requires agencies to review rules which may have "a significant economic impact on a substantial number of small entities."

This rule will not impose any additional incremental costs over those that would have been incurred when SFAR 38-2 was first issued. Therefore, the FAA has determined that this rule will not have a significant cost impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

International Trade Impact Analysis

The FAA finds this amendment will have no impact on international trade.

Federalism Implications

The amendment herein would not have substantial direct effects on the states, on the relationship between the national government and the states, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this amendment would not have sufficient federalism applications to warrant the preparation of a Federalism Assessment.

Conclusion

The FAA has determined that this document involves an amendment that imposes no additional burden on any person. Accordingly, it has been determined that: The action does not involve a major rule under Executive Order 12291; it is not signficant under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and its anticipated impact is so minimal that a full regulatory evaluation is not required.

List of Subjects

14 CFR Part 121

Air carrier, Aircraft, Airmen, Air transportation, Aviation safety.

14 CFR Part 125

Aircraft, Airmen, Airports, Airspace, Air traffic control, Air transportation, Chemicals, Children, Drugs, Flammable materials, Handicapped, Hazardous materials, Infants, Smoking.

14 CFR Part 127

Air carriers, Aircraft, Airmen, Airworthiness.

14 CFR Part 129

Air carriers, Aircraft, Airmen, Air transportation, Aviation safety, Safety.

14 CFR Part 135

Air carriers, Aircraft, Airmen, Air taxis, Air transportation, Airworthiness, Aviation safety, Safety.

Adoption of the Amendment

In consideration of the foregoing SFAR 38-2 (14 CFR parts 121, 125, 127, 129, and 135) of the Federal Aviation Regulations is amended as follows:

PART 121—[AMENDED]

1. The authority citation for part 121 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421, 1423, 1424, and 1502; 49 U.S.C. 106(g) (revised Pub. L. 97-449, January 12, 1983).

PART 125—[AMENDED]

2. The authority citation for part 125 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421, though 1430, and 1502; 49 U.S.C. 106(g) (revised Pub. L. 97-449, January 12, 1983).

PART 127—[AMENDED]

3. The authority citation for part 127 is revised to read as follows:

Authority: 49 U.S.C. 1354(a), 1421, 1422, 1423, 1424, 1425, 1430; 49 U.S.C. 106(g) (revised Pub. L. 97-449, January 12, 1983).

PART 129—[AMENDED]

4. The authority citation for part 129 is revised to read as follows:

Authority: 49 U.S.C. 1346, 1354(a) 1356, 1357, 1421, 1502, 1511, and 1522; 49 U.S.C. 106(g) (revised Pub. L. 97-449, January 12, 1983).

PART 135—[AMENDED]

5. The authority citation for part 135 is revised to read as follows:

Authority: 49 U.S.C. 1354(a), 1355(a), 1421 through 1431, and 1502; 49 U.S.C. 106(g) (revised Pub. L. 97-449, January 12, 1983).

Special Federal Aviation Regulation No. 38-2 is amended by removing the words "June 1, 1991" in the last paragraph, and by adding in their place the words "June 1, 1992."

Issued in Washington, DC, on May 28, 1991.

James B. Busey,

Administrator.

[FR Doc. 91-13068 Filed 5-30-91; 8:45 am]

BILLING CODE 4910-13-M

federal register

Tuesday
June 4, 1991

Part III

Department of Education

Office of Special Education and Rehabilitative Services

Discretionary Programs for Minority Entities, Underrepresented Populations, etc.; Notice

DEPARTMENT OF EDUCATION

Discretionary Programs for Minority Entities, Underrepresented Populations, etc.

Office of Special Education and Rehabilitative Services

AGENCY: Department of Education.

ACTION: Notice of proposed priority for fiscal year 1991.

SUMMARY: The Secretary proposes a priority for fiscal year (FY) 1991 under the Individuals with Disabilities Education Act (IDEA). The Secretary takes this action to implement the Department plan for providing outreach services to minority entities and underrepresented populations to assist them in participating more fully in discretionary programs funded under the Act.

DATES: Comments must be received on or before July 5, 1991.

ADDRESSES: All comments concerning this priority should be addressed to Max Mueller, Department of Education, 400 Maryland Avenue SW. (Switzer Building, room 3512–M/S 2651), Washington, DC 20202–2651.

FOR FURTHER INFORMATION CONTACT: Max Mueller. Telephone: (202) 732–1554; (TDD (202) 732–1999).

SUPPLEMENTARY INFORMATION: The legislation authorizing special education programs has recently been revised (The Education of the Handicapped Act Amendments of 1990, Public Law 101–476). This priority is being proposed as a principal component to carry out the Department's outreach services plan that has been developed pursuant to a recommendation made by Congress in section 610(j)(2) of the IDEA. Outreach activities are to be designed to increase the participation of minority entities and underrepresented populations in discretionary programs (parts C through G) of the IDEA.

The Secretary will announce the final priority in a notice in the Federal Register. The final priority will be determined by responses to this notice, available funds, and other considerations of the Department. Funding of particular projects depends on the availability of funds, the nature of the final priority, and the quality of applications received. The publication of this proposed priority does not preclude the Secretary from publishing additional priorities, nor does it limit the Secretary to funding only this priority, subject to meeting applicable rulemaking requirements.

Note: This notice of proposed priority does *not* solicit applications. A notice inviting applications under this competition will be published in the Federal Register concurrent with or following publication of the notice of final priority.

Priority

Under 34 CFR 75.105(c)(3) and section 610(j) of the IDEA the Secretary proposes to give an absolute preference to applications that meet the following priority. The Secretary proposes to fund under this competition only applications that meet the absolute priority in this notice.

The Secretary proposes to make one or more 48-month awards for outreach centers to provide technical assistance to the agencies, institutions, organizations, and populations identified by Congress in the minority outreach program under section 610(j) in order to increase the participation of those entities in competitions for grants, cooperative agreements, and contracts under any of parts C through G of the IDEA.

The IDEA urges the Department to mobilize the Nation's resources to prepare minorities for careers in special education and related services. The legislation emphasizes the recruitment of minorities into teaching and related service disciplines, and financial assistance to minority institutions. The specific focus of this proposed priority is on providing outreach services to minority entities to increase their participation in competitions for awards under OSEP discretionary programs.

The immediate goal of this program is to increase access to and participation by minority institutions in discretionary programs authorized under parts C through G of the IDEA. A secondary goal is to strengthen special education and related programs of minority entities. The desired ultimate outcomes of the priority are improved programs for minority children with disabilities and increased numbers of minority personnel in the workforce serving children with disabilities.

Under the statute, the entities targeted for outreach services are:

• Historically Black Colleges and Universities,

• Other institutions of higher education whose minority student enrollment is at least 25 percent,

• Eligible institutions as defined under section 312 of the Higher Education Act of 1965,

• Nonprofit and for-profit agencies at least 51 per cent controlled by one or more minority individuals (however, it should be noted that for-profit agencies are not eligible for most IDEA programs), and

• Underrepresented populations. Underrepresented populations are further defined as—

• Populations such as minorities, the poor, the limited English proficient, and individuals with disabilities.

Background

The Congress has provided in the legislation a substantial rationale that should guide the efforts of the Center. As a part of the IDEA (section 610(j)), the Congress has provided extensive "findings" regarding minority issues relating to the education of people with disabilities. Concerns noted relate to minority students with disabilities, minority personnel to serve such children, and minority institutions. Though the findings concentrate largely on Historically Black Colleges and Universities, the law provides for equal attention to other institutions and agencies defined as minority entities.

With respect to the discretionary programs authorized by parts C through G, the Congress found, in summary:

The Federal Government must be responsive to the growing needs of an increasingly more diverse society. A more equitable allocation of resources is essential for the Federal Government to meet its responsibility to provide an equal educational opportunity for all individuals.

America's racial profile is rapidly changing. The minority population is increasing in society generally and in the schools in particular. In addition, more minority children continue to be served in special education than would be expected from the percentage of minority students in the general population. Greater efforts are needed to prevent the problems associated with mislabeling and higher dropout rates among minority children with disabilities. This combination of factors means that meeting the special needs of minority children with disabilities is a major issue to be addressed in delivery of special education and related services.

At the same time, minorities are seriously underrepresented in the teaching force. As the number of African-Americans and Hispanic students in special education increases, the number of minority teachers and related service personnel produced in our colleges and universities continues to decrease. Recruitment efforts within special education at the level of preservice training, continuing education, and teacher recruitment in the school must focus on bringing larger

numbers of minorities into the profession in order to provide appropriate practitioner knowledge, role models, and sufficient manpower to address the clearly changing demography of special education.

The Congress concluded that the opportunity for full participation in awards for grants, cooperative agreements, and contracts by minority entities is essential if we are to obtain greater success in the recruitment and training of minority personnel and in the education of minority children with disabilities.

Eligible Applicants: The following are eligible for assistance under this priority:

(1) Public agencies; and

(2) Private nonprofit agencies, organizations, and institutions.

Priority: Under this priority, the Secretary will fund one or more centers that provide effective and cost-efficient technical assistance to the agencies, institutions, organizations, and populations listed in section 610(j)(2) to promote their participation in programs authorized under parts C through G of the IDEA.

Each center must establish an advisory group of at least 10 persons to provide advice and recommendations to the Center on all aspects of this project. The advisory group must represent relevant professional organizations, parents of minority children with disabilities, and different disciplinary areas (e.g., special education, health, social work). The center shall select each member of the advisory group on the basis of experience and ability to provide sound recommendations and advice to the Center relative to both minority and disability issues.

Each center shall establish and maintain a clearinghouse of critically important information and materials that can be used effectively to assess and meet the technical assistance needs of minority entities and underrepresented groups. As a part of this task, the Center shall, at least annually, conduct literature searches, identify and visit programs demonstrating exemplary practices, and conduct other activities to secure the most current and effective information available. The center shall also develop materials and other information packages that may be necessary for conducting needs assessments, for delivering technical assistance, for evaluating technical assistance, and for providing training to the center's core staff and national experts.

Each center annually shall conduct technical assistance needs assessments and negotiate technical assistance agreements with target agencies, institutions, organizations, programs, and projects.

In establishing final plans, the Center may propose cross-institutional activities if similar objectives are established in several agencies, and if combining activities could create cost savings. In developing these plans, the Center shall analyze the needs of each entity and determine the most effective and cost efficient means of addressing them. As a final step, the Center shall develop a specific technical assistance agreement, with each entity identified, that—

(a) Reconciles technical assistance needs with the Center's designated fiscal and human resources for that entity;

(b) Describes the technical assistance objectives and mechanisms and strategies that will be used;

(c) Identifies the persons involved in the technical assistance activity;

(d) Specifies the beginning and end dates of the activity;

(e) Describes how the technical assistance activity will contribute to promoting the immediate and long-term goals of the project; and

(f) Describes a plan for coordinating with other technical assistance providers (e.g., the Regional Resource Centers) that may be involved in related activities.

For each competition which the Secretary runs under parts C through G, the Center shall—

• Prepare special materials explaining the competition to the entities (that are the focus of this program);

• Disseminate these materials to these entities on a timely basis;

• Where appropriate, conduct one or more special "potential bidders" conferences for these entities, at which representatives of the Secretary may appear, to explain in more detail how the entities might apply;

• Analyze the results of each competition in terms of the degree to which these entities applied and the degree to which they were successful, and make this analysis available to the Secretary and the entities; and

• Provide advice to the Secretary at least annually on ways in which competitions under parts C through G might be modified to further advance the purposes of this program.

For the purpose of carrying out this function, the Secretary intends to make available to the center(s) the maximum information on the selection process for each competition which the Secretary is permitted to make public under applicable law.

Intergovernmental Review

This program is subject to the requirements of Executive Order 12372 and the regulations in 34 CFR part 79. The objective of the Executive Order is to foster an intergovernmental partnership and a strengthened federalism by relying on processes developed by State and local governments for coordination and review of proposed Federal financial assistance.

In accordance with the order this document is intended to provide early notification of the Department's specific plans and actions for these programs.

Invitation to Comment: Interested persons are invited to submit comments and recommendations regarding this proposed priority.

The Secretary is especially interested in comments on the relative advantages of implementing the mandate for outreach to minority entities through a single award or a small number of related projects. The issues involve whether the differences among various OSEP programs, the needs of various types of minority entities, or the needs of various minority populations are sufficient to require separate attention through separate awards.

All comments submitted in response to this proposed priority will be available for public inspection during and after the comment period, in room 3072, Switzer Building, 330 C Street SW., Washington, DC, between the hours of 8:30 a.m. and 4 p.m., Monday through Friday of each week except Federal holidays.

Program Authority: 20 U.S.C. 1410.

(Catalog of Federal Domestic Assistance Number 84.029: Training Personnel for the Education of Individuals with Disabilities)

Dated: April 26, 1991.

Lamar Alexander,

Secretary of Education.

[FR Doc. 91-13088 Filed 6-3-91; 8:45 am]

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June 4, 1991

Part IV

Department of Health and Human Services

Health Care Financing Administration

42 CFR Part 412

Medicare Program; Medicare Geographic Classification Review Board—Procedures and Criteria; Final Rule with Comment Period

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 412

[BPD-684-FC]

RIN 0938-AF19

Medicare Program; Medicare Geographic Classification Review Board—Procedures and Criteria

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period responds to public comments on the September 6, 1990 interim final rule with comment period that established the Medicare Geographic Classification Review Board (MGCRB) and sets forth the criteria for the MGCRB to use in issuing its decisions concerning the geographic reclassification of hospitals for purposes of payment under the prospective payment system. In addition, this final rule with comment period implements provisions of the Omnibus Budget Reconciliation Act of 1990 concerning the MGCRB.

DATES:

Effective date: This final rule with comment period is effective on June 4, 1991. We refer the reader to section VII.A. of this preamble for a discussion of the effective dates of specific provisions.

Comment date: Comments on changes to the September 6, 1990 interim final rule resulting from provisions of the Omnibus Budget Reconciliation Act of 1990 will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on August 5, 1991. These changes concern discretionary review by the Administrator of MGCRB decisions, calculation of the wage index, and urban to urban group reclassifications. We will not consider comments concerning provisions that remain unchanged from the September 6, 1990 interim final rule with comment period or on provisions that were changed based on public comments.

ADDRESSES: Mail comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD-684-FC, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert Humphrey Building, 200 Independence Ave., SW., Washington, DC.

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

Due to staffing and resource limitations, we cannot accept facsimile (FAX) copies of comments.

In commenting, please refer to file code BPD-684-FC. Comments received timely will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202-245-7890).

Copies: To order copies of the **Federal Register** containing this document, send your request to the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325. Specify the date of the issue requested and enclose a check payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 783-3238 or by faxing to (202) 275-6802. The cost for each copy (in paper or microfiche form) is $1.50. In addition, you may view and photocopy the **Federal Register** document at most libraries designated as U.S. Government Depository Libraries and at many other public and academic libraries that receive the **Federal Register**. Ask the order desk operator for the location of the Government Depository Library nearest to you.

FOR FURTHER INFORMATION CONTACT:
Paul Olenick—MGCRB and Administrative Review Procedures (301) 966-4472.

Barbara Wynn—Reclassification Guidelines (301) 966-4529.

SUPPLEMENTARY INFORMATION:

I. Background

Section 6003(h)(1) of the Omnibus Budget Reconciliation Act of 1989, enacted on December 19, 1989, added section 1886(d)(10) to the Social Security Act (the Act) to provide for creation of the Medicare Geographic Classification Review Board (MGCRB). On September 6, 1990, we published an interim final rule with comment period (55 FR 36754) that provided for the establishment of the MGCRB and set forth the criteria for the MGCRB to use in considering applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system. As enacted, section 1886(d)(10) of the Act provided that reclassifications resulting from applications filed by October 1, 1990 would take effect October 1, 1991.

As required by section 1886(d)(10)(A) of the Act, the interim final rule provided for the establishment of the MGCRB and set forth criteria to be used by the MGCRB in making decisions on hospital requests for reclassification. The interim final rule also set forth requirements regarding the MGCRB's composition and operational procedures.

Subsequently, the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508) was enacted on November 5, 1990. Section 4002(h) of Public Law 101-508 contained several provisions relating to the geographic classification of hospitals. This final rule with comment period makes changes in the September 6, 1990 interim final rule with comment period based on both the provisions of Public Law 101-508 and the public comments received on the interim final rule.

II. Geographic Classification of Hospitals

Under the prospective payment system, a hospital's payment rate is dependent, to some degree, on whether the county in which a hospital is located is classified as a large urban area, an urban area, or a rural area. These terms are defined in section 1886(d)(2)(D) of the Act. The term "urban area" means an area within a Metropolitan Statistical Area (MSA). An urban area in New England is defined as a New England County Metropolitan Area (NECMA). The term "large urban area" means an urban area with a population of more than one million (or more than 970,000 in New England) as determined by the Secretary using the most recent available population data published by the Bureau of the Census. We use the term "other urban area" for an urban area that is not a large urban area. The term "rural area" means any area outside an urban area. Section 1886(d)(2)(D) of the Act requires that average standardized amounts per discharge be determined for hospitals located in large urban areas, other urban areas, and rural areas. The MSA and NECMA classification are also used to define labor market areas for purposes of establishing a hospital's wage index value under section 1886(d) of the Act.

Effective with discharges on or after October 1, 1988, section 4005(a) of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203), as amended by section 411(b)(4) of the Medicare Catastrophic Coverage Act of 1988 (Pub.

L. 100-360), revised 1886(d)(8)(B) of the Act to provide that, if certain conditions are met, the Secretary treats a hospital located in a rural county adjacent to one or more urban areas as being located in the urban area to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs (and NECMAs), published in the Federal Register on January 3, 1980 (45 FR 956). (We use the terms "classified" and "designated" interchangeably in referring to the area in which a hospital is considered to be located.) The commuting rates used in determining outlying counties are based on the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs (or NECMAs). Thus, hospitals in rural counties adjacent to one or more MSAs or NECMAs are deemed to be urban if the counties meet the following criteria:

• The rural county would otherwise be considered a part of an MSA (as an outlying county) but for the fact that the rural county does not meet the OMB standard relating to the commuting rate of workers between the rural county and the central county or counties of any single adjacent MSA or NECMA.

• The aggregate commuting rate to the central county or counties of all adjacent MSAs or NECMAs is at least 15 percent of the number of residents of the rural county who are employed, or the total commuting rate to and from the central county or counties of all adjacent MSAs is at least 20 percent of the number of residents of the rural county who commute for employment and the county meets the applicable population criteria.

For purposes of payment under the prospective payment system, a hospital located in a rural county that qualifies under this provision is deemed to be located in the MSA to which the greatest number of workers in the rural county commute.

Congress intended that section 1886(d)(8)(B) of the Act apply to a limited number of hospitals that it believed merited payment as urban hospitals because of their location in counties adjacent to at least one MSA and their commuting patterns. However, many hospitals have sought urban classification under this provision, but their requests have been denied because the hospitals do not meet the specific criteria necessary for redesignation.

Congress addressed the many requests by hospitals for geographic reclassification with the enactment of Section 6003(h)(1) of Public Law 101-239, which added new paragraph (10) to section 1886(d) of the Act. Section 1886(d)(10) of the Act provides for the establishment of the MGCRB, which has the authority to issue decisions on hospital requests for geographic reclassification. In addition, section 1886(d)(10)(D)(i) of the Act requires that the Secretary publish guidelines to be used by the MGCRB in making decisions on reclassification requests.

III. The MGCRB Provisions of the Omnibus Budget Reconciliation Act of 1989

On December 19, 1989, Public Law 101-239 was enacted. Section 6003(h)(1) of Public Law 101-239 added section 1886(d)(10) to the Act, which includes the following provisions that affect the geographic classification of hospitals for purposes of payment under the Medicare prospective payment system:

• Section 1886(d)(10)(A) of the Act establishes the MGCRB, which has the authority to issue decisions on hospital requests for geographic reclassification. Under section 1886(d)(10)(C)(i) of the Act, a geographic classification change is effective for the purposes of the hospital's average standardized amount, wage index value, or both, for a Federal fiscal year.

• Under section 1886(d)(10)(B)(i) of the Act, the MGCRB is to consist of five members appointed by the Secretary. Section 1886(d)(10)(B)(ii) of the Act required the Secretary to appoint the MGCRB members by 180 days after enactment of Public Law 101-239; that is, the appointments were to have been made by May 18, 1990.

• Section 1886(d)(10)(C)(ii) of the Act provides that a prospective payment system hospital may obtain a change in geographic classification on a prospective basis only. That is, if a hospital requests reclassification by the first day of a Federal fiscal year (October 1) and meets the specified criteria, the MGCRB reclassifies the hospital or hospitals effective the first day of the following Federal fiscal year.

• Under section 1886(d)(10)(C)(iii)(I) of the Act, the MGCRB is required to issue decisions on hospital applications for geographic reclassification filed within the above time frame no later than 180 days after the first day of the Federal fiscal year.

• Section 1886(d)(10)(C)(iii)(II) of the Act provides for appeals to the Secretary of an MGCRB decision and specifies that the Secretary's decision is to be issued not later than 90 days after the appeal is filed. The Secretary's decision is final, and is not subject to judicial review.

• Under section 1886(d)(10)(D)(i) of the Act, the Secretary is to publish guidelines by July 1, 1990 for use by the MGCRB in issuing reclassification decisions. These guidelines are to address the following issues:

—The comparison of wages, taking into account occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be reclassified.

—The determination of whether the county in which the hospital is located should be treated as being a part of a particular MSA.

—The consideration of information provided by a hospital concerning the effects of the hospital's geographic reclassification on access to inpatient hospital services of Medicare beneficiaries.

—The appropriateness of criteria used to define NECMAs.

• Section 1886(d)(10)(E)(i) of the Act authorizes the MGCRB to make rules and establish procedures that are not inconsistent with the provisions of title XVIII of the Act or regulations of the Secretary.

• Section 1886(d)(10)(E)(i) of the Act also provides that the MGCRB may administer oaths and affirmations in the course of any oral hearing. In addition, the provisions of section 205 (d) and (e) of the Act with respect to subpoenas apply to the MGCRB to the same extent as these provisions apply to the Secretary under title II of the Act.

• The other provisions in section 1886 (d)(10)(E) and (d)(10)(F) of the Act provide for financial compensation for MGCRB members.

In addition, section 6003(h)(1) of Public Law 101-239 included the following provisions, which were later amended in part by the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508), as described in section IV below:

• Under section 1886(d)(10)(B)(i) of the Act, the MGCRB was to include: Two members who are representatives of prospective payment system hospitals located in rural areas; at least one member of the Prospective Payment Assessment Commission (ProPAC); and at least one MGCRB member knowledgeable in analyzing inpatient hospital service costs.

• Section 1886(d)(10)(C)(iii)(II) of the Act specified that a decision of the MGCRB was final unless an unsuccessful hospital or group of hospitals appealed the decision to the Secretary no later than 15 days after the date of the MGCRB decision. It also provided that the Secretary might not receive any new evidence on appeal, and must issue a decision based only

upon the record as it appeared before the MGCRB.

IV. The Omnibus Budget Reconciliation Act of 1990

On November 5, 1990, Public Law 101–508 was enacted. Section 4002(h) of Public Law 101–508 contained several provisions relating to the geographic classification of hospitals.

Section 4002(h)(1)(A)(ii) of Public Law 101–508 amended section 1886(d)(8)(C)(i)(II) of the Act effective for discharges occurring on or after January 1, 1991 by specifying that if including the wage data for the hospitals redesignated under section 1886 (d)(8) and (d)(10) reduces the wage index value for an urban area by more than one percentage point, the wage index value for that urban area is to be calculated and applied separately to hospitals already located in that urban area (excluding the redesignated hospitals). The hospitals that are redesignated are to use the wage index value of the MSA that results from including the wage data of all the hospitals that are redesignated to the MSA in the determination. However, the wage index value for the redesignated hospitals cannot be less than the Statewide rural wage index value. This change was implemented in our January 7, 1991 final rule with comment period (56 FR 568), Mid-Year FY 1991 Changes to the Inpatient Hospital Prospective Payment System, and is also explained in section V of this preamble.

Next, section 4002(h)(2)(A) of Public Law 101–508 extended the deadline for hospitals to submit applications for geographic reclassification for Federal fiscal year 1992 from October 1, 1990 until November 6, 1990 (that is, 60 days after publication of the interim final rule with comment period). The interim final rule also had set November 6, 1990 as the deadline for complete applications, but it had required that hospitals submit initial applications by October 1, 1990.

Public Law 101–508 also contained several technical corrections to section 1886(d)(10) of the Act. First, section 4002(h)(2)(B)(i) of Public Law 101–508 changed the title of the Medicare Geographical Classification Review Board to Medicare Geographic Classification Review Board. In addition, section 4002(h)(2)(B)(ii)(I) of Public Law 101–508 amended section 1886(d)(10)(B)(i) of the Act to specify that two members of the MGCRB will be "representative of" but not be "representatives of" rural hospitals. Because we had concluded in developing the September 6, 1990 interim final rule that Congress meant that two members of the MGCRB were to be representative of and familiar with rural hospitals, our implementation of the provision in that document (55 FR 36756) is consistent with section 4002(h)(2)(B)(ii)(I) of Public Law 101–58. Section 4002(h)(2)(B)(ii)(II) of Public Law 101–508 also amended section 1886(d)(10)(B) of the Act to delete the requirement that one member of the MGCRB be a member of the Prospective Payment Assessment Commission (ProPAC).

Finally, section 4002(h)(2)(B)(iv)(I) of Public Law 101–508 amended section 1886(d)(10)(C)(iii)(II) of the Act to require that the appeal of MGCRB decisions be subject to the provisions in section 557(b) of the Administrative Procedure Act (5 USC 557(b)), which specifies that:

> "* * * When the * * * [MGCRB] makes an initial decision, that decision then becomes the decision of the agency without further proceedings unless there is an appeal to, or review on motion of, the agency within time provided by rule. On appeal from or review of the initial decision, the agency has all the powers which it would have in making the initial decision except as it may limit the issues on notice or by rule * * *"

Previously, section 1886(d)(10)(C)(iii)(II) of the Act had only addressed the right of an unsuccessful hospital to appeal an MGCRB decision, while it remained silent with respect to review at the discretion of the Secretary.

As directed by revised section 1886(d)(10)(C)(iii)(II) of the Act, this final rule with comment period provides an explicit mechanism for the review of an MGCRB decision on the motion of the Secretary. The Secretary has delegated the authority to conduct this "own motion review" to the Administrator of HCFA who has redelegated it to the Deputy Administrator. The procedures that we are implementing for conducting own motion review, that is, discretionary review by the Administrator, are consistent with the provisions of section 5 U.S.C. 557(b). The new discretionary review procedure is set forth in section V.B.17 of this preamble and § 412.278 of the regulations.

In addition to the statutory changes, the Conference Committee Report accompanying Public Law 101–508 noted that, although section 4002(h)(2)(B)(iv)(I) of Public Law 101–508 struck the provision of section 1886(d)(10)(C)(iii)(II) of the Act that an MGCRB decision was final unless a hospital appealed the decision to the Secretary within 15 days after the decision, the Secretary shall retain the 15-day limit on hospital appeals. The Conference Committee report also directed the Secretary to provide that urban hospitals could be reclassified jointly to another urban area. (H.R. Rep. No. 964, 101st Cong. 2nd Sess. 715 (1990).) Consequently, as explained in section V.C.7 below, we have added criteria (at § 412.234) concerning reclassification of all hospitals in a county located in an urban area to another urban area.

V. Discussion of Public Comments Concerning the September 6, 1990 Interim Final Rule

We received 48 timely comments from or on behalf of hospitals in response to the September 6, 1990 interim final rule. The main areas of concern addressed by the commenters were the following:

- Timeliness of publication of the interim final rule
- MGCRB composition and operating procedures
- Criteria and conditions for hospital reclassification

In the discussion below we have set forth the provisions of the September 6, 1990 interim final rule with comment, the relevant provisions of section 4002(h) that amended sections 1886 (d)(8) and (d)(10) of the Act, the public comments that we have received concerning the September 6, 1990 interim final rule, our responses to those comments, and appropriate changes in response to public comments or to the provisions of revised sections 1886(d)(8) and 1886(d)(10) of the Act. In addition, we have made several technical changes to the provisions of the September 6, 1990 interim final rule.

A. Timeliness of Publication of the Interim Final Rule

Section 6003(h) of Public Law 101–239 provided that by July 1, 1990, the Secretary should publish guidelines to be used by the MGCRB in making decisions on applications for reclassification. The statute further provides that the MGCRB must issue its decisions on hospital requests for reclassification by March 30, 1991. This schedule allows hospitals to be paid during Federal fiscal year 1992 based on the new standardized amounts and wage index values that reflect the effects of the geographic reclassifications that take effect on October 1, 1991.

Comment: The regulations set forth in the interim final rule should not be implemented because they are procedurally flawed. That is, the rule was not published in a timely manner, and the use of an interim final rule with comment period forced hospitals to comply with regulations without having had a prior opportunity to comment.

Response: The use of an interim final rule with comment period to implement these regulations was essential to ensure that hospitals could apply timely for reclassification for FY 1992 and that the MGCRB can issue decisions on the applications by March 30, 1991, as required by section 1886(d)(10)(C)(iii)(I) of the Act. The delay that would have been necessitated by a prior notice and comment period would have been contrary to the public interest because it would have diminished opportunities for hospitals to file timely applications for reclassification for FY 1992 and to receive the potential benefits of reclassification. Although we were unable to provide a public comment period before the effective date of the interim final rule, we did provide for a 60-day public comment period in that rule. We are responding to the 48 public comments that we received in this final rule with comment period.

Comment: Publication of the interim final rule on September 6, 1990 did not allow enough time for hospitals to file applications with the MGCRB by the November 6, 1990 deadline. The MGCRB should have provided hospitals an additional 30 days to complete their applications.

Response: Because the interim final rule was published on September 6, we recognized the difficulty that hospitals would encounter in attempting to file complete applications by the then statutorily-mandated deadline of October 1 (see section 1886(d)(10)(C)(ii) of the Act). For this reason, we provided in the interim final rule for an extended deadline of November 6, 1990 (60 days after the publication of the interim final rule) for completing an initial application that had been filed with the MGCRB by October 1. In order to qualify for this one-time only extension, we required hospitals to comply with the requirement in section 1886(d)(10)(C)(ii) of the Act by filing initial applications with the MGCRB by October 1, 1990 and then to complete them by November 6, 1990. Congress also recognized the possible burden for hospitals in meeting the October 1, 1990 due date, and so included the provision in section 4002(h)(2)(A) of Public Law 101-508 to extend the application deadline for Federal fiscal year 1992 only until November 6, 1990.

In response to the interim final rule, the MGCRB received over 1,000 complete applications for geographic reclassification before the November 6, 1990 deadline. We believe that the large volume of timely and complete applications clearly demonstrated that Medicare hospitals were afforded sufficient time for filing applications with the MGCRB.

In addition, under section 1886(d)(10)(C)(iii)(I) of the Act, the MGCRB is required to issue decisions on hospital applications no later than 180 days after October 1, that is, by the following March 30. Congress established this time limit so that the effects of reclassification could be reflected in the new standardized amounts and wage index values that take effect on October 1 of each year for prospective payment hospitals. If the MGCRB generally permitted hospitals to extend the filing deadline beyond November 6, it would be unable to satisfy the 180-day requirement for issuing decisions. However, in compelling circumstances, the MGCRB has granted short extensions beyond November 6, 1990 for completing an application to a hospital that met the November 6, 1990 filing deadline, but whose application failed to contain all the necessary elements of a complete application. Also, as discussed in section V.B.6 of this preamble, we have revised § 412.256(c) to specify that the MGCRB may for good cause grant a hospital an extension beyond the deadline of October 1 (for applications for reclassification for FY 1993 and thereafter) to complete its application.

B. MGCRB Composition and Procedures

1. Composition of the MGCRB

Section 1886(d)(10)(B)(i) of the Act provides that the MGCRB shall be composed of five members appointed by the Secretary. Prior to the enactment of section 4002(h)(2)(B)(ii) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508) on November 5, 1990, it further provided that two of the members shall be "representatives of" prospective payment system hospitals located in rural areas. We interpreted this provision to mean that the two members should be representative of and, therefore, familiar with, the concerns of rural hospitals, rather than serve as members who are representatives of or are selected by rural hospitals. Prior to the enactment of Public Law 101-508, the Secretary was also to appoint one member of ProPAC and at least one member who is knowledgeable in analyzing inpatient hospital service costs. (Section 4002(h)(2)(B)(ii) of Pub. L. 101-508 later eliminated the requirement that one member be a member of ProPAC.) The provisions concerning the composition of the MGCRB are set forth in 42 CFR § 412.246(a).

Under § 412.246(b), the term of office for MGCRB members is 3 years, except that the Secretary may designate initial appointments for shorter terms to permit staggered terms of office. The Secretary will not appoint a member for more than two consecutive 3-year terms of office. The Secretary has the authority to terminate a member's tenure prior to its full term.

The Secretary designated one member of the MGCRB as the chairman. The chairman coordinates and directs the administrative activities of the MGCRB.

Comment: HCFA has misinterpreted the law in providing that two MGCRB members be "representative" of, and therefore, familiar with, the concerns of rural hospitals rather than serve as members who are "representatives" of or are selected by rural hospitals. HCFA's interpretation runs counter to the interests of rural hospitals and counter to the intent of the law. MGCRB members who are representatives of hospitals located in rural areas should be selected by rural hospitals with the assistance of the American Hospital Association, instead of HCFA, to ensure that rural hospitals are truly represented.

Response: Section 4002(h)(2)(B)(ii) of Public Law 101-508 substituted the word "representative" for the word "representatives" in section 1886(d)(10)(B)(i) of the Act to affirm, as the Secretary stated in the September 6, 1990 interim final rule, that rural hospital members of the MGCRB would represent rural hospital interests but would not be actual representatives of rural hospitals. A requirement that appointees be "representatives" of special interests would not only constitute an inappropriate constraint on the appointive power of the Secretary but would also be inconsistent with the undivided loyalty that an appointee owes to the public at large.

HCFA shares the concern about the safeguarding of rural hospital interests and believes such interests are being protected. Pursuant to section 1886(d)(10)(B)(i) of the Act the Secretary has appointed two members who are representative of rural hospital interests. While we do not agree that rural hospitals or the American Hospital Association should have the authority to appoint members of the MGCRB, we will consider their recommendations for future MGCRB membership.

Comment: In contrast with members of the Provider Reimbursement Review Board (PRRB), MGCRB members may be terminated before their three-year term has expired, potentially compromising their effectiveness.

Response: There is precedent in the PRRB regulations for termination of a

MGCRB member's 3-year term. Section 405.1845(b) of the regulations governing PRRB procedures states that "The Secretary shall have the authority to terminate a Board member's term of office for good cause." The Secretary has not invoked this authority to date. The Secretary needs to have similar termination authority over the MGCRB in case a member of the MGCRB fails to carry out his or her duties under the Act and regulations.

2. A Quorum

Under § 412.248, a quorum is required for making MGCRB decisions. A majority of all MGCRB members currently seated, at least one of whom, if possible, represents the interests of rural hospitals, constitutes a quorum.

Under § 412.448(b), in the event that four members are deciding a case, three votes are needed to change the hospital's classification. If less than a quorum is present for an oral hearing, the chairman, with the consent of the hospital, may designate less than a quorum to conduct the hearing. The member(s) in such cases submits a recommended decision for approval by a majority of the MGCRB members, including, if possible, a member who represents rural hospital interests.

