"major" and therefore subject to the requirement of a Regulatory Impact Analysis. This action will not result in an annual effect on the economy of $100 million or more or cause any of the other effects which would result in its being classified by the Executive Order as a "major" rule. Consequently, this rule does not necessitate preparation of a Regulatory Impact Analysis. This final rule does not contain any information collection requirements subject to Office Management and Budget review under the Paperwork Reduction Act of 1980, 44 U.S.C. 3501 *et seq.*

List of Subjects in 40 CFR Part 228

Water pollution control.

Dated: August 16, 1991.

Patrick M. Tobin,

Approved by: Patrick M. Tobin, Acting Regional Administrator.

In consideration of the foregoing, subchapter H of chapter I of title 40 is to be amended as set forth below.

PART 228—[AMENDED]

1. The authority citation for part 228 continues to read as follows:

Authority: 33 U.S.C. 1412 and 1418.

2. Part 228 is amended by removing from § 228.12(a)(3) in the Approved Interim Dumping Sites, the entry for Pascagoula, MS, and adding paragraph (b)(87) as follows:

§ 228.12 Delegation of management authority for interim ocean dumping sites.

* * * * *

(b) * * *

(87) Pascagoula, Mississippi; Ocean Dredged Material Disposal Site—Region IV.

Location:
30°12'06" N 88°44'30" W
30°11'42" N 88°33'24" W
30°08'30" N 88°37'00" W
30°08'18" N 88°41'54" W

Center Coordinates:
30°10'09" N 88°39'12" W

Size: 18.5 square nautical miles.

Depth: Average 46 feet, range 38 to 53 feet.

Primary use: Dredged material.

Period of use: Continuing use.

Restriction: Disposal shall be limited to suitable dredged material from the Mississippi Sound and vicinity.

[FR Doc. 91-22870 Filed 9-23-91; 8:45 am]

BILLING CODE 6560-50-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 408

[BPO-78-F]

RIN 0938-AD97

Medicare Program; Grace Period and Termination for Nonpayment of Supplementary Medical Insurance (Part B) Premiums for Insured and Uninsured Persons

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

ACTION: Final rule.

SUMMARY: This final rule changes the termination date for Supplementary Medical Insurance (SMI) (Part B) enrollees who fail to pay their Medicare Part B premiums. Presently, there is a 90 day grace period for the enrollee during which he or she may pay all overdue premiums and continue Part B coverage uninterrupted. The grace period begins at different times depending on whether the individual is or is not eligible for monthly social security, railroad retirement or civil service retirement benefits. This final rule establishes a uniform timeframe for determining the 90 day grace period which precedes the termination of SMI enrollees who fail to pay their Medicare Part B premiums.

EFFECTIVE DATE: The rules are effective October 24, 1991. Termination under these rules would begin December 31, 1991.

FOR FURTHER INFORMATION CONTACT: Paul Boerschel (301) 966-5941.

SUPPLEMENTARY INFORMATION:

I. Background

On November 2, 1990, we published at 55 FR 46222 a proposed rule with a 60 day comment period that would change the termination date for Supplementary Medical Insurance (Part B) enrollees who fail to pay their Medicare Part B premiums. Under current rules there is a 90 day grace period for the enrollee during which he or she may pay all overdue premiums and continue Part B coverage uninterrupted. The grace period begins at different times depending on whether the individual is or is not eligible for monthly social security, railroad retirement or civil service retirement benefits.

In the proposed rule, we proposed changes for enrollees who are eligible for cash benefits (insured), but are not receiving their cash benefits because they are working. Under existing regulations their grace period did not begin until the taxable (calendar) year ended and another 90 days had elapsed. The change in regulations will establish their grace period for payment as the end of the third month after the initial billing month. Bills will be sent every 3 months. If payment is not received within 60 days, a second notice will be sent. If payment is not received within 90 days, a delinquent notice will be sent.

Section 1838(b) of the Act and our regulations at 42 CFR 408.8 provide for a grace period for payment of overdue premiums. This period generally may not exceed 90 days, unless good cause is established. If good cause is established, the grace period may be extended up to 180 days. As long as the enrollee pays all overdue premiums before the end of the grace period, Part B coverage continues uninterrupted.