3. Sources of MGCRB's Authority

Under § 412.250(a), the MGCRB, in exercising the authority to consider applications under section 1886(d)(10)(C) of the Act, complies with all the provisions of title XVIII of the Act and regulations issued under that title (which include guidelines published in the **Federal Register** under section 1886(d)(10)(D) of the Act) and HCFA Rulings issued under the authority of the Administrator. In addition, under § 412.250(b), the MGCRB affords great weight to other interpretive rules, general statements of policy and rules of agency organization, procedure, or practice established by HCFA.

4. Right To Submit Application to MGCRB

Under § 412.252(a), an individual hospital under the Medicare prospective payment system has the right to submit an application to the MGCRB concerning its request for a change in geographic classification based on hospital-specific criteria.

Under § 412.252(b), all prospective payment hospitals within a county, but only as a group, have the right to submit a joint application to the MGCRB concerning their request for the redesignation of all hospitals in the county into a different geographic area based on county-specific criteria.

5. Proceedings Before the MGCRB

Under § 412.254(a), the MGCRB is to issue an on-the-record decision (that is, a decision based on a review of submitted written material without any oral presentations) in each case, unless under § 412.254(b) the MGCRB schedules an oral hearing on its own motion or if a hospital can show to the MGCRB's satisfaction that a hearing is necessary.

Comment: We received specific recommendations regarding the operating procedures of the MGCRB as follows:

The MGCRB should lay out the basic application process, complete with format and instructions.

HCFA's final rule should provide the names and phone numbers of all MGCRB staff contacts as well as instructions on how to obtain information on individual applications.

The MGCRB should revise its form letter to eliminate the arbitrary and incorrect statement that the application will be dismissed if all applicable information is not submitted with the application.

The MGCRB's requirement that a hospital sign an affidavit to accompany its application is unnecessary and offensive.

Response: These comments concern internal MGCRB operating procedures and, as such, are governed by section 1886(d)(10)(E)(i) of the Act, which states that "the Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary and appropriate. * * *" Therefore, these comments should be submitted directly to the MGCRB. Correspondence to the MGCRB should be addressed to the following individual: Mr. Steven R. Kirsh, Staff Director, MGCRB, Professional Building, suite 13, 6660 Security Boulevard, Baltimore, MD 21207. Phone: (301) 966-2038.

Comment: Each hospital should be provided with at least a 15-day notice as to the date and time its application is scheduled for review and consideration by the MGCRB. In addition, the regulations should be changed to grant hospitals the absolute right to an oral hearing.

Response: Since on-the-record review consists of examination of all written material and data submitted, no administrative purpose would be served by notifying a hospital of the date and time the review will take place. Also, such notification would prove to be a cumbersome task for the MGCRB, for example, in cases in which applications receive review by individual MGCRB members at different times.

The Act does not require the MGCRB to conduct oral hearings on hospital applications. If the MGCRB were compelled by regulation to hold oral hearings on all, or even a portion, of the applications it received from hospitals, it would be unable to issue decisions by the deadline of March 30. In addition, due process of law under the Fifth Amendment to the United States Constitution does not require oral hearings under these circumstances. As stated in the interim final rule, on-the-record decisions are entirely appropriate given the tight statutory timeframes for issuing decisions and the types of issues to be decided by the MGCRB. However, § 412.254 provides that the MGCRB may hold an oral hearing on its own motion or if a hospital demonstrates to the MGCRB's satisfaction that an oral hearing is necessary. Thus, a hospital may request an oral hearing and articulate in the request why an oral hearing may be necessary in a particular case.

6. Timing and Content of Application

A prospective payment system hospital may obtain a change in geographic classification on a prospective basis only. Under § 412.274(b)(1), a hospital may request the MGCRB to change its classification effective with the beginning of the second Federal fiscal year following the year in which the request is filed. (However, under § 412.274(b)(2), if a complete application is filed on October 1, the reclassification is effective the following October 1.) For example, a hospital desiring a reclassification for Federal fiscal year 1993 (October 1, 1992 through September 30, 1993) must file its written application no later than October 1, 1991. The MGCRB will dismiss a hospital's request for reclassification for Federal fiscal year 1993 that is filed after October 1, 1991.

Although applications may be submitted to the MGCRB as late as October 1, there is no guarantee that the MGCRB will find that an initial application contains the necessary elements of a complete application. Therefore, it is incumbent upon hospitals to submit their applications as early as possible so that the MGCRB may identify incomplete applications and allow hospitals to complete them prior to the October 1 deadline.

Under § 412.256(c)(1), the MGCRB has 15 days from the receipt of a hospital's application to review it and decide whether it is complete. The MGCRB notifies the hospital within that timeframe if the application is incomplete and advises the hospital that

it has until October 1 to complete the application. If a hospital submits its application by September 1, this should give the hospital 15 days or more to complete the application in accordance with the necessary criteria. A hospital submitting an incomplete application between September 2 and October 1 runs the risk of filing an incomplete application and not having enough time to complete the application by the filing deadline of October 1.

Under § 412.256(c)(2) in the interim final rule, the MGCRB dismisses an application that is not complete by the filing deadline. Dismissals are based on a hospital's failure to submit timely an application that contains all the necessary elements of a complete application, as explained below in this section. The MGCRB will not dismiss an application when the hospital has timely submitted all necessary elements of an application, but the data submitted do not support the hospital's request for reclassification. (As discussed below in a response to a comment, this final rule with comment period revises § 412.256(c) to specify that the MGCRB may for good cause grant a hospital an extension beyond the filing deadline to complete its application.)

A decision by the MGCRB dismissing a hospital's application as being incomplete or filed untimely will be mailed to the hospital and to HCFA. The dismissal order will contain the reasons for the action taken by the MGCRB. Under § 412.256(d)(1), the hospital may request that the Administrator review the dismissal within 15 days of the date of the notice of dismissal. Under § 412.256(d)(2), within 20 days of receipt of the hospital's appeal request, the Administrator may affirm the dismissal or reverse the dismissal and remand the case to the MGCRB to determine whether reclassification would be appropriate.

Under § 412.256(b)(2), the hospital, or all the hospitals in a county, must identify the guidelines under which reclassification is requested. As required by § 412.256(b)(3), the application must also contain sufficient documentation for the MGCRB to evaluate whether the criteria for reclassification are met. Under § 412.256(b)(3), the filing date of the application is the date the application is received by the MGCRB. Under § 412.256(a)(2), complete applications must be received by October 1 preceding the Federal fiscal year for which reclassification is requested. Applications must be mailed to the following address: Medicare Geographic Classification Review Board, Professional Bldg., suite 13, 6660 Security Blvd., Baltimore, MD 21207.

Because the interim final rule with comment period was published so close to October 1, 1990, we recognized that many hospitals seeking reclassification for Federal fiscal year 1992 would be unable to submit complete applications to the MGCRB by October 1, 1990. Therefore, for the first application period only, we extended the deadline for completing applications to the MGCRB. We required that hospitals submit as complete an application as possible by October 1, 1990. However, if a hospital filed an application by that date, the MGCRB would consider additional information necessary to complete the application if the information was received by the MGCRB no later than 5:00 p.m. on November 6, 1990. (Section 4002(h)(2)(A) of Public Law 101–508 subsequently ratified this later deadline.) All other procedures connected with the applications process remain applicable.

Under § 412.256(a)(1), the MGCRB does not accept a facsimile (FAX) copy of an application or any additional material from the hospital or group of hospitals or from HCFA for any purpose related to filing or completing an application.

In the preamble of the interim final rule with comment period, we specified at 55 FR 36757 the elements that are necessary for a complete application:

a. Information required of individual hospitals

- Name of hospital.
- Address of hospital.
- Name and signature of responsible hospital official.
- County in which hospital is located.
- Demonstration of status as a rural referral center or sole community hospital status, if applying on the basis of access.
- Fiscal year for which the hospital is applying for redesignation.
- Names of all adjacent MSAs or NECMAs (or nearest MSA or NECMA if the applicant is a rural referral center or sole community hospital applying on the basis of access).
- Medicare provider numbers.
- Narrative explaining reason for requesting reclassification that must include:
  —Which criteria in the guidelines constitute the basis of the hospital's application, that is, under which provisions in the regulations the hospital is applying; and
  —An explanation of how the hospital meets the relevant criteria.
- Data from approved sources (as also described in the criteria contained in § 412.230) to support the hospital's application.

b. Information Required for Joint Application From All Hospitals in a County Seeking Redesignation

- Names, addresses, county, and provider numbers of all hospitals.
- Names and signatures of responsible officials of all hospitals.
- Federal fiscal year for which hospitals are applying
- Narrative explaining reason for requesting reclassification must include:
  —Which criteria in the guidelines constitute the basis for the hospitals' application, that is, under which provisions in the regulations the hospitals are applying; and
  —An explanation of how the hospitals meet the relevant criteria.
- Data (from approved sources as also described in § 412.232(d)) to support the hospitals' application.

Comment: The definition of a complete application needs clarification.

Response: The interim final rule describes in great detail the elements necessary for a hospital to submit a complete application with the MGCRB. (See the September 6, 1990 interim file rule at 55 FR 36757, section III.A.6., and §§ 412.230 through 412.234.) Since the MGCRB received over 1,000 complete applications, and we received only one written comment questioning the definition, we believe that the criteria for a complete application included in the interim final rule provide hospitals with sufficient information to prepare their applications for geographic reclassification.

Comment: With regard to future applications submitted to the MGCRB, there may be a timing problem in that the interim final rule requires applications to be submitted by September 1, so that they may be perfected by October 1. Since final wage data are not available prior to September 1, it would be impossible for applications to be submitted by that date.

Response: The interim final rule does not require that applications be submitted by September 1. We have merely recommended that applications be submitted as early as possible, so that an incomplete application submitted prior to October 1 may be completed before the deadline prescribed in § 412.256(a)(2). Section § 412.256(c)(2) of the September 6, 1990 interim final rule also specified that the MGCRB would dismiss an application that was not complete by the statutory deadline ot October 1. However, in this final rule with comment period, we are revising § 412.256 (c)(1) and (c)(2) to

specify that the MGCRB may dismiss an application which is not complete by October 1 and that, at the request of the hospital, the MGCRB may for good cause extend the deadline of October 1 for filing a complete application if an application has been submitted to the MGCRB by October 1.

We note that the appropriate wage data used for reclassification requests are available before September 1. Although the final wage index values are not published each year until September 1 as part of the final prospective payment rule, the wage survey data necessary to apply for reclassification for wage index purposes (see the wage comparison example at section V.B.5 of this preamble) is available from HCFA before that time. The survey data, rather than the wage index values, are used in determining whether a hospital qualifies for a wage index reclassification. Thus, there is nothing to preclude the hospital from filing an application prior to the September 1 final rule based on the latest hospital wage data available from HCFA. Except in those areas which require wage data corrections, the same wage data would be used to construct both the proposed wage index published in May and the final wage index published in September. (Regardless of when the application is filed, we anticipate that the MGCRB will base its decision on the best wage survey data available from HCFA as of the date the MGCRB makes its decision. We plan to furnish the MGCRB with information regarding wage data corrections on a routine basis so that these corrections can be taken into account.)

Comment: The official filing date for an application submitted with the MGCRB should be the postmark date rather than the date the application is received by the MGCRB, as required by § 412.256(a)(3) of the interim final rule.

Response: We believe that adopting the date of receipt of an application rather than the postmark date on the application as the applicable filing date is a reasonable, acceptable legal practice. This position is consistent with the regulations concerning the filing requirements for PRRB hearings. Additionally, courts require documents to be "in hand" to be considered filed. We suggest that applications be submitted by certified mail, return receipt requested, so that there will be no question of when an application is received by the MGCRB.

Comment: Section 412.256(d) of the interim final rule addresses the Administrator's authority to review the MGCRB's dismissal of an application. When the Administrator reverses the dismissal and remands the case to the MGCRB, what is the timeframe for the MGCRB's decision?

Response: The MGCRB is still obligated to issue a decision on remand by March 30 in accordance with the deadline contained in section 1886(d)(10)(C)(iii)(I) of the Act. Section 412.256(c)(1) requires that the MGCRB notify a hospital that its application has been dismissed within 15 days of the filing date, and the hospital then has 15 days to appeal the dismissal to the Administrator (§ 412.256(d)(1)). If the Administrator reverses the dismissal, the case is remanded to the MGCRB within 20 days to determine whether reclassification is appropriate (§ 412.256(d)(2)). Therefore, the MGCRB should have sufficient time to issue a decision by March 30.

7. Party or Parties to MGCRB Proceeding

Under § 412.258(a), the party or parties to the MGCRB proceeding are the hospital requesting a change in geographic classification or group of hospitals requesting reclassification to an urban or rural area. Although not a party under § 412.258(b), HCFA reviews all applications and may offer comments and recommendations on selected applications, if appropriate, within 30 days of receipt of notification from the MGCRB that a complete application has been received. Under § 412.258(c), a hospital has 15 days from the date of receipt of HCFA's comments to submit written comments to the MGCRB, with a copy to HCFA, for the purpose of responding to HCFA's comments.

Therefore, when a hospital submits its application to the MGCRB for consideration, the hospital also sends an informational copy of the application and any accompanying evidence to HCFA in care of the Office of Payment Policy at the following address: Office of Payment Policy, Division of Hospital Payment Policy, Room 1-H-1, East Low Rise Building, 6325 Security Blvd., Baltimore, MD 21207. Re: MGCRB Applications.

Comment: There is no statutory basis for HCFA to participate in the MGCRB process.

Response: As stated in the interim final rule, HCFA is not a party before the MGCRB. However, HCFA is the Federal agency responsible for administration of the prospective payment system, including the establishment of geographic criteria for hospital classification and reclassification and the standardized amounts and wage index values. As such, it is important that HCFA be given an opportunity to provide the MGCRB with technical information regarding geographical classification, and to comment on individual applications when HCFA deems it necessary. HCFA does not have an adversarial role in the MGCRB proceedings. Instead, its interests are in seeing that the MGCRB issues correct and fully-informed decisions on applications for geographic reclassification. The MGCRB is not bound to adopt HCFA's case-by-case comments or recommendations in its decisions. Moreover, a hospital has the opportunity to review and address HCFA's comments on its application prior to the issuance of the MGCRB's decision.

8. Establishment of Time and Place of an Oral Hearing by the MGCRB

Under § 412.260, if the MGCRB decides that an oral hearing is necessary, it sets the time and place for the hearing and notifies the hospital or group of hospitals in writing, with a copy to HCFA, not less than 10 days before the scheduled time. Either on its own motion or for good cause shown by the hospital or group of hospitals, the MGCRB may, as appropriate, reschedule, adjourn, postpone, or reconvene the hearing, provided that reasonable written notice is given to the hospital (or group of hospitals), with a copy to HCFA.

9. Disqualification of MGCRB Members

Section 412.262 concerns the disqualification of MGCRB members. A MGCRB member may not participate in a decision in a case in which he or she is prejudiced or partial with respect to a requesting hospital or has any interest in the matter pending before the MGCRB. If the hospital believes that an MGCRB member is prejudiced or partial and, therefore, should not participate in the decision, the hospital states its objection in writing to the MGCRB. HCFA may also submit such a suggestion to the MGCRB.

The MGCRB member considers the objection and, at his or her discretion, either proceeds in the conduct of the case or withdraws. If the MGCRB member does not withdraw, the hospital may petition the MGCRB for withdrawal of the member. At the earliest opportunity and before the reclassification decision is made, the MGCRB rules on this issue.

10. Evidence

Under § 412.264 (a) and (b), the parties may submit evidence during the course of an MGCRB proceeding, including evidence that is generally inadmissible under the rules of evidence applicable to court procedures. Under § 412.264(d), the

MGCRB rules upon the admissibility of evidence and comments and excludes irrelevant, immaterial, or unduly repetitious evidence and comments.

11. Ex Parte Communications

Under § 412.264(c)(1), the members of the MGCRB and its staff may not consult or be consulted by an individual representing the interests of an applicant hospital or by any other individual on any matter at issue before the MGCRB without notice to the hospital or HCFA. If such communication occurs, the MGCRB discloses it to the hospital or HCFA, as appropriate, and makes it part of the record after the hospital or HCFA has had an opportunity to comment. MGCRB members and staff may not consider any information outside the record about matters concerning a hospital's application for reclassification.

Under § 412.264(c)(2), the prohibition of ex parte communications does not apply to the following: communications among MGCRB members and staff; communications concerning the MGCRB's administrative functions or procedures; requests from the MGCRB to a party or HCFA for a document; and material that the MGCRB includes in the record after notice and an opportunity to comment.

Comment: In view of HCFA's role as technical advisor to the MGCRB, HCFA should be prohibited from engaging in ex parte communications. The same prohibition should apply to HCFA engaging in ex parte communications with the Administrator with regard to appeals.

Response: We believe that the existing regulations concerning MGCRB procedures provide adequate safeguards against ex parte communications. Under § 412.258(b), HCFA may provide written comments and recommendations to the MGCRB on a case-by-case basis, and it must provide simultaneously copies of any such communications to the hospital. Moreover, under § 412.264(c), if an ex parte communication occurs between MGCRB staff and HCFA, the MGCRB will disclose the communication to the hospital and make it part of the record after the hospital has had an opportunity to comment.

We agree that the restrictions on ex parte communications similar to those provided in § 412.264(c) should also apply to communications between HCFA policymaking components and the Administrator, when a case is reviewed by the Administrator. Accordingly, we have added new §§ 412.278 (c)(3) and (e) to address this issue. (Similar to the provisions in § 412.264(c)(2)(i), these restrictions do not apply to communications between the Administrator and staff of the Office of the Attorney Advisor, which assists the Administrator in the review of PRRB and MGCRB decisions (55 FR 32149).)

When a hospital appeals a decision of the MGCRB, § 412.278(b) requires that the hospital and HCFA submit all comments and recommendations to the Administrator in writing and that the hospital or HCFA be given an opportunity to respond in writing to any comments or recommendations. When the Administrator undertakes discretionary review of a MGCRB decision, new § 412.278(c)(2) requires that the Administrator promptly notify the hospital that he or she has decided to review the MGCRB decision. The notice of review to the hospital indicates the particular issues to be considered, and includes copies of any comments submitted to the Administrator by HCFA staff concerning the MGCRB decision. New § 412.278(c)(3) specifies that the hospital has 15 days to submit to the Administrator a written response to the notice of review. New § 412.278(e) provides additional communication safeguards by specifying that all communications between HCFA staff and the Administrator concerning the Administrator's review of an MGCRB decision must be in writing, with copies furnished to the hospital. The communication procedures set forth in § 412.278(e) apply both to the Administrator's discretionary review of an MGCRB decision and to the Administrator's review at a hospital's request. The above provisions have been included to reduce hospital concerns about ex parte communications in the MGCRB and Administrator review processes.

12. Requests for Information or Data

Section 412.266 concerns requests for information and data. A hospital may request from HCFA wage data information necessary for a complete application. If the information is requested by September 1 (or by October 1, 1990 for applications for reclassification to be effective for Federal fiscal year 1992), HCFA provides the information to the hospital within 15 days in order for the hospital to complete its application by October 1. The request for this information from HCFA should be made to the following address: Office of Payment Policy, Division of Hospital Payment Policy, Room 1-H-1, East Low Rise Building, 6325 Security Blvd., Baltimore, MD 21207. Re: Request for HCFA Wage Data.

If HCFA does not respond timely to the request for wage data necessary for the hospital to file a complete application timely, the hospital should file its application; provide a copy of the prior request to HCFA for data; and request the necessary information through the MGCRB. That request must accompany the application to the MGCRB. If the MGCRB grants the request, HCFA must respond within 15 days of the MGCRB's ruling.

13. Subpoenas

Section 412.268 sets forth rules concerning use of subpoenas by the MGCRB. When reasonably necessary for the full presentation of a case, and only after a predecision request for information or data has failed to produce the necessary evidence, the MGCRB may, either upon its own motion or upon the request of the hospital, issue subpoenas for the attendance and testimony of witnesses (for an oral hearing) or for the production of books, records, correspondence, papers, or other documents that are relevant and material to any matter in issue. A party that desires the issuance of a subpoena files with the MGCRB a written request prior to the decision. The request must designate which witnesses or documents are to be produced, and describe the addresses or locations with sufficient particularity to permit these witnesses or documents to be found. The request for a subpoena must state the pertinent facts that the party expects to establish by the requested witnesses or documetns and whether these facts could be established by other evidence without the use of a subpoena. Subpoenas are issued as provided in section 205(d) of the Act.

14. Witnesses

Under § 412.270, witnesses at an oral hearing testify under oath or affirmation, unless excused by the MGCRB for cause. The MGCRB may examine the witnesses and also allow the hospital or its representative to examine any witnesses called. In addition, the hospital may cross-examine any witnesses who are called to testify.

15. Record of Proceedings Before the MGCRB

Under § 412.272, a complete record of the proceedings before the MGCRB is made in all cases. The record is not closed until a decision has been issued by the MGCRB. A transcription of an oral hearing is made at a party's request, at the expense of that party.

16. MGCRB Decision and Notice

Under § 412.276, the MGCRB issues a written decision within 180 days after the first day of the Federal fiscal year preceding the Federal fiscal year for which a hospital has filed a complete application for reclassification. The decision is based on the evidence of record, including the hospital's application and other evidence obtained or received by the MGCRB. A MGCRB decision changing a hospital's classification is effective for one year, effective for discharges occurring on or after the first day of the Federal fiscal year following the MGCRB decision, and expiring with discharges occurring on the last day of that same Federal fiscal year.

A copy of the decision is mailed to the hospital and to HCFA. The MGCRB notifies the hospital or group of hospitals that it has 15 days from the date of the decision to request the Administrator to review the decision. The decision of the MGCRB is final and binding on the hospital and HCFA, unless it is reviewed by the Administrator in accordance with § 412.278.

Comment: Hospital redesignations should be granted for more than one year because of the difficulty of engaging in long-term financial planning.

Response: Section 1886(d)(10)(C)(i) of the Act specifies that the MGCRB's determination regarding a hospital's application for geographic reclassification be for a period of a fiscal year. Accordingly, the prescribed term of an MGCRB decision is one year. As provided under § 412.274(c), however, the MGCRB may determine that the facts supporting the decision will remain essentially unchanged through the end of the fiscal year following that for which application is made. In this case, the MGCRB may provide for either a one-year automatic renewal of its decision or an abbreviated application and decision process for renewal under § 412.274(c).

If the Board decides that it is possible the supporting data will vary to the point that a hospital would not qualify for reclassification in subsequent years, it would be inappropriate for the Board's decision to be for a longer term than one year. In this regard, we note that the results of the comparison between the hospital's cost per case and the standardized amount will change annually based on the more recent cost report data and updated standardized amounts. Beginning in FY 1994, the wage comparison results will also change annually since the wage data will be updated annually.

Comment: Although the fiscal intermediary is not involved in the MGCRB proceedings, HCFA should establish a procedure for notifying the intermediary of a hospital's successful application for reclassification.

Response: We agree that fiscal intermediaries must be informed regarding hospital reclassifications and are now developing procedures to do so on a routine basis. We will notify intermediaries of all hospital reclassifications before the beginning of the Federal fiscal year in which the redesignations take effect, and provide the necessary instructions for updating the provider-specific files to reflect the redesignations. In addition, the new wage index value applicable to a reclassified hospital will be incorporated into the PRICER program used to determine the amount of a hospital's prospective payment.

Comment: If the MGCRB fails to issue a decision by the required deadline of March 30, a hospital's request for redesignation should be automatically approved.

Response: Under section 1886(d)(10)(C)(iii)(I) of the Act, the MGCRB must issue all decisions on hospital requests for reclassification by March 30. The Board fully understands its statutory duty and will endeavor to issue decisions by this deadline for all timely and complete applications filed by hospitals. The statute does not provide any basis for the automatic approval of a hospital's request for redesignation.

At the same time, we recognize that in its first year of operation, the MGCRB has been inundated with applications for reclassification and, as a result, it is possible that the MGCRB may not be able to issue decisions on every application by March 30. If this occurs, we will base the FY 1992 proposed wage index and budget neutrality adjustment on the cases that have been decided by March 30. However, we anticipate that all decisions will be made and the administrative review process completed in time for all decisions to be reflected in the final rule setting forth the FY 1992 prospective payment rates for Medicare inpatient hospital services.

Comment: Several of the timeframes set forth in the interim final rule are not fair to hospitals. In particular, the requirement under § 412.278(a) that a hospital must request Administrator review of a Board decision within 15 days after the MGCRB issues its decision is unduly burdensome and should be changed to "within 15 days of receipt of the MGCRB's decision."

Response: Time is of the essence throughout the MGCRB decision-making and appeals process. Under section 1886(d)(10)(C)(iii)(I) of the Act, the MGCRB must issue its decisions no later than 180 days after October 1, and the Administrator must issue a decision within 90 days of the date of an appeal. Congress specified these very tight timeframes in order to ensure that the effects of reclassifications could be reflected in the new standardized amounts and wage index values for prospective payment hospitals that go into effect on October 1 of each year. We urge hospitals to both familiarize themselves with, and adhere to, the necessarily tight timeframes for application and appeal. Relaxation of these requirements would jeopardize the ability of the MGCRB and the Administrator to meet their statutory decision-making deadlines.

17. Administrator's review

Under section 1886(d)(10)(C)(iii)(II) of the Act, the Secretary has the authority to review decisions by the MGCRB regarding geographic reclassification or redesignation. The Secretary has delegated this authority to the HCFA Administrator who has redelegated it to the Deputy Administrator. Thus, the Deputy Administrator's review is the final Department review of MGCRB decisions. (For the sake of simplicity, the final Department review of MGCRB decisions which is conducted by the Deputy Administrator is referred to hereafter in this preamble and in § 412.278 as "Administrator's review".)

Prior to the enactment of Public Law 101–508, section 1886(d)(10) of the Act did not specifically address HCFA's authority to review and MGCRB decision at the discretion of the Administrator or the Secretary. Accordingly, in the interim final rule, the Secretary delegated to the MGCRB the authority to issue final decisions on applications for geographic reclassification, unless the MGCRB's decision is appealed to the Administrator by a hospital. However, we asserted that nothing in this delegation to the MGCRB prejudiced the Secretary's authority to amend the delegation at some future date and to delegate the authority to review all MGCRB decisions to the Administrator of HCFA or elsewhere.

Subsequently, as noted in section IV of this preamble, section 4002(h)(2)(B)(iv) of Public Law 101–508 amended section 1886(d)(10)(C)(iii)(II) of the Act by deleting the first two sentences, which read:

> A decision of the Board [MGCRB] shall be final unless the unsuccessful applicant appeals such decision to the Secretary by not

later than 15 days after the Board renders its decision. The Secretary in considering the appeal of an applicant shall receive no new evidence but shall consider the record as a whole as such record appeared before the Board.

Section 4002(h)(2)(B)(iv) of Public Law 101-508 further amended section 1886(d)(10)(C)(iii)(II) of the Act to require that the appeal of MGCRB decisions be subject to section 557(b) of the Administrative Procedure Act. Section 557(b) of the Administrative Procedure Act specifies that:

" * * * When the * * * [MGCRB] makes an initial decision, that decision then becomes the decision of the agency without further proceedings unless there is an appeal to, or review on motion of, the agency within time provided by rule. On appeal from or review of the initial decision, the agency has all the powers which it would have in making the initial decision except as it may limit the issues on notice or by rule * * *"

In response to the provisions of Public Law 101-508, we have revised § 412.278 to incorporate procedures for discretionary review by the Administrator. For those instances in which the Administrator decides to review MGCRB decisions, the process is as follows:

• Under § 412.278(c)(1), the Administrator has the discretion to review any final decision of the MGCRB.

• Section 412.278(c)(2) specifies that if the Administrator decides to review the decision, the Office of the Attorney Adviser (OAA) will promptly send a notice of review to the hospital and to HCFA and will indicate the particular issues to be considered. The notice will include copies of any comments submitted to the Administrator by HCFA staff concerning the MGCRB's decision.

• Under § 412.278(c)(3), the hospital has 15 days from receipt of this notice to submit its comments to the Administrator, with a copy to HCFA.

• Section 412.278(d) sets forth the criteria for discretionary review by the Administrator. In deciding whether to review an MGCRB decision, the Administrator will normally consider whether it appears that:

—The MGCRB made an erroneous interpretation of law, regulation or HCFA Ruling;
—The MGCRB's decision is not supported by substantial evidence;
—The case presents a significant policy issue based in law or regulation, and review may be needed to clarify a provision in law or regulation;
—The MGCRB's decision requires clarification, amplification or an alternative legal basis; or
—The MGCRB has incorrectly extended its authority beyond that provided by law, regulation or HCFA Ruling.

• For cases reviewed at his or her discretion, the Administrator must issue a decision in writing within 105 days of the MGCRB decision. The statute does not prescribe a period for the Administrator to issue decisions on cases reviewed at his or her discretion. However, we are requiring that the Administrator's decision be issued within 105 days of the MGCRB decision to ensure that these cases are decided within a time period consistent with those decided on appeal, that is, the 15 days in which the hospital may appeal the MGCRB's decision to the Administrator plus the 90-day review period.

Public Law 101-508 did not necessitate changes in the procedures set forth in the interim final rule (under § 412.278) for appeals at the request of hospitals. As noted in section IV of this preamble, the Conference Committee Report accompanying Public Law 101-508 directed that the Secretary retain the requirement that a hospital must appeal an MGCRB decision to the Secretary within 15 days of the decision. (H.R. Rep. No. 964, 101st Cong. 2nd Sess. 715 (1990).) In addition, we have retained in this rule the provision in § 412.278(c) prohibiting the consideration of new evidence by the Administrator in reviewing an MGCRB decision. The prohibition on new evidence (which is redesignated in this final rule with comment period to § 412.278(f)(1)) is necessary because the Administrator must issue a decision within 90 days from the date of the hospital's appeal request or, in cases decided pursuant to discretionary review authority, within 105 days from the date of the MGCRB decision. If the Administrator were permitted to consider new evidence on appeal, it is unlikely that he or she would be able to satisfy these requirements. As stated above in a response to comment, these tight timeframes are needed in order to permit the effects of reclassifications to be reflected in the new standardized amounts and wage index values for prospective payment hospitals that go into effect on October 1. In addition, the regulations already specify in great detail what documentation is necessary to support a request for reclassification. That documentation should all be included with the original application.

However, as detailed below, we have redesignated portions of § 412.278 to accommodate the addition of the new provisions regarding discretionary review by the Administrator. We have also revised former § 412.278(c)(3) to provide at § 412.278(f)(2)(i) that the Administrator must "issue" a decision within 90 days of a hospital's request for review, rather than "furnish" the decision to the hospital within 90 days.

Under § 412.278(a), if a hospital is dissatisfied with the MGCRB's decision regarding its geographic classification, the hospital may request the Administrator to review the decision. In addition, a hospital may request that the Administrator review the dismissal of its application by the MGCRB. In conjunction with considering the request for review, the Administrator may also review rulings made by the MGCRB regarding admissibility of evidence, and if the Administrator decides that an MGCRB evidentiary ruling is erroneous, the Administrator has the authority to consider the previously excluded evidence or exclude (or assign a different probative value to) previously considered evidence.

Under § 412.278(b)(1), "the hospital's request for review must be in writing and sent to the Administrator, in care of the Office of the Attorney Advisor, as follows: Office of the Attorney Advisor, Room 669, East High Rise Building, 6325 Security Blvd., Baltimore, MD 21207. Re: Appeal of MGCRB Decision.

The request must be received by the Administrator within 15 days after the date of the MGCRB's decision. A request for Administrator review filed by facsimile or other electronic means will not be accepted. The hospital must also mail a copy of the request for Administrator review to HCFA's Office of Payment Policy at the following address: Office of Payment Policy, Division of Hospital Payment Policy, Room 1-H-1, East Low Rise Building, 6325 Security Blvd., Baltimore, MD 21207. Re: Appeal of MGCRB Decision.

Under § 412.278(b)(2), the request for review may contain proposed findings of fact and conclusions of law, disagreements with the MGCRB's decision, and supporting reasons therefore.

Under § 412.278(b)(3), within 15 days of receipt of the hospital's request for review, HCFA may submit to the Administrator, with a copy to the hospital, written comments concerning the hospital's request. Section 412.278(b)(4) allows the hospital 10 days from receipt of HCFA's comments to submit a response to the Administrator. As noted above in a response to comment, new § 412.278(e) provides for additional communication safeguards applicable to the Administrator's review of an MGCRB decision both at a hospital's request or at his or her discretion.

Under 412.278(f), the Administrator may not consider any new evidence and is to issue a decision based only upon the record as it appeared before the MGCRB. The Administrator's decision is issued in writing to the party with a copy to HCFA not later than 90 days following receipt of the hospital's request for review or not later than 105 days following the MGCRB's decision for cases reviewed at the discretion of the Administrator. The Administrator's decision is final and is not subject to judicial review.

Comment: According to § 412.278(c) of the interim final rule, the Administrator's review of an MGCRB decision is to be based only upon the record as it appeared before the MGCRB. This requirement precludes a hospital from giving reasons why it believes the MGCRB decision is incorrect.

Response: Although the Administrator is constrained from considering any new evidence in reviewing the MGCRB decision, a hospital's request for review may contain proposed findings of fact and conclusions of law, as well as other supporting reasons for disagreement with the MGCRB decision. Both the preamble to the interim final rule (55 FR 36759) and § 412.278(b)(2) of the regulations discuss the permitted contents of a hospital's review request.

18. Representation

The rules concerning representation are set forth in § 412.280. A hospital may be represented by legal counsel or any other person appointed to act as its representative with regard to any application filed by a hospital, which is under consideration by the MGCRB or the Administrator.

A representative appointed by the hospital may accept or give on behalf of its client any request or notice relative to any application before the MGCRB or the Administrator. A representative is entitled to present evidence and allegations as to facts and law regarding a hospital application to the same extent as the party he or she represents. Notice of any action or decision sent to the representative of a party has the same effect as if it had been sent to the party itself.

B. Criteria and Conditions for Geographic Reclassification

As required by section 1886(d)(10)(D) of the Act, the September 6, 1990 interim final rule with comment period set forth guidelines to be used by the MGCRB in making its decisions on requests for geographic reclassification. Guidelines concerning the criteria and conditions for hospital redesignation are located in §§ 412.230 through 412.236. The purpose of these criteria is to provide direction, to both the MGCRB and those hospitals seeking geographic reclassification, with respect to the situations that merit an exception to the rules governing the geographic classification of hospitals for purposes of payment under the Medicare prospective payment system.

Section 1886(d)(10)(D) of the Act specifies that the criteria address the following:

- The comparison of wages, taking into account occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.
- The determination of whether the county in which the hospital is located should be treated as being a part of a particular MSA.
- The consideration of information provided by an applicant with respect to the effects of the hospital's geographic classification on access to inpatient hospital services of Medicare beneficiaries.
- The consideration of the appropriateness of criteria used to define NECMAS.

1. General Principles

The following general principles apply to the criteria:

- The MGCRB has the authority to make decisions with respect to reclassification from a rural area to an urban area or another rural area and reclassification from an urban area to another urban area.
- In order to be reclassified, a hospital, or group of hospitals, must be located in a county or MSA that is adjacent to the MSA or rural area to which that hospital or group of hospitals seeks reclassification. That is, the border must be contiguous. However, this requirement does not apply with respect to rural referral centers and sole community hospitals that apply for urban redesignation, as explained below.
- Decisions of the MGCRB may be applicable either to a single hospital based on hospital-specific criteria, or to all hospitals in a county based on county-specific criteria. In the latter case, an application must be signed by all hospitals in the county that are subject to the prospective payment system.
- Although all hospitals located in a qualifying rural county could be deemed a part of an adjacent MSA or NECMA for payment purposes under the prospective payment system, the population of that county would not be included in the MSA or NECMA for purposes of determining whether the MSA or NECMA is a large urban area (that is, an MSA with a population of at least 1,000,000 or an NECMA with a population of at least 970,000). The MGCRB does not have the authority to designate areas as large urban areas by including the population of additional counties.
- It is the responsibility of the hospital to acquire and furnish data to support its application. In general, only substantiated data from an official source are acceptable for use by the MGCRB in issuing its decisions. Moreover, where data are available on a national basis, the national data must be used since all hospitals have equal access to these data sources. For example, with respect to population and commuting data, the Bureau of Census is the only national data source available to all hospitals. Therefore, local population and commuting studies would not be acceptable since these studies may not be consistent with Census Bureau data and are not available to all hospitals on a national basis.

With respect to hospital-specific data, for the most part only data used in preparing a hospital's Medicare cost report or HCFA wage survey form would be acceptable, since these data were used in official documents submitted by hospitals and have generally been substantiated by the fiscal intermediaries. In the September 6, 1990 interim final rule with comment, we provided the following list of acceptable data sources (55 FR 36760):

—Financial Data

Hospital-specific data—Most recently settled and most recently filed cost report data.

Data for other hospitals—Appropriate published **Federal Register** final rule revisions to the prospective payment system rates for Medicare inpatient hospital services; and data from the most recent HCFA wage survey.

HCFA wage data can be obtained by contacting Lana Price at the following address: Office of Payment Policy, Division of Hospital Payment Policy, Room 1-H-1, East High Rise Building, 6325 Security Blvd., Baltimore, MD 21207, (301) 966-4534.

—Occupational Data

Bureau of Labor Statistics, Industry Wage Survey: Hospitals.

Occupational mix data from the American Hospital Association annual survey data "Hospital Personnel by Occupational Category, Annual Survey of Hospitals."

AHA wage data can be obtained by contacting Ollie Williams of the AHA at (312) 280–5991.

—Access, Appropriateness and Population

Residence of employees—verified by hospital payroll records.

Population, population density, and commuting data—Bureau of the Census, specifically, population surveys and estimates made periodically by the Bureau of the Census.

The MGCRB may not consider commuting data that are more recent than the most recent decennial census because the Bureau of Census does not update commuting data more often than once every ten years. However, the MGCRB will consider requests based on more recent Bureau of Census data regarding population density, population growth, and changes in designation of urbanized areas.

Comment: HCFA's reliance in the reclassification guidelines on a historical cost-based methodology is biased since it perpetuates payment inequities and rewards inefficiency. Hospitals should be able to qualify for reclassification based on various demonstrations of comparability, such as range of services, occupations, case-mix index, or, for a rural referral center, service certifications.

Response: Under the prospective payment system, the geographic classification system is intended to group hospitals which face similar market conditions. Urban hospitals tend to have higher costs even after accounting for wage differences, case mix, teaching intensity and services to low income patients. The higher costs are largely attributable to differences in the mix and volume of services provided that reflect a wider range of available services and differences in practice patterns. Thus, hospitals in urban areas tend to treat relatively more complex cases, employ more technologically-intensive treatment practices, and offer a broader range of services. Rural hospitals tend to treat less complex cases and use fewer and less costly resources. Within each labor market area, hospitals are assumed to compete for employees.

We believe that the geographic reclassifications should be limited to those hospitals which are disadvantaged by their current geographic classification because they compete with the hospitals that are located in the geographic area to which they seek to be reclassified. We believe it is appropriate for the reclassification guidelines pertaining to the standardized amount to have a direct relationship to the hospital's costs per case since it is a measurement of whether the hospital is providing services that are more comparable to those provided by an urban hospital or a rural hospital. We do not have standard measurements that would allow us to compare directly and readily differences in service intensity that are not accounted for by the DRG case mix measurement. The use of cost per case as the measure rests on an underlying assumption that the hospital is operating efficiently and that costs are comparable because it is treating a similar mix of patients with comparable resources.

Regarding reclassification for purposes of the wage index, we believe that the comparison of the hospital's average hourly wage with the average hourly wage of the area to which it seeks reclassification is the appropriate measure of whether it competes with hospitals in the adjacent area for employees.

With respect to the concern that the guidelines for reclassification perpetuate historical payment inequities, we do not believe that the geographic reclassifications under section 1886(d)(10) are intended to address the broader issue of payment equity and the urban/rural differential in the standardized amounts under the prospective payment system. We believe that section 1886(d)(10) addresses those situations where a hospital competes in the same market with hospitals in an adjacent area; that is, the hospital is more like the hospitals in the adjacent area than the hospitals in its geographic area. We recognize that in relying on cost comparisons in making that determination, hospitals with lower costs per case or wage costs will not be able to qualify for reclassification. However, we do not believe it would be appropriate to reclassify these hospitals since their current cost level does not indicate that they are comparable to hospitals in the adjacent area. The broader issue of urban/rural differentials was addressed by section 4002(c) of Public Law 101–508, which phases out the differential between the rural and other urban standardized amounts by FY 1995.

Comment: The regulations set forth in the September 6, 1990 interim final rule do not allow the Board enough latitude to make decisions concerning the reclassification applications. Specifically, the Secretary was directed to issue "guidelines", rather than the more strict "criteria" contained in the interim final rule. One commenter suggested that HCFA establish an administrative resolution process to expedite decisions on cases that clearly met the guidelines for reclassification.

Response: The legislative history of section 1886(d)(10) of the Act does not provide guidance as to Congressional intent concerning the type of circumstances that would merit reclassification and, therefore, the exact nature and extent of guidelines that the Secretary should establish. We note that Public Law 101–508 included a number of revisions to section 1886(d)(10) of the Act; however, none of the provisions in Public Law 101–508 dealt with the specific criteria included in the interim final rule. While the language in the Conference committee report accompanying Public Law 101–508 (H.R. Rep. No. 964, 101st Cong., 2nd Sess. 715 (1990)), did suggest an alternative threshold with respect to the wage criteria and clarified Congressional intent concerning joint applications for urban to urban reclassifications, there was no indication that the establishment of specific guidelines and numeric thresholds were contrary to Congressional intent. Moreover, the fact that the Conference committee language did suggest an alternative threshold would imply that the Congress generally endorsed the approach set forth in the interim final rule.

We believe the specific criteria with respect to data requirements and qualifying thresholds are necessary to ensure that all hospitals are treated fairly and consistently. In addition, our goal in establishing the guidelines was to develop a simplified process, whereby hospitals could readily complete their own applications. The numeric thresholds help to facilitate this application process as well as to expedite the determination process. Given the volume of applications, a determination process with less specific criteria would likely be a more time-consuming process and, therefore, would make it less feasible for the MGCRB to meet the March 30 deadline for issuing its decisions. We note that although commenters suggested that the MGCRB be provided with more discretion, these commenters did not suggest alternative guidelines that could be readily applied in a consistent and equitable manner.

Moreover, we believe that the regulations do provide the MGCRB with a substantial amount of latitude both to evaluate applications and render decisions with respect to the acceptability of the documentation submitted to support the reclassification requests. Following are examples from each stage of the process that illustrate

the areas of discretion afforded the MGCRB in the interim final rule:

• *Application process.* The MGCRB has the responsibility to determine if a complete application was filed timely and whether circumstances warrant additional time to submit supplemental information in the case of an incomplete application.

• *Methodology.* Although we have described a methodology that should be followed by hospitals in determining if the various criteria are met, the MGCRB has the discretion to accept an alternative methodology that establishes that the specified criteria are met if the MGCRB determines it is also appropriate. For example, we have established a methodology to determine if the hospital meets the cost criterion for reclassification for purposes of the standardized amount. If a hospital uses a different methodology to make the cost comparison based on acceptable data, the MGCRB may nevertheless determine that the hospital has demonstrated that it qualifies for reclassification.

• *Standardized cost comparison.* The MGCRB has the responsibility to determine if the hospital's costs reported on the hospital's most recently filed cost report appear reasonable and should be used in making the cost comparison.

• *Wage data comparison.* The MGCRB is responsible for determining if the occupational mix categories used by the hospital are reasonable.

• *Special access rule.* The MGCRB has discretion in defining the closest MSA for purposes of SCH and RRC reclassifications.

• *Renewals.* Depending on its assessment of the individual hospital or group of hospitals seeking reclassification, the MGCRB has the discretion to grant a reclassification for one year only, to provide for an automatic one-year renewal, or to provide for an abbreviated application process in the second year.

We note that if we were to expand the variables which the MGCRB may consider in determining if reclassification is appropriate, we would provide the MGCRB with authority both to deny certain reclassifications even though the specified criteria are met, as well as to permit certain reclassifications even though the specified criteria are not met. The guidelines that we have established are quite liberal, as evidenced by the volume of applications from hospitals contending that they meet the current criteria. Therefore, we believe that there is a greater likelihood that the MGCRB would determine, if given the discretion, that in particular cases the specified criteria are too lenient rather than too restrictive. For example, the cost comparison for purposes of the standardized amount is based on an assumption that the hospital is operating efficiently. There may be cases where a hospital's higher costs per case result from low occupancy rather than the volume and mix of services it provides. Another example is a situation where there is no evidence that access to care is threatened by a hospital's current labor market classification because Medicare payments more than adequately compensate the hospital for the services it provides to Medicare patients. Since aggregate payment levels are unaffected by geographic reclassifications, we believe that our responsibility to other hospitals to protect against inappropriate reclassifications is equal to our responsibility to assure that hospitals meriting reclassification are afforded proper consideration.

Accordingly, we plan to evaluate the extent and appropriateness of reclassifications under the current criteria. If our analysis indicates that specific criteria do not result in appropriate reclassifications because they are either too liberal or too stringent, or do not allow the MGCRB adequate discretion, we will propose revisions to the guidelines for future application cycles.

In establishing the MGCRB, Congress expressed its clear intent that the MGCRB make the initial decision on hospital requests for reclassification. Given the MGCRB's clear responsibility to make decisions concerning reclassification applications and the degree of judgment required of the MGCRB in doing so, we do not believe that HCFA should have any initial decision-making authority in a hospital's request for reclassification. Thus, an administrative review process to expedite decisions on cases that appear on the surface to meet the guidelines would not be appropriate. However, we note that the MGCRB has the authority to establish necessary and appropriate procedures that are consistent with the statute and regulations. Thus, the Board would not be precluded from establishing internal procedures to expedite decisions on certain cases.

Comment: The MGCRB interim final rule was flawed in that it failed to address the disparate wage levels paid by inner-city hospitals and suburban hospitals within an existing urban area. Specifically, the guidelines do not authorize the MGCRB to recognize the substantially higher wages paid by hospitals in "core" urban areas compared to hospitals in the suburban "ring" areas within the existing MSAs and NECMAS. When Congress established the MGCRB under section 1886(d)(10) of the Act, it intended to create a mechanism under which any prospective payment hospital could request a change in geographic reclassification, without restricting such reclassifications to the existing MSAs or NECMAs. By not expressly granting the MGCRB the authority to recognize and approve reclassification requests by city hospitals, HCFA has unreasonably restricted the MGCRB's authority.

Response: When Congress added section 1886(d)(10) to the Act its intent was to allow hospital reclassification from one established geographic area to another. Congress made no provision for the establishment of new labor market areas by the MGCRB. In directing the Secretary to establish guidelines to be utilized by the MGCRB in furnishing its decisions, Congress specified in section 1886(d)(10)(D) of the Act that the guidelines address reclassifications from one labor market area to another; reclassifications from one area to a particular MSA; the effects of geographic classification on access to care; and the appropriateness of the criteria used to define NECMAs. Had Congress intended that the MGCRB be given authority to redefine labor market areas, the Secretary would have been directed to establish such guidelines under section 1886(d)(10)(D) of the Act.

Section 1886(d)(3)(E) of the Act provides that the Secretary shall adjust the proportion of hospitals' costs which are attributable to wages and wage-related costs for area differences in hospital wage levels by a factor established by the Secretary. Under this authority, the Secretary establishes labor market areas in order to adjust for different area wage levels. In contrast, the MGCRB's function is to consider whether hospitals are appropriately classified into the labor market areas established by the Secretary. Absent specific Congressional direction, we believe that it would be inappropriate for the Secretary to delegate to the MGCRB the authority to establish guidelines that would give the MGCRB jurisdiction to consider requests to establish new labor market areas.

Comment: The interim final rule did not provide sufficient flexibility in terms of the data sources permissible for use with hospital reclassification requests. Hospitals should be able to use the Medicare cost report, as well as other alternative data sources such as local survey data, market research and hospital payroll records. One commenter asserted that in view of

perceived inaccuracies in the American Hospital Association (AHA) Annual Survey data, other data sources should be used.

Another commenter suggested that a hospital should be able to submit any evidence it chooses to the MGCRB, and the MGCRB should then decide whether such evidence is relevant. Further, a hospital should be allowed to submit relevant evidence that becomes available after the deadline for filing an application.

Response: While it is true that no data source is perfect, consistency must be a requirement for the data used for reclassification purposes. In order to ensure that no individual hospital or groups of hospitals can obtain an unfair advantage in the reclassification process, it is necessary to require that hospitals rely on data that are uniformly available throughout the nation. While the local data in one area may be valid, the inability of another area to access the same data introduces a bias to the process. Also, the data must be verifiable by the MGCRB. Therefore, local commuting surveys, market research, or individual hospital payroll records other than those specified in § 412.230 are not acceptable.

With respect to the wage data, it is essential to use standard data for the same time period so that the wage comparisons can appropriately reflect labor costs for the same point in time. The Medicare cost report cannot be used because it does not show paid hours. Hospital payroll data for other than the cost reporting period ending in 1988 would not be audited or otherwise verified and therefore cannot be used. Other than the Bureau of Labor Statistics' data, there are no alternative occupational mix data sources to the AHA Annual Survey that are comparable across areas and can be consistently applied.

Section 412.230(e) provides that only hospital-specific wage data from the most recent HCFA hospital wage survey may be used, so that the data can be verified. An individual hospital's wage survey data are for its cost reporting period ending in calendar year 1988. The individual hospital wage data are adjusted to a common point in time, in calendar year 1988, in constructing the wage index. Thus, the average hourly wage for the individual hospital is for its cost reporting period ending in calendar year 1988 (for example, July 1, 1987 through June 30, 1988), whereas the average hourly wage for the geographic area to which the hospital seeks reclassification is for calendar year 1988. The interim final rule was silent with regard to how the hospital-specific wage survey data should be adjusted to be comparable to the calendar year 1988 hourly wage amount when the hospital's cost reporting period is on other than a calendar year basis. We understand that some hospitals chose to submit calendar year 1988 payroll data in lieu of adjusting their hospital-specific wage survey data to its calendar equivalent in making the occupational mix comparison.

Since the interim final rule did not address this issue, we do not believe it would be appropriate to require on an across-the-board basis that these hospitals reconstruct their hospital-specific wage survey data by occupational category. Therefore, we are providing a limited exception that would allow the MGCRB to consider hospital payroll data based on calendar year 1988 if, in the MGCRB's judgment, the hospital has submitted sufficient documentation to substantiate that it is providing accurate and complete wage data. This exception applies only with respect to reclassification applications based on the occupational mix wage comparison that would be effective for FY 1992. For subsequent reclassification determinations and for wage index comparisons that do not involve occupational mix, only hospital-specific wage survey data may be utilized. Given the limited and temporary nature of this exception, we are not revising the regulation to incorporate the exception.

Under § 412.264(d), the MGCRB has the authority to rule upon the admissibility of evidence, and § 412.264(b) provides that the MGCRB is not limited by the rules of evidence applicable to court procedures. In general, however, we expect that the Board will only consider substantiated data from an official source in making its decisions. Also, in view of the tight timeframes the MGCRB must meet in its decision-making process, it is generally constrained from considering evidence submitted after the filing deadline. However, as explained in section V.B.6 above, we have revised § 412.256(c)(2) to provide that the MGCRB may, for good cause, grant a hospital an extension beyond the filing deadline to complete its application.

Comment: The interim final rule does not address whether a reclassification based on the commuting data would be retroactive to the first Federal fiscal year after the date of the 1990 census, that is, FY 1991.

Response: As specified in section 1886(d)(10)(C)(ii) of the Act, hospitals must submit requests for reclassification not later than the first day of the Federal fiscal year preceding the Federal fiscal year for which the decision will be effective. (However, as stated above, for reclassifications effective for Federal fiscal year 1992, the filing deadline was extended to November 6, 1990.) Accordingly, all reclassifications granted by the MGCRB become effective on a prospective basis only. Therefore, all reclassifications granted by the MGCRB during a fiscal year will be effective prospectively for discharges occurring on or after October 1 of the following fiscal year even if data from earlier years are used to support the reclassification request.

2. General Reclassification Guidelines

An individual hospital may seek reclassification for purposes of its wage index, standardized amount, or both. The September 6, 1990 interim rule set forth separate guidelines for each situation. A hospital that is reclassified from one area to another area only for purposes of the wage index is not considered urban for any other purpose than its labor market area designation. A hospital seeking reclassification for purposes of its wage index must demonstrate that its wages are comparable to the wages paid in the geographic area to which it requests reclassification.

A hospital that is reclassified only for purposes of its standardized amount is considered urban for all purposes except use of the wage index under 1886(d)(2)(D) of the Act. With respect to a reclassification request for purposes of a hospital's standardized amount, the hospital must demonstrate that its costs per case are more comparable to the amount the hospital would be paid if it were reclassified than the amount it is currently paid.

Except for rural referral centers and sole community hospitals, a hospital must be located in a county that is adjacent to the rural area or urban area to which it seeks redesignation. In addition, any individual hospital seeking reclassification from one area to another must meet one of the following proximity guidelines.

• *Distance:* A rural hospital requesting redesignation to an urban area or a rural area in another State must be located no more than 35 road miles from the border of the area to which it is requesting redesignation. An urban hospital requesting redesignation to another urban area must be located no more than 15 road miles from the border of the urban area to which it is requesting to be redesignated. For this purpose, as defined in § 412.92(c)(1), the term road miles means "the shortest distance in miles measured over improved roads. An improved road for

this purpose is any road that is maintained by local, State, or Federal government entity and which is available for use by the general public."

• *Residence of employees:* A hospital requesting redesignation from one geographic area to another area must demonstrate that 50 percent or more of its employees reside in zip code areas located within the area to which it is requesting to be redesignated.

Comment: The requirement that a hospital must meet both adjacency and mileage criteria is too restrictive. If a hospital meets the mileage criteria, the requirement that the hospital be located in an adjacent area should be waived. In addition, hospitals should be able to qualify for redesignation based on characteristics such as driving time and various demonstrations of comparability to the MSA, such as range of services. The MGCRB should also consider requests that demonstrate that a hospital is not similar to the hospitals located in its immediate area. Finally, what are acceptable means for the verification of road miles for purposes of meeting the mileage criteria? Response: There is ample precedent for requiring that hospitals seeking reclassification to a different geographic area be located in a county that is adjacent (that is, contiguous) to that area. This is consistent with the way urban geographic areas are defined by OMB, which considers only adjacent areas in determining which counties are grouped into a given MSA. The adjacency requirement is also consistent with the special provision in section 1886(d)(8)(B) of the Act that allows hospitals located in certain rural counties that are adjacent to more than one MSA to be deemed urban for purposes of the wage index and standardized amounts. Since urban labor market areas are defined in terms of contiguous counties it is appropriate to require that a hospital be located in an area that adjoins the geographic area to which it is requesting reclassification.

The mileage criteria included in the proximity guidelines at § 412.230(b) were established to ensure that a hospital located in an adjacent county is also within a reasonable distance from the area to which it seeks redesignation and, thus, could be expected to compete in the same market area for both its employees and hospital inpatients. In some cases, a county may cover an unusually large area. The mileage criteria prevent these hospitals from reclassifying to areas that are not within their competitive marketplace.

Alternatively, hospitals that do not meet the mileage criteria can demonstrate economic ties to the area in which they are seeking redesignation under the proximity guideline at § 412.230(b)(2), which requires that at least 50 percent of the hospital's employees reside in the adjacent area. The use of numeric guidelines lends objectivity to the reclassification decision-making process and ensures that hospitals are treated uniformly. The guidelines set forth in the interim final rule were intended to assist hospitals in demonstrating that they do in fact compete with hospitals in another geographic area.

Finally, in order to demonstrate that it meets the guidelines set forth in the regulations, a hospital seeking reclassification must provide enough information to enable the MGCRB to make a reliable determination on the case. An official road map should be sufficient if it clearly shows that the hospital is located within the mileage limit. If the hospital is close to the mileage limit, and a map does not clearly show its location, the hospital may choose to verify the distance through the use of a road test. However, it is up to the MGCRB to determine if the hospital has adequately demonstrated that it meets the requirements for reclassification.

Comment: In the interim final rule, the references for "the necessary geographic relationship" are different in paragraphs (d) and (e) of § 412.230. Section 412.230(d) references § 412.230(b) while § 412.230(e) references § 412.230(a).

Response: We are correcting this omission in this final rule with comment period. Since both the adjacency and proximity guidelines must be met in order to qualify for redesignation (unless the facility is a rural referral center or a sole community hospital), we have revised paragraphs (d) and (e) of § 412.230 to specify that both paragraphs (a) and (b) of § 412.230 must be met to establish the necessary geographic relationship.

Comment: The qualification guideline at § 412.230(b) regarding the residence of employees criteria is too strict. This guideline states that a hospital that does not meet the proximity criteria for mileage may qualify if 50 percent or more of the hospital's employees reside in the area to which the hospital is seeking redesignation.

Response: A significant level of economic integration is necessary for reclassification. In cases where the mileage proximity criteria are met, the limited distance between the provider and the area to which reclassification is requested is sufficient evidence of economic integration. To demonstrate a significant level of economic interaction in cases where the mileage criteria are not met, there must be convincing evidence of interaction between the hospital and the area to which it is applying. We determined, and continue to believe, that a commuting level of 50 percent or more indicates this significant level of economic interaction with the area to which the hospital is seeking redesignation.

3. Special Access Rule for Rural Referral Centers and Sole Community Hospitals Seeking Reclassification

Section 1886(d)(10)(D)(i)(III) of the Act requires that the guidelines include criteria for considering information provided by a hospital with respect to the effects the hospital's geographic classification has on access to inpatient hospital services for Medicare beneficiaries. Generally, access to care is not an issue except for those areas serviced by rural referral centers (RRCs) and sole community hospitals (SCHs). Accordingly, we provide special access guidelines applicable to RRCs and SCHs at § 412.230(a)(4).

We do not require RRCs or SCHs to be located in counties adjacent to an urban area in order to be reclassified urban since their continued financial viability is necessary in order to preserve access to needed services for Medicare beneficiaries residing in these providers' service areas. Similarly, the proximity requirement does not apply for RRCs and SCHs because of the need to maintain access to tertiary care for Medicare beneficiaries in relatively isolated rural areas. RRCs and SCHs that compete with urban areas for labor, or which experience costs per case comparable to urban hospitals, have the opportunity to qualify for the urban wage index, and, where applicable, the large urban or other urban payment rate

If an RRC or an SCH can qualify for reclassification on the basis of its wages or costs, then it can apply for reclassification based on the need of the institution to provide access to care for Medicare beenficiaries. The requirement that the hospital be located in a county that is adjacent to an MSA or NECMA does not apply. However, if the MGCRB finds that the hospital qualifies for urban redesignation, then it must be redesignated as part of the MSA closest to the hospital.

Comment: Are SCHs and RRCs precluded from applying under the general adjacency and proximity criteria for reclassification in § 412.230(a) (2) and (3)?

Response: The special access provisions in § 412.230(a)(4) are intended to provide a means of reclassification for SCHs and RRCs that

are unable to meet the general adjacency and proximity criteria. SCHs and RRCs may also apply for reclassification under the general adjacency and proximity criteria in § 412.230(a) (2) and (3), in which case they would not be limited to reclassification to the closest urban area, as required under the special access provisions in § 412.230(a)(4).

Comment: Section 412.230(a)(4)(iii) provides for the redesignation of an SCH or an RRC to the closest urban area. However, the definition being used for determining the closest area needs to be changed. Instead of measuring the distance to the closest MSA based on the MSA border, HCFA should measure the distance to the border of the core urbanized area of the MSA as defined by the Bureau of the Census. Section 1886(d)(2)(D) of the Act defines urban areas for the purposes of the prospective payment system as areas "within a Metropolitan Statistical Area * * *." The MSA that is closest by this alternative measurement is the MSA with which the RRC or SCH most closely competes for labor. Further, accurate measures of the closest MSA are difficult to determine, and it is possible that an MSA may be closer in mileage but farther away by travel time, due to the quality of the roads.

Response: MSA borders are defined on county lines, and these are the borders that are recognized in all cases for prospective payment system purposes. To recognize a different set of borders for MGCRB purposes would be inappropriate. We note that areas "within an MSA" constitute all areas within the MSA, and not just the core urbanized area. For applications based on the special access provisions, the MGCRB has the discretion to identify cases where travel time is a more appropriate measure of distance than is mileage, and we foresee circumstances where time would be the appropriate measure. For example, if an RRC is 55 miles from one MSA using a four-lane highway, and 45 miles from a second MSA using a two-lane road, it may well be the case that the more distant MSA is the MSA more appropriate for the facility's reclassification.

4. Cost Guidelines for a Hospital Seeking Reclassification for Purposes of its Standardized Payment Amount.

With respect to costs per case, a hospital qualifies for reclassification for purposes of its standardized amount if it can demonstrate that its costs per case are more comparable to the amount the hospital would be paid if it were reclassified than to the amount it is paid under its current classification. Accordingly, in order to qualify for reclassification for purposes of its standardized payment amount, § 412.230(d)(2) requires that a hospital demonstrate that its case-mix adjusted cost per discharge is at least equal to its current rate plus 75 percent of the difference between that rate and what it would receive as a redesignated hospital.

In the September 6, 1990 interim final rule, we provided a wage comparison example (55 FR 36761) and a cost comparison example (55 FR 36762). In response to comments received on the interim final rule, we provide a revised cost comparison example below and a revised wage comparison example in section V(B)(5) below regarding wage guidelines.

Comment: The example published at 55 FR 36762 for calculating the standardized amounts for cost comparisons should be clarified. In particular, clarification is needed in the following areas: how to determine cost per discharge, which case-mix index should be used, how to pro-rate the standardized amount to match up with different cost reporting periods, and which wage index value should be used in these calculations.

Response: For the convenience of the reader, we have provided below a revised cost comparison example for determining whether a hospital qualifies for redesignation for purposes of its standardized amount.

The purpose of the cost comparison is to determine the relationship between the hospital's costs per case with the per case payment the hospital would receive with and without redesignation. A difficulty in making the comparison is that the current standardized amounts and payment adjustment factors do not match the period covered by the hospital's most recently filed cost reporting period. To avoid distorting the relationship between the hospital's costs per case and the standardized amount, the hospital-specific adjustment factors (that is, the case-mix index and the disproportionate share patient percentage) and the standardized amount should match the applicable cost reporting period. In addition, the hospital's costs must be reduced to reflect its outlier payments, because the standardized amounts used in the cost comparison do not include outlier payments.

Other payment adjustment factors should be used that will result in the best estimates of comparative payments per case with and without redesignation. The disproportionate share adjustment should be based on the formula that will be effective during the fiscal year for which redesignation is requested. The wage index value to be used depends on whether the hospital is seeking reclassification based solely on the standardized amount or is also seeking reclassification for purposes of the wage index. If the hospital is seeking reclassification for the wage index as well as the standardized amount, the wage index value applicable to the area to which the hospital is seeking redesignation is applied to the standardized amount calculation both before and after reclassification. Otherwise, the hospital's current wage index value is used.

We believe that requests for reclassification for purposes of the wage index and the standardized amount should be considered together, and that the determination of payments per case with and without redesignation for purposes of the standardized amount should reflect the best estimate of the wage index adjustment factor that will be applicable during the fiscal year. To the extent the wage index value after redesignation already accounts for the hospital's higher costs, those costs should not impact on the determination that reclassification for purposes of the standardized amount is appropriate.

Cost Comparison Example

Hospital A is a 170 bed rural hospital located in De Kalb County, Illinois that is applying to be part of the Chicago, Illinois MSA for purposes of both its wage index value and standardized amount. Hospital A's fiscal year ends 06/30/90.

Medicare costs net of passthroughs (Form 2552, Worksheet D-1, Part II, line 54)	$1,753,960
Total Medicare discharges (Form 2552, Worksheet S-3, Column 13, line 8)	400
Disproportionate share patient percentage	.25
Indirect Medical Education (IME) Adjustment Factor	.0618
Case Mix Index (CMI) (from applicable Federal Register document)	1.1000
DRG amount other than Outlier Payments (Form 2552, Schedule E, part A, line 1A)	$1,356,879
Outlier Payments (Form 2552, Schedule E, part A, line 1B)	$41,807

Step 1—Determine Hospital A's cost per discharge reduced for outliers:

A. Medicare costs net of passthroughs divided by total Medicare discharges = Hospital A's cost per case ($1,753,960 ÷ 400 = $4,384.90)

B. Outlier adjustment factor = 1 − (outlier payments divided by DRG amount other than outlier payments) = 0.9692

C. Hospital A's cost per discharge reduced for outliers = Hospital A's cost per case (from

step 1A)×outlier adjustment factor (from step 1B)=$4,384.90×0.9692=$4,249.85

Step 2—Determine Hospital A's case-mix adjusted cost per discharge:

Hospital A's cost per discharge reduced for outliers divided by its case-mix index for the applicable cost reporting period ($4,249.85÷1.1000=$3,863.50)

Since the case-mix index can change from year to year depending upon the service furnished, it is important that the case-mix value correspond to the applicable cost reporting period. To be verifiable, the hospital should use the case-mix index values that are published annually as part of the prospective payment final rule. Hospitals with cost reporting periods other than the Federal fiscal year should prorate the case-mix value to the applicable cost reporting period. Alternatively, a case-mix index value developed by the intermediary may be used, as it is based on data accumulated from Medicare bills for the cost reporting period. A case-mix index value developed by the provider is not acceptable since it cannot be readily verified.

Step 3—Determine the payment Hospital A would receive as a large urban hospital in the Chicago, Illinois MSA:

Hospital A is a rural hospital whose: Disproportionate share adjustment factor=0.0; Indirect medical education adjustment factor=.0616

As an urban hospital, Hospital A's disproportionate share adjustment factor=(0.25−0.202)×0.70+0.0562=0.898

Since four difference standardized amounts from four **Federal Register** documents apply during the period from July 1, 1989 through June 30, 1990, the standardized amount is prorated.

For purposes of this illustration, we have prorated the standardized amount based on the number of months in the cost reporting period in which the applicable standardized amount was in effect. A provider may wish to submit, or the MGCRB may wish to require, a more accurate proration based on the number of calendar days or Medicare discharges that occurred during the period the applicable standardized amount was in effect.

FEDERAL REGISTER DOCUMENT

Date of FR doc.	Effective date	Period covered	Months in effect
09/30/88	10/01/88	07/01/89–09/30/89	3
09/01/89	10/01/89	10/01/89–12/31/89	3
12/29/89	01/01/90	01/01/90–03/31/90	3
04/20/90	04/01/90	04/01/90–06/30/90	3

Date of FR doc.	Chicago, IL		Rural, IL	
	Labor portion	Non-labor portion	Labor portion	Non-labor portion
09/30/88	2520.39	907.78	2281.73	664.15
09/01/89	2660.91	958.11	2403.67	700.19
12/29/89	2664.24	959.31	2500.49	728.39
04/20/90	2663.61	959.08	2500.26	728.33

Hospital A requested and qualifies for reclassification for purposes of the wage index. Therefore, the Chicago, Illinois wage index value (1.0538) should be used to determine the amount that would be payable.

Per discharge payment rate after reclassification equals the sum of the following:

[(Labor portion of standardized amount)×(Wage index value)+(Nonlabor portion of standardized amount)]×(1+DSH+IME)×(Months in effect/12)

For 07/01/89–09/30/89:
($2,520.39×1.0538+$907.78)
× (1+0.0898+0.0616)×(3/12) =$1,025.83

For 10/01/89–12/31/89:
($2,660.91×1.0538+$958.11)
× (1+0.0898+0.0616)×(3/12) =$1,082.94

For 01/01/90–03/31/90:
($2,664.24×1.0538+$959.31)
× (1+0.0898+0.0616)×(3/12) =$1,084.30

For 04/01/90–06/30/90:
($2,663.61×1.0538+$959.08)
× (1+0.0898+0.0616)×(3/12) =$1,084.04

Payment Hospital A would receive as part of the Chicago, Illinois MSA =$4,277.11

Step 4—Determine the payment Hospital A would receive as a rural hospital (after redesignation for purposes of the wage index).

Per discharge payment rate without reclassification for standardized amount equals the sum of the following:

(Labor portion of standardized amount)×(Wage Index Value+(Nonlabor portion of standardized amount)×(1+DSH+IME)×(Months in effect/12)

For 07/01/89–09/30/89:
($2,281.73×1.0538+$664.15)
× (1+0.0616)×(3/12) =$814.42

For 10/01/89–12/31/89:
($2,403.67×1.0538+$700.19)
× (1+0.0616)×(3/12) =$858.09

For 01/01/90–03/31/90:
($2,500.49×1.0538+$728.39)
× (1+0.0616)×(3/12) =$892.65

For 04/01/90–06/30/90:
($2,500.26×1.0538+$728.33)
× (1+0.0616)×(3/12) =$892.57

Payment Hospital A would receive as an Illinois rural hospital =$3,457.73

Step 5—Determine whether Hospital A qualifies for redesignation as part of the Chicago, IL MSA on the basis of its costs.

To qualify, Hospital A's case-mix adjusted cost per discharge (Step 2) must be equal to its payment rate without reclassification (Step 4) plus 75 percent of the difference between that rate and what it would receive as an urban hospital (Step 3).

Rural rate+[75%×(Urban rate−Rural rate)]
$3,457.73+[75%×($4,277.11−$3,457.73)]=$4,072.27

Hospital A's case mix adjusted cost per discharge (Step 2)	=$3,863.50
Hospital A's rural rate plus 75 percent of the difference between that rate and what it would receive as an urban hospital (Step 5)	=$4,072.27

Since the result in Step 2 is less than the result in Step 5, Hospital A does not meet the cost guidelines for purposes of the standardized amount for reclassification as part of the Chicago, Illinois MSA.

Comment: The calculation for the disproportionate share adjustment should be eliminated from the payment computations for urban and rural hospitals because the disproportionate share percentage is an add-on to the prospective payment system rate.

Response: The calculation of the disproportionate share adjustment is needed for an accurate comparison between the hospital's costs per discharge and the per discharge payments it would receive with and without reclassification. The hospital's cost per discharge reflects any impact the hospital's disproportionate share percentage may have on its costs. Since the amount of the disproportionate share adjustment is dependent on the hospital's status as being located in an urban or rural area, it is appropriate to include the disproprotionate share adjustment in the comparisons. Otherwise, the impact that reclassification would have on the hospital's payments per discharge would be distorted.

Comment: When a hospital requests a reclassification based solely on the standardized amount, the hospital should use the wage index value for the geographic area in which it is located.

Response: We agree with the commenter. If a hospital is seeking reclassification only for purposes of the standardized amount, the wage index value for the area to which it wants to be reclassified should not be used in the cost comparison because the hospital's payments will not be determined using this wage index value. Only when a hospital is applying for redesignation based on both the standardized amount and the wage index, should the wage index value for the area to which it is requesting reclassification be used in the cost comparison.

Comment: In calculating the standardized amount, should hospitals use total discharges or Medicare discharges?

Response: Since the standardized amounts are based on Medicare discharges, hospitals should use Medicare discharges and costs in these calculations. Thus, hospitals must use the amount from the Medicare Cost Report Worksheet, Schedule S-3, Column 13, line 8, which represents total Medicare discharges. (See Step 1 of the cost comparison example above.)