Currently, Medicare regulations afford a 90-day grace period that begins at different times, based on receipt or nonreceipt of cash benefits. The grace period for enrollees who do not have qualifying employment to receive cash benefits ends on the last day of the third month after billing month if they are billed monthly, or the last day of each 3-month period for which the enrollee is billed if they are billed quarterly. For enrollees whose monthly cash benefits have been suspended, the grace period ends on the last day of the fourth month after the end of the enrollee's taxable year, usually April 30. For enrollees whose monthly benefit is less than their monthly premium, the grace period ends April 30 of the year following the calendar year for which the premiums are due, if the amount still overdue on the date is equal to or greater than the premium for three months (enrollees are billed at the beginning of each calendar year).

We noted that the regulation would eliminate an inequity and the potential for abuse of the system that may occur because some beneficiaries are afforded an opportunity to utilize up to 16 months of Part B protection without paying premiums before they are terminated for nonpayment of premiums.

We proposed to revise §§ 408.8 and 408.50 of our regulations to establish a uniform timeframe for determining the 90 day grace period for Medicare beneficiaries enrolled in Part B who make premium payments to HCFA, regardless of how they pay their Part B premium, that would end on the last day of the third month following the billing, with one exception. The one exception would be that those enrollees whose monthly benefits are less than the monthly premiums would not be terminated any earlier than current rules allow, viz., until April 30 of the year

following the calendar year for which unpaid premiums are due. We believe that current regulation (§ 408.63) affords the best administrative application to collect premiums while still providing for termination after a 90 day grace period. The amounts owed are small and if not paid can be recouped from current benefits payable.

Since we proposed to establish a different timeframe for determining the start of the 90-day grace period for virtually all Medicare Part B enrolless and no longer routinely would be using closed taxable years in all our calculations, we proposed to delete § 408.47.

We also proposed to make several technical revisions to §§ 408.1 and 408.10 to correct or update cross references.

II. Comments on Proposed Rule

In response to the November 2, 1990 proposed rule, we received one timely item of correspondence. The timely letter of comment was from a State committee on aging. The commenter did not specifically address the content of the proposed regulations, but recommended that we withdraw the proposed rule as written. The commenter was concerned that those elderly individuals who do not receive monthly benefits from which their premium can be deducted were frail and often depended on others to reply to correspondence or make payments, and hence, needed as much time as possible to pay their Medicare Part B premiums. However, the commenter did not address our proposal to treat all beneficiaries equally nor submit any data that our proposal was inappropriate or any alternatives to the proposed rules.

In response, we note that our intention is to treat all beneficiaries who do not have their full Part B premium deducted from a Federal benefit payment equally. We currently bill all such beneficiaries every 3 months and the majority pay promptly within the 3 month cycle. The change in the regulation would prevent potentially long periods of utilization of Medicare Part B by those who we believe intend to let their coverage expire. We believe that individuals who let Part B lapse primarily are individuals who are working or whose spouse is working and have employment related health coverage. We believe most of the population about which the commenter is concerned would be eligible for Medicaid and have their premiums routinely paid by the State Medicaid agency. For those individuals who, due to illness or other extenuating circumstances, fail to pay their premiums, we have very lenient reinstatement provisions. The change to the regulation is intended to give the insured beneficiary the same 3 month grace period that has always applied to the uninsured.

Based on our review of the comment submitted, we are making no changes to the rule as published on November 2, 1990. Therefore, we are adopting as final, the rule as proposed. In addition, for consistency in format, we are revising § 408.50(b)(3) to print the heading in italics.

III. 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. criteria for a "major rule"; that is, that would be likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in cost 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.

The purpose of this final rule is to establish consistent timeframes for determining when the grace period begins for Medicare beneficiaries enrolled in Part B who make full premium payments. This final rule may affect the entitlement status of approximately 344,000 individuals who are being billed premiums. If these individuals fail to take action regarding their overdue premiums within the 90 day grace period, they will lose their entitlement to Part B coverage at that time, rather than, perhaps, months later. For those who lose their Part B entitlement, the economic consequences may be significant, depending on their need for health care services and availability of other insurance. However, we are unable to determine how many individuals would fail to meet the payment deadline, and how severe the effect of failing to pay timely would be on those individuals. Savings to the Medicare program that we may achieve as a result of this final rule are expected to be insignificant.

Since we do not believe this rule would meet any of the criteria for a "major rule" specified in E.O. 12291, we have not prepared a regulatory impact analysis.

B. Regulatory Flexibility Act

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 purpose of the RFA, all physicians and suppliers are treated as 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 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 50 beds located outside of a Metropolitan Statistical Area.