Comment: The cost of transfer cases to other prospective payment hospitals should be removed from the calculation for the case-mix adjusted cost per discharge.

Response: As noted above, the number of discharges used in calculating the cost per case calculation comes from the Medicare Cost Report Worksheet, Schedule D-1, Part II, line 55. For cost reporting purposes, a discharge is a formal release of a patient, including transfers. Thus, all transfers count as discharges in calculating the hospital's allowable Medicare cost per discharge. Since a hospital's Medicare cost per discharge represents an average cost, we believe it is appropriate to include all costs and discharges in the computation. This is consistent with the way we compute hospital-specific rates under the prospective payment system. Moreover, any computations adjusting costs and discharges reported on the cost report would not be readily verifiable by the MGCRB.

Comment: A hospital's cost per case should be inflated to match the standardized amounts published for a later period.

Response: When a hospital uses its adjusted cost per discharge to compare the standardized amount under its current classification with that under its requested reclassification, it should use the appropriate standardized rate for the cost reporting period. Thus, there is no need to inflate the cost per case. This methodology allows the decision to be based on actual cost data and avoids the subjectivity and uncertainty inherent in the selection of an appropriate inflation factor.

5. Wage Guidelines for a Hospital Requesting Reclassification for Wage Index Purposes

Under § 412.230(e), a hospital requesting reclassification to an adjacent labor market area for purposes of determining its wage index must demonstrate that its average hourly wage is equal to at least 85 percent of the average hourly wage of hospitals in the labor market area to which it is applying for reclassification. If the hospital's average hourly wage is less than 85 percent of the average hourly wage for the labor market area to which it is requesting reclassification because of a lower occupational mix, the hospital must demonstrate that its average hourly wage weighted for occupational categories is equal to at least 90 percent of the average hourly wage in the MSA, NECMA or State rural area to which the hospital is requesting to be reclassified. Weighting for occupational categories is accomplished by using data that demonstrates the average occupational mix for the labor market area to which the hospital is requesting redesignation and weighting the hospital's average hourly wage by occupational category based on that information. If the hospital's weighted average hourly wage is equal to or greater than 90 percent of that in the labor market area to which it is requesting reclassification, then the hospital may be reclassified for purposes of its wage index.

Comment: Further clarification is needed on the wage comparison example and occupational mix analysis provided in the September 6, 1990 interim final rule at 55 FR 36761.

Response: The wage comparison example used in the interim final rule was unclear because we used a national average hourly wage that applied to an earlier year and wage survey data base. For clarity, we have revised the labor cost comparison and occupational mix analysis as follows:

Wage Comparison Example

Hospital Y is a rural hospital located in Gratiot County, Michigan that requests reclassification as part of the Lansing, Michigan MSA.

A. Labor Cost Computation

Hospital Y's 1988 adjusted average hourly wage=$12.05. (from the computer listing supplied upon request from HCFA)

This figure is found in the column entitled "Inflated AVW" and represents the sum of the following:

Total salaries minus excluded salaries plus home office salaries plus fringe benefits times an inflation factor (to bring all cost reporting periods to a common point) divided by the equivalent hours. The inflation factors are shown in step 4 below.

Average hourly wage for Lansing, Michigan=$14.31 85 percent of $14.31=$12.16 an hour.

Hospital Y cannot demonstrate that its labor costs are 85 percent of the labor costs for Lansing, Michigan. Since Hospital Y cannot meet the labor cost comparison, it submits data to establish that it meets the occupational mix requirement.

B. Occupational Mix Analysis

Step 1—Determine Hourly Wage by Occupational Category

The hospital must determine the categories it will use for the occupational mix calculation. Hospital Y

chooses five occupational category groupings: administrative, registered nurses, other nursing (including licensed practical nurses), therapists and other professionals, and all other personnel. Hospital Y then determines the average hourly wage for each category in its fiscal year for which the wage survey was completed, which for Hospital Y is its cost reporting period ending June 30, 1988.

Category	Salaries	Hours	Average hourly wage
Administrative	$1,860,016	116,251	$16.00
Registered Nurses	1,257,113	100,569	12.50
Other Nursing	6,549,906	595,446	11.00
Therapists and Other Profs.	1,094,951	84,227	13.00
All Other Personnel	4,548,234	758,039	6.00
Totals	15,310,220	1,654,532	

The total salaries and hours match the total salaries and hours reported on Hospital Y's wage survey and reflected in the wage index.

The wage survey data include fringe benefits. If Hospital Y is able to determine fringe benefits by occupational category, the fringe benefit data can be considered with the salary data to determine an hourly amount for wages and fringe benefits combined. Otherwise, an adjustment for fringe benefits is made in Step 3.

Step 2—Determine Occupational Mix-Adjusted Average Hourly Wage

Hospital Y now calculates its occupational mix-adjusted average wage:

Employment category	Hospital wage	MSA occupational mix
Administrative	$16.00×	20%=$3.20
Register Nurses	12.50×	10%=1.25
LPN & other Nurses	11.00×	30%=3.30
Therapist and other professionals	13.00×	25%=3.25
All other personnel	6.00×	15%=0.90
Total		11.90

To calculate the MSA occupational mix percentages, the number of hospital employees in the MSA should be determined for each of the occupational categories used in the wage comparison. For this purpose, each part-time employee (PTE) counts as 0.5 full time employee (FTE). Thus, the occupational mix percentage for a given category equals the sum of the number of MSA FTEs in the occupational category plus one-half of the MSA PTEs in the category divided by the total number of FTEs plus one-half of the PTEs, totalled across all allowable categories.

Step 3—Fringe Benefit Adjustment

Hospital Y cannot determine fringe benefits for each employment category, so it calculates a fringe benefit factor to apply to the occupational mix-adjusted average wage as follows:

Fringe benefit factor equals fringe benefits reported on wage survey divided by salaries reported on wage survey.

$1,828,959 / $15,310,220 = 0.11946

The average hourly wage, including fringe benefits, adjusted for occupational mix, will then be (1 + fringe benefit factor) × average hourly wage, adjusted for occupational mix.

Occupational Mix Adjusted Average Hourly Wage, Including Fringe Benefits = $13.32

$11.90 × 1.11946 = $13.32

Step 4—Inflation Factor Adjustment

Hospital A must determine its inflation factor adjustment by determining the inflation factor applicable to the midpoint of the cost reporting period from the table below. Hospital A then multiplies the applicable inflation factor by the Occupational Mix Adjusted Average Hourly Wage Adjustment Amount (including fringe benefits) derived in Step 3.

Cost reporting period is 7/1/87 through 6/30/88

Midpoint of cost reporting period is 12/31/87

Applicable inflation factor (from table below) = 1.033150521

Occupational Mix Adjusted Average Hourly Wage Adjustment Amount (from Step 3) = $13.32

Inflated Occupational Mix Adjusted Average Hourly Wage = $13.76

$13.32 × 1.033150521 = $13.76

Inflation Factors for the 1988 Area Wage Index

If the Midpoint of the Cost Reporting Period is:

After	Before	Adjustment factor
02/14/87	03/15/87	1.090861457
03/14/87	04/15/87	1.084948184
04/14/87	05/15/87	1.079066966
05/14/87	06/15/87	1.073217629
06/14/87	07/15/87	1.067400000
07/14/87	08/15/87	1.061613906
08/14/87	09/15/87	1.055859175
09/14/87	10/15/87	1.050135641
10/14/87	11/15/87	1.044443132
11/14/87	12/15/87	1.038781481
12/14/87	01/15/88	1.033150521
01/14/88	02/15/88	1.027550084
02/14/88	03/15/88	1.021980006
03/14/88	04/15/88	1.016440122
04/14/88	05/15/88	1.010930268
05/14/88	06/15/88	1.005450281
06/14/88	07/15/88	1.000000000
07/14/88	08/15/88	0.994549719
08/14/88	09/15/88	0.989069732
09/14/88	10/15/88	0.983559878
10/14/88	11/15/88	0.978019994
11/14/88	12/15/88	0.972449916
12/14/88	01/15/88	0.966849479

Step 5—Wage Comparison

If Hospital Y's occupational mix-adjusted average hourly wage is at least 90 percent of the MSA's average hourly wage, the hospital meets the wage guideline for reclassification.

Hospital Y's average hourly wage adjusted for occupational mix = $13.76.

Hospital Y's average hourly rate adjusted for occupational mix is at least 90 percent of the average hourly wage for Lansing, Michigan. (90% of $14.31 = $12.88)

Because $13.76 is greater than $12.88, Hospital Y meets the required wage guideline.

Comment: In performing the occupational mix calculation, further clarification is needed on the following issues:

- Which categories on the AHA survey should be used.
- Which providers covered by the AHA survey data should be used.
- Which hospital-specific data should be used.
- How to calculate the average wage for each category.
- How to deal with fringe benefits if the hospital could not break out fringe benefits separately by job classification.

Response: The AHA survey data cover 35 occupational categories, 32 of which must be used. The categories not to be used are the following: physicians, dentists, and psychologists. This is because the salary costs for these categories are generally not payable under Medicare part A.

The remaining categories must be used even if the applicant hospital does not have any employees in those categories. (The categories should, of course, be grouped with occupations in which the hospital does have employees). For example, the MSA may have categories for three types of therapists, such as speech, physical, and occupational, whereas the hospital only has physical and speech therapists. In this situation all therapists could be grouped as one occupational category.

Although one commenter recommended that HCFA set required groupings of occupational categories, we believe that no single grouping is clearly

preferable, and the MGCRB has the discretion to determine whether the groupings of occupational categories by the hospital are appropriate. The groupings in the example above are for illustrative purposes and are not intended as recommended groupings. Groupings can be either more general (as in the wage comparison example in the September 6, 1990 interim final rule at 55 FR 36761) or more specific (up to the 32 allowable categories in the AHA data base), subject to the MGCRB's approval. Part-time employees in the MSA should be counted as half-time employees in determining the proportions of each occupational group among MSA employees. Only acute care hospitals should be included in the MSA occupational mix. These are identified by a "0" in the third digit of their Medicare provider number.

The hospital data should match the data used to fill out the HCFA wage survey for the hospitals fiscal year that ended in 1988, and not calendar year 1988, so that the MGCRB can compare the data used to those appearing in the hospital's wage survey. However, as indicated in response to an earlier comment on data requirements, the use of calendar year 1988 payroll data is acceptable for reclassification determinations that would be effective for FY 1992 if the MGCRB concludes that the hospital has submitted sufficient documentation to substantiate that it is providing accurate and complete wage data.

The total employee wages, fringe benefits, and hours for all occupational groupings for the hospital must equal the amounts found on the 1988 survey. In other words, each employee who was counted in the 1988 survey, and only those employees, should appear in one of the occupational groupings. This is necessary in order to maintain comparability to the average hourly wage of the MSA, which is computed using the wage surveys of the prospective payment hospitals in the MSA.

If the hospital cannot determine fringe benefits by class of employees, the hospital may use a fringe benefit factor, determined by dividing fringe benefits as reported on the survey into total salaries as reported on the survey (excluding contract labor and excluded salaries, but including home office salaries if appropriate). When the provider has a fiscal year other than calendar year 1988, it should apply an inflation factor (as provided above) to the average wage, adjusted for occupational mix, in order to ensure comparability with the MSA average wage.

Comment: Clarification is needed regarding how wage data corrections should be taken into account.

Response: We anticipate that the MGCRB will use the latest updated survey data, including midyear corrections, to determine reclassification outcomes. As midyear corrections are made to the survey data, the corrected data will be forwarded to the MGCRB for its consideration. We believe it is appropriate that the MGCRB use the latest corrected data in making its determinations, since these data are currently used for payment purposes. Moreover, we note that a number of wage index applications submitted by hospitals are based on corrected data. If the MGCRB relied on the wage data in effect at the time the reclassification request was filed, rather than using the latest available data in making its determinations, these hospitals would not be able to benefit from the use of the corrected hospital specific data.

We also want to note that, in applying for reclassification for wage index purposes for FY 1993 and thereafter, it is essential that hospitals contact HCFA to request the average hourly wage data that are appropriate for use in reclassification requests. Using the latest available average hourly wage data is necessary for hospitals to determine whether they qualify for reclassification for purposes of the wage index. In addition, unlike for FY 1992 applications, hospitals should not rely on the published wage index values to compute the average hourly wage for the area to which they are seeking reclassification. This is because the published wage index values will reflect geographic reclassifications approved under section 1886(d)(10) of the Act for each fiscal year and thus may not reflect the actual labor market for a given area for the upcoming fiscal year.

Unlike the geographic reclassifications granted under section 1886(d)(8) of the Act that are permanent, the geographic reclassifications granted by the MGCRB are temporary and are generally limited to a 1-year period. Considering such reclassifications in determining whether a hospital qualifies for a wage index reclassification in subsequent periods would not be appropriate because it would invalidate the process of comparing the wages of a hospital applying for reclassification with the wages of the hospitals in the area to which the hospital is requesting to be reclassified. For example, consider the case of a hospital that was reclassified to a given area for FY 1992 that wishes to reapply for reclassification to that same area for FY 1993. A comparison of the hospital's wage data with the wage data of all hospitals (including reclassified hospitals) in the area in FY 1992 would result in the hospital's wage data being compared in part with its own wage data, rather than strictly with the wage data of hospitals that originally made up the area. The anomalous effects of basing reclassification determinations on such comparisons would be particularly evident in smaller MSAs that include only one or two hospitals or in MSAs in which most hospitals were reclassified to another area for FY 1992.

Another possibility is that all the hospitals originally in an MSA would be granted reclassification to other areas for FY 1992. Thus, the area would contain either no hospitals in FY 1992 or only hospitals that were reclassified to the area. If there were no hospitals reclassified to the area, using reclassified hospitals in making wage comparisons would be impossible because there would be neither a published wage index value for FY 1992 nor any comparative wage data that could be used for making a reclassification determination if in the subsequent year other hospitals would seek reclassification to that MSA. If the area contained only reclassified hospitals, hospitals reapplying for reclassification in the subsequent year would conceivably be compared solely to themselves.

Therefore, in making wage comparisons for purposes of meeting the guidelines for reclassification for wage index purposes, hospitals must use the wage survey data for a labor market area absent any reclassifications granted by the MGCRB. As noted in a response to comment in section V.A.6 of this preamble, these data are available from HCFA upon request.

Comment: HCFA should lower the criterion requiring that the hospital's average hourly wage be equal to 85 percent of the average hourly wage in the adjacent area to 80 percent in order to permit a group of hospitals to qualify for reclassification for purposes of their wage index. In addition, language in the Conference committee report accompanying Public Law 101–508 suggested that the Secretary consider lowering the 85 percent wage threshold to 70 percent. (H.R. Rep. No. 964, 101st Cong., 2nd Sess. 715 (1990).) Another option would be to replace the 85 percent threshold with a statistical measure such as two standard deviations or a specified coefficient of variation.

Response: We continue to believe that a minimum 85 percent threshold for determining comparability among adjacent areas is appropriate. We note that a significant proportion of the over 1,000 complete applications submitted to the MGCRB requested reclassified based on this guideline, which indicates that the threshold is sufficiently low. While reducing the qualifying criteria would permit more hospitals to qualify for a higher wage index value, it would also result in diminishing the degree of wage comparability among hospitals in a given labor market area. That is, we believe that a hospital whose average hourly wage is more than 15 percent below the adjacent labor market area does not incur wage costs comparable to that area and, therefore, does not warrant reclassification.

In any system using a numeric threshold, there will be some hospitals who fall just short of meeting the threshold. An arbitrary reduction in the wage criterion simply to accommodate a specific group of hospitals is not appropriate. Moreover, given the requirement that the geographic redesignations granted by the MGCRB be budget neutral with respect to aggregate payments to hospitals, it would be inequitable to lower the 85 percent criterion to reclassify, at the expense of urban hospitals, additional hospitals that do not have comparable wages.

Finally, the use of two standard deviations or a specified coefficient of variation would not produce a consistent guideline that can be applied to all hospitals seeking to reclassify to alternative labor market areas. The 85 percent threshold provides a constant measure against which all hospitals can compare themselves. In addition, we structured the guidelines so that hospitals can apply for redesignation without necessarily relying on consultants. Using a complicated statistical procedure to achieve reclassification defeats this purpose.

Comment: The criteria for use of another area's wage index value at § 412.230(e) should be revised to take into consideration a hospital's contract labor costs. One hospital noted that, due to the scarcity of specialized labor in the area, its contract labor costs constitute more than 15 percent of its total labor costs. Exclusion of these costs results in a distorted view of the actual labor costs of rural hospitals. Further, the historical wage survey data may not reflect current market conditions.

Response: Including contract labor costs in a hospital's average hourly wage is inappropriate because it would provide a distorted comparison with the wages for the MSA, which do not reflect these costs. HCFA did not include contract labor salaries and hours in the final 1988 wage survey data because these data were not uniformly available. We previously addressed this issue in the September 4, 1990 prospective payment system FY 1991 final rule (55 FR 36038). At that time, we had received a number of comments both supporting and opposing the inclusion of contract labor data. We decided to exclude contract labor data based on our analysis that showed that only 50 percent of hospitals reported contract services and at least 11 percent of those not reporting these services indicated that it was because they could not accurately determine contract hours. In some cases, hospitals included services with a high average hourly wage, such as CRNAs and physicians, which are billed under Part B. Therefore, because of the inconsistency noted in the reporting of contract services on the 1988 HCFA wage survey, we did not include those data in the average hourly wage used to construct the wage index. With respect to the use of historical wage data, it is essential to use standard data for the same time period so that the wage comparisons can appropriately reflect labor costs for the same point in time. In addition, any data for a year other than 1988 would not be edited or otherwise verified.

Moreover, the 1988 wage data represent the latest available data at the time the survey was conducted. As such, there is no way to avoid a time lag in the data used to construct the wage index. However, once the wage index updates are done on an annual basis, beginning in FY 1994, changes in wage levels across areas will be reflected in the wage index more timely.

We are in the process of developing more detailed instructions on the reporting of contract labor costs as part of the Medicare cost report, which may allow the inclusion of contract labor data in future wage index updates. Until contract labor costs are incorporated into the hospital wage index, we believe that these costs cannot be reflected in the average hourly wages of individual hospitals for purposes of their reclassification requests.

6. Guidelines for a Joint Application for All Hospitals in a Rural County Seeking Urban Reclassification

In order for all the Medicare prospective payment system hospitals located in a rural county to be reclassified as part of an adjacent MSA or NECMA, all of the Medicare prospective payment system hospitals in the county must apply jointly to the MGCRB. If all hospitals in a county do not wish to be part of a group application for redesignation, then each of these hospitals seeking redesignation must do so using the individual hospital guidelines in § 412.230.

The county in which the hospitals are located must first meet one of the census guidelines that follow:

a. *Bureau of the Census Data—1980:* If the county failed to qualify for urban classification because it did not meet the OMB standards that were published in the **Federal Register** on January 3, 1980 (45 FR 956) or because it did not meet the standards under section 1886(d)(8)(B) of the Act, with respect to hospitals in certain rural counties adjacent to urban areas, it must be able to demonstrate that based on updated Bureau of the Census data, estimates, or projections, it now meets the standards.

b. *Bureau of the Census Data—1990:* If the county would qualify for reclassification as part of a MSA or NECMA based on the revised standards issued by OMB for the 1990 Census (55 FR 12154, March 31, 1990), those standards may be used to qualify for redesignation. The Appendix to the interim final rule (55 FR 36770) included the part of those standards that is relevant to this issue.

Finally, all the hospitals in the county must meet the wage guidelines set forth in § 412.232(c). That is, the aggregate average hourly wage of all the hospitals in the county must be at least 85 percent of the average hospital hourly wage, or 90 percent of the occupationally adjusted hourly wage, in the MSA or NECMA to which the hospitals in the county seek reclassification. The wage comparison must be based on HCFA wage survey data.

Comment: In cases where not all the hospitals in a county wish to seek reclassification, hospitals that do wish to request reclassification should be permitted to do so as a group. Alternatively, all hospitals in a county that meet the proximity guidelines should be allowed to file for redesignation as a group.

Response: Given the potential impact a county-wide reclassification could have on certain hospitals (such as Medicare-dependent small, rural hospitals that would lose their rural status), we believe it is appropriate to require that all hospitals in the county apply as a group. For those situations where a group application based on county-specific criteria may not be viable, we have provided an alternative process by which individual hospitals may seek reclassification based on hospital-specific criteria. This process

adequately recognizes those situations where individual hospitals that demonstrate close economic ties to adjacent areas may be reclassified even though the county in which they are located may not meet the criteria that would permit a group reclassification.

With respect to group applications for those hospitals in a county that meet the proximity guidelines, we believe that each hospital should demonstrate that it also meets the other criteria for redesignation. Otherwise, reclassification requests by select groups of hospitals could allow hospitals that do not qualify for redesignation to "piggyback" on qualified hospitals.

Comment: The effect the MGCRB provisions have on the criteria for a county to be designated as urban under section 1886(d)(8)(B) of the Act should be clarified. These counties are designated as urban if they are adjacent to one or more urban areas and would otherwise be considered part of an urban area, under the standards for designating MSAs and NECMAS, but for the fact that the county does not meet the OMB standard relating to the commuting rate of workers between the rural county and the central county or counties of any single adjacent MSA or NECMA. Will these counties have to apply for urban designation once 1990 Census data become available, or will HCFA designate them?

Response: At HCFA's request, OMB will identify all qualifying counties as soon as it receives final commuting data for the 1990 census from the Bureau of the Census. Urban designations under section 1886(d)(8)(B) of the Act will automatically take effect on October 1 following the date of the revised MSA designations, which are expected to be announced by OMB in June 1992. Therefore, it is not necessary for hospitals to apply for urban designation under this provision.

7. Guidelines for a Joint Application for All Hospitals in an Urban County Seeking Reclassification to Another Urban Area

As discussed in the following comment and response, this final rule with comment period sets forth at § 412.234 criteria for all hospitals in an urban county applying for redesignation to another urban area. These guidelines will be effective for applications filed October 1, 1991 with respect to reclassifications that would be effective in FY 1993.

Comment: The interim final rule specified criteria for group redesignations of all hospitals in a rural county to an adjacent urban area. However, it did not provide for all hospitals in an urban county to be reclassified as a group to another urban area. Since hospitals in urban counties are essentially in the same situation as hospitals in rural counties, they should be allowed to apply as a group for redesignation to another urban area. Also, the Conference Committee report accompanying Public Law 101-508 demonstrates Congressional intent that the Secretary establish guidelines for joint applications by urban hospitals classified as other urban to seek reclassification to a large urban area. (H.R. Rep. No. 964, 101st Cong., 2nd Sess. 715 (1990).)

Response: In developing the guidelines to be used by the MGCRB in making its determinations, we specifically limited group applications to cases where county-specific population data related to the OMB standards for designating MSAs could be considered. However, given the explicit language included in the Conference Committee report clarifying Congressional intent in this regard, we are adding a new § 412.234 to provide the following guidelines under which all hospitals in an urban county may seek reclassification to another urban area.

Guidelines for a Joint Application for All Hospitals in an Urban County Seeking Reclassification to Another Urban Area.

1. All hospitals in the urban county must apply for redesignation as a group.

2. The urban county in which the hospitals are located must be part of the Consolidated Metropolitan Statistical Area (CMSA) that includes the urban area to which the hospitals are seeking redesignation. In the case of NECMAs, the urban county would be considered part of a consolidated urban area under section 5 of the OMB standards for designating CMSAs published in the January 3, 1980 **Federal Register** (45 FR 956).

We believe that hospitals seeking classification to another area must demonstrate an economic connection to the area to which reclassification is requested. The CMSA requirement is an objective standard that can be used to measure the economic relationship between an urban county seeking redesignation and the other urban area. The CMSA definition (at 45 FR 960) involves various characteristics of the MSAs that are part of a CMSA, including commuting data, urbanization, and total population. The CMSA designation differentiates between adjacent MSAs that are not closely tied economically and adjacent MSAs that have a close economic relationship with each other.

3. *Wage guideline:* The aggregate average hourly wage of all hospitals in the county must be at least 85 percent of the average hospital hourly wage, or 90 percent of the occupationally adjusted hourly wage, in the MSA or NECMA to which the hospitals in the county seek reclassification. The wage comparison must be based on HCFA wage survey data.

4. *Cost guideline:* On average, the case-mix adjusted cost per case reduced for outliers for all hospitals seeking reclassification must at least equal the payment each hospital currently receives plus 75 percent of the difference between that amount and the amount it would receive if reclassified.

To determine if the cost guideline is met, an individual cost threshold is calculated for each hospital requesting reclassification. The threshold equals the amount the hospital would receive under its current classification plus 75 percent of the difference between that amount and the amount it would receive if reclassified. The ratio of each hospital's cost threshold to its case-mix adjusted cost per case, reduced for outliers (from the most recently filed cost report), is then calculated. These ratios are then weighted by the hospital's share of the group's Medicare discharges. These weighted ratios are added together, and the total must be at least one.

Discharge weighting ensures that the cost of each Medicare case in the hospitals requesting redesignation is counted equally. Simple averaging by the number of hospitals would result in cases in hospitals with more than the average number of Medicare discharges being under-counted and cases in hospitals with fewer than average Medicare discharges being over-counted.

The ratios of payments to costs are used because the hospitals requesting reclassification have different relationships between their costs per case and payments per case. The appropriate test is whether or not, on average, the hospitals meet the cost guidelines rather than whether aggregate payments equal an aggregate cost threshold. When determining the current payment and the payment if reclassified, the standardized amounts may have to be prorated as in the cost comparison example for an individual hospital. The disproportionate share patient percentage from the most recently filed cost report is used, but the disproportionate share payment is calculated using the formula applicable to the Federal fiscal year for which redesignation is requested. The indirect

medical education adjustment is calculated in similar fashion.

Urban to Urban Group Reclassification Example

There are only two prospective payment hospitals (Hospital A and Hospital B) in County Z, an other urban county. Both hospitals apply for reclassification to MSA Q, which is a large urban area.

Step 1—Each hospital calculates its case-mix adjusted cost per case, reduced for outliers (see Step 1 and 2 of Cost comparison example above), and its share of the total discharges of the two hospitals.

Case-mix adjusted cost per case, reduced for outliers	Percentage of total cases in both hospitals
Hospital A: $3,886.54	40 percent
Hospital B: $3,540.36	60 percent

Step 2—Determine the ratio of cost to payment threshold for each hospital.

In order to determine the ratio, the following must be determined: the payment hospitals A and B currently receive and the payments they would receive if they are reclassified, using each hospital's most recently filed cost report and the disproportionate share formula and the indirect medical education formula appropriate for FY 1992, the year for which reclassification is requested. (See Step 3 of Cost comparison example for prorating standardized amount based on a hospital's cost reporting period).

Prorated standard payment per case=Prorated standardized amount × (1+IME adjustment factor+DSH adjustment factor)

The threshold level for each hospital=Current standard payment per case+[0.75×(Standard payment per case if reclassified—current standard payment per case)]

A. Determine ratio of cost to payment threshold for Hospital A.

1. Determine prorated standard payments, before and after reclassification.

Hospital A's prorated standard amount before reclassification (using current wage index value)=$3,356.55

Hospital A's prorated standard amount if reclassified (calculated using MSA Q's wage index values)=$3,442.41

Hospital A's disproportionate share patient percentage=0.302

Hospital A's disproportionate share adjustment factor, using FY 1993 payment formula=0.7×(0.302–0.202)+0.0562=0.1262

Hospital A's IME adjustment factor=0.0616

Hospital A's prorated standard payment per case before reclassification=$3,356.55×(1+0.1262+0.0616)=$3,986.91

Hospital A's prorated standard payment per case if reclassified=$3,442.41×(1+0.1262+0.0616)=$4,088.89

2. Determine threshold level for hospital A.

Threshold for Hospital A=$3,986.91+0.75×($4,088.89–$3,986.91)=$4,063.40

3. Determine ratio of cost to threshold level for Hospital A.

Hospital A's case mix-adjusted cost per case reduced for outliers=$3,886.54

Threshold for Hospital A=$4,063.40

Ratio for Hospital A=$3,886.54/$4,063.40=0.9565

B. Determine the ratio of cost to payment threshold for Hospital B.

1. Determine the prorated standard payments before and after reclassification.

Hospital B's prorated standard amount before reclassification (using current wage index value)=$3,361.95

Hospital B's prorated standard amount if reclassified (using MSA Q's wage index values)=$3,452.75

Hospital B's disproportionate share patient percentage=0.045

Hospital B's disproportionate share adjustment factor=0.0

Hospital B's IME adjustment factor=0.0

Hospital B's prorated standard payment per case before reclassification=$3,361.95

Hospital B's prorated standard payment per case if reclassified=$3,452.75

2. Determine threshold level for Hospital B.

Threshold for Hospital B=$3,361.95+0.75×($3,452.75–$3,361.95)=$3,430.05

3. Determine ratio of cost to threshold level for Hospital B.

Hospital B's case mix-adjusted cost per case reduced for outliers=$3,540.36

Threshold for Hospital B=$3,430.05

Ratio for Hospital B=$3,540.36/$3,430.05=1.0322

Step 3—Determine whether the hospitals in County Z qualify to be reclassified as part of MSA Q on the basis of cost. The discharge weighted ratio of cost to threshold level for an urban hospital must be at least one.

Hospital A's ratio=0.9565

Hospital A's share of discharges=40%

Hospital B's ratio=1.0322

Hospital B's share of discharges=60%

Discharge-weighted ratio=(0.9565×0.40)+(1.0322×0.60)=1.0019

The hospitals in County Z meet the cost guidelines because their discharge-weighted ratio of cost to payment is greater than one. If the hospitals in County Z also meet the required wage guideline, they would qualify for reclassification to MSA Q.

8. Alternative Guidelines Applicable to Hospital Located in New England County Metropolitan Areas (NECMAS)

These guidelines (at § 412.236) apply only to urban hospitals in New England whose designation is affected by the use of NECMAs to define urban areas, in lieu of MSAS. An individual hospital located in a NECMA may also qualify for redesignation based on the criteria contained in § 412.230.

a. *Guidelines Applicable to Individual NECMA Hospitals.* A hospital currently classified as urban due to its location in a NECMA, may be redesignated as part of another NECMA if it meets the following criterion:

The hospital demonstrates that it would have been classified in a different urban area under the criteria for designating MSAs in New England. For example, part of Bristol County was included in the Boston, Massachusetts MSA. However, under the criteria establishing NECMA boundaries, this area was included in a separate NECMA (that is, the New Bedford-Fall River-Attleboro Massachusetts NECMA). Under this guideline, a hospital located in the section of Bristol County that is included in the Boston MSA may qualify for inclusion in the Boston NECMA.

b. *Guidelines Applicable to All Hospitals Within a NECMA.* All hospitals in a NECMA may qualify for redesignation to another NECMA either by meeting the criteria for group reclassification from one urban area to another urban area at § 412.234 or by meeting the following two criteria:

i. All hospitals in the NECMA apply for redesignation as a group.

ii. The hospitals can show that the NECMA to which they are designated would be combined as part of the NECMA to which they seek redesignation if the criteria for combining NECMAs were the same as the criteria used for combining MSAs. It should be noted that combining MSAs should not be confused with consolidating MSAs. We do not recognize Consolidated MSAs (CMSAs) as a single urban area for purposes of classifying hospitals under the prospective payment system.

These criteria apply regardless of whether the hospitals pay wages comparable to hospitals located in the NECMA to which the hospitals seek redesignation.

The basis for these criteria is section 6 of the Office of Management and Budget Standards for Defining Metropolitan Statistical Areas published on January 3, 1980 (45 FR 960). Section 6 states that

"two adjacent MSAs not included in a consolidation by the above criteria (in section 5) will be combined as a single MSA if:

A. Their largest central cities are within 25 miles of one another, or their urbanized areas are contiguous; and

B. There is definite evidence that the two areas are closely integrated with each other economically and socially * * *; *and*

C. Local opinion in both areas supports the combination."

Definite evidence that the two areas are closely integrated with each other economically and socially is demonstrated by the commuting and urbanized area criteria, as stated in section 5 of the OMB standards (45 FR 960):

The commuting interchange between the two metropolitan statistical areas is equal to:

(1) At least 15 percent of the employed workers residing in the smaller metropolitan statistical area, or

(2) At least 10 percent of the employed workers in the smaller metropolitan statistical area, and

a. The urbanized area of a central city of one metropolitan statistical area is contiguous with the urbanized area of a central city of the other metropolitan statistical area, or

b. A central city in one metropolitan statistical area is included in the same urbanized area as a central city in the other metropolitan statistical area.

For purposes of these guidelines, the criterion involving local opinion is not considered with respect to NECMAs.

Section 14.C of the OMB standards is explicit in stating that section 6 does not apply in New England (45 FR 961). These guidelines are intended to provide that hospitals that are located in NECMAs that would qualify for combination based on standards applicable outside of New England may qualify for this redesignation.

Comment: Hospitals located in a NECMA should be permitted reclassification to another NECMA based on the OMB standards for designating CMSAs (Section 5—Consolidating Adjacent Metropolitan Statistical Areas (45 FR 960; January 3, 1980)) and should not be limited to qualifying under the OMB standards for combining MSAs (Section 6—Combining Adjacent Metropolitan Statistical Areas (45 FR 960; January 3, 1980)).

Response: The September 6, 1990 interim final rule clearly states that CMSAs will not be recognized for classification purposes. This issue was previously addressed in the September 30, 1988, final rule (53 FR 38498) in response to a public comment.

Under the prospective payment system, we have never recognized CMSAs for purposes of defining urban areas. CMSAs are made up of two or more Primary Metropolitan Statistical Areas (PMSAs). A PMSA is recognized as a separate urban area because it demonstrates very strong internal economic and social links in addition to its ties with another portion of a CMSA. In defining urban areas under the prospective payment system, we recognize MSAs and PMSAs only. The criteria for reclassifying hospitals to another NECMA are intended to afford these hospitals the same treatment as they would have received under the MSA definitions. Therefore, since hospitals located in PMSAs cannot be reclassified based on the CMSA designations, we are applying the same restrictions with respect to the NECMA designations.

However, as discussed in section V.B.7 above, we are establishing guidelines whereby all hospitals located in an urban county may seek reclassification to another urban area that is part of the same CMSA. In addition to meeting the cost and wage criteria under § 412.234, hospitals located in an urban county that is part of a NECMA may qualify for reclassification under the provision of § 412.236 based on the OMB standards for designating CMSAs. The guidelines set forth in § 412.234 will be effective for applications to be considered by the MGCRB during Federal FY 1992 for reclassification beginning October 1, 1993.

9. Effect of Decisions of the MGCRB on Payment to Hospitals

Hospitals that are reclassified only for wage index purposes are not considered urban for any other purpose other than the labor market area (for example, the disproportionate share hospital formula). Hospitals that are reclassified only for purposes of the standardized payment amounts are considered urban for all purposes under section 1886(d)(2)(D) of the Act, except for use of the wage index.

With respect to the wage index, section 1886(d)(8)(C) of the Act did not specify prior to the enactment of Public Law 101-508 how reclassifications of individual hospitals were to be treated. We stated in the interim final rule that we would continue to evaluate this issue and that in the FY 1992 proposed prospective payment system update, we would propose a methodology to address the application of the wage index where not all hospitals in a county or MSA have been reclassified.

Subsequently, section 4002(h)(1)(A) of Public Law 101-508 amended section 1886(d)(8)(C) of the Act to provide that for purposes of the wage index, all hospitals that are granted reclassification are to be grouped together based on the MSA to which they have been reclassified. The effect of the reclassification on the wage index value of the affected areas depends on the hypothetical impact the wage data for the reclassified hospitals would have on the wage index value of the area to which they have been reclassified as explained below:

a. *Impact on Wage Index of One Percentage Point or Less.* If the wage data for the reclassified hospitals would reduce the wage index for the MSA or the rural area to which the hospitals are reclassified by one percentage point or less, the reclassified hospitals are subject to the MSA or rural wage index computed exclusive of the reclassified hospitals. If the wage data for the reclassified hospitals would increase the wage index for the MSA or the rural area to which the hospitals are reclassified, the wage data for the reclassified hospitals will be included in the computation of the MSA or rural wage index.

b. *Impact on Wage Index of More Than One Percentage Point.* If the wage data for the reclassified hospitals would reduce the wage index for the MSA or rural area to which the hospitals are reclassified by more than one percentage point, the hospitals that are reclassified are subject to the wage index value of the MSA or rural area that results from including the wage data of the reclassified hospitals. However, the wage index for the reclassified hospitals cannot be less than the wage index value for the rural areas of the State in which the hospitals are located.

Rural areas whose wage index values would be reduced by excluding the data for reclassified hospitals will continue to have their wage index calculated as if no reclassification had occurred. Finally, section 1886(d)(8)(D) of the Act requires that the effect of decisions of the MGCRB be budget neutral. That section also requires that a proportional adjustment to the standardized amount for urban hospitals be made to ensure that total aggregate payments made in the prospective payment system be neither greater than nor less than aggregate payments that would otherwise be made. In addition, that section requires that aggregate payments to those rural hospitals not affected by this provision remain constant.

Comment: Further clarification is needed on how the wage index will be constructed once all reclassification requests have been decided by the MGCRB. One suggestion was that since a hospital is seeking reclassification based on comparability to an adjacent area, it should be granted the wage index value applicable to that area without any adjustment. Another commenter suggested that in situations where a hospital qualifies for reclassification to more than one area, HCFA allow redesignation to the area that will result in the highest wage index for the hospital. Finally, a commenter asked if a hospital has the option to withdraw from its approved reclassification if the adjusted wage index for the new area turns out to be lower than expected.

Response: The way in which the wage index is applied to redesignated hospitals has been set forth by Congress under section 1886(d)(8)(C) of the Act as amended by section 4002(h)(1)(A) of Public Law 101-508. All hospitals that are granted redesignation are grouped together based on the area to which they have been redesignated. The redesignated hospitals' wage index value is determined by calculating the impact that these hospitals have on the wage index of the MSA or rural area to which they are being reclassified. If the impact of including the reclassified hospitals reduces the wage index by one percent or more, the redesignated hospitals receive a combined wage index value determined by using all the hospitals located in the MSA or rural area and the redesignated hospitals. If the reclassifications result in a reduction in the wage index of less than one percent, the redesignated hospitals will receive the MSA or rural area wage index value without including the redesignated hospitals in that area's wage index value. In addition, the revised wage index value is never less than the rural wage index value for the State in which the reclassified hospitals are located.

In the September 6, 1990 interim final rule, we indicated that the law was silent with respect to the treatment of the wage index value for individual hospitals granted reclassification by the MGCRB and that we would evaluate this issue. This issue has now been clarified by section 4002(h)(1)(A) of Public Law 101-508.

When a hospital submits an application for geographic reclassification, it describes in detail why, and to what area, it believes it should be redesignated. The MGCRB must evaluate the application and decide if the hospital has met the relevant criteria for that particular geographic classification. The MGCRB has no duty to look beyond an application and decide that a more favorable redesignation is supportable. We note that the wage index that will be applicable to the hospital after reclassification cannot be established until the impact of all reclassifications to that geographic area is determined. Redesignated hospitals may not always receive the MSA wage index value without an adjustment. Thus, it is appropriate for the hospital to be responsible for determining to which area it wishes to be reclassified when it qualifies for reclassification to more than one area.

Because hospitals did not know how the wage index value would be computed for redesignated hospitals at the time they submitted applications to the MGCRB for Federal fiscal year 1992 reclassifications, we are allowing hospitals to withdraw their applications even if an MGCRB decision has already been made. A request for the withdrawal of an application after an MGCRB decision will be permitted only for a Federal fiscal year 1992 application, provided that the request for withdrawal is received by the MGCRB within 60 days of publication of this final rule with comment. However, a hospital cannot request a different reclassification to an alternate area within the same Federal fiscal year. A hospital that wishes to be redesignated to an alternative area will have to submit a new application to the MGCRB for the following Federal fiscal year.

In new § 412.273 of these final regulations, we are establishing rules for the withdrawal of applications for reclassification for Federal fiscal year 1993 and thereafter. Under these rules, a hospital may request withdrawal of its application at any time prior to the issuance of an MGCRB decision. The request must be made in writing and will not be considered once a decision has been issued.

Comment: One commenter asked whether an SCH, and RRC, or an MDH that qualifies for a reclassification of its standardized amount will lose its designation as an SCH, RRC, or MDH. The commenter believes that such a hospital should be permitted to retain its special status during the term of the classification or, alternatively, should be allowed to resume such status without meeting requalification criteria should reclassification cease.

Response: The guidelines for geographic reclassification state that a provider reclassified for the purposes of its standardized amount is considered to be reclassified for all purposes other than the wage index (see 55 FR 36761). This is because a rural hospital must be deemed to be located in an urban area under section 1886(d)(2)(D) of the Act before it can be paid the urban standardized amount. Thus, to the extent that a hospital's status as an RRC, SCH, or MDH is dependent upon its being located in a rural area, it will lose its special status if it qualifies for reclassification to an urban area for its standardized amount. This is consistent with our policy with respect to rural hospitals that are deemed to be located in an urban area under section 1886(d)(8) of the Act. Although the hospital will lose its special status as an RRC or rural SCH during the period of reclassification, we believe it is appropriate for these hospitals to continue to be able to qualify for geographic reclassification under the special access provision at § 412.230(a)(4). We are amending § 412.230(a)(4) to clarify this point. If we did not make this revision, hospitals that qualify under § 412.230(a)(4) would not be able to qualify under this provision in subsequent years since they would no longer be an RRC or SCH. We believe this would be contrary to the intent of the guideline.

The hospital's special status as an RRC or SCH will not be held in abeyance during the term of the hospital's geographic reclassification. In the event the hospital's reclassification ceases, it must reapply for special status and must meet all of the applicable qualifying criteria in effect at the time it seeks requalification. There are some exceptions to this policy which are discussed in the individual special status sections below.

We believe this policy is reasonable in light of the fact that each of the special status adjustments is designed to recognize the special needs and patient characteristics of particular categories of hospitals. For instance, RRC status is granted to those hospitals that draw patients from widely diverse geographical locations and offer a broad range of sophisticated services to large numbers of patients. SCH status is available to those hospitals that are isolated by distance, weather conditions, or travel time or that receive a high percentage of the inpatient market share compared to other hospitals in their service area. MDH status is designed to protect small, rural hospitals that have historically served a high percentage of Medicare patients.

Thus, each of these special status adjustments was created to recognize

the special characteristics of particular categories of hospitals, and the qualifying criteria for each adjustment are framed to identify those hospitals that should receive the adjustment. A hospital's patient characteristics and operating procedures (and, thus, its ability to meet the qualifying criteria) may be altered either since it initially qualified for special payment status or during its period of geographic reclassification. We, therefore, believe it is reasonable to require a hospital to demonstrate that it meets the criteria for a special payment adjustment when its reclassification status ends. Except in the limited instances discussed below, a hospital approved for geographic reclassification of its standardized amount will be considered to have voluntarily given up its MDH, RRC or rural SCH status. The hospital must meet the provisions at § 412.96(a) to requalify for RRC status or at § 412.92(b)(4) to requalify for SCH status. Since some hospitals may not have understood the effect reclassification would have on their special status, we are permitting hospitals to withdraw their applications for reclassification for FY 1992, even if the MGCRB has issued a decision, providing that the request for withdrawal is received within 60 days of publication of this final rule with comment period.

Rural Referral Centers

All three sets of criteria under which a hospital can qualify as a referral center (§ 412.96) are applicable to hospitals located in rural areas. However, only the criteria at § 412.96(b)(2) are also applicable to urban hospitals. That is, the bed-size criterion (§ 412.96)(b)(1)) and the case-mix index/number of discharges/one-of-three optional criteria (§ 412.96(c)) are applicable only to hospitals located in rural areas. However, the referral pattern criteria at § 412.96(b)(2) are applicable to hospitals located in either urban or rural areas. Thus, a hospital that qualifies for RRC status based on the criteria at § 412.96 (b)(1) or (c) and that is reclassified to an urban area for the purpose of its standardized amount, will lose its RRC status effective with the date that it is reclassified. A hospital qualified as a referral center under the criteria at § 412.96(b)(2) will not lose its referral center status.

Since an RRC's standardized amount is already based on the other urban amount, we anticipate that there will be few qualified RRCs seeking geographic reclassification for purposes of their standardized amount. Only those RRCs that meet the requirements to be reclassified to a large urban standardized amount would benefit from reclassification.

Approved RRCs should keep in mind that if they voluntarily terminate their RRC status (including being approved for reclassification of their standardized amount), and then are not reclassified for a subsequent term, they can refile for RRC status only during the 3-month period preceding the start of their cost reporting period. They must meet the applicable criteria in effect at the time they reapply, and subsequent requalification as an RRC, if approved, will be effective at the start of their cost reporting period. The 3-month filing deadline and the effective date of RRC qualification are statutory requirements specified in section 1886(d)(5)(C)(i)(I) of the Act and, as in the past, there can be no exceptions to these requirements. Thus, a hospital that voluntarily terminates its RRC status in favor of geographic reclassification may face a period of time of being paid the standardized rural payment amounts between the date it loses its geographic reclassification status and the date it can requalify as an RRC.

Sole Community Hospitals

Prior to the implementation of the prospective payment system on October 1, 1983, some hospitals located in urban areas were approved for SCH status. Effective with the implementation of the prospective payment system, we limited the approval of SCH status to only those hospitals located in rural areas. However, we provided that all urban SCHs whose request for SCH status was received by the fiscal intermediary prior to October 1, 1983 and was subsequently approved could retail that status. Thus, since October 1, 1983, approval of new SCHs has been limited to hospitals located in rural areas.

Section 6003(e) of Public Law 101-239 amended section 1886(d)(5) of the Act to provide that an SCH is defined as "* * * any hospital that the Secretary determines is located more than 35 road miles from another hospital, or that, by reason of factors * * * (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A." When we implemented this change in the law as a part of our April 20, 1990 final rule with comment period, we continued our requirement that only rural hospitals are eligible for SCH status. In response to an issue raised by this commenter, we have reviewed the statutory language carefully and, based on this review, we have decided to revise somewhat our definition of an SCH.

We note that the language of the law does not require that SCHs isolated by more than 35 road miles be located in a rural area. We have, therefore, determined that effective June 4, 1991, hospitals located in urban areas, either large urban or other urban, can qualify for SCH status if they are located more than 35 road miles from the nearest like hospital. We are amending § 412.92(a) to reflect this revision. We are making this revision effective upon publication of this final rule with comment period so that affected hospitals will know with certainty that, even after reclassification to an urban area, they will continue to qualify for SCH status.

The same definitions of "miles" and "like hospital" as are found at § 412.92(c) will apply to urban hospitals seeking SCH status. Likewise, the same criteria regarding all classification procedures as are found at § 412.92(b) will apply. Distances are measured from the front door of the requesting hospital to the front door of the nearest like hospital based on the shortest distance over improved roads. Rounding of mileage is not permissible, that is, 34.9 miles does not meet the standard; 35.0 does.

No urban hospital located fewer than 35 miles from the nearest like hospital can be qualified for SCH status (except those in existence prior to implementation of the prospective payment system and those redesignated pursuant to court order). That is, the provisions such as weather conditions, market share, and travel time that are applicable to rural hospitals located fewer than 35 miles from another hospital do not apply to urban hospitals. We base this decision on the fact that the law does not grant Secretarial discretion for the 35-mile criterion, but it clearly provides that the Secretary should publish the standards to be met for hospitals located fewer than 35 miles from another hospital. Because urban areas generally have better roads, faster snow-clearing, and the choice of more available hospitals, we do not believe SCH status should be granted to an urban hospital located fewer than 35 miles from another like hospital.

With this revision to the criteria for SCH status in mind, we note that any rural SCH that is approved for reclassification of its standardized amount and that is located fewer than 35 miles from the nearest like hospital, will lose its SCH status effective with the date of its reclassification Rural SCHs that are located more than 35 miles from the nearest like hospital will

not lose their SCH status as a result of geographic reclassification to an urban area.

Hospitals that voluntarily terminate their SCH status in favor of geographic reclassification will no longer be paid based on the highest of the fully Federal rates, 100 percent of their updated 1987 hospital-specific rate, or 100 percent of their updated 1982 hospital specific rate. They will no longer be exempt from the capital reduction and they will not be eligible for the 5 percent volume adjustment for any full cost reporting period during which they were not classified as an SCH.

As with RRCs discussed above, we consider that a rural SCH located fewer than 35 miles from the nearest like hospital that is approved for reclassification of its standardized amount has voluntarily given up its SCH status. Should be hospital not be granted reclassification for subsequent terms, it can requalify for SCH status only if it meets the requirements at § 412.92(b)(4). That is, a hospital cannot be reclassified as an SCH unless one full year has passed since the effective date of its cancellation (including acceptance of geographic reclassification of its standardized amount) and unless it meets the criteria at § 412.92(a) for qualification for SCH status in effect at the time it reapplies.

Medicare Dependent, Small Rural Hospitals

Section 1886(d)(5)(G)(iii) of the Act specifies that MDHs must be located in a rural area. Thus, for this special category of hospitals, it is clear that geographic reclassification to an urban standardized amount immediately cancels MDH status. Such a hospital would no longer be paid based on the highest of the applicable Federal rate, 100 percent of its updated 1987 hospital-specific amount, or 100 percent of its updated 1982 hospital-specific amount. During the term of its reclassification, it will be paid based on the applicable fully Federal rates. It will also not be eligible for the five percent volume adjustment for any full cost reporting period during which it was not classified as an MDH.

Should be previously classified MDH not be approved for subsequent reclassification, it will automatically be reclassified as an MDH effective with discharges occurring on the first day after its reclassification ceases, provided it continues to meet all of the requirements, that is, it is located in a rural area, it is not classified as an SCH, and it has 100 or fewer beds. Regardless of geographic classification, however, the MDH status expires for all hospitals at the end of their last cost reporting ending on or before March 31, 1993.

Comment: A commenter was concerned about potential transition problems when an SCH or MDH whose cost reporting year does not coincide with the Federal fiscal year is reclassified for purposes of the standardized payment amount. The commenter questioned which Federal payment amount would be used in determining the aggregate payment for the year based on the greater of the SCH's or MDH's hospital-specific rate or the Federal payment amount. The commenter is particularly concerned that the intermediary will use a weighted average of the different applicable Federal payment amounts when making the comparison to the hospital-specific rate for purposes of determining the payment rate that results in the greatest aggregate payment amount to the hospital.

Response: As discussed in greater detail in a preceding comment and response, all MDHs and some SCHs will lose their special classification effective with their reclassification to an urban area for purposes of receiving the urban payment amount. In these cases, the hospital will receive payment under the SCH or MDH payment methodology for the part of its cost reporting period prior to the reclassification. For that portion of the cost reporting period, the Federal standardized amount applicable to the hospital before reclassification will be used to determine the hospital's payment under the "greater of" payment methodology. Once the hospital is reclassified and it loses its special status as an SCH or MDH, it will begin receiving payment based on its new Federal payment amount in the same manner as any other hospital. It will no longer be paid based on the greater of its hospital-specific rate or the Federal rate.

Those hospitals that continue to be classified as SCHs after, their geographic reclassification will continue to be paid under the SCH payment methodology. In making the final determination of which rate results in the greatest payment amount, the change in Federal payment amount due to reclassification will be handled in exactly the same way as it currently in when there is a change in the Federal payment amount. As was discussed in detail in the September 4, 1990 prospective payment final rule (55 FR 35994–35998), it is not always possible to determine at the start of an SCH's cost reporting period which of its applicable payment rates results in the greatest aggregate payment for that period. Therefore, interim payment is made on an individual bill basis, using the higher of the hospital's applicable hospital-specific amount (that is, the higher of its FY 1982 or 1987 amount) and the applicable Federal payment amount. This determination is made by the PRICER program used to pay Medicare bills. Each bill is priced based on the Federal rate. In addition, if PRICER determines that the hospital-specific rate would yield, on average, a higher payment, an add-on payment will be made for each discharge based on the estimated difference between the higher hospital-specific rate and the average Federal payment for the DRG to which the discharge is assigned. This methodology can incorporate any number of changes in the Federal payment amount. Therefore, for discharges occurring on or after the effective date of the SCH's reclassification, the new Federal payment amount will be used to determine an individual bill's payment. Of course, when the hospital's cost reporting period is completed, there is a final determination of precisely which of the payment rates resulted in the highest aggregate payment for the period and any necessary adjustments are made.

VI. Changes to the Regulations

This final rule with comment period makes the following changes to the text of regulations:

- Section 412.92 has been revised to state that a hospital need not be located in a rural area to be classified as a sole community hospital, as long as it is located more than 35 miles from other like hospitals.
- The title of 42 CFR part 412, subpart L, has been changed from The Medicare Geographical Classification Review Board to The Medicare Geographic Classification Review Board.
- In § 412.230, paragraph (a)(4)(iv) has been added to clarify that if an SCH or RRC loses its special status as a result of geographic redesignation, it is considered to retain its special status for the purpose of applying for continued geographic redesignation under the special rules for SCHs and RRCs at § 412.230(a)(4). In addition, paragraphs (d)(1) and (e)(1)(ii) of § 412.230 have been revised to clarify that a hospital must demonstrate the necessary geographic relationship specified in paragraphs (a) and (b) of § 412.230 to receive either an adjacent area's standardized amount or its wage index. Last, paragraph (e)(2)(ii) of § 412.230 has been corrected to state that occupational mix data is required only if a hospital is requesting classification

under the weighted average hourly wage provision at § 412.230(e)(1)(iii)(B).

- We have added criteria at § 412.234 concerning reclassification of all hospitals in a county located in an urban area to another urban area, and we have moved the alternative criteria for reclassification of all hospitals located in a NECMA from § 412.234 to § 412.236. In addition, the redesignated criteria at § 412.236 have been revised to provide that all the hospitals located in a county in a NECMA may also qualify for redesignation by meeting the new criteria § 412.234.
- In § 412.236, paragraphs (c)(1) and (c)(2) have been revised to state that, at the request of the hospital, the MGCRB may for good cause grant a hospital an extension beyond October 1 to complete its application for reclassification.
- We have added new § 412.273 to provide that a hospital may withdraw its application for reclassification at any time before the MGCRB issues a decision.
- In § 412.278, we have added a new paragraph (c) to provide for discretionary review by the Administrator of any final decision of the MGCRB and a new paragraph (d) setting forth criteria for the Administrator to use in deciding whether to review an MGCRB decision. We have added a new § 412.278(e) to provide for additional communication procedures applicable to the Administrator's review of an MGCRB decision both at a hospital's request or at his or her own discretion. We have also added a new § 412.278(f)(2)(ii) specifying that, in cases of discretionary review, the Administrator issues a decision in writing within 105 days of the MGCRB decision.
- Finally, we have redesignated portions of other sections of regulations to accommodate the addition of these provisions and have made several other technical corrections.

VII. Regulatory Impact Statement

A. Executive Order 12291

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a regulatory impact analysis for any final rule that meets one of the E.O. 12291 criteria for a "major rule"; that is, a rule that is likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Hospitals reclassified as a result of this final rule will receive increased Medicare payments. However, in accordance with section 1886(d)(8)(D) of the Act, proportional adjustments will be made to the urban and rural standardized amounts, thereby eliminating any effect of the increased hospital payments on aggregate Medicare payments. Because this rule's effect is budget neutral, this final rule is not a major rule under E.O. 12291 criteria, and a regulatory impact analysis is not required.

B. Regulatory Flexibility Act

1. Introduction

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that a final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all prospective payment hospitals to be small entities.

Section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a final rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b), we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area (NECMA) and has fewer than 101 beds.

This final rule conforms our regulations to the legislative provisions of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101-239) and the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508), and will specify procedures to be followed in implementing the law.

2. Summary of the Initial Impact Analysis

In the initial regulatory flexibility analysis that was published as part of the September 6, 1990 interim final rule, we explained that we were unable to estimate the impact the rule will have on hospitals because we could not predict which hospitals would apply for reclassification, or how the MGCRB will rule on the applications received by the deadline for consideration for FY 1992. In the initial impact analysis, we estimated that about 300 applications would be submitted to the MGCRB. In point of fact, the MGCRB received over 1,000 complete applications by the closing date of November 6, 1990. The MGCRB has until March 30, 1991 to issue decisions on these applications. Moreover, there is a 105 day time period from the date of an MGCRB decision and completion of Administrator review. Until the MGCRB reaches its decisions on the applications and Administrator review is completed, we will not know what impact this rule will have for FY 1992.

In the initial impact analysis, we presented hypothetical examples to illustrate the potential effects on a hospital's Medicare revenues resulting from a successful reclassification application. Using those hypothetical cases, it is evident that a successful application could not only mean a substantial increase in revenues for a hospital, but could also represent a boost to the local economy. This would be especially true in the case of a successful group application, in which all the hospitals in a particular county were reclassified. The amount of the increased revenues could run into several million dollars, much of which could eventually flow into the surrounding community in the form of increased employment and additional purchases of goods and services. Even the effect of applying section 1886(d)(8)(D) of the Act in order to maintain the budget neutrality of the prospective payment system will not have a substantial impact on reclassified hospitals. The impact of reclassification on those hospitals that are reclassified will be much greater than the offsetting budget neutrality adjustment will be on those same hospitals.

3. Impact of Statutory and Other Changes Implemented in This Final Rule

We did not receive any comments regarding the initial impact analysis. Nor did we receive any data from commenters to assist with our analysis. As a result, we are unable to furnish any additional insight into the possible effects of this final rule above that which we presented in the initial impact analysis. We note, however, several changes in this final rule. Most of these changes are the result of provisions that were enacted by section 4002(h) of Public Law 101-508. As explained above, we cannot estimate the specific effects of these changes because of the unpredictable nature of the application and adjudicative process. We are, therefore, confining our discussion to describing whether the changes being

implemented will or will not benefit prospective payment hospitals.

a. *Group reclassification of urban hospitals.* One change that is likely to have an impact on prospective payment hospitals is the addition of § 412.234 establishing guidelines for the MGCRB to follow when considering a joint application from hospitals in a county located in an urban area seeking to be reclassified into another urban area. We are adding this section in response to language in the conference committee report accompanying Public Law 101-508 directing the Secretary to establish such guidelines. (H.R. Rep. No. 964, 101st Cong., 2nd Sess. 715 (1990).) These guidelines will apply to all joint urban hospital applications for reclassification for FY 1993.

As stated earlier, the reclassification of groups of hospitals could mean a substantial redistribution of Medicare funds, and this could not only have a substantial impact on reclassified hospitals, but on their communities as well. The increased flow of funds to these hospitals could mean greater employment in the area, which in turn could translate into more sales by local merchants to these employees. Also, direct sales of goods and services to hospitals may increase as a result of the enhanced revenues. If hospitals are able to spend the additional funds for patient care services, then access to care may also increase.

b. *Section 1886(d)(8)(C)(i)(II) of the Act.* Section 1886(d)(8)(C)(i)(II) of the Act modifies the way we compute the wage index value for reclassified hospitals if the reclassification results in a reduction of the wage index value of more than 1.0 percent for the urban area into which the hospital is reclassified. Before enactment of revised section 1886(d)(8)(C)(i)(II) of the Act, if reclassification would have produced a decrease of more than 1.0 percent in the urban wage index value, we maintained the old wage index value (computed without regard to the reclassified hospitals) for those hospitals in the urban area, and computed a separate, county-specific wage index value for the group of hospitals being reclassified. We did not specify how the wage index would be calculated for individual hospitals that were reclassified. With the enactment of revised section 1886(d)(8)(C)(i)(II), of the Act, if the urban wage index value is lowered by more than 1.0 percent, instead of paying the reclassified hospital on the basis of a separate, county-specific wage index value, a reclassified hospital will be paid using a wage index value that combines wages of all reclassified hospitals in a given area and wages of that urban area into which the hospital is being reclassified. The wage index value for the other hospitals in the urban area will continue to be computed without taking into account reclassified hospitals.

We believe that most hospitals applying for reclassification are located in rural areas. Generally, rural area wage index values are lower than the urban area wage index values in the same State. By computing a blended wage index comprise of the wages paid to reclassified hospitals with the wages paid to hospitals in the adjacent urban area, a reclassified hospital will receive an increase in payments over what it would have received before section 1886(d)(8)(C)(i)(II) was revised.

c. *Section 1886(d)(10)(C)(iii)(II) of Act.* Revised section 1886 (d)(10)(C)(iii)(II) of the Act provides the Administrator with the authority to review decisions of the MGCRB at his or her discretion. That is, the Administrator may review a decision by the MGCRB even if the hospital has not requested review. It is highly likely that the Administrator will review some of the MGCRB's decisions and that the Administrator will modify or reverse some of the MGCRB's decisions. However, the likely effect of this provision is unclear because it is impossible to predict how many MGCRB decisions the Administrator will decide to review and how many MGCRB decisions will be modified or reversed. Although those hospitals whose favorable decisions are overturned based on the Administrator's discretionary review will be adversely affected, these adverse effects may be mitigated by a smaller adjustment in the budget neutrality factor for reclassification if the overall effect of the discretionary review results in fewer hospitals being reclassified.

d. *Right to withdraw an application for reclassification.* In response to comments, we added § 412.273 that allows a hospital to withdraw an application for reclassification at any time before the MGCRB issues its decision on the hospital's requested reclassification. This provision will be effective with applications for reclassification for FY 1993 (that is, filed by October 1, 1991).

We cannot predict what percent of those hospitals that withdraw their applications would receive favorable decisions on their reclassification application. However, generally, this provision should benefit a hospital applying for reclassification by allowing it to withdraw its application if it determines that a favorable decision on an application would not be to the hospital's advantage because of changes in either the hospital's wage index value or the wage index value for the area into which the hospital is seeking reclassification.

In addition to this general provision allowing hospitals to withdraw their applications before the MGCRB reaches a decision, for FY 1992 only, we are allowing all hospitals to withdraw their applications after a decision has been issued by the MGCRB, if their request is received by [60 days after date of publication in the **Federal Register**]. Again, it is impossible for us to know what effect this opportunity to withdraw an application for FY 1992 will have on prospective payment hospitals. However, we surmise that it will benefit hospitals.

C. Conclusion

In the absence of data, we are unable to reach any specific, quantifiable conclusions regarding the potential effects of this final rule. We have, however, pointed to the sizable redistributive effects that may flow from some of the MGCRB's decisions (especially those that involve group applications). We have also briefly discussed the possible effects of the changes implemented in this final rule. For the most part, we believe these changes will benefit hospitals applying for geographic reclassification.

VIII. Other Required Information

A. Effective Dates

The September 6, 1990 interim final rule set forth procedures and criteria for the MGCRB to use in making its decisions on hospital applications for geographic reclassification. Nothing in this final rule with comment period changes the effective date of those provisions, which permit hospital reclassifications beginning October 1, 1991 for approved requests filed by November 6, 1990. However, this final rule contains several changes to the September 6, 1990 interim final rule, with various effective dates as described below:

- The revised method for applying the wage index to redesignated hospitals (first set forth at 56 FR 570) is effective for discharges occurring on or after January 1, 1991, as specified by Congress under section 1886(d)(8)(C) of the Act as amended by section 4002(h)(1)(A) of Public Law 101-508.
- The new procedures for review of any MGCRB decision at the discretion of the Administrator at § 412.278(c) are effective June 4, 1991.

• The provision that a hospital may, for an application for reclassification for Federal fiscal year 1992 only, withdraw its application after the MGCRB issues a decision is effective June 4, 1991, through August 5, 1991.

• The provision that a hospital located in an urban area can qualify for sole community hospital status if it is located more than 35 road miles from the nearest like hospital is effective June 4, 1991.

• All other changes implemented by this final rule with comment period are applicable beginning October 1, 1991, that is, for applications for geographic reclassification for Federal fiscal year 1993. These changes include a hospital's right to withdraw an application before the MGCRB issues a decision and the criteria for all hospitals in a county located in an urban area to request reclassification to another urban area.

B. Waiver of Notice of Proposed Rulemaking and 30-day Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking for a rule to provide a period for public comment. However, we may waive that procedure if we find good cause that prior notice and comment are impractical, unnecessary, or contrary to public interest. We find good cause to issue this rule as a final rule with comment period because the delay involved in prior notice and comment procedures for the new provisions of this rule would be contrary to the public interest.

First, as explained elsewhere in this preamble, the MGCRB faces a statutory deadline of March 30, 1991 for issuing decisions on hospital reclassifications for Federal FY 1992. If hospitals are to receive timely the potential benefits of reclassification, if is necessary that complete appeal procedures immediately be in place. Timely adjudication is also essential to ensure that the budget neutrality requirement imposed by Congress in section 1886(d)(6) of the Act can be met for Federal FY 1992 prospective payment system rates. In addition, section 4207(k) of Public Law 101–508 provides the authority to implement its provisions through a final rule with comment period when necessary. Thus, with regard to the new procedures for discretionary review by the Administrator of MGCRB decisions, a waiver of the notice of proposed rulemaking and prior public comment procedures is necessary and justified.

The only other new provision in this final rule with comment period that did not result solely from a comment on the September 6, 1990 interim final rule is the establishment of criteria for all hospitals located in a county in an urban area to request joint reclassification to another urban area. As noted above, we added this provision based both on a commenter's suggestion and on explicit instructions from Congress in the Conference Committee Report accompanying Public Law 101–508 that the Secretary establish such guidelines at the earliest possible date. Therefore, in order for groups of hospitals to be able to apply for joint reclassification by October 1, 1992 for reclassification for FY 1993, it is necessary that these guidelines be issued as final regulations at this time.

Therefore, we have concluded that it is appropriate to issue a final rule in this instance. However, we are providing a 60-day period for public comment, as indicated at the beginning of this rule, on changes to the September 6, 1990 interim final rule resulting from provisions of Public Law 101–508. After considering comments that are received timely, we will respond to the comments, include any changes in the rule that might be necessitated in light of those comments, and publish a final rule in the **Federal Register**.

We also normally provide a delay of 30 days in the effective date for documents such as this. However, if adherence to this procedure would be impractical, unnecessary, or contrary to public interest, we may waive the delay in the effective date. We find good cause to waive the usual 30-day delay for the provisions scheduled to take effect upon the publication of this final rule with comment period.

As explained above, it is essential that the new administrative review provisions have immediate effect so that the complete appeal procedures to be followed for MGCRB decisions during the current application period will be in place. Any delay in the effective date for this rule would also jeopardize the budget neutrality requirement described above. The provision that a hospital or hospitals may, for an application for reclassification for FY 1992 only, withdraw an application after the MGCRB issues its decision is entirely beneficial to hospitals and needs to take effect as soon as possible after the MGCRB issues a decision. Finally, the provision that a hospital located in an urban area can qualify for SCH status if it is located more than 35 miles from a like hospital also needs to take effect upon publication, so that affected hospitals can know with certainty that even after reclassification to an urban area, they continue to qualify for SCH status.

Thus, a 30-day delay in the effective date would be contrary to the public interest. Therefore, we find good cause to waive the usual 30-day delay in effective date.

C. Paperwork Reduction Act

Sections 412.230, 412.232, 412.234, 412.236, 412.254, 412.260, 412.266 and 412.278 of this final rule with comment contain information collection requirements subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1980. The cited sections have been approved by OMB through October 1993 under OMB control number 0938–0573.

D. Public Comments

Because of the large number of items of correspondence we normally receive concerning regulations, we cannot acknowledge or respond to the comments individually. However, we will respond to all comments received by the date and time specified in the "Dates" section of this preamble, and issue any necessary changes in a final rule.

List of Subjects in 42 CFR Part 412

Health facilities, Medicare, Reporting and recording requirements.

42 CFR part 412 is amended as set forth below:

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Subchapter B—Medicare Program

Part 412 is amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

A. The authority citation for part 412 is revised to read as follows:

Authority: Sections 1102, 1815(e), 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395g(e), 1395hh, and 1395ww).

B. In subpart G, § 412.92, the introductory text of paragraph (a) is revised; paragraph (a)(1) is removed; paragraphs (a)(2), (a)(3), and (a)(4) are redesignated as paragraphs (a)(1), (a)(2), and (a)(3), respectively; the reference to "paragraph (a)(2)(i)" in newly redesignated paragraph (a)(1)(ii) is revised to read "paragraph (a)(1)(i)"; and the reference to "paragraph (a)(2)(i) or (a)(2)(ii)" in paragraph (b)(1)(ii) is revised to read "paragraphs (a)(1)(i) or (a)(1)(ii)".

Subpart G—Special Treatment of Certain Facilities

§ 412.92 Special treatment: Sole community hospitals.

(a) *Criteria for classification as a sole community hospital.* HCFA classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in § 412.83(b)) and meets one of the following conditions:

* * * * *

C. Subpart L is amended to read as follows:

1. The title of Subpart L is revised to read as follows:

Subpart L—The Medicare Geographic Classification Review Board

2. In § 412.230, new paragraph (a)(4)(iv) is added; paragraph (d)(1) is revised; the introductory text of paragraphs (e)(1) and (e)(2) are republished; and paragraphs (e)(1)(ii) and (e)(2)(ii) are revised to read as follows:

§ 412.230 Criteria for an individual hospital seeking redesignation to a different rural or urban area.

(a) *General.*

* * * * *

(4) *Special rules for sole community hospitals and rural referral centers.*

* * * * *

(iv) If a sole community hospital or rural referral center loses its special status as a result of redesignation, the hospital is considered to retain its special status for the purpose of applicability of the special rules in paragraph (a)(4) of this section.

* * * * *

(d) *Use of an adjacent area's standardized amount*—(1) *Criteria.* To receive an adjacent area's standardized amount, a hospital must demonstrate that its incurred costs are more comparable to the amount it would be paid if it were reclassified than the amount it would be paid under its current classification, and that it has the necessary geographic relationship (as specified in paragraphs (a) and (b) of this section) with the area to which it seeks redesignation.

* * * * *

(e) *Use of urban or other rural area's wage index*—(1) *Criteria for use of adjacent area's wage index.* To use an adjacent area's wage index, a hospital must demonstrate the following.

* * * * *

(ii) The hospital has the necessary geographic relationship as specified in paragraphs (a) and (b) of this section; and

* * * * *

(2) Appropriate wage data. For a wage index change, the hospital must submit appropriate data as follows:

* * * * *

(ii) For data for other hospitals, the hospital must provide data concerning both of the following:

(A) The average hourly wage in the adjacent area, which is taken from the most recent HCFA hospital wage survey; and

(B) If the hospital is requesting reclassification under § 412.230(e)(1)(iii)(B), occupational-mix data to demonstrate the average occupational mix for each employment category in the adjacent area. Occupational-mix data can be obtained from the Bureau of labor Statistics' survey of a limited number of metropolitan areas; or surveys conducted by the American Hospital Association.

3. Section § 412.234 is redesignated as § 412.236; a new § 412.234 is added; and paragraph (a)(2) of newly redesignated § 412.236 is revised to read as follows:

§ 412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

(a) *General criteria.* For all prospective payment hospitals in an urban county to be redesignated to another urban area, the following conditions must be met:

(1) All hospitals in an urban county must apply for redesignation as a group.