We do not believe this rule would have a significant effect on small entities as defined under RFA or on small rural hospitals. Therefore, we are not preparing either a regulatory flexibility analysis or a rural impact statement since we have determined, and the Secretary certifies that this final rule will not have a significant economic impact on small entities or on the operations of a substantial number of small rural hospitals.

IV. Paperwork Reduction Act of 1980

Section 408.50(b)(2) of this final rule contains information collection requirements that are subject to review by the Office of Management and Budget (OMB) under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.). A notice will be published in the **Federal Register** when approval is obtained.

List of Subjects in 42 CFR Part 408

Administrative practice and procedure, Health insurance, Medicare, Premiums.

PART 408—PREMIUMS FOR SUPPLEMENTARY MEDICAL INSURANCE

42 CFR part 408, subpart C is amended as follows:

1. The authority citation for part 408 continues to read as follows:

Authority: Secs. 1102, 1818, 1837–1840, 1843, 1871 and 1881(d) of the Social Security Act (42 U.S.C. 1302, 1395i–2, 1395p, 1395q, 1395r, 1395s, 1395v, 1395hh, and 1395rr(d)), and the Federal Claims Collection Act (31 U.S.C. 3711).

2–3. Section 408.8 is amended by revising paragraph (a)(1), removing paragraphs (a)(2) and (a)(3), and redesignating paragraph (a)(4) as paragraph (a)(2) and revising it to read as follows:

§ 408.8 Grace period and termination date.

(a) *Grace period.* (1) For all initial premium payments (monthly or quarterly), and subsequent monthly or quarterly payments, the grace period ends with the last day of the third month after the billing month.

(2) For payments required because the monthly benefit is less than the monthly premium, the grace period ends on April 30 of the year following the calendar year which the premiums are due.

* * * * *

§ 408.47 [Removed and Reserved]

4. Section 408.47 is removed and reserved.

5. In § 408.50, paragraphs (b)(2) and (b)(3) are revised and paragraph (c) is removed, to read as follows:

§ 408.50 When premiums are considered paid.

* * * * *

(b) *Payments within the grace period.*

* * *

(2) *Annual earnings report or other report submitted during the grace period shows a benefit is due.*

(i) Before the end of the grace period, the enrollee submits a report clearly showing that monthly cash benefits, previously withheld, are payable; and

(ii) Those benefits are sufficient to permit deduction of the full amount of the overdue premiums.

(3) *Premium arrears are paid by direct remittance.* The enrollee makes a direct remittance payment of all overdue premiums before the end of the grace period.

Technical Amendments

§ 408.1 [Amended]

6. In § 408.1(b), the reference to "45 CFR part 430" is revised to read "45 CFR part 30".

§ 408.10 [Amended]

7. In § 408.10(b)(2)(ii), the reference to "§ 408.8(a)(3)" is revised to read "§ 408.8(a)".

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare-Supplementary Medical Insurance Program)

Dated: May 27, 1991.

Gail R. Wilensky,

Administrator, Health Care Financing Administration.

Approved: August 2, 1991.

Louis W. Sullivan,

Secretary.

[FR Doc. 91–22380 Filed 9–23–91; 8:45 am]

BILLING CODE 4120–01–M

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42 CFR Part 441

[MB–049–IFC]

RIN 0938–AF66

Medicaid Program; Community Supported Living Arrangements Services

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule specifies minimum protection requirements that must be met in order for a State to be eligible to provide optional community supported living arrangements services to individuals with developmental disabilities as defined in section 1930(b) of the Social Security Act (the Act).

This rule implements section 1930(h)(1)(B) of the Act, as added by section 4712 of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Public Law 101–508, enacted on November 5, 1990.

DATES: *Effective date:* These interim final rules are effective on October 24, 1991.

Comment date: Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on November 25, 1991.

ADDRESSES: Mail comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: MB–049–IFC 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 H. Humphrey Building, 200 Independence Avenue, SW., Washington DC, or

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

Due to staffing and resource limitations, we cannot accept audio, video or facsimile (FAX) copies of comments. In commenting, please refer to file code MB–049–IFC. Written 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 Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202–245–7890).

Organizations and individuals desiring to submit comments on the reporting requirements discussed under the section on "Collection of Information Requirements" of this preamble should direct them to the Health Care Financing Administration at one of the addresses cited above, and to the Office of Information and Regulatory Affairs, Attention: Allison Herron Eydt, Office of Management and Budget, New Executive Office Building (room 3201), Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Robert Wardwell, (301) 966–5659.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1905(a) of the Social Security Act (the Act) specifies services that States may provide as medical assistance under title XIX. Certain services listed in section 1905(a) of the Act are mandatory for certain groups specified in sections 1902(a)(10) (A) and (C) of the Act. These include services such as inpatient and outpatient hospital services, physician services, and laboratory and x-ray services. Other services listed in section 1905(a) of the Act may be provided under a Medicaid State plan at the State's option. These include such services as home health care, private duty nursing, case management, and physical therapy.

Under section 1915(c) of the Act, States may obtain waivers to provide certain home and community-based services beyond those included under its State plan listed in section 1905(a) of the Act to individuals who, except for the provision of such services, would require institutionalization. The section 1915(c) waivers include such services as personal care services, adult day health services, habilitation services, and respite care services.

Prior to the enactment of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Public Law 101–508, enacted November 5, 1990, community supported living arrangements (CSLA) services were not available under title XIX, except to the extent that some of the services may have been provided under section 1915(c) home and community-based services waivers. CSLA services represent a new approach in service

systems for individuals with developmental disabilities. CSLA services programs offer highly personalized services that assist individuals with disabilities to live their lives in homes they choose for themselves and are based on the concepts of consumer empowerment and non-facility-based services for individuals with various levels of disabilities.

II. Legislative Changes

Section 4712 of OBRA '90 amended section 1905(a) of the Act by adding CSLA services as an optional Medicaid service, to the extent allowed and as defined in section 1930 of the Act. Section 1930, as added by section 4712 of OBRA '90, places limits on the extent to which States may offer CSLA services as an optional Medicaid service. Specifically, section 1930(c) provides that, during the first five years that CSLA services are allowed as an optional Medicaid service, the Secretary must select a minimum of two and a maximum of eight States that would be eligible to provide one or more CSLA services to developmentally disabled individuals and receive Federal financial participation (FFP). Section 1930(a) defines CSLA services to mean one or more of the following services that are furnished in a community supported living arrangement setting and are designed to assist a developmentally disabled individual in activities of daily living necessary to permit the individual to live in his or her own home, apartment, family home, or rental unit:

- Personal assistance;
- Training and habilitation services necessary to assist the individual in achieving increased integration, independence, and productivity;
- 24-hour emergency assistance (as defined by the Secretary);
- Assistive technology;
- Adaptive equipment;
- Support services necessary to aid an individual to participate in community activities; and
- Other nonexcluded services as approved by the Secretary (excluded services are room and board, and the cost of prevocational, vocational, and supported employment services).

Section 1930(b) of the Act defines the term "developmentally disabled individuals" to mean individuals, as defined by the Secretary, who are residing in their own home, apartment or rental unit or their family's home in which no more than three other individuals receiving CSLA services reside, without regard to whether or not they are at risk of institutionalization.

To implement the provisions in section 4712 of OBRA '90, section 1930(g) of the Act specifies that States may request waivers of such provisions of title XIX as necessary, including but not limited to the requirements of comparability of amount, duration and scope of services under section 1902(a)(10)(B) of the Act, and the statewideness requirements under section 1902(a)(1).

Section 1930(d) specifies that to be eligible to provide CSLA services and to receive Federal financial participation (FFP) for such services, States must establish and maintain a quality assurance program that includes requirements for:

- Provider survey and certification (such surveys to be unannounced and average at least one a year);
- Standards for survey and certification that include minimum qualifications and training requirements for provider staff, financial operating standards, and a consumer grievance process;
- A system that allows for monitoring boards;
- Ongoing monitoring of the well-being of each recipient;
- Reporting procedures to make available information to the public;
- Development of individual support plans (as defined by the Secretary in regulations); and
- Review of a State plan amendment.

Additionally, section 1930(h)(1)(B) of the Act specifies that, in addition to the quality assurance programs specified in section 1930(d) of the Act and State licensure processes, States selected to provide CSLA services must also meet minimum requirements to, among other things, protect individuals receiving CSLA services from neglect, physical and sexual abuse and financial exploitation.

Section 4712(c)(1) of OBRA '90 specifies that the implementing amendments of section 4712 apply to CSLA services furnished on or after the later of July 1, 1991 or 30 days after publication of interim regulations implementing the minimum protection requirements under section 1930(h)(1)(B) of the Act.