(2) The county in which the hospitals are located must be adjacent to the urban area to which they seek redesignation.

(3) The county in which the hospitals are located must be part of the Consolidated Metropolitan Statistical Area (CMSA) that includes the urban area to which they seek redesignation.

(b) *Wage Criteria*—(1) *Aggregate hourly wage.* The aggregate average hourly wage of all hospitals in the urban county must be at least 85 percent of the average hospital hourly wage in the MSA or NECMA to which the hospitals in the county seek reclassification; or

(2) *Aggregate hourly wage weighted for occupational mix.* The aggregate average hourly wage of all hospitals in the urban county, weighted for occupational categories, is at least 90 percent of the occupationally adjusted hourly wage, in the MSA or NECMA to which the hospitals in the county seek reclassification.

(c) *Standardized amount.*—(1) *Criteria.* The urban hospitals must demonstrate that their average incurred costs are more comparable to the amount the hospitals would be paid if they were reclassified than the amount they would be paid under their current classification.

(2) *Demonstrating comparable costs.* The urban hospitals demonstrate that their costs are more comparable to the average amount they would be paid if they were reclassified if, on average, each hospital's case-mix adjusted cost per case is at least equal to the amount it would be paid under its current classification plus 75 percent of the difference between that amount and the amount the hospital would receive if it were reclassified.

(d) *Appropriate data.*—(1) *Wage data.* The hospitals must submit appropriate wage data as provided for in § 412.230(e)(2).

(2) *Cost data.* The hospitals must submit appropriate data as provided for in § 412.230(d)(3).

§ 412.236 Alternative criteria for hospitals located in an NECMA.

(a) *General.*

* * * * *

(2) All the hospitals in a NECMA may qualify for redesignation by meeting the criteria in either § 412.234 or in paragraph (c) of this section.

* * * * *

§ 412.250 [Amended]

4. In § 412.250, the reference to "§ 412.230 through § 412.234 in paragraph (a) is revised to read "§ 412.230 through § 412.236".

5. In § 412.256, the reference to "§ 412.230 through § 412.234" in paragraph (b)(3) is revised to read "§ 412.230 through § 412.236"; and paragraph (c) is revised to read as follows:

§ 412.256 Application requirements.

* * * * *

(c) *Opportunity to complete a submitted application.* (1) The MGCRB will review an application within 15 days of receipt to determine if the application is complete. If the MGCRB determines that an application is incomplete, the MGCRB will notify the hospital, with a copy to HCFA, within the 15 day period, that it has determined that the application is incomplete and may dismiss the application if a complete application is not filed by October 1.

(2) At the request of the hospital, the MGCRB may, for good cause, grant a hospital that has submitted an application by October 1, an extension

beyond October 1 to complete its application.

* * * * *

6. New § 412.273 is added to read as follows:

§ 412.273 Withdrawing an application.

(a) A hospital, or group of hospitals, may withdraw an application at any time before the MGCRB issues a decision.

(b) A request to withdraw an application must be made in writing by all hospitals that are party to the application.

7. In § 412.278, the heading of paragraph (a) and paragraph (b)(1) are revised; the introductory text in paragraph (c), and paragraphs (c)(3), (c)(4), and (c)(5) are redesignated as paragraphs (f)(1), (f)(2), (f)(3), and (f)(4), respectively; new paragraph (c), (d), and (e) are added; and redesignated paragraph (f)(2) is revised to read as follows:

§ 412.278 Administrator's review.

(a) *Hospital's request for review.*

* * * * *

(b) *Procedures for hospital's request for review.* (1) The hospital's request for review must be in writing and sent to the Administrator, in care of the Office of the Attorney Advisor. The request must be received by the Administrator within 15 days after the date the MGCRB issues its decision. A request for Administrator review filed by facsimile (FAX) or other electronic means will not be accepted. The hospital must also mail a copy of its request for review to HCFA's Office of Payment Policy.

* * * * *

(c) *Discretionary review by the Administrator.* (1) The Administrator may, at his or her discretion, review any final decision of the MGCRB.

(2) The Administrator promptly notifies the hospital that he or she has decided to review a decision of the MGCRB. The notice of review indicates the particular issues to be considered and includes copies of any comments submitted to the Administrator by HCFA staff concerning the MGCRB decision.

(3) Within 15 days of the receipt of the Administrator's notice of review, the hospital may submit a response in writing to the Administrator, with a copy of HCFA.

(d) *Criteria for discretionary review.* In deciding whether to review an MGCRB decision, the Administrator normally considers whether it appears that any of the following situations apply:

(1) The MGCRB made an erroneous interpretation of law, regulation, or HCFA Ruling.

(2) The MGCRB's decision is not supported by substantial evidence.

(3) The case presents a significant policy issue having a basis in law and regulations, and review is likely to lead to issuance of a HCFA Ruling or other directive needed to clarify a provision in the law or regulations.

(4) The decision of the MGCRB requires clarification, amplication, or an alternative legal basis.

(5) The MGCRB has incorrectly extended its authority to a degree not provided for by law, regulation, or HCFA Ruling.

(e) *Communication procedures.* All communications between HCFA staff and the Administrator concerning the Administrator's review of an MGCRB decision must be in writing. As specified in paragraphs (b) and (c) of this section, copies of comments by HCFA staff are sent to applicant hospitals within 15 days of receipt of a hospital's request for review, or, in cases in which the Administrator decides to review a case at his or her discretion, are included with the Administrator's notice of review. In the event there are additional communications between HCFA staff and the Administrator concerning MGCRB decisions reviewed by the Administrator under paragraphs (b) or (c) of this section, HCFA furnishes copies of the communications to the hospital or group of hospitals.

(f) *Administrator decision.*

* * * * *

(2) The Administrator issues a decision in writing to the party with a copy to HCFA—

(i) Not later than 90 days following receipt of the party's request for review, or

(ii) Not later than 105 days following issuance of the MGCRB decision in the case of review at the discretion of the Administrator.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: March 24, 1991.

Gail R. Wilensky,

Administrator, Health Care Financing Administrator.

Approved: May 21, 1991.

Louis W. Sullivan,

Secretary.

[FR Doc. 91-13082 Filed 5-30-91; 12:11 pm]

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Tuesday
June 4, 1991

Part V

Department of Health and Human Services

Office of Community Services

Request for Applications Under the Office of Community Services' Fiscal Year 1991 Discretionary Grants Program; Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Community Services

[Program Announcement No. OCS-91-1]

Request for Applications Under the Office of Community Services' Fiscal Year 1991 Discretionary Grants Program

AGENCY: Office of Community Services, ACF, HHS.

ACTION: Request for applications under the Office of Community Services' Discretionary Grants Program.

SUMMARY: The Administration for Children and Families, Office of Community Services [OCS] announces that competing applications will be accepted for new and continuation grants pursuant to the Secretary's discretionary authority under section 681(a)(2) of the Community Services Block Grant Act of 1981, as amended. This Program Announcement consists of seven parts:

Part A covers information on legislative authorities and defines terms used in the Program Announcement;

Part B lists the three program priority areas under which grants will be made, describes the types of projects that will be considered for funding under each priority area, and defines who is eligible to apply;

Part C provides details on application prerequisites, funds available in each priority area, limitations on grant amounts, project periods, who should benefit from the programs, and other application requirements;

Part D describes the application procedures, including the availability of forms, where and how to submit an application, the criteria used in screening and evaluating applications, and compliance with Federal requirements regarding the drug-free workplace and debarment requirements in submitting the application;

Part E describes the contents of the application package and receipt process;

Part F provides instructions for completing the SF-424 following standard Federal guidelines as well as OCS specific requirements, and describes how the project narrative should be ordered and presented; and

Part G details post-award information and reporting requirements.

CLOSING DATE: The closing date for submission of applications is August 5, 1991.

FOR FURTHER INFORMATION CONTACT: Office of Community Services, Office of State and Project Assistance, 370 L'Enfant Promenade SW., Washington, DC 20447, Telephone (202) 401-9345.

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Part A—Preamble

1. Legislative Authority

Section 681(a)(2) of the Community Services Block Grant Act as amended authorizes the Secretary to make funds available to support program activities of national or regional significance to alleviate the causes of poverty in distressed communities.

2. Departmental Goals

The Secretary has established seven strategic goals guiding the Department of Health and Human Services' policies and programs over the next several years. One of those goals is particularly relevant to OCS' Discretionary Grants Program, i.e. strengthening the American family. The Secretary's Program Directions on how programs should be managed in order to achieve this goal include improving access of youth living in low-income families to needed support services, including employment training and other transition to work services, and improving the integration, coordination and continuity of the various HHS funded services potentially available to families currently living in poverty.

3. Definition of Terms

For purposes of this Program Announcement the following definitions apply:

—*Affiliate:* An entity which has legal and/or financial ties to a community development corporation, and which also meets the statutory requirement that it be governed by a board consisting of residents of the community and business and civic leaders.

—*Community development corporation:* A private, locally initiated, nonprofit entity, governed by a board consisting of residents of the community and business and civic leaders, which has a record of implementing economic develoment projects or whose Articles of Incorporation and/or By-Laws indicate that it has a focus in the area of economic development.

—*Displaced worker:* An individual who is in the labor market but has been unemployed for six months or longer.

—*Distressed community:* A geographic urban neighborhood or rural community of high unemployment and pervasive poverty.

—*Eligible applicant:* (See appropriate Priority Area under part B).

—*Indian tribe:* A tribe, band, or other organized group of Indians recognized in the State in which it resides or which is considered by the Secretary of the Interior to be an Indian tribe or an Indian organization for any purpose.

—*Migrant farmworker:* An individual who works in agricultural employment of a seasonal or other temporary nature who is required to be absent from his/her place of permanent residence in order to secure such employment.

—*Rural:* An area that is not within the outer boundary of a metropolitan entity having a population of 25,000 or more and contiguous communities with a population density of 100 persons or more per square mile according to the latest decennial census. Such an area may be located entirely within one State or made up of contiguous interstate communities.

—*Seasonal farmworker:* Any individual employed in agricultural work of a seasonal or other temporary nature who is able to remain at his/her place of permanent residence while employed.

—*Budget period:* The interval of time into which a grant period of assistance is divided for budgetary and funding purposes.
—*Project period:* The total time for which a project is approved for support, including any approved extensions.

Part B—Program Priority Areas

The program priority areas of the Office of Community Services' Discretionary Grants Program and their purposes are as follows:

Priority Area 1.0 Urban and Rural Community Economic Development.
1.1 Urban and Rural Community Economic Development (Operational).
1.2 Urban and Rural Community Economic Development (HBCU Set-Aside).
1.3 Urban and Rural Community Economic Development (Pre-development).
1.4 Urban and Rural Community Economic Development (YOU Program Set-Aside).
Priority Area 2.0 The Planning and Development of Rural Housing (including rental housing for low-income individuals) and community facilities.
2.1 Rural Housing (including rental housing for low-income individuals).
2.2 Rural Community Facilities Development (Water and Waste Water Treatment Systems Development).
Priority Area 3.0 Assistance for Migrants and Seasonal Farmworkers.
3.1 Assistance for Migrants and Seasonal Farmworkers (Set-Aside).

Priority Area 1.0 Urban and Rural Community Economic Development

The purpose of this priority area is to encourage the creation of projects intended to provide employment and business development opportunities for low-income people through business, physical or commercial development, and generally to improve the quality of the economic and social environment of low-income residents, including displaced workers, at-risk teenagers, individuals residing in public housing, and individuals who are homeless. It is intended to provide resources to eligible applicants but also has the broader objectives of arresting tendencies toward dependency, chronic unemployment, and community deterioration in urban and rural areas.

To this end, the program also seeks to attract additional private capital into distressed communities, including enterprise zones, and to build and/or expand the ability of local institutions to better serve the economic needs of local residents.

Applications under this Priority Area should include an Executive Summary of the proposal not to exceed five pages. This summary must address the program principles within this announcement and document that the proposed project will have national or regional significance.

Priority Area 1.1 Urban and Rural Community Economic Development (Operational)

Funds will be provided for a limited number of private non-profit community development corporations (or affiliates of such corporations) for business development activities at the local level. Funding will be provided for specific projects and will require the submission of business plans or developmental proposals that meet the test of economic feasibility.

Projects must further the Departmental goals of strengthening American families and promoting their self-sufficiency. OCS is particularly interested in receiving applications that stress public-private partnerships that are directed toward the development of economic self-sufficiency through a focus on economic expansion.

Applicants located in State-designated enterprise zones, i.e. an area in which a legislative entity has enacted a program of tax and regulatory relief to encourage business development, are urged to submit applications. Such projects must be linked with—and complement—enterprise zone initiatives, and may request funds for a business development project or a project that demonstrates innovative ways to involve the poverty community in the implementation of the enterprise zone concept.

Applications must show that the proposed project:

(1) Creates full-time permanent jobs. Seventy-five percent (75%) of those jobs created must be filled by low-income residents of the community and must also provide for career development opportunities. Project emphasis should be on employment of individuals who are unemployed or on public assistance, with particular emphasis on at-risk teenagers, individuals residing in public housing, and individuals who are homeless. While projected employment in future years may be included in the application, it is essential that the focus of employment projects concentrate on those jobs created during the duration of the OCS project period; and/or

(2) Creates a significant number of business development opportunities for low-income residents of the community or significantly aids such residents in maintaining economically viable businesses; and

(3) Provides for establishing the self-sufficiency of program participants.

In the evaluation process, favorable consideration will be given to applicants under this priority area who show the lowest cost-per-job created. Unless there are extenuating circumstances, OCS will not fund projects where the cost-per-job in OCS funds exceeds $15,000.

Any applicant which proposes to use the requested OCS funds to make an equity investment such as the purchase of stock, or a loan to a business concern, including a wholly-owned subsidiary, or to make a sub-grant with a portion of the OCS funds, must include in its application a written agreement with the third party that commits the latter to the following:

1. A minimum of 75% of the jobs to be created under the grant will be for low-income individuals.

2. The grantee will have authority to screen applicants for jobs to be filled by low-income individuals and to verify their eligibility.

3. The grantee will have a seat on the Board of Directors of the third party's if the grantee's investment equal 25% or more of the firm's assets. (Not applicable to loans.)

4. Reports will be made on a quarterly basis to the grantee on the use of grant funds.

5. A procedure will be developed to assure that there are no duplicative counts of jobs created.

6. Detailed information will be provided on how the grant funds will be used by the third party. In addition, the agreement will provide details on how the community development corporation will provide support and technical assistance to the firm in areas of recruitment and retention of low-income individuals.

Any funds that are proposed to be used for training purposes must be limited to providing specific job-related training to those poverty level individuals who have been selected for employment in the grant supported project or who have been selected for training or participation in a project where potential jobs have already been identified.

OCS encourages applications that create linkages with community organizations administering the JOBS program which will train and place residents dependent on public assistance into jobs created by the project funded under this priority area.

Projects which would result in the relocation of a business from one geographic area to another with the possible displacement of employees are discouraged.

OCS will not consider applications that propose to establish or expand revolving loan funds, nor proposals that are geared towards the establishment of Small Business Investment Corporations or Minority Enterprise Small Business Investment Corporations.

OCS does not anticipate approving the funding of applications which propose to sub-grant all or most of the grant activities to an unrelated entity, with the exception of applications eligible for the special set-aside fund described below.

Applicants must be aware that projects funded under this priority area must be operational by the end of the project period, i.e. businesses must be in place, and low-income individuals actually employed in those businesses.

Eligible applicants are private, locally initiated, non-profit community development corporation (or affiliates of such corporations) governed by a board consisting of residents of the community and business and civic leaders which sponsor enterprises providing employment and business development opportunities for low-income residents of the community designed to increase business and employment opportunities in the community.

See part F, 6, for special instructions on developing a work program for this priority area.

Priority Area 1.2 Urban and Rural Community Economic Development (HBCU Set-Aside)

For Fiscal Year 1991, a set-aside fund of $2.5 million will be included under this priority area for eligible applicants that submit projects that will be carried out in conjunction with Historically Black Colleges and Universities through contract or sub-grant. Such projects must conform to the purposes, requirements, and prohibitions applicable to those submitted under Priority Area 1.1.

These projects should reflect a significant partnership role for the college or university and the applicant in doing so will be considered to have fulfilled the goals of the Public-Private Partnerships evaluation criterion and will be granted the maximum number of points in that category. Applications for these set-aside funds which are not funded due to the limited amount of funds available will also be considered competitively within the larger pool of eligible applicants under priority area 1.1.

See Part F, 6, for special instructions on developing a work program for this priority area.

Priority Area 1.3 Urban and Rural Community Economic Development (Pre-developmental)

OCS intends in this priority area to provide funds to recently-establish private, non-profit community development corporations (or affiliates of such corporations) which propose to undertake economic development activities in distressed communities.

OCS recognizes that there are a number of newly-organized non-profit community development corporations who have identified needs in their communities but who have not had the staff or other resources to develop projects to address those needs. This lack of resources also might be affecting their ability to compete for funds, such as those provided under OCS's Urban and Rural Community Development Program (Operational Grants) since their limited resources would preclude them developing a comprehensive business plan and/or mobilizing resources. OCS has an interest in providing support to these new entities in order to enable them to become more firmly established in their communities thereby bringing technical expertise and new resources to these previously unserved or underserved communities. Therefore, OCS is setting aside $500,000 in Fiscal Year 1991 for grants to private non-profit community development corporations, or affiliates of such corporations, which have been in existence for no more than three years and have never received OCS funding. From this sum, grants of up to $500,000 each will be made to eligible applicants.

These grants will be made for a period of six months and will not require matching funds.

The grants will be pre-developmental grants under which CDCs or their affiliates may incur costs to: (1) Evaluate the feasibility of potential projects which address identified needs in the low-income community and which conform to those projects and activities allowable under Priority Areas 1.1 and 1.2; (2) develop a Business Plan related to one of those projects; and (3) mobilize resources to be contributed to the project, including the utilization of Historically Black Colleges and Universities. Based on the availability of funds in Fiscal Year 1992, grantees would be able to compete for any OCS funds and OCS would consider establishing a set-aside. Grants might be for a maximum of $200,000 and competition for those funds restricted to those organizations receiving Fiscal Year 1991 pre-development grants. The Business Plan developed as part of the pre-developmental grants would be submitted as part of the competitive application.

Each application for Fiscal Year 1991 funding under this Priority Area must inlude the following as part of the project narrative in part IV of the SF 424.

1. Description of the impact area, i.e., a description of the low-income area it proposes to address;

2. Analysis of need in the distressed community;

3. Project objectives and measurable impact, i.e., a discussion of the types of projects that might be implemented to address the identified needs and how the proposed projects relate to the applicant's organizational goals and previous experience (if any); and

4. Implementation factors; quarterly work plans with specific task timeliness

Priority Area 1.4 Urban and Rural Community Economic Development (YOU Program Set-Aside)

For Fiscal Year 1991, $1.5 million will be set aside to specifically address the Secretary's Program Direction related to improving the integration, coordination and continuity of HHS funded services potentially available to families curently living in poverty. In this instance, OCS is interested in the integration and coordination of services funded under this priority area with those funded by the Department of Labor under its Youth Opportunities Unlimited Program (YOU).

The YOU Program is a demonstration program aimed at high poverty urban neighborhoods and rural counties. The demonstration concentrates a large amount of resources into a relatively small geographic area (neighborhoods of 25,000 or less) with the goal of fundamentally changing the entire set of opportunities facing youth growing up in the area. In July 1990 grants of $2.7 million each were awarded to seven organizations by the Department of Labor.

This set-aside will be available to applicants eligible for funding under OCS' Urban and Rural Community Economic Development Program who submit applications for projects which will be implemented within the target areas of the YOU demonstration. These target areas are prescribed communities within the cities of Atlanta, Baltimore, Columbus, Los Angeles, Philadelphia, and San Diego and two rural counties within the State of Mississippi. The exact boundaries of these areas are available from the respective YOU coordinators listed in Attachment K to this Program Announcement.

OCS is particularly interested in funding projects under this set-aside

that both provide jobs with wages sufficient to support a family and that enhance the long-term economic and social environment of the target area.

Projects funded under this set-aside must conform to the purposes, requirements, and prohibitions applicable to those submitted under Priority Area 1.1. In addition, there must be a formal, cooperative relationship established between the applicant and the agency which received funding under DOL's YOU Program. The application must include a written agreement between the applicant and the YOU Program grantee which contains specific language confirming that the project will be carried out in the target area. The agreement must include the goals and objectives that the applicant and the YOU Program grantee expect to achieve through their collaboration. It also must describe the cooperative relationship, including specific activities and/or actions each of these entities proposes to carry out in support of the project and the mechanism(s) to be used in coordinating those activities if the project is funded by OCS. The extent to which services will be integrated and coordinated and the significance of those services will receive consideration in the review process.

Any applicant which proposes to use the requested OCS funds to make an equity investment such as the purchase of stock, or a loan to a business concern, including a wholly-owned subsidiary, or to make a sub-grant with a portion of the OCS funds, must include in its application a written agreement with the third party that commits the latter to the following:

1. A minimum of 75% of the jobs to be created under the grant will be for low-income individuals.

2. The grantee will have authority to screen applicants for jobs to be filled by low-income individuals and to verify their eligibility.

3. The grantee will have a seat on the Board of Directors of the third party's firm if the grantee's investment equals 25% or more of the firm's assets. (Not applicable to loans made to third parties.)

4. Reports will be made on a quarterly basis to the grantee on the use of grant funds.

5. A procedure will be developed to assure that there are no duplicative counts of jobs created.

6. Detailed information will be provided on how the grant funds will be used by the third party. In addition, the agreement will provide details on how the grantee will provide support and technical assistance to the third party in areas of recruitment and retention of low-income individuals.

OCS will make up to two grants under this set-aside with a maximum of $750,000 to be granted for each project. Only one grant will be made to address problems in a particular target area.

Applications for these set-aside funds which are not funded due to the limited amount of funds available also will be considered competitively within the larger pool of eligible applications under priority area 1.1.

Priority Area 2.0 The Planning and Development of Rural Housing (including rental housing for low-income individuals) and Community Facilities

Priority Area 2.1 Rural Housing (including rental housing for low-income individuals)

The purpose of this priority area is to assist low-income residents in rural communities by providing grants to eligible applicants to: (a) Provide technical assistance to help low-income families and individuals more effectively utilize existing local, State and Federal housing assistance programs; and (b) develop innovative ways to meet the housing needs of low-income people, e.g. the rehabilitation or repair of existing substandard housing units for occupancy by low-income residents, the conversion of non-residential buildings to low-income residential use, and the purchase of homes by low-income people.

OCS encourages applications that will assist low-income homeowners to improve their housing through self-help rehabilitation. These applications should not include projects which can be funded through other existing Federal programs.

OCS also encourages the submission of proposals whose aim is to assist homeless families and those at risk of homelessness. Innovative ways to address housing needs of homeless families is of particular interest to OCS.

Projects should produce the following types of tangible improvements and benefits related to housing conditions for rural poor people: Interior or exterior structural repairs including weatherization and alternative energy systems; jobs created for local unskilled residents while assuring quality work; technical assistance and professional services related to housing and community planning by community-based design and planning organizations. (Such projects should be conducted with maximum use of voluntary services of professional and community personnel, and development of innovative housing strategies to help low-income rural residents acquire housing.)

Applications calling for new construction or "gut" rehabilitation will only be considered if the application documents that there is insufficient existing housing stock that can be economically rehabilitated.

Funds will not be available for the repair or rehabilitation of low-income rental housing unless the structure is either occupied by a low-income owner or the properties to be repaired are (a) owned by a private non-profit organization and (b) covered by a written agreement which will ensure continued occupancy by low-income people for at least three years after completion of repairs and rehabilitation.

Funds will not be available under this program priority area for projects that establish or expand a revolving loan fund.

Eligible applicants are States, public agencies or private non-profit organizations, including Historically Black Colleges and Universities.

OCS is particularly interested in receiving applications from such entities as rural housing development corporations, cooperatives, and other public and private organizations with proven accomplishments in the area of rural housing.

See part F, 6, for special instructions on developing a work program for this priority area.

Priority Area 2.2 Rural Community Facilities Development (Water and Waste Water Treatment Systems Development)

Funds will be provided under this priority area only for non-competitive continuation grants to the seven organizations which received grants under this priority area in FY 1990. Funds will be provided to the FY 1990 grantees based upon a report of satisfactory performance during the first nine months of the FY 1990 grant period.

Priority Area 3.0 Assistance for Migrants and Seasonal Farmworkers

The purpose of this priority area is to fund a limited number of projects which focus exclusively on the problems and special needs of migrants and seasonal farmworkers in order to improve their quality of life and advance self-sufficiency.

OCS will entertain proposals that directly meet farmworker needs in such areas as: Homelessness; crisis nutritional relief; the development of self-help systems of food production; emergency health and social services referral and assistance; home repair,

rehabilitation, and ownership; direct assistance to low-income farmworkers, including at-risk teenagers, to improve their job skills for them to qualify for long term and permanent full-time employment in agriculture; and/or assistance to low-income farmworkers, including at-risk teenagers, who wish to leave agricultural employment and find jobs in other lines of work. Linkages with the local JOBS program are encouraged wherever appropriate.

Applicants must provide quantifiable objectives for each of the above activities which will be included in the project. OCS encourages applicants to develop linkages with other public and private sector service providers who also are working with migrant and seasonal farmworkers or with issues affecting this target group.

For projects that relate to job skills and training, OCS will not consider applications proposing to use funds exclusively for classroom instruction. Placement must be an integral activity of any training project.

Applications submitted under this priority area must not contain requests for OCS funding for projects that would duplicate Community Services Block Grant funding or activities for which funding is available from other Federal agencies such as the Department of Labor, the Department of Agriculture's Food and Women, Infants and Children (WIC) programs, etc.

Eligible applicants are States, public agencies and private non-profit organizations including Historically Black Colleges and Universities.

See part F, 6, for special instructions on developing a work program for this priority area.

Priority Area 3.1 Assistance for Migrants and Seasonal Farmworkers (Set-Aside)

For Fiscal Year 1991, a fund of $300,000 will be set aside for Historically Black Colleges and Universities to enable them to offer continuing education to migrants and seasonal farmworkers and to increase participant employment opportunities. Applicants must provide quantifiable objectives for each of the activities which will be included in the project. Applications which are not funded within this set-aside due to the limited amount of funds available will also be considered competitively within the larger pool of eligible applicants under priority area 3.0.

See part F, 6, for special instructions on developing a work program for this priority area under priority area 3.0.

Part C—Application Prerequisites

1. Eligible Applicants

Priority areas included in this Program Announcement have differing eligibility requirements. Therefore, eligible applicants are identified in the individual priority area descriptions found in part B, above.

2. Availability of Funds

a. FY 1991 Funds

The Office of Community Services expects to award funds by September 30, 1991 for new grants. The maximum amount of funds available for each Priority Area is summarized below:

Priority area	Fiscal year 1991 funds
1.0 Urban and Rural Community Economic Developments:	
1.1 Urban and Rural Community Economic Development (Operational)	$15,993,734
1.2 Urban and Rural Community Economic Development (HBCU Set-Aside)	2,500,000
1.3 Urban and Rural Community Economic Development (Pre-development)	500,000
1.4 Urban and Rural Community Economic Development (YOU Program Set-Aside)	1,500,000
2.0 Planning and Development of Rural Housing and Community Facilities Development	4,098,947
3.0 Assistance for Migrants and Seasonal Farmworkers	2,724,961
3.1 Assistance for Migrants and Seasonal Farmworkers (Set-Aside)	300,000

b. Grant Amounts

No more than the below stated amounts will be granted for projects under the Priority Areas as indicated:

Priority area	Funding unit
1.1	$500,000
1.2	500,000
1.3	50,000
1.4	750,000
2.0	250,000
3.0	250,000
3.1	75,000

3. Project and Budget Periods

For Priority Areas 1.1, 1.2, and 1.4, applicants may request project and budget periods of up to 36 months and for Priority Areas 2.1, 3.0 and 3.1 up to 17 months. For Priority Area 1.3 applicants may request project and budget periods up to six months. By fully funding the projects in FY 91 funding stability in future years will be insured.

For Priority Area 2.2 only: FY 1990 grantees have been funded for a two-year project period. Based upon a report of satisfactory performance during the first nine months of the FY 1990 grant period, FY 1991 funds will be provided to the seven FY 1990 grantees on a non-competitive basis for the period beginning October 1, 1991.

4. Mobilization of Resources

OCS will give favorable consideration in the review process to applicants who document public/private partnerships which mobilize cash and/or third-party in-kind contributions. (See part D, Criterion IV.)

5. Program Beneficiaries

Projects proposed for funding under this announcement must result in direct benefits to low-income people as defined in the most recent Annual Revision of Poverty Income Guidelines published by DHHS.

Attachment A to this announcement is an excerpt from the guidelines currently in effect (1991). Annual revisions of these guidelines are normally published in the **Federal Register** in February or early March of each year. Grantees will be required to apply the most recent guidelines throughout the project period. These revised guidelines also may be obtained at public libraries, Congressional offices, or by writing the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

No other government agency or privately-defined poverty guidelines are applicable for the determination of low-income eligiblity for these OCS programs.

Note, however, that low-income individuals granted lawful temporary resident status under sections 245A or 210A of the Immigration and Nationality Act, as amended by the Immigration Reform and Control Act of 1986 (Public law 99-603) may not be eligible for direct or indirect assistance based on financial need under this program for a period of five years from the date such status was granted.

6. Number of Projects in Application

An application may contain only one project (although, except for Priority Area 1.4, activities undertaken may be in a number of communities or impact areas) and this project must be identified as responding to one of the program priority areas stated in this announcement. Applications which are not in compliance with this requirement will be ineligible for funding.

7. Multiple Submittals

There is no limit to the number of applications that can be submitted under a specific program priority area as long as each application contains a proposal for a different project. However, an applicant will receive only one grant in any Priority Area.

8. Sub-contracting or Delegating Projects

OCS does not fund projects where the role of the applicant is primarily to serve as a conduit for funds to organizations other than the applicant. The applicant must have a substantive role in the implementation of the project for which funding is requested.

Part D—Application Procedures

1. Availability of Forms

Attachments B, C and D contain all of the standard forms necessary for the application for awards under these OCS programs. These forms may be photocopied for the application.

Copies of the **Federal Register** containing this announcement are available at most local libraries and Congressional District Offices for reproduction. If copies are not available at these sources, they may be obtained by writing or telephoning the office listed under the section entitled "**FOR FURTHER INFORMATION**" at the beginning of this announcement.

For purposes of this announcement, all applicants will use SF–424, SF–424A, and SF–424B, regardless of the priority area governing the project. Applications proposing construction projects will also present all required financial data using SF–424A. Instructions for completing the SF–424, SF–424A, and SF–424B are found in Attachments B, C, and D.

Part F contains instructions for the project narrative. The project narrative will be submitted on plain bond paper along with the SF–424 and related forms.

Attachment J provides a checklist to aid applicants in preparing a complete application package for OCS.

The applicant must be aware that in signing and submitting the application for this award, it is certifying that it will comply with the Federal requirements concerning the drug-free workplace and debarment regulations set forth in Attachments E and F.

2. Application Submission

Applications must be submitted to ACF by the closing date. Refer to "Closing Date" at the beginning of this document for the specific date. Applications may be mailed to: Administration for Children and Families, Division of Grants Management, 6th floor OFM/DGM, 370 L'Enfant Promenade, SW., Washington, DC 20447.

Hand-delivered applications are accepted during normal working hours of 8 a.m. to 4:30 p.m., Monday through Friday, on or prior to the established closing date at: Administration for Children and Families, Division of Grants Management, 6th Floor OFM/DGM, 901 D Street, SW., Washington, DC 20447.

An application will be considered to be received on time if sent on or before the closing date as evidenced by a legible U.S. Postal Service postmark or a legibly dated receipt from a commercial carrier. Private metered postmarks will not be considered acceptable as proof of timely mailing. Applications submitted by any means other than through the U.S. Postal Service or commercial carrier shall be considered as acceptable only if physically received at the above address before close of business on or before the deadline date.

Note: Applicants should note that the U.S. Postal Service does not uniformly provide a dated postmark. Before relying on this method, applicants should check with their local post office. In some instances packages presented for mailing after a pre-determined time are postmarked with the next day's date. In other cases, postmarks are not routinely placed on packages. Applicants are cautioned to verify that there is a date on the package, and that it is the correct date of mailing, before accepting a receipt.

Applications which have a postmark later than the closing date, or which are hand-delivered after the closing date, will be returned to the sender without consideration in the competition.

One signed original application and four copies is required. The first page of the SF–424 must contain in the lower right-hand corner, a designation indicating under which priority area funds are being requested (See Part F,11).

3. Intergovernmental Review

This program is covered under Executive Order 12372, "Intergovernmental Review of Federal Programs," and 45 CFR part 100, "Intergovernmental Review of Department of Health and Human Services Programs and Activities." Under the Order, States may design their own processes for reviewing and commenting on proposed Federal assistance under covered programs.

All States and Territories except Alaska, Idaho, Kansas, Louisiana, Minnesota, Nebraska, Virginia, American Samoa and Palau have elected to participate in the Executive Order process and have established Single Points of Contact (SPOCs). Applicants from these nine jurisdictions need take no action regarding E.O. 12372. Applicants for projects to be administered by Federally-recognized Indian Tribes are also exempt from the requirements of E.O. 12372. Otherwise, applicants should contact their SPOCs as soon as possible to alert them of the prospective applications and receive any necessary instructions. Applicants must submit any required material to the SPOCs as soon as possible so that the program office can obtain and review SPOC comments as part of the award process. It is imperative that the applicant submit all required materials, if any, to the SPOC and indicate the date of this submittal (or the date of contact if no submittal is required) on the Standard Form 424, item 16a.

Under 45 CFR 100.8(a)(2), a SPOC has 60 days from the application deadline date to comment on proposed new or competing continuation awards. However, because applications are due 60 days from the date of the announcement and the grants are to be awarded in September, there is not sufficient time to allow for a complete SPOC comment period. Therefore, we have reduced the comment period to July 5, 1991.

SPOCs are encouraged to eliminate the submission of routine endorsements as official recommendations. Additionally, SPOCs are requested to clearly differentiate between mere advisory comments and those official State process recommendations which they intend to trigger the "accommodate or explain" rules.

When comments are submitted directly to ACF, they should be addressed to: Department of Health and Human Services, Administration for Children and Families, Division of Grants Management, 6th floor, OFM/DGM, 370 L'Enfant Promenade, SW, Washington, DC 20447.

A list of the Single Points of Contact for each State and Territory is included as appendix H of this announcement.

4. Application Consideration

Applications which meet the screening requirements in sections 5 a and b below will be reviewed competitively. Such applications will be referred to reviewers for a numerical score and explanatory comments based solely on responsiveness to program priority area guidelines and evaluation criteria published in this announcement.

Applications submitted under all priority areas will be reviewed by persons outside of the OCS unit which will be directly responsible for programmatic management of the grant. The results of these reviews will assist the Director and OCS program staff in

considering competing applications. Reviewers' scores will weigh heavily in funding decisions but will not be the only factors considered. Applications generally will be considered in order of the average scores assigned by reviewers. However, highly ranked applications are not guaranteed funding since other factors are taken into consideration, including, but not limited to, the timely and proper completion of projects funded with OCS funds granted in the last five (5) years: Comments of reviewers and government officials; staff evaluation and input; geographic distribution; previous program performance of applicants; compliance with grant terms under previous DHHS grants; audit reports; investigative reports; and applicant's progress in resolving any final audit disallowances on previous OCS or other Federal agency grants.

OCS reserves the right to discuss applications with other Federal or non-Federal funding sources to ascertain the applicant's performance record.