III. Provisions of the Regulation

This interim final rule deals exclusively with the minimum protection requirements under section 1930(h)(1)(B) of the Act. Separate regulations dealing with the remaining provisions of section 4712 of OBRA '90 will be published at a later date. Until that time, States selected to provide CSLA services will be bound by the requirements of the statute and the terms of a HCFA-approved application and HCFA-approved State plan amendment in providing the services.

To implement the provisions under section 1930(h)(1)(B) of the Act, we are adding a new subpart I to 42 CFR part 441 that consists of three sections. New § 441.400, Basis and purpose, specifies the statutory authority for the provision of CSLA services and the minimum protection requirements. New § 441.402, State plan requirements, provides that any State eligible to provide CSLA services must specify that it complies with the minimum protection requirements in new § 441.404, Minimum protection requirements. New § 441.404 implements the minimum protection requirements described in section 1930(h)(1)(B) of the Act.

Specifically, § 441.404 provides that, to be eligible to provide CSLA services to developmentally disabled individuals, a State must assure, through methods other than reliance on State licensure processes or the State quality assurance programs described under section 1930(d) of the Act, that:

- Individuals receiving CSLA services are protected from neglect, physical and sexual abuse, and financial exploitation;
- Providers of CSLA services do not use individuals who have been convicted of child or client abuse, neglect, or mistreatment or of a felony involving physical harm to an individual;
- Providers of CSLA services take all reasonable steps to determine whether applicants for employment by the provider have histories indicating involvement in child or client abuse, neglect, or mistreatment or a criminal record involving physical harm to an individual;
- Individuals or entities delivering CSLA services are not unjustly enriched as a result of abusive financial arrangements (such as owner lease-backs); and
- Individuals or entities delivering CSLA services to developmentally disabled individuals, or the relatives of such individuals, are not named beneficiaries of life insurance policies purchased by or on behalf of developmentally disabled clients.

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking for a regulation in the **Federal Register** to provide a period for public comment prior to publication of a final rule. Section 4207(j) of OBRA '90 provides specific authority for the issuance of interim final rules as necessary to implement provisions of OBRA '90. We are exercising our

discretion under section 4207(j) in this instance by issuing this rule as an interim final rule. However, we are providing a 30-day comment period for public comments on this interim final rule as indicated at the beginning of this document.

Section 4712(c)(1) of OBRA '90 further specifies that the implementing amendments of section 4712 apply to CSLA services furnished on or after the later of July 1, 1991 or 30 days after publication of interim regulations dealing with the minimum protection requirements under section 1930(h)(1)(B) of the Act. The promulgation of interim final regulations results in the earlier availability of this optional Medicaid service than if we were to issue a proposed rule.

VI. Regulatory Impact Statement

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, that would be 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.

In addition, 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 do not consider States or individuals to be small entities.

This interim final rule conforms the Medicaid regulations to certain provisions in OBRA '90. The FFP available for CSLA services provided in fiscal years 1991 through 1995 is explicitly limited to the amounts specified in section 1930(j) of the Act. Sums for subsequent fiscal years will be as specifically provided by Congress. We do not believe that this rule produces an effect that meets the criteria of E.O. 12291 or will have a significant effect on a substantial number of small entities. Therefore, we have not prepared a final regulatory impact statement under E.O. 12291 or a regulatory flexibility analysis under the RFA.

Section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a final rule will 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) of the Act, we define a small rural hospital as a hospital that has fewer than 50 beds and is located outside a Metropolitan Statistical Area.

We have determined, and the Secretary certifies, that these interim final rules with comment period will not have a significant economic impact on the operations of a substantial number of small rural hospitals, and therefore have not prepared a rural hospital impact statement.

VII. Collection of Information Requirements

The new regulation at § 441.402 contains information collection or recordkeeping requirements, or both, that are subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*). The information collection requirements concern the development of State plan amendment material concerning the provision of CSLA services. The respondents who will provide the information include State Medicaid agencies. Public reporting burden for this collection of information is estimated to be less than one hour per amendment. The Office of Management and Budget has approved this information collection under approval number 0938–0585. Organizations and individuals desiring to submit comments on the information collection and recordkeeping requirements should direct the comments to HCFA and to the OMB official whose name appears in the "**ADDRESSES**" section of this preamble.

VIII. Response to Public Comments

Because of the large volume of public comments that we usually receive on rules, we cannot acknowledge or respond to them individually. However, we will address all public comments that we receive by the date specified in the "**DATES**" section of this preamble and respond to them in the preamble to the subsequent final rule that we issue.