5. Criteria for Screening Applicants

a. Initial Screening

All applications that meet the published deadline for submission will be screened to determine completeness and conformity to the requirements of this announcement. Only those applications meeting the following requirements will be reviewed and evaluated competitively. Others will be returned to the applicants with a notation that they were unacceptable.

(1) The application must contain a Standard Form 424 "Application for Federal Assistance" (SF–424), a budget (SF–424A), and signed "Assurances" (SF 424B) completed according to instructions published in part F and Attachments B, C, and D of this Program Announcement.

(2) A project narrative must also accompany the standard forms.

(3) The SF–424 and the SF–424B must be signed by an official of the organization applying for the grant who has authority to obligate the organization legally.

(4) The application must be submitted for consideration under one priority area only.

b. Pre-rating Review

Applications which pass the initial screening will be forwarded to reviewers and/or OCS staff prior to the programmatic review to verify that the applications comply with this Program Announcement in the following areas:

(1) *Eligibility:* Applicant meets the eligibility requirements for the priority area under which funds are being requested. Proof of non-profit status must be included in the Appendices of the Project Narrative where applicable. Applicants must also be aware that the applicant's legal name as required in SF–424 (Item 5) *must match* that listed as corresponding to the Employer Identification Number (Item 6).

(2) *Number of Projects:* The application contains only one project which responds to one of the priority areas in this announcement.

(3) *Grant amount:* The amount of funds requested does not exeed the limits indicated in part C, 2, b for the appropriate priority area.

(4) *Cooperative Partnership Agreement* (Priority Area 1.4 only)

(a) The application contains a written agreement signed by the applicant and the YOU Program grantee in the target service area; and

(b) The agreement contains specific language confirming that the project will be carried out in the target area.

(5) *Written Agreement When Applicant Proposes to Make Equity Investment, Loan, or Sub-Grant:* (Priority Areas 1.1 and 1.4 only): The application contains a written agreement signed by the applicant and the third party which includes all of the elements required in part B, Priority Area 1.1 and Priority 1.4.

An application may be disqualified from the competition and returned if it does not conform to one or more of the above requirements.

c. Evaluation Criteria

Applications which pass the pre-rating review will be assessed and scored by reviewers. Each reviewer will give a numerical score for each application reviewed. These numerical scores will be supported by explanatory statements on a formal rating form describing major strengths and weaknesses under each applicable criterion published in the announcement.

The in-depth evaluation and review process will use the following criteria coupled with the specific requirements contained under each program priority area as described in part B.

(**Note:** The following review criteria reiterate collection of information requirements contained in part F of this announcement. These requirements are approved under OMB Control Number 0970–0062.)

6. Criteria for Review and Evaluation of All Applications except Priority Area 1.3

(a) Criterion I: Analysis of Need (Maximum: 5 points)

The application documents that the project addresses a vital need in a distressed community and provides statistics and other data and information in support of its contention.

(b) Criterion II: Organizational Experience in Program Area and Staff Responsibilities (Maximum: 15 points)

(i) *Organizational Experience in Program Area (sub-rating: 0–5 points).* Documentation provided indicates that projects previously undertaken have been relevant and effective and have provided permanent benefits to the low-income population.

Organizations which propose providing training and technical assistance have detailed competence in the specific program priority area and as a deliverer with expertise in the fields of training and technical assistance. If applicable, information provided by these applicants also addresses related achievements and competence of each cooperating or sponsoring organization.

Applicable to Priority Areas 1.1, 1.2, and 1.4

The applicant has demonstrated: The ability to implement major activities in such areas as business development, commercial development, physical development, or financial services; the ability to mobilize dollars from sources such as the private sector (corporations, banks, etc.), foundations, the public sector, including State and local governments, or individuals; that it has a sound organizational structure and proven organizational capability; and an ability to develop and maintain a stable program in terms of business, physical or community development activities that will provide needed permanent jobs, services, business development opportunities, and other benefits to community residents.

(ii) *Staff Skills, Resources and Responsibilities (sub-rating: 0–10 points).* The application describes in brief resume form the experience and skills of the project director who is not only well qualified, but his/her professional capabilities are relevant to the successful implementation of the project. If the key staff person has not yet been identified, the application contains a comprehensive position description which indicates that the responsibilities to be assigned to the project director are relevant to the

successful implementation of the project. The applicant has adequate facilities and resources (i.e. space and equipment) to successfully carry out the work plan. The assigned responsibilities of the staff are appropriate to the tasks identified for the project and sufficient time of senior staff will be budgeted to assure timely implementation and cost effective management of the project.

(c) Criterion III: Project Implementation (Maximum: 25 points)

The work plan, or Business Plan where appropriate, is both sound and feasible. The project is responsive to the needs identified in the Analysis of Need. It sets forth realistic quarterly time targets by which the various work tasks will be completed. Critical issues or potential problems that might impact negatively on the project are defined and the project objectives can be reasonably attained despite such potential problems.

(d) Criterion IV A: (Applicable to Priority Area 1.1, 1.2, and 1.4) Significant and Beneficial Impact (Maximum: 30 points)

(i) *Significant and Beneficial Impact (sub-rating: 0–15 points).* The application contains a full and accurate description of the proposed use of the requested financial assistance. The proposed project will produce permanent and measurable results that will reduce the incidence of poverty in the community. The OCS grant funds, in combination with private and/or other public resources, are targeted into low-income communities, distressed communities, and/or designated enterprise zones.

(ii) *Cost-per-Job (sub-rating: 0–10 points).* During the project period the proposed project will create new, permanent jobs or maintain permanent jobs for low-income residents at a cost-per-job below $15,000 in OCS funds.

[Note: The maximum number of points will be given to those applicants proposing cost-per-job estimates of $5,000 or less of OCS requested funds. Higher cost-per-job estimates will receive correspondingly fewer points.]

(iii) *Career Development Opportunities (sub-rating: 0–5 points).* The application documents that the jobs to be created for low-income people have career development opportunities which will promote self-sufficiency.

Criterion IV B: (Applicable to Priority Areas 2.1, 2.2, 3.0 and 3.1)

Significant and Beneficial Impact (Maximum: 30 points)

The application contains a full and accurate description of the proposed use of the requested financial assistance. The proposed project will produce permanent and measurable results that will reduce the incidence of poverty in the areas targeted and significantly enhance the self sufficiency of program participants. Results are quantifiable in terms of program area expectations, e.g., number of units of housing rehabilitated, agricultural and non-agricultural job placements, etc. The OCS grant funds, in combination with private and/or other public resources, are targeted into low-income and/or distressed communities and/or designated enterprise zones.

(e) Criterion V: Public-Private Partnerships (Maximum: 20 points) (Applicable to All Priority Areas Except 1.4.)

The application documents that the applicant will mobilize from public and/ or private sources cash and/or in-kind contributions valued at an amount equal to the OCS funds requested. Applicants documenting that the value of such contributions will be at least equal to the OCS funds requested will receive the maximum number of points for this Criterion. Lesser contributions will be given consideration based upon the value documented. Applicants under Priority Area 1.2 who are proposing to enter into a partnership with Historically Black Colleges and Universities are deemed to have fully met this criterion and will receive the maximum number of points.

(f) Criterion V: Public-Private Partnerships (Maximum: 20 points) (Applicable to Priority Area 1.4 only.)

(1) Mobilization of resources (sub-rating: 10 points). The application documents that the applicant will mobilize from public and/or private sources cash and/or in-kind contributions valued at an amount equal to half of the OCS funds requested. Applicants documenting that the value of such contributions will be at least equal to half of the OCS funds requested will receive the maximum points (10) of this subcriterion.

(2) Integration/coordination of services (sub-rating: 10 points). The written agreement between the applicant and the organization which received FY 90 funding under the Department of Labor's Youth Opportunities Unlimited Program indicates that the actions to be taken to integrate/coordinate services relate directly to the project for which funds are being requested. The agreement clearly describes the following: (1) The goals and objectives that the applicant and the YOU program grantee expect to achieve through their collaboration; (2) a number of specific activities/actions that will be taken to integrate/ coordinate services on an on-going basis; (3) the mechanism(s) to be used in integrating/coordinating activities; (4) how those activities will be significant in relation to the goals and objectives to be achieved through the collaboration; and (5) how those activities will be significant in relation to their impact on the success of the OCS-funded project.

(g) Criterion VI: Budget Appropriateness and Reasonableness (Maximum: 5 points)

Funds requested are commensurate with the level of effort necessary to accomplish the goals and objectives of the project. The application includes a detailed budget break-down for each of the budget categories in the SF-424A. The applicant presents a reasonable administrative cost. The estimated cost to the government of the project also is reasonable in relation to the anticipated results.

7. Criteria for Review and Evaluation of Applications Submitted Under Priority Area 1.3

a. Criterion I: Organizational Capability and Capacity (Maximum: 20 points)

(1) Organizational experience in program area (sub-rating: 5 points). Where the applicant has a history of prior activity or achievement in economic development, the documentation must address the relevance and effectiveness of projects undertaken, especially their cost effectiveness and the relevance and effectiveness of any services and the permanent benefits provided to the targeted population. Applicants must also indicate why they feel that they can successfully implement the project for which they are requesting funding.

(2) Management capacity (sub-rating: 5 points). Applicants must fully detail their ability to implement sound and effective management practices and if they have been recipients of other Federal or other governmental grants, they must also detail that they have consistently complied with financial and program progress reporting and audit requirements. Applicants should submit any available documentation on their management practices and progress reporting procedures along with a certification by a Certified or Licensed Public Accountant as to the sufficiency of the applicant's financial management system to protect adequately any Federal funds awarded under the application submitted.

(3) Staffing (sub-rating: 5 points). The application must fully describe (e.g. resumes) the experience and skills of key staff showing that they are not only well qualified but that their professional capabilities are relevant to the successful implementation of the project.

(4) Staffing responsibilities (sub-rating: 5 points). The application must describe how the assigned responsibilities of the staff are appropriate to the tasks identified for the project.

b. Criterion II: Significant and beneficial impact (Maximum: 35 points)

A work plan funded under this announcement must show that there is a clearly identified need in a low-income area which is not being effectively addressed currently.

Project funds under this announcement must be used to develop a Business Plan for a project which would produce permanent and measurable results that will reduce the incidence of poverty in the areas targeted and mobilize non-Discretionary Program dollars from private sector individuals, corporations, and foundations if the project is implemented. The project around which the Business Plan is developed with the use of OCS grant funds, must be targeted into low-income communities, and/or designated enterprise zones, with the goal of increasing the economic conditions and social self-sufficiency of residents. Activities must be designated to achieve the specific Program Priority Area 1.3 objectives as defined in this program announcement.

c. Criterion III: Project implementation and evaluation (Maximum: 30 points)

(1) Project Implementation Component (sub-rating: 25 points). The application must contain a detailed and specific work plan that is both sound and feasible. It must set forth realistic quarterly time targets by which the various work tasks will be completed. Because quarterly time schedules are used by OCS as a key instrument to monitor progress, failure to include these time targets may seriously reduce an applicant's point score in this criterion. It must define critical issues or potential problems that might impact negatively on the project and it must indicate how the project objectives will be attained notwithstanding any such potential problems.

(2) Evaluation Component (sub-rating: 5 points). All proposals should include a self-evaluation component. The evaluation data collection and analysis procedures should be specifically oriented to assess the degree to which the stated goals and objectives are achieved. Qualitative and quantitative measures reflective of the scheduling and task delineation in (1) above should be used to the maximum extent possible. This component should indicate the ways in which the potential grantee would integrate qualitative and quantitative measures of accomplishment and specific data into its program progress reports that are required by OCS from all grantees.

d. Criterion IV: Budget appropriateness and reasonableness (Maximum: 15 points)

Each applicant should carefully review the requirements of Program Priority Area 1.3 and the budget submitted must coincide with those requirements.

The proposal request for funds must include a detailed budget breakout for each of the pertinent budget categories in part III, section B of the SF-424. (Please identify any positions for which less than full-time funding is requested.)

Part E—Contents of Application and Receipt Process

1. Contents of Application

Each application, whether involving construction or not, should include one original and four additional copies of the following:

a. A signed "Application for Federal Assistance" (SF-424);

b. "Budget Information-Non-Construction Program" (SF-424A);

c. A signed "Assurances-Non-Construction Program" (SF-424B);

d. A Project Narrative consisting of the following elements preceded by a consecutively numbered Table of Contents that will describe the project in the following order:

(i) Eligibility Confirmation

(ii) Analysis of Need

(iii) Organizational Experience and Staff Responsibilities

(iv) Work Program

(v) Appendices, including By-Laws; Articles of Incorporation; proof of non-profit status where applicable; resumes; Single Point of Contact comments; and, for Priority Area 1.4 only, a written agreement signed by the applicant and an organization funded by the Department of Labor in FY 90 under the YOU Program.

The original must bear the signature of the authorizing representative of the applicant organization.

The total number of pages for the entire application package should not exceed 50 pages.

Applications should be submitted in ring-binders that will allow for easy separation and reassembly.

Applications must be uniform in composition since OCS may find it necessary to duplicate them for review purposes. Therefore, applications must be submitted on white 8½ X 11 inch paper only. They must not include colored, oversized or folded materials. Do not include organizational brochures or other promotional materials, slides, films, clips, etc. in the proposal. They will be discarded, if included.

2. Acknowledgement of Receipt

All applicants will receive an acknowledgement postcard with an assigned identification number. Applicants are requested to supply a self-addressed mailing label with their application which can be attached to this acknowledgement postcard. This number and the program priority area letter code must be referred to in all subsequent communication with OCS concerning the application. If an acknowledgement is not received within three weeks after the deadline date, please notify ACF by telephone (202) 401-9230.

Part F—Instructions for Completing Application Package

(Approved by the Office of Management and Budget under Control Number 0970-0062. The standard forms attached to this announcement shall be used to apply for funds for all priority areas described in this announcement.)

It is suggested that you reproduce the SF-424 and SF-424A, and type your application on the copies. If an item on the SF-424 cannot be answered or does not appear to be related or relevant to the assistance requested, write "NA" for "Not Applicable."

Prepare your application in accordance with the standard instructions given in Attachments B and C corresponding to the forms, as well as the OCS specific instructions set forth below:

1. SF-424 "Application for Federal Assistance"

Item

1. For the purposes of this announcement, all projects are considered "Applications"; there are no "pre-Applications." Also for the purposes of this announcement, construction projects are those which involve major renovations or construction. All others are considered nonconstruction. Check the appropriate box under "Application."

5 and 6. The legal name of the applicant must match that listed as corresponding to the Employer Identification Number. Where the applicant is a previous Department of Health and Human Services grantee, enter the Central Registry System Employee Identification Number (CRS/EIN) and the Payment Identifying Number, if one has been assigned, in the Block entitled "Federal Identifier" located at the top right hand corner of the form.

7. If the applicant is a non-profit corporation, enter "N" in the box and specify "non-profit corporation" in the space marked "Other." Proof of non-profit status, such as IRS determination or appropriate sections of the Articles of Incorporation, or By-laws, must be included as an appendix to the project narrative.

8. For the purposes of this announcement, all applications are "New" with the possible exceptions of those submitted under Priority Area 2.2. These applications should be marked "Continuation" if the applicants received funds from OCS in fiscal year 1990 for similar projects.

9. Enter DHHS-ACF/OCS.

10. The Catalog of Federal Domestic Assistance number for OCS programs covered under this announcement is 93.032. The title is "CSBG Discretionary Awards."

11. The following letter program priority area designations must be used:

UR—for Priority Area 1.1. Urban and Rural Community Economic Development (Operational)

HB—for Priority Area 1.2. Urban and Rural Community Economic Development (HBCU Set-Aside)

PD—for Priority Area 1.3. Urban and Rural Community Economic Development (Pre-development)

UY—for Priority Area 1.4. Urban and Rural Community Economic Development (YOU Program Set-Aside)

RH—for Priority Area 2.1. Rural Housing Repairs and Rehabilitation

RF—for Priority Area 2.2. Rural Community Facilities Development (Water and Waste Water Treatment Systems Development)

MS—for Priority Area 3.0. Assistance for Migrants and Seasonal Farmworkers

HM—for Priority Area 3.1. Assistance for Migrants and Seasonal Farmworkers (Set-Aside)

2. SF-424A—"Budget Information—Non-Construction Programs"

See Instructions accompanying this form as well as the instructions set forth below:

In completing these sections, the "Federal Funds" budget entries will relate to the requested OCS discretionary funds only, and "Non-Federal" will include mobilized funds from all other sources—applicant, state, local, and other. Federal funds other than requested OCS discretionary funding should be included in "Non-Federal" entries.

The budget forms in SF-424A are only to be used to present grant administrative costs and major budget categories. Financial data that is generated as part of a project Business Plan or other internal project cost data must be separate and should appear as part of the project Business Plan or other project implementation data.

Sections A and D of SF-424A must contain entries for both Federal (OCS) and non-Federal (mobilized) funds. Section B contains entries for Federal (OCS) funds only. Clearly identified continuation sheets in SF-424A format should be used as necessary.

Section A—Budget Summary

Lines 1-4

Col. (a):

Line 1 Enter "CSBG Discretionary";

Col. (b):

Line 1 Enter "93.032";

Col. (c) and (d):

Columns (c) and (d) should be completed only by those applicants requesting funds for continuation grants (Priority Area 2.2 only), and show the amounts of funds which will be needed after the first 12 month period. All other applicants should leave columns (c) and (d) blank. Column (e)-(g)

For line 1, enter in columns (e), (f) and (g) the appropriate amounts needed to support the project for the budget period.

Line 5 enter the figures from Line 1 for all columns completed as required, (c), (d), (e), (f), and (g).

Section B—Budget Categories

Allowability of costs are governed by applicable cost principles set forth in 45 CFR parts 74 and 92. Columns (1) and (5):

In OCS applications, it is only necessary to complete Columns (1) and (5).

Column 1: Enter the total requirements for OCS Federal funds by the Object Class Categories of this section:

Personnel-Line 6a: Enter the total costs of salaries and wages of applicant/grantee staff only. Do not include costs of consultants or personnel costs of delegate agencies or of specific project(s) or businesses to be financed by the applicant.

Fringe Benefits—Line 6b; Enter the total costs of fringe benefits unless treated as part of an approved indirect cost rate which is entered on line 6j. Provide a breakdown of amounts and percentages that comprise fringe benefit costs.

Travel—Line 6c: Enter total costs of out-of-town travel by employees of the project. Do not enter costs for consultant's travel or local transportation. Provide justification for requested travel costs. (See Line 6h and Line 21 for additional instructions).

Equipment—Line 6d: Enter the total costs of all non-expendable personal property to be acquired by the project. "Non-expendable personal property" means tangible personal property having an acquisition cost per unit of $500 or more for non-profit organizations and $5,000 or more for public organizations and having a useful life of one year. An applicant may use its own definition of non-expendable personal property, provided that such a definition would at least include all tangible personal property as defined in the preceding sentence. (See Line 21 for additional requirements).

Supplies—Line 6e: Enter the total costs of all tangible personal property (supplies) other than that included on line 6d.

Contractual—Line 6f: Enter the total costs of all contracts, including (1) procurement contracts (except those which belong on other lines such as equipment, supplies, etc.) and (2) contracts with secondary recipient organizations including delegate agencies and specific project(s) or businesses to be financed by the applicant. Also include any contracts with organizations for the provision of technical assistance. Do not include payments to individual service contractors on this line. If available at the time of application, attach a list of contractors indicating the name of the organization, the purpose of the contract and the estimated dollar amount of the award. If the name of contractor, scope of work, or estimated total are not available or have not been negotiated, include these in Line h, "Other". Travel costs for the Executive Director or Project Director to attend a two day national workshop in Washington, DC should be included.

Note: Whenever the applicant/grantee intends to delegate part of the program to another agency, the applicant/grantee must submit sections A and B of this form (SF-424A), completed for each delegate agency by agency title, along with the required supporting information referenced in the applicable instructions. The total costs of all

such agencies will be part of the amount shown on Line 6f. Provide back-up documentation identifying name of contractor, purpose of contract and major cost elements.

Construction—Line 6g: Enter the costs of renovation, repair, or new construction. Provide narrative justification and breakdown of costs.

Other—Line 6h: Enter the total of all other costs. Such costs, where applicable, may include but are not limited to insurance, food, medical and dental costs (noncontractual), fees and travel paid directly to individual consultants, local transportation (all travel which does not require per diem is considered local travel), space and equipment rentals, printing and publication, computer use, training costs, including tuition and stipends, training service costs including wage payments to individuals and supportive service payments, and staff development costs.

Total Direct Charges—Line 6i: Show the total of Lines 6a through 6h.

Indirect Charges—Line 6j: Enter the total amount of indirect costs. This line should be used only when the applicant currently has an indirect cost rate approved by the Department of Health and Human Services or another Federal agency. With the exception of local governments, applicants should enclose a copy of the current rate agreement if it was negotiated with a Federal agency other than the Department of Health and Human Services.

If the applicant organization is in the process of initially developing or renegotiating a rate, it should immediately, upon notification that an award will be made, develop a tentative indirect cost rate proposal based on its most recently completed fiscal year in accordance with the principles set forth in the pertinent DHHS Guide for Establishing Indirect Cost Rates, and submit it to the appropriate DHHS Regional Office.

It should be noted that when an indirect cost rate is requested, those costs included in the indirect cost pool should not be also charged as direct costs to the grant.

Totals—Line 6k: Enter the total amounts of Lines 6i and 6j. The total amount shown in section B, Column (5), Line 6k, should be the same as the amount shown in section A, Line 5, Column (e).

Program Income—Line 7: Enter the estimated amount of income, if any, expected to be generated from this project. Separately show expected program income generated from OCS support and income generated from other mobilized funds. Do not add or subtract this amount from the budget total. Show the nature and source of income in the program narrative statement.

Column 5: Carry totals from Column 1 to Column 5 for all line items.

Section C—Non-Federal Resources

This section is to record the amounts of "non-Federal" resources that will be used to support the project. "Non-Federal" resources mean other than OCS funds for which the applicant is applying. Therefore, mobilized funds from other Federal programs, such as the Job Training Partnership Act program, should be entered on these lines. Provide a brief listing of the non-Federal resources on a separate sheet and describe whether it is a grantee-incurred cost or a third-party in-kind contribution. The firm commitment of these resources must be documented and submitted with the application in order to be given credit in the Public-Private Partnerships criterion.

Except in unusual situations, this documentation must be in the form of letters of commitment from the organization(s)/individuals from which funds will be received.

Line 8:

Column (a) enter the project title.

Column (b): Enter the amount of contributions to be made by the applicant to the project.

Column (c): Enter the State contribution. If the applicant is a State agency, enter the non-Federal funds to be contributed by the State other than the applicant.

Column (d): Enter the amount of cash and in-kind contributions to be made from all other sources.

Column (e): Enter the total of columns (b), (c), and (d).

Lines 9, 10, and 11 should be left blank.

Line 12:

Carry the total of each column of Line 8, (b) through (e). The amount in Column (e) should be equal to the amount on section A, Line 5, Column (f).

Section D—Forecasted Cash Needs

Line 13—Enter the amount of Federal (OCS) cash needed for this grant, by quarter, during the budget period.

Line 14—Enter the amount of cash from all other sources needed by quarter during the budget period.

Line 15—Enter the total of Lines 13 and 14.

Section E—Budget Estimates of Federal Funds Needed for Balance of Project(s)

To be completed by applicants applying under Priority Area 2.2 only.

Section F—Other Budget Information

Line 21—Use this space and continuation sheets as necessary to fully explain and justify the major items included in the budget categories shown in section B. Include sufficient detail to facilitate determination of allowability, relevance to the project, and cost benefits. Particular attention must be given to the explanation of any requested direct cost budget item which requires explicit approval by the Federal agency. Budget items which require identification and justification shall include, but not be limited to, the following:

A. Salary amounts and percentage of time worked for those key individuals who are identified in the project narrative;

B. Any foreign travel;

C. A list of all equipment and estimated cost of each item to be purchased wholly or in part with grant funds which meet the definition of nonexpendable personal property provided on Line 6d, section B. Need for equipment must be supported in program narrative.

D. *Contractual:* Major items or groups of smaller items; and

E. *Other:* Group into major categories all costs for consultants, local transportation, space, rental, training allowances, staff training, computer equipment, etc. Provide a complete breakdown of all costs that make up this category.

Line 22—Enter the type of HHS or other Federal agency approved indirect cost rate (provisional, predetermined, final or fixed) that will be in effect during the funding period, the estimated amount of the base to which the rate is applied and the total indirect expense. Also, enter the date the rate was approved, where applicable. Attach a copy of the rate agreement if it was negotiated with a Federal agency other than the Department of Health and Human Services.

Line 23—Provide any other explanations and continuation sheets required or deemed necessary to justify or explain the budget information.

3. SF-424B "Assurances—Non-Construction"

Fill out, sign and date form found at Attachment D.

4. Restrictions on Lobbying Activities

Certification for Contracts Grants, Loans, and Cooperative Agreements: Fill out, sign and date form found at Attachment H.

5. Disclosure of Lobbying Activities, SF-LLL

Fill out, sign and date form found at Attachment H, if applicable.

6. Project Narrative

The project narrative must address the specific concerns mentioned under the relevant priority area description in part B. The narrative should provide information on how the application meets the evaluation criteria in part D, section 5 c of this Program Announcement and should follow the format below:

a. Eligibility Confirmation

This section must explain how the applicant has complied with each of the basic requirements listed in part D, 5 b (1)-(5), i.e. (1) that the applicant meets the eligibility requirements for the priority area under which funds are being requested; (2) the application contains only one project which responds to one of the priority areas in the announcement; (3) the amount of funds requested does not exceed the limits indicated in part C, section 2, b for the apppropriate priority area; (4) [Priority Area 1.4 only] the application contains a written agreement signed by the applicant and the YOU Program grantee in the target area and the agreement contains specific language confirming the project will be carried out in the YOU Program target area.

b. Analysis of Need

The application should include a description of the target area and population to be served as well as a discussion of the nature and extent of the problem to be solved. It should also include documentation supportive of its needs assessment such as employment statistics, housing statistics, etc.

c. Organizational Experience and Staff Responsibilities

(i) *Organizational Experience.* Each applicant must document competence in the specific program priority area under which an application is submitted.

Documentation must be provided which addresses the relevance and effectiveness of projects previously undertaken in the specific priority area for which funds are being requested and especially their cost effectiveness, the relevance and effectiveness of any services provided, and the permanent benefits provided to the low-income population. Organizations which propose providing training and technical assistance must detail their competence in the specific program priority area and as a deliverer with expertise in the fields of training and technical assistance. If applicable, information provided by these applicants must also address related achievements and competence of each cooperating or sponsoring organization.

Applicable to Priority Areas 1.1, 1.2, and 1.4

Applicants in these priority areas must also document a firmly established and quantifiable performance record that shows the following:

—The ability to implement major activities such as business development, commercial development, physical development, or financial services;
—Successful working relationships within the community including public officials, financial institutions, corporations, other community organizations and residents;
—A sound asset base and organizational structure in terms of (a) net worth, (b) management stability, and (c) organizational capability;
—An ability to develop and maintain a stable program in terms of business, physical or community development activities that will provide needed permanent jobs, services, business development opportunities and other benefits to community residents, and impact on community-wide economic problems and needs;
—Sound administrative and fiscal systems and controls, and the ability to establish and maintain partnerships with the private sector in such forms as financial support, volunteerism or executives on loan.

(ii) *Staff Skills, Resources and Responsibilities.*

The application must fully describe (e.g. a resume or position description) the experience and skills of the proposed project director showing that the individual is not only well qualified but that his/her professional capabilities are relevant to the successful implementation of the project.

The application must include statements regarding who will have the responsibilities of the chief executive officer, who will be responsible for grant coordination with OCS, and how the assigned responsibilities of the staff are appropriate to the tasks indentified for the project. It must show clearly that sufficient time of senior staff will be budgeted to assure timely implementation and cost effective management of the project.

d. Work Program

The application must contain a detailed and specific work program, or Business Plan where appropriate, that is both sound and feasible. (For those applicants submitting proposals under Priority Areas 1.1, 1.2, and 1.4 the Business Plan will be accepted in lieu of the work program.)

The work program will be evaluated according to Criteria III, IV, and V set forth in part D of this announcement: Project Implementation, Significant and Beneficial Impact, and Public-Private Partnerships.

Projects funded under this announcement must be designed to produce permanent and measurable results that will reduce the incidence of poverty in the areas targeted. The OCS grant funds, in combination with private and/or other public resources, must be targeted into low-income communities, distressed communities, and/or designated enterprise zones. Projects must be designed to achieve the specific program priority area objectives defined in this Program Announcement.

It must set forth realistic quarterly time targets by which the various work tasks will be completed. It must identify critical issues or potential problems that might impact negatively on the project and it must indicate how the project objectives will be attained despite such potential problems.

If an applicant is proposing a project which will affect a property listed in, or eligible for inclusion in the National Register of Historic Places, it must identify this property in the narrative and explain how it has complied with the provisions of Section 106 of the National Historic Preservation Act of 1966 as amended. If there is any question as to whether the property is listed in or eligible for inclusion in the National Register of Historic Places, the applicant should consult with the State Historic Preservation Officer. (See Attachment D: SF-424B, Item 13 for additional guidance.) The applicant should contact OCS early in the development of its application for instructions regarding compliance with the Act and data required to be submitted to the Department of Health and Human Services. Failure to comply with the cited Act may result in the application being ineligible for funding consideration.

Applicable to Priority Areas 1.1, 1.2, and 1.4

Applications submitted under Priority Areas 1.1, 1.2 and 1.4 which propose to use the requested OCS funds to make an equity investment or a loan to a business concern, including a wholly-owned subsidiary, or to make a sub-grant with a portion of the OCS funds, much include a writtten agreement

between the community development corporation and the recipient of the grant funds which contains all of the elements listed in part B under the appropriate Priority Area.

Applications submitted under Priority Areas 1.1, 1.2, and 1.4 must include a complete Business Plan where it is appropriate to the project/venture. An application that does not include a Business Plan where one is appropriate may be disqualified and returned to the applicant.

In some cases a Business Plan may not be required under the Priority Areas. All applicants under the Priority Areas, however, must nevertheless submit the information which is required in sections 7 through 10, as set forth below.

The Business Plan is one of the major components that will be evaluated by OCS to determine the feasibility of an economic development project. It must be well prepared and address all the major issues noted herein.

The following guidelines show what should be included in order to produce a complete and professional Business Plan which makes an orderly presentation of the facts necessary to be judged responsive to the program announcement.

Because the guidelines were written to cover a variety of possibilities, rigid adherence to them is not possible nor even desirable for all projects. For example, a plan for a service business would not require a discussion of manufacturing nor product design.

The Business Plan should include the following:

1. The business and its industry. This section should describe the nature and history of the business and provide some background on its industry.

a. The Business: As a legal entity; the general business category.

b. Description and Discussion of Industry: Current status and prospects for the industry;

2. Products and Services: This section deals with the following:

a. Description: Describe in detail the products or services to be sold.

b. Proprietary Position: Describe priorietary features if any of the product, e.g. patents, trade secrets.

c. Potential: Features of the product or service that may give it an advantage over the competition.

3. Market Research and Evaluation: This section should present sufficient information to show that the product or service has a substantial market and can achieve sales in the face of competition.

a. Customers: Describe the actual and potential purchasers for the product or service by market segment.

b. Market Size and Trends: State the size of the current total market for the product or service offered.

c. Competition: An assessment of the strengths and weaknesses of competitive products and services.

d. Estimated Market Share and Sales: Describe the characteristics of the product or service that will make it competitive in the current market.

4. Marketing Plan: The marketing plan should detail the product, pricing, distribution, and promotion strategies that will be used to achieve the estimated market share and sales projections. The marketing plan must describe what is to be done, how it will be done and who will do it. The plan should address the following topics—Overall Marketing Strategy, Packaging, Service and Warranty, Pricing, Distribution and Promotion.

5. Design and Development Plans: If the product, process or service of the proposed venture requires any design and development before it is ready to be placed on the market, the nature and extent and cost of this work should be fully discussed. The section should cover items such as Development Status and Tasks, Difficulties and Risks, Product Improvement and New Products, and Costs.

6. Manufacturing and Operations Plan: A manufacturing and operations plan should describe the kind of facilities, plant location, space, capital equipment and labor force (part and/or full time and wage structure) that are required to provide the company's product or service.

7. Management Team: The management team is the key in starting and operating a successful business. The management team should be committed with a proper balance of technical, managerial and business skills, and experience in doing what is proposed. This section must include a description of: The key management personnel and their primary duties; compensation and/or ownership; the organizational structure; Board of Directors; management assistance and training needs; and supporting professional services.

8. Overall Schedule: A schedule that shows the timing and interrelationships of the major events necessary to launch the venture and realize its objectives. Prepare, as part of this section, a month-by-month schedule that shows the timing of such activities as product development, market planning, sales programs, and production and operations. Sufficient detail should be included to show the timing of the primary tasks required to accomplish such activity.

9. Critical Risks and Assumptions: The development of a business has risks and problems and the Business Plan should contain some explicit assumptions about them. Accordingly, identify and discuss the critical assumptions in the Business Plan and the major problems that will have to be solved to develop the venture. This should include a description of the risks and critical assumptions relating to the industry, the venture, its personnel, the product's market appeal, and the timing and financing of the venture.

10. Community Benefits: The proposed project must contribute to economic, community and human development within the project's target area. A section that describes and discusses the potential economic and non-economic benefits to low-income members of the community must be included as well as a description of the strategy that will be used to identify and hire individuals being served by public assistance programs and how linkages with community agencies/organizations administering the JOBS program will be developed.

The following project benefits must be described:

Economic

—Number of permanent jobs that will be created for low-income people during the grant period;

—Number of jobs to be created for low-income people that will have career development opportunities and a description of those jobs;

—Number of jobs that will be filled by individuals on public assistance;

—Ownership opportunities created for poverty-level project area residents;

—Specific steps to be taken to promote the self-sufficiency of program participants.

Other benefits which might be discussed are:

Human Development

—New technical skills development and associated career opportunities for community residents;

—Management development and training.

Community Development

—Development of community's physical assets;

—Provision of needed, but currently unsupplied, services or products to community;

—Improvement in the living environment.

11. The Financial Plan: The Financial Plan is basic to the development of a Business Plan. Its purpose is to indicate

the project's potential and the timetable for financial self-sufficiency. In developing the Financial Plan, the following exhibits must be prepared for the first three years of the business' operation:

a. Profit and Loss Forecasts—quarterly for each year;

b. Cash Flow Projections—quarterly for each year;

c. Pro forma balance sheets—quarterly for each year;

d. Initial sources of project funds;

e. Initial uses of project funds; and

f. Any future capital requirements and sources.

Applicable to Priority Area 2.1 Only

Each applicant must include a full discussion of the project including the following information:

—*Basic Housing Data for Targeted Area.* Information on the number of sub-standard housing units available to low-income people in the target area, deficiencies of the housing units to be repaired, i.e., lack of or inadequate plumbing, upgrading of electrical systems, etc., new construction inventory, property values, rents and mortgage rates. While specific census data may be included, this information must be project specific. Applicants must show that other Federal programs do not exist to address the rehabilitation needs of the targeted area.

—*Priorities.* Provide a rationale for the strategies and priorities for which OCS support is requested.

—*Participant Application Process.* A description of the participant application process including: (a) Verification of participant need and income eligibility, (b) proposed diagnostic repair forms and contract bid procedures (where applicable), and (c) completion verification and quality workmanship assurance procedures.

—*Types of Work to be Performed.* The quantitative and qualitative measures in the work plan should reflect the types of work to be performed, e.g., (a) technical assistance and training for each proposed organization/community; and/or (b) repairs or rehabilitation or construction work, noting which types of work will be done in order to bring properties up to minimum housing standards, inspection procedures and construction schedules.