List of Subjects in 42 CFR Part 441

Family planning, Grant programs—health, Infants and children, Medicaid, Penalties, Prescription drugs, Reporting and recordkeeping requirements.

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

42 CFR part 441 is amended as set forth below:

1. The authority citation for part 441 continues to read as follows:

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

2. The table of contents is amended by adding a new Subpart I, Community Supported Living Arrangements Services, and new §§ 441.400 through 441.404 to read as follows:

Sec.

* * * * *

Subpart I—Community Supported Living Arrangements Services

441.400 Basis and purpose.
441.402 State plan requirements.
441.404 Required minimum protections.

3. A new subpart I is added to read as follows:

Subpart I—Community Supported Living Arrangements Services

§ 441.400 Basis and purpose.

This subpart implements section 1905(a)(24) of the Act, which adds community supported living arrangements services to the list of services that States may provide as medical assistance under title XIX (to the extent and as defined in section 1930 of the Act), and section 1930(h)(1)(B) of the Act, which specifies minimum protection requirements that a State which provides community supported living arrangements services as an optional Medicaid service to developmentally disabled individuals must meet to ensure the health, safety and welfare of those individuals.

§ 441.402 State plan requirements.

If a State that is eligible to provide community supported living arrangements services as an optional Medicaid service to developmentally disabled individuals provides such services, the State plan must specify that it complies with the minimum protection requirements in § 441.404.

§ 441.404 Minimum protection requirements.

To be eligible to provide community supported living arrangements services to developmentally disabled individuals, a State must assure, through methods other than reliance on State licensure processes or the State quality assurance programs described under section 1930(d) of the Act, that:

(a) Individuals receiving community supported living arrangements services are protected from neglect, physical and sexual abuse, and financial exploitation;

(b) Providers of community supported living arrangements services—

(1) Do not use individuals who have been convicted of child or client abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual; and

(2) Take all reasonable steps to determine whether applicants for employment by the provider have histories indicating involvement in child or client abuse, neglect, or mistreatment, or a criminal record involving physical harm to an individual;

(c) Providers of community supported living arrangements services are not unjustly enriched as a result of abusive financial arrangements (such as owner lease-backs) with developmentally disabled clients; and

(4) Providers of community supported living arrangements services, or the relatives of such providers, are not named beneficiaries of life insurance policies purchased by or on behalf of developmentally disabled clients.

(Catalog of Federal Domestic Assistance Program No. 93.774, Medical Assistance Program.)

Dated: August 7, 1991.

Gail R. Wilensky,

Administrator, Health Care Financing Administration.

Approved: August 30, 1991.

Louis W. Sullivan,

Secretary.

[FR Doc. 91-22598 Filed 9-23-91; 8:45 am]

BILLING CODE 4120-01-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 216

[Docket No. 901231-1203]

Taking and Importing of Marine Mammals

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

ACTION: Notice of finding of non-conformance; correction.

SUMMARY: This action corrects a notice of finding of non-conformance announcing that the Republic of Vanuatu and the Republic of Venezuela submitted documentary evidence establishing that the average rates of incidental taking of marine mammals by their vessels are not comparable to the average rate of incidental taking of marine mammals by U.S. vessels in the course of harvesting yellowfin tuna by purse seine in the eastern tropical Pacific Ocean (ETP). This correction is necessary to clarify that, as a result of the court order of March 26, 1991, only the importation of yellowfin tuna, or products derived from yellowfin tuna, harvested in the ETP by Venezuelan or Vanuatuan purse seine vessels is prohibited.

SUPPLEMENTARY INFORMATION: In rule document 91-19887 beginning on page 41308 in the issue of Tuesday, August 20, 1991, make the following corrections:

1. On page 41308, the last sentence of the **SUMMARY** paragraph should read: "As a result of these findings, yellowfin tuna and yellowfin tuna products harvested by purse seine vessels from Vanuatu and Venezuela operating in the ETP may not be imported into the United States until the Assistant Administrator determines otherwise."

2. On page 41309, in the first column, the last sentence of the first full paragraph should read: "Nevertheless, as a result of the finding of the average incidental taking of marine mammals, yellowfin tuna and yellowfin tuna products harvested by purse seine vessels from Vanuatu or Venezuela operating in the ETP may not be imported into the United States until the Assistant Administrator makes a positive finding to allow such importation."

Dated: September 17, 1991.

Samuel W. McKeen,

Program Management Officer.

[FR Doc. 91-22894 Filed 9-23-91; 8:45 am]

BILLING CODE 3510-22-M