Applications proposing to repair or rehabilitate low-income rental housing (see part B, Priority Area 2.1, regarding restrictions) must state the current rents for the units in question as well as what rents will be charged for the rehabilitated units. Applicants should also state the number of low-income residents who will be helped to purchase or acquire adequate housing.

—*Job Creation.* Data regarding the number of direct jobs that will be created in the proposed project, noting the number of low-income residents that will be trained and/or placed in these jobs.

—*Public-Private Partnership.* A description of the degree of involvement by private sector individuals, corporations, and foundations in the implementation of the project and the amount of dollars which will be mobilized.

Applicable to Priority Area 2.2 Only

Each applicant must include a full discussion of how the proposed use of funds will enable low-income rural communities to develop the capability and expertise to establish and maintain affordable, adequate and safe water and waste water systems. Applicants must also discuss how they will disseminate information about water and waste water programs serving rural communities, and how they will better coordinate Federal, State, and local water and waste water program financing and development to assure improved service to rural communities.

Among the benefits that merit discussion under this priority are: The number of rural communities to be provided with technical and advisory services; the number of rural poor individuals who are expected to be directly served by applicant-supported improved water and waste water systems; the decrease in the number of inadequate water systems related to applicant activity; the number of newly-established and applicant-supported treatment systems (all of the above may be expressed in terms of equivalent connection units); the increase in local capacity in engineering and other areas of expertise; and the amount of non-discretionary program dollars expected to be mobilized.

Applicable to Priority Areas 3.0 and 3.1

Each applicant must include a full discussion of the proposed project and how it will address one or more farmworker needs as described in part B.

Among the benefits which merit discussion under this priority area are: The number of farmworkers who are expected to improve their agricultural skills and thus improve their agricultural employment situation; the number of farmworkers and/or their dependents who will be afforded an opportunity to continue their formal education; the number of farmworkers/families who will receive crisis nutritional relief, emergency health and social services referrals and assistance, and assistance in the development of self-help systems of food production; the number of farmworkers who are expected to gain longer term or permanent private sector employment in areas outside agriculture; the number of farmworkers who will receive help in the areas of housing; the number of housing units to be repaired or rehabilitated; the degree and kind of such help; the amount of non-Discretionary program dollars expected to be mobilized, and the degree of private sector involvement that will be utilized in developing and carrying out projects funded under this announcement.

Part G—Post Award Information and Reporting Requirements

Following approval of the applications selected for funding, notice of project approval and authority to draw down project funds will be made in writing. The official award document is the Notice of Grant Award which provides the amount of Federal funds approved for use in the project, the budget period for which support is provided, the terms and conditions of the award, the total project period for which support is contemplated, and the total financial participation from the award recipient.

General Conditions and Special Conditions (where the latter are warranted) which will be applicable to grants, are subject to the provisions of 45 CFR parts 74 and 92.

Grantees will be required to submit quarterly progress and financial reports (SF-269) as well as a final progress and financial report.

Grantees are subject to the audit requirements in 45 CFR parts 74 and 92 and OMB Circular A-128 or A-133. If an applicant will not be requesting indirect costs, it should anticipate in its budget request the cost of having an audit performed at the end of the grant period.

Section 319 of Public Law 101-121, signed into law on October 23, 1989, imposes new prohibitions and requirements for disclosure and certification related to lobbying on recipients of Federal contracts, grants, cooperative agreements, and loans. It provides limited exemptions for Indian tribes and tribal organizations. Current and prospective recipients (and their subtier contractors and/or grantees) are prohibited from using appropriated funds for lobbying Congress or any Federal agency in connection with the award of a contract, grant, cooperative

agreement or loan. In addition, for each award action in excess of $100,000 (or $150,000 for loans) the law requires recipients and their subtier contractors and/or subgrantees (1) to certify that they have neither used nor will use any appropriated funds for payment to lobbyists, (2) to submit a declaration setting forth whether payments to lobbyists have been or will be made out of nonappropriated funds and, if so, the name, address, payment details, and purpose of any agreements with such lobbyists whom recipients or their subtier contractors or subgrantees will pay with the nonappropriated funds and (3) to file quarterly up-dates about the use of lobbyists if an event occurs that materially affects the accuracy of the information submitted by way of declaration and certification. The law establishes civil penalties for noncompliance and is effective with respect to contracts, grants, cooperative agreements and loans entered into or made on or after December 23, 1989. See Attachment H for certification and disclosure forms to be submitted with the applications for this program.

Attachment I indicates the regulations which apply to all applicants/grantees under the Discretionary Grants Program.

Dated: May 24, 1991.

Eunice S. Thomas,

Director, Office of Community Services.

Attachment A—1991 Poverty Income Guidelines for all States (Except Alaska and Hawaii) and the District of Columbia

Size of family unit	Poverty guideline
1	$6,620
2	8,880
3	11,140
4	13,400
5	15,660
6	17,920
7	20,180
8	22,440

For family units with more than 8 members, add $2,260 for each additional member.

Poverty Income Guidelines for Alaska

Size of family unit	Poverty guideline
1	$8,290
2	11,110
3	13,930
4	16,750
5	19,570
6	22,390
7	25,210
8	28,030

For family units with more than 8 members, add $2,820 for each additional member.

Poverty Income Guidelines for Hawaii

Size of family unit	Poverty guideline
1	$7,610
2	10,210
3	12,810
4	15,410
5	18,010
6	20,610
7	23,210
8	25,810

For family units with more than 8 members, add $2,600 for each additional member.

BILLING CODE 4150-04-M

Attachment B—SF 424, Application for Federal Assistance and Instructions for the SF 424

OMB Approval No. 0348-0043

APPLICATION FOR FEDERAL ASSISTANCE

1. TYPE OF SUBMISSION: *Application* ☐ Construction ☐ Non-Construction *Preapplication* ☐ Construction ☐ Non-Construction	2. DATE SUBMITTED	Applicant Identifier
	3. DATE RECEIVED BY STATE	State Application Identifier
	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION

Legal Name:	Organizational Unit:
Address (*give city, county, state, and zip code*):	Name and telephone number of the person to be contacted on matters involving this application (*give area code*)
6. EMPLOYER IDENTIFICATION NUMBER (EIN): ☐☐ — ☐☐☐☐☐☐☐	7. TYPE OF APPLICANT: (*enter appropriate letter in box*) ☐ A. State H. Independent School Dist. B. County I. State Controlled Institution of Higher Learning C. Municipal J. Private University D. Township K. Indian Tribe E. Interstate L. Individual F. Intermunicipal M. Profit Organization G. Special District N. Other (Specify)
8. TYPE OF APPLICATION: ☐ New ☐ Continuation ☐ Revision If Revision, enter appropriate letter(s) in box(es): ☐ ☐ A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration Other (*specify*):	9. NAME OF FEDERAL AGENCY:
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: ☐☐-☐☐☐ TITLE:	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
12. AREAS AFFECTED BY PROJECT (*cities, counties, states, etc.*):	

13. PROPOSED PROJECT:		14. CONGRESSIONAL DISTRICTS OF:	
Start Date	Ending Date	a. Applicant	b. Project

15. ESTIMATED FUNDING:		
a. Federal	$	.00
b. Applicant	$	.00
c. State	$	.00
d. Local	$	.00
e. Other	$	.00
f. Program Income	$	.00
g. TOTAL	$	.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON

DATE ____________

b. NO. ☐ PROGRAM IS NOT COVERED BY E.O. 12372

☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

☐ Yes If "Yes," attach an explanation. ☐ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED

a. Typed Name of Authorized Representative	b. Title	c. Telephone number
d. Signature of Authorized Representative		e. Date Signed

Previous Editions Not Usable

Standard Form 424 (REV 4-88)
Prescribed by OMB Circular A-102

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INSTRUCTIONS FOR THE SF 424

This is a standard form used by applicants as a required facesheet for preapplications and applications submitted for Federal assistance. It will be used by Federal agencies to obtain applicant certification that States which have established a review and comment procedure in response to Executive Order 12372 and have selected the program to be included in their process, have been given an opportunity to review the applicant's submission.

Item:	Entry:
1.	Self-explanatory.
2.	Date application submitted to Federal agency (or State if applicable) & applicant's control number (if applicable).
3.	State use only (if applicable).
4.	If this application is to continue or revise an existing award, enter present Federal identifier number. If for a new project, leave blank.
5.	Legal name of applicant, name of primary organizational unit which will undertake the assistance activity, complete address of the applicant, and name and telephone number of the person to contact on matters related to this application.
6	Enter Employer Identification Number (EIN) as assigned by the Internal Revenue Service.
7.	Enter the appropriate letter in the space provided.
8.	Check appropriate box and enter appropriate letter(s) in the space(s) provided: —"New" means a new assistance award. —"Continuation" means an extension for an additional funding/budget period for a project with a projected completion date. —"Revision" means any change in the Federal Government's financial obligation or contingent liability from an existing obligation.
9.	Name of Federal agency from which assistance is being requested with this application.
10.	Use the Catalog of Federal Domestic Assistance number and title of the program under which assistance is requested.
11	Enter a brief descriptive title of the project. if more than one program is involved, you should append an explanation on a separate sheet. If appropriate (e.g., construction or real property projects), attach a map showing project location. For preapplications, use a separate sheet to provide a summary description of this project.
12.	List only the largest political entities affected (e.g., State, counties, cities)
13.	Self-explanatory.
14.	List the applicant's Congressional District and any District(s) affected by the program or project.
15.	Amount requested or to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions should be included on appropriate lines as applicable. If the action will result in a dollar change to an existing award, indicate *only* the amount of the change. For decreases, enclose the amounts in parentheses. If both basic and supplemental amounts are included, show breakdown on an attached sheet. For multiple program funding, use totals and show breakdown using same categories as item 15.
16.	Applicants should contact the State Single Point of Contact (SPOC) for Federal Executive Order 12372 to determine whether the application is subject to the State intergovernmental review process.
17.	This question applies to the applicant organization, not the person who signs as the authorized representative. Categories of debt include delinquent audit disallowances, loans and taxes.
18.	To be signed by the authorized representative of the applicant. A copy of the governing body's authorization for you to sign this application as official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)

SF 424 (REV 4-88) Back

Attachment C—SF 424A, Budget Information—Non-Construction Programs and Instructions for the SF 424A

OMB Approval No. 0348-0044

BUDGET INFORMATION — Non-Construction Programs

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1.		$	$	$	$	$
2.						
3.						
4.						
5. TOTALS		$	$	$	$	$

SECTION B - BUDGET CATEGORIES					
6 Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1)	(2)	(3)	(4)	
a. Personnel	$	$	$	$	$
b. Fringe Benefits					
c. Travel					
d. Equipment					
e. Supplies					
f. Contractual					
g. Construction					
h. Other					
i. Total Direct Charges (sum of 6a - 6h)					
j. Indirect Charges					
k. TOTALS (sum of 6i and 6j)	$	$	$	$	$
7. Program Income	$	$	$	$	$

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	$	$	$	$
9.				
10.				
11.				
12. TOTALS (sum of lines 8 and 11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$	$	$	$
14. NonFederal					
15. TOTAL (sum of lines 13 and 14)	$	$	$	$	$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16.	$	$	$	$
17.				
18.				
19.				
20. TOTALS (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

(Attach additional Sheets if Necessary)

21. Direct Charges:	22. Indirect Charges:
23. Remarks	

SF 424A (4-88) Page 2
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INSTRUCTIONS FOR THE SF-424A

General Instructions

This form is designed so that application can be made for funds from one or more grant programs. In preparing the budget, adhere to any existing Federal grantor agency guidelines which prescribe how and whether budgeted amounts should be separately shown for different functions or activities within the program. For some programs, grantor agencies may require budgets to be separately shown by function or activity. For other programs, grantor agencies may require a breakdown by function or activity. Sections A,B,C, and D should include budget estimates for the whole project except when applying for assistance which requires Federal authorization in annual or other funding period increments. In the latter case, Sections A,B, C, and D should provide the budget for the first budget period (usually a year) and Section E should present the need for Federal assistance in the subsequent budget periods. All applications should contain a breakdown by the object class categories shown in Lines a-k of Section B.

Section A. Budget Summary
Lines 1-4, Columns (a) and (b)

For applications pertaining to a *single* Federal grant program (Federal Domestic Assistance Catalog number) and *not requiring* a functional or activity breakdown, enter on Line 1 under Column (a) the catalog program title and the catalog number in Column (b).

For applications pertaining to a *single* program *requiring* budget amounts by multiple functions or activities, enter the name of each activity or function on each line in Column (a), and enter the catalog number in Column (b). For applications pertaining to multiple programs where none of the programs require a breakdown by function or activity, enter the catalog program title on each line in *Column* (a) and the respective catalog number on each line in Column (b).

For applications pertaining to *multiple* programs where one or more programs *require* a breakdown by function or activity, prepare a separate sheet for each program requiring the breakdown. Additional sheets should be used when one form does not provide adequate space for all breakdown of data required. However, when more than one sheet is used, the first page should provide the summary totals by programs.

Lines 1-4, Columns (c) through (g.)

For new applications, leave Columns (c) and (d) blank. For each line entry in Columns (a) and (b), enter in Columns (e), (f), and (g) the appropriate amounts of funds needed to support the project for the first funding period (usually a year).

Lines 1-4, Columns (c) through (g.) (continued)

For continuing grant program applications, submit these forms before the end of each funding period as required by the grantor agency. Enter in Columns (c) and (d) the estimated amounts of funds which will remain unobligated at the end of the grant funding period only if the Federal grantor agency instructions provide for this. Otherwise, leave these columns blank. Enter in columns (e) and (f) the amounts of funds needed for the upcoming period. The amount(s) in Column (g) should be the sum of amounts in Columns (e) and (f).

For supplemental grants and changes to existing grants, do not use Columns (c) and (d). Enter in Column (e) the amount of the increase or decrease of Federal funds and enter in Column (f) the amount of the increase or decrease of non-Federal funds. In Column (g) enter the new total budgeted amount (Federal and non-Federal) which includes the total previous authorized budgeted amounts plus or minus, as appropriate, the amounts shown in Columns (e) and (f). The amount(s) in Column (g) should not equal the sum of amounts in Columns (e) and (f).

Line 5 — Show the totals for all columns used.

Section B Budget Categories

In the column headings (1) through (4), enter the titles of the same programs, functions, and activities shown on Lines 1-4, Column (a), Section A. When additional sheets are prepared for Section A, provide similar column headings on each sheet. For each program, function or activity, fill in the total requirements for funds (both Federal and non-Federal) by object class categories.

Lines 6a-i — Show the totals of Lines 6a to 6h in each column.

Line 6j - Show the amount of indirect cost.

Line 6k - Enter the total of amounts on Lines 6i and 6j. For all applications for new grants and continuation grants the total amount in column (5), Line 6k, should be the same as the total amount shown in Section A, Column (g), Line 5. For supplemental grants and changes to grants, the total amount of the increase or decrease as shown in Columns (1)-(4), Line 6k should be the same as the sum of the amounts in Section A, Columns (e) and (f) on Line 5.

INSTRUCTIONS FOR THE SF-424A *(continued)*

Line 7 - Enter the estimated amount of income, if any, expected to be generated from this project. Do not add or subtract this amount from the total project amount. Show under the program narrative statement the nature and source of income. The estimated amount of program income may be considered by the federal grantor agency in determining the total amount of the grant.

Section C. Non-Federal-Resources

Lines 8-11 - Enter amounts of non-Federal resources that will be used on the grant. If in-kind contributions are included, provide a brief explanation on a separate sheet.

Column (a) - Enter the program titles identical to Column (a), Section A. A breakdown by function or activity is not necessary.

Column (b) - Enter the contribution to be made by the applicant.

Column (c) - Enter the amount of the State's cash and in-kind contribution if the applicant is not a State or State agency. Applicants which are a State or State agencies should leave this column blank.

Column (d) - Enter the amount of cash and in-kind contributions to be made from all other sources.

Column (e) - Enter totals of Columns (b), (c), and (d).

Line 12 — Enter the total for each of Columns (b)-(e). The amount in Column (e) should be equal to the amount on Line 5, Column (f), Section A.

Section D. Forecasted Cash Needs

Line 13 - Enter the amount of cash needed by quarter from the grantor agency during the first year.

Line 14 - Enter the amount of cash from all other sources needed by quarter during the first year.

Line 15 - Enter the totals of amounts on Lines 13 and 14.

Section E. Budget Estimates of Federal Funds Needed for Balance of the Project

Lines 16 - 19 - Enter in Column (a) the same grant program titles shown in Column (a), Section A. A breakdown by function or activity is not necessary. For new applications and continuation grant applications, enter in the proper columns amounts of Federal funds which will be needed to complete the program or project over the succeeding funding periods (usually in years). This section need not be completed for revisions (amendments, changes, or supplements) to funds for the current year of existing grants.

If more than four lines are needed to list the program titles, submit additional schedules as necessary.

Line 20 - Enter the total for each of the Columns (b)-(e). When additional schedules are prepared for this Section, annotate accordingly and show the overall totals on this line.

Section F. Other Budget Information

Line 21 - Use this space to explain amounts for individual direct object-class cost categories that may appear to be out of the ordinary or to explain the details as required by the Federal grantor agency.

Line 22 - Enter the type of indirect rate (provisional, predetermined, final or fixed) that will be in effect during the funding period, the estimated amount of the base to which the rate is applied, and the total indirect expense.

Line 23 - Provide any other explanations or comments deemed necessary.

Attachment D—SF 424B, Assurances—Non-Construction Programs

OMB Approval No. 0348-0040

ASSURANCES — NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§ 4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§ 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§ 6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§ 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. 290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. § 3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§ 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§ 276a to 276a-7), the Copeland Act (40 U.S.C. § 276c and 18 U.S.C. §§ 874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§ 327-333), regarding labor standards for federally assisted construction subagreements.

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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program andto purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§ 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. § 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§ 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. 470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§ 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

SF 424B (4-88) Back

Attachment E—U.S. Department of Health and Human Services Certification Regarding Drug-Free Workplace Requirements—Grantees Other Than Individuals

U.S. Department of Health and Human Services

Certification Regarding Drug-Free Workplace Requirements

Grantees Other Than Individuals

By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

This certification is required by regulations implementing the Drug-Free Workplace Act of 1988, 45 CFR Part 76, Subpart F. The regulations, published in the May 25, 1990 Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may taken action authorized under the Drug-Free Workplace Act. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or governmentwide suspension or debarment.

Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios.)

If the workplace identified to HHS changes during the performance of the grant, the grantee shall inform the agency of the change(s), if it previously identified the workplaces in question (see above).

Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

"**Controlled substance**" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 USC 812) and as further defined by regulation (21 CFR 1308.11 through 1308.15).

"**Conviction**" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

"**Criminal drug statute**" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

"**Employee**" means the employee of a grantee directly engaged in the performance of work under a grant, including: (i) All "direct charge" employees; (ii) all "indirect charge" employees unless their impact or involvement is insignificant to the performance of the grant; and, (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

The grantee certifies that it will or will continue to provide a drug-free workplace by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace; (2) The grantee's policy of maintaining a drug-free workplace; (3) Any available drug counseling, rehabilitation, and employee assistance programs; and, (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

(d) Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:

(1) Abide by the terms of the statement; and, (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(Continued on reverse side of this sheet)

HHS–Certification Regarding Drug-Free Workplace Requirements–continued from reverse page

(f) Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or, (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e) and (f).

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments, if needed):

Place of Performance (Street address, City, County, State, ZIP Code)____________________________

Check ___ if there are workplaces on file that are not identified here.

Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For the Department of Health and Human Services, the central receipt point is: Division of Grants Management and Oversight, Office of Management and Acquisition, Department of Health and Human Services, Room 517-D, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Signature______________________________ **Date**________________

Title____

Organization____________________________________

DGMO Form#2 Revised May 1990

BILLING CODE 4150-04-C

Attachment F—Certification Regarding Debarment, Suspension, and Other Responsibility Matters—Primary Covered Transactions

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR part 76, certifies to the best of its knowledge and belief that its principals involved:

(a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

(b) Have not within a 3-year period preceding this proposal been convicted of or had a civil judgement rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) Are not presently indicted or otherwise criminally or civilly charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and

(d) Have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

The inability of a person to provide the certification required above will not necessarily result in denial of participation for this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the Department of Health and Human Services' (HHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction. The prospective primary participant agrees that by submitting this proposal, it will include the clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion—Lower Tier Covered Transactions", provided below, without modification in all lower tier covered transactions and in all solicitations for lower tier covered actions.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusions—Lower Tier Covered Transactions (To Be Supplied to Lower Tier Participants)

By signing and submitting this lower tier proposal, the prospective lower tier participant, as defined in 45 CFR part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(b) Where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal.

The prospective lower tier participant further agrees by submitting this proposal that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusions—Lower Tier Covered Transactions" without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Attachment G—State Single Points of Contact

Alabama

Mrs. Moncell Thornell, State Single Point of Contact, Alabama Department of Economic & Community Affairs, 3465 Norman Bridge Road, Post Office Box 250347, Montgomery, Alabama 36125–0347, Telephone (205) 284–6905.

Arizona

Ms. Janice Dunn, Arizona State Clearinghouse, 3800 N. Central Avenue, Fourteenth floor, Phoenix, Arizona 85012, Telephone (602) 280–1315.

Arkansas

Mr. Joseph Gillesbie, Manager, State Clearinghouse, Office of Intergovernmental Service, Department of Finance and Administration, P.O. Box 3278, Little Rock, Arkansas 72203, Telephone (501) 371–1074.

California

Glenn Stober, Grants Coordinator, Office of Planning and Research, 1400 Tenth Street, Sacramento, California 95814, Telephone (916) 323-7480.

Colorado

State Single Point of Contact, State Clearinghouse, Division of Local Government, 1313 Sherman Street, room 520, Denver, Colorado 80203, Telephone (303) 866–2156.

Connecticut

Under Secretary, Attn: Intergovernmental Review coordinator, Comprehensive Planning Division, Office of Policy and Management, 80 Washington Street, Hartford, Connecticut 06106–4459, Telephone (203) 566–3410.

Delaware

Francine Booth, State Single Point of Contact, Executive Department, Thomas Collins Building, Dover, Delaware 19903, Telephone (302) 736–3326.

District of Columbia

Lovetta Davis, State Single Point of Contact, Executive Office of the Mayor, Office of Intergovernmental Relations, room 416, District Building, 1350 Pennsylvania Avenue, NW., Washington, DC 20004, Telephone (202) 727–9111.

Florida

Karen McFarland, Director, Florida State Clearinghouse, Executive Office of the Governor, Office of Planning and Budgeting, The Capitol, Tallahassee, Florida 32399–0001, Telephone (904) 488–8114.

Georgia

Charles H. Badger, Administrator, Georgia State Clearinghouse, 270 Washington Street, SW., Atlanta, Georgia 30334, Telephone (404) 656–3855.

Hawaii

Mr. Harold S. Masumoto, Acting Director, Office of State Planning, Department of Planning and Economic Development, Office of the Governor, State Capitol, Honolulu, Hawaii 96813, Telephone (808) 548–3016 or 548–3085.

Illinois

Tom Berkshire, State Single Point of Contact, Office of the Governor, State of Illinois, Springfield, Illinois 62706, Telephone (217) 782–8639.

Indiana

Frank Sullivan, Budget Director, State Budget Agency, 212 State House, Indianapolis, Indiana 46204, Telephone (317) 232–5610.

Iowa

Steven R. McCann, Division for Community Progress, Iowa Department of Economic Development, 200 East Grand Avenue, Des Moines, Iowa 50309, Telephone (515) 281–3725.

Kentucky

Robert Leonard, State Single Point of Contact, Kentucky State Clearinghouse, 2nd Floor Capital Plaza Tower, Frankfort, Kentucky 40601, Telephone (502) 564–2382

Maine

State Single Point of Contact, Attn: Joyce Benson, State Planning Office, State House Station #38, Augusta, Maine 04333, Telephone (207) 289–3261

Maryland

Mary Abrams, Chief, Maryland State Clearinghouse, Department of State Planning, 301 West Preston Street, Baltimore, Maryland 21201–2365, Telephone (301) 255–4490

Massachusetts

State Single Point of Contact, Attn: Beverly Boyle, Executive Office of Communities & Development, 100 Cambridge Street, room 1803, Boston, Massachusetts 02202, Telephone (617) 727-7001

Michigan

Milton O. Waters, Director of Operations, Michigan Neighborhood Builders Alliance, Michigan Department of Commerce, Telephone (517) 373-7111

Please direct correspondence to: Manager, Federal Project Review, Michigan Department of Commerce, Michigan Neighborhood Builders Alliance, P.O. Box 30242, Lansing, Michigan 48909, Telephone (517) 373-6223.

Mississippi

Cathy Mallette, Clearinghouse Officer, Department of Finance and Administration, Office of Policy Development, 421 West Pascagoula Street, Jackson, Mississippi 39203, Telephone (601) 960-4280

Missouri

Lois Pohl, Federal Assistance Clearinghouse, Office of Administration, Division of General Services, P.O. Box 809, Room 430, Truman Building, Jefferson City, Missouri 65102, Telephone (314) 751-4834

Montana

Deborah Stanton, State Single Point of Contact, Intergovernmental Review Clearinghouse, c/o Office of Budget and Program Planning, Capitol Station, Room 202—State Capitol, Helena, Montana 59620, Telephone (406) 444-5522

Nevada

Department of Administration, State Clearinghouse, Capitol Complex, Carson City, Nevada 89710, ATTN: John B. Walker, Clearinghouse Coordinator

New Hampshire

Jeffrey H. Taylor, Director, New Hampshire Office of State Planning, Attn: Intergovernmental Review Process/James E. Bieber, 2½ Beacon Street, Concord, New Hampshire 03301, Telephone (603) 271-2155

New Jersey

Barry Skokowski, Director, Division of Local Government Services, Department of Community Affairs, CN 803, Trenton, New Jersey 08625-0803, Telephone (609) 292-6613

Please direct correspondence and questions to: Nelson S. Silver, State Review Process, Division of Local Government Services, CN 803, Trenton, New Jersey 08625-0803, Telephone (609) 292-9025.

New Mexico

Dorothy E. (Duffy) Rodriguez, Deputy Director, State Budget Division, Department of Finance & Administration, Room 190, Bataan Memorial Building, Santa Fe, New Mexico 87503, Telephone (505) 827-3640

New York

New York State Clearinghouse, Division of the Budget, State Capitol, Albany, New York 12224, Telephone (518) 474-1605

North Carolina

Mrs. Chrys Baggett, Director, Intergovernmental Relations, N.C. Department of Administration, 116 W. Jones Street, Raleigh, North Carolina 27611, Telephone (919) 733-0499

North Dakota

William Robinson, State Single Point of Contact, Office of Intergovernmental Affairs, Office of Management and Budget, 14th Floor, State Capitol, Bismarck, North Dakota 58505, Telephone (701) 224-2094

Ohio

Larry Weaver, State Single Point of Contact, State/Federal Funds Coordinator, State Clearinghouse, Office of Budget and Management, 30 East Broad Street, 34th Floor, Columbus, Ohio 43266-0411, Telephone (614) 466-0698

Oklahoma

Don Strain, State Single Point of Contact, Oklahoma Department of Commerce, Office of Federal Assistance Management, 6601 Broadway Extension, Oklahoma City, Oklahoma 73116, Telephone (405) 843-9770

Oregon

Attn: Dolores Streeter, State Single Point of Contact, Intergovernmental Relations Division, State Clearinghouse, 155 Cottage Street NE., Salem, Oregon 97310, Telephone (503) 373-1998

Pennsylvania

Sandra Kline, Project Coordinator, Pennsylvania Intergovernmental Council, P.O. Box 11880, Harrisburg, Pennsylvania 17108, Telephone (717) 783-3700

Rhode Island

Daniel W. Varin, Associate Director, Statewide Planning Program, Department of Administration, Division of Planning, 265 Melrose Street, Providence, Rhode Island 02907, Telephone (401) 277-2656

Please direct correspondence and questions to: Review Coordinator, Office of Strategic Planning.

South Carolina

Danny L. Cromer, State Single Point of Contact, Grant Services, Office of the Governor, 1205 Pendleton Street, room 477, Columbia, South Carolina 29201, Telephone (803) 734-0493

South Dakota

Susan Comer, State Clearinghouse Coordinator, Office of the Governor, 500 East Capitol, Pierre, South Dakota 57501, Telephone (605) 773-3212

Tennessee

Charles Brown, State Single Point of Contact, State Planning Office, 500 Charlotte Avenue, 309 John Sevier Building, Nashville, Tennessee 37219, Telephone (615) 741-1676

Texas

Tom Adams, Governor's Office of Budget and Planning, P.O. Box 12428, Austin, Texas 78711, Telephone (512) 463-1778

Utah

Utah State Clearinghouse, Attn: Carolyn Wright, Office of Planning and Budget, State of Utah, 116 State Capitol Building, Salt Lake City, Utah 84114, Telephone (801) 538-1547

Vermont

Bernard D. Johnson, Assistant Director, Office of Policy Research & Coordination, Pavilion Office Building, 109 State Street, Montpelier, Vermont 05602, Telephone (802) 828-3326

Washington

Marilyn Dawson, Washington Intergovernmental Review Process, Department of Community Development, 9th and Columbia Building, Mail Stop GH-51, Olympia, Washington 98504-4151, Telephone (206) 753-4978

West Virginia

Fred Cutlip, Director, Community Development Division, Governor's Office of Community and Industrial Development, Building #6, room 553, Charleston, West Virginia 25305, Telephone (304) 348-4010.

Wisconsin

James R. Klauser, Secretary, Wisconsin Department of Administration, 101 South Webster Street, GEF 2, P.O. Box 7864, Madison, Wisconsin 53707-7864, Telephone (608) 266-1741.

Please direct correspondence and questions to: William C. Carey, Section Chief, Federal-State Relations Office, Wisconsin Department of Administration, (608) 266-0267.

Wyoming

Ann Redman, State Single Point of Contact, Wyoming State Clearinghouse, State Planning Coordinator's Office, Capitol Building, Cheyenne, Wyoming 82002, Telephone (307) 777-7574.

Territories

Guam

Michael J. Reidy, Director, Bureau of Budget and Management Research, Office of the Governor, P.O. Box 2950, Agana, Guam 96910, Telephone (671) 472-2285.

Northern Mariana Islands

State Single Point of Contact, Planning and Budget Office, Office of the Governor, Saipan, CM, Northern Mariana Islands 96950.

Puerto Rico

Patria Custodio/Israel Soto Marrero, Chairman/Director, Puerto Rico Planning Board, Minillas Government Center, P.O. Box 41119, San Juan, Puerto Rico 00940-9985, Telephone (809) 727-4444.

Virgin Islands

Jose L. George, Director, Office of Management and Budget, No. 32 & 33 Kongens Gade, Charlotte Amalie, V.I. 00802, Telephone (809) 774–0750.

Attachment H—Restrictions on Lobbying

Restrictions on Lobbying

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form–LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for subawards at all tiers (including subcontracts, subgrants and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

____

Signature

____

Organization

____

Date

BILLING CODE 4150-04-M

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:
☐ a. contract
b. grant
c. cooperative agreement
d. loan
e. loan guarantee
f. loan insurance

2. Status of Federal Action:
☐ a. bid/offer/application
b. initial award
c. post-award

3. Report Type:
☐ a. initial filing
b. material change
For Material Change Only:
year ______ quarter ______
date of last report ______

4. Name and Address of Reporting Entity:
☐ Prime ☐ Subawardee
Tier ______, *if known*:

Congressional District, *if known*:

5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, *if known*:

6. Federal Department/Agency:

7. Federal Program Name/Description:

CFDA Number, *if applicable*: ______

8. Federal Action Number, *if known*:

9. Award Amount, *if known*:
$

10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI)*:

b. Individuals Performing Services *(including address if different from No. 10a) (last name, first name, MI)*:

(attach Continuation Sheet(s) SF-LLL-A, if necessary)

11. Amount of Payment *(check all that apply)*:
$ ______ ☐ actual ☐ planned

12. Form of Payment *(check all that apply)*:
☐ a. cash
☐ b. in-kind; specify: nature ______
value ______

13. Type of Payment *(check all that apply)*:
☐ a. retainer
☐ b. one-time fee
☐ c. commission
☐ d. contingent fee
☐ e. deferred
☐ f. other; specify: ______

14. Brief Description of Services Performed or to be Performed and Date(s) of Service, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11:

(attach Continuation Sheet(s) SF-LLL-A, if necessary)

15. Continuation Sheet(s) SF-LLL-A attached: ☐ Yes ☐ No

16. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: ______
Print Name: ______
Title: ______
Telephone No.: ______ **Date:** ______

Federal Use Only:

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Standard Form - LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 mintues per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, D.C. 20503.

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Approved by OMB
0348-0046

Reporting Entity: ____________________ Page ______ of ______

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Standard Form - LLL-A

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Attachment I—DHHS Regulations That Apply to All Applicants/Grantees Under the OCS Discretionary Program

Title 45 of the Code of Federal Regulations:

Part 16—Procedures of the Departmental Grant Appeals Board
Part 74—Administration of Grants (non-governmental)
Part 74—Administration of Grants (state and local governments and Indian Tribal affiliates):
Sections 74.62(a) Non-Federal Audits
74.173 Hospitals
74.174(b) Other Nonprofit Organizations
74.304 Final Decisions in Disputes
74.710 Real Property, Equipment and Supplies
74.715 General Program Income
Part 75—Informal Grant Appeal Procedures
Part 76—Debarment and Suspension form Eligibility for Financial Assistance

Subpart F—Drug Free Workplace Requirements

Part 80—Non-discrimination
Under Programs Receiving Federal Assistance through the Department of Health and Human Services
Effectuation of Title VI of the Civil Rights Act of 1964
Part 81—Practice and Procedures for Hearings Under Part 80 of this Title
Part 83—Nondiscrimination on the basis of sex in the admission of individuals to training programs
Part 84—Non-discrimination on the Basis of Handicap in Programs
Part 91—Non-discrimination on the Basis of Age in Health and Human Services Programs or Activities Receiving Federal Financial Assistance
Part 92—Uniform Administrative Requirements for Grants and Cooperative Agreements to States and Local Governments (Federal Register, March 11, 1988)
Part 93—New Restrictions on Lobbying
Part 100—Intergovernmental Review of Department of Health and Human Services Programs and Activities

Attachment J—Checklist for Use in Submitting OCS Grant Applications (Optional)

The application should contain:

1. A completed, *signed* SF-424, "Application for Federal Assistance". The letter code for the priority area (TA or TD) should be in the lower right-hand corner of the page;

2. A completed "Budget Information-Non-Construction" (SF-424A);

3. A *signed* "Assurances-Non-Construction" (SF-424A);

4. A Project Narrative beginning with a Table of Contents that describes the project in the following order:

(a) Analysis of Needs/Priorities
(b) Work Program
(c) Significant and Beneficial Impact
(d) Management History
(e) Staffing and Resources

5. Appendices including proof of non-profit status, Single Points of Contact comments (where applicable), resumes;

6. A *signed* copy of "Certification Regarding Anti-Lobbying Activities";

7. A completed "Disclosures of Lobbying Activities", if appropriate; and

8. A self-addressed mailing label which can be affixed to a postcard to acknowledge receipt of application.

The application should not exceed a total of 30 pages. It should include one original and four identical copies, printed on white 8½ by 11 inch paper, and be presented in a ring binder. The applicant must be aware that in signing and submitting the application for this award, it is certifying that it will comply with the Federal requirements concerning the drug-free workplace and debarment regulations set forth in Attachments D and E.

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