Emergency & Remedial Response Division, 290 Broadway, 19th Floor, New York, NY 10007.

Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID no. EPA–HQ–SFUND–2009–0654. EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *http://www.regulations.gov*, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov* or e-mail. The *http://www.regulations.gov* Web site is an "anonymous access" system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov*, your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket:

All documents in the docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, *e.g.,* CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in the hard copy. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy at: U.S. Environmental Protection Agency, Region II, Superfund Records Center, 290 Broadway, Room 1828, (212) 637–4308, Hours: 9 a.m. to 5 p.m., Monday through Friday; and at Long Hill Township Free Public Library, 91 Central Avenue, Sterling, NJ 07930, (908) 647–2088, Hours: 9 a.m. to 8 p.m., Monday through Thursday, 9 a.m. to 5 p.m., Friday and Saturday.

FOR FURTHER INFORMATION CONTACT: Theresa Hwilka, Remedial Project Manager, U.S. Environmental Protection Agency, Region II, 290 Broadway, New York, NY 10007, (212) 637–4409, *e-mail: hwilka.theresa@epa.gov.*

SUPPLEMENTARY INFORMATION:

In the "Rules and Regulations" Section of today's **Federal Register**, we are publishing a direct final Notice of Deletion of the Asbestos Dump Superfund Site without prior Notice of Intent to Delete because we view this as a noncontroversial revision and anticipate no adverse comment. We have explained our reasons for this deletion in the preamble to the direct final Notice of Deletion, and those reasons are incorporated herein. If we receive no adverse comment(s) on this deletion action, we will not take further action on this Notice of Intent to Delete. If we receive adverse comment(s), we will withdraw the direct final Notice of Deletion, and it will not take effect. We will, as appropriate, address all public comments in a subsequent final Notice of Deletion based on this Notice of Intent to Delete. We will not institute a second comment period on this Notice of Intent to Delete. Any parties interested in commenting must do so at this time.

For additional information, see the direct final Notice of Deletion which is located in the Rules section of this **Federal Register**.

List of Subjects in 40 CFR Part 300

Environmental protection, Air pollution control, Chemicals, Hazardous waste, Hazardous substances, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Superfund, Water pollution control, Water supply.

Authority: 33 U.S.C. 1321(c)(2); 42 U.S.C. 9601–9657; E.O. 12777, 56 FR 54757, 3 CFR, 1991 Comp., p. 351; E.O. 12580, 52 FR 2923; 3 CFR, 1987 Comp., p. 193.

Dated: April 1, 2010.

Judith A. Enck,

Regional Administrator, Region 2.

[FR Doc. 2010–10848 Filed 5–10–10; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

42 CFR Part 5

Designation of Medically Underserved Populations and Health Professions Shortage Areas; Intent To Form Negotiated Rulemaking Committee

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Notice of Intent To Form Negotiated Rulemaking Committee.

SUMMARY: As required by Section 5602 of Public Law 111–148, the Patient Protection and Affordable Care Act of 2010, HRSA plans to establish a comprehensive methodology and criteria for Designation of Medically Underserved Populations (MUPs) and Primary Care Health Professions Shortage Areas (HPSAs) [under sections 330(b)(3) and 332 of the Public Health Service (PHS) Act, respectively], using a Negotiated Rulemaking process. To do this, HRSA intends to establish a Negotiated Rulemaking Committee under the Federal Advisory Committee Act (FACA).

Use of this Negotiated Rulemaking (NR) process follows two previous publications of Proposed Rules on MUP/HPSA designation for public comment, one in 1998 and one in 2008. In both cases, many public comments were received, and the concerns expressed resulted in a HRSA decision to reconsider and develop a new proposal to be published at a later date; no final revised rule has yet been adopted. It is hoped that use of the NR process will yield a consensus among technical experts and stakeholders on a new rule, which will then be published as an Interim Final Rule in accordance with Section 5602.

HRSA plans that the NR Committee on designations will include technical experts on indicators of underservice/shortage, data analysis, and on methodologies for combining multiple indicators, representing the public's interest in assuring that the areas, populations and entities to be designated under these rules, which become eligible for various Federal programs/resources, are truly underserved and/or have workforce shortages and representatives of programs and other stakeholders that are involved in the designation process and/or likely to be significantly affected by the designation rules; and (c) a HRSA representative. The Committee will also be assisted by a neutral facilitator.

Topics on which Public Comments are solicited are:

(1) Whether HRSA has properly identified the key issues in this designation rulemaking effort;

(2) Whether HRSA has adequately identified key sources of subject matter technical expertise relevant to defining underservice and shortage and designating underserved areas and populations; and

(3) Whether we have identified appropriate representatives of the various stakeholders/interests that will be affected by the final designation rules.

DATES: Comments, including requests to participate on the committee, will be considered if we receive them at the address provided below no later than 5 p.m. June 10, 2010.

Address and Mode of Transmission for Comments: You may submit comments in one of three ways, as listed below. The first is the preferred method. Please submit your comments in only one of these ways, so that no duplicates are received.

1. *Federal eRulemaking Portal.* You may submit comments electronically to *http://www.regulations.gov.* Click on the link "Submit electronic comments on HRSA regulations with an open comment period." Submit your actual comments as an attachment to your message or cover letter. (Attachments should be in Microsoft Word or WordPerfect; however, we prefer Microsoft Word.)

2. *By regular, express or overnight mail.* You may mail written comments to the following address only: Health Resources and Services Administration, Department of Health and Human Services, Attention: HRSA Regulations Officer, Parklawn Building Rm. 14A–11, 5600 Fishers Lane, Rockville, MD 20857. Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *Delivery by hand (in person or by courier).* If you prefer, you may deliver your written comments before the close of the comment period to the same address: Parklawn Building Room 14A–11, 5600 Fishers Lane, Rockville, MD 20857. Please call in advance to schedule your arrival with one of our HRSA Regulations Office staff members at telephone number (301) 443–1785.

Because of staffing and resource limitations, and to ensure that no comments are misplaced, we cannot accept comments by facsimile (FAX) transmission.

In commenting, please refer to file code # HRSA–1. Comments received on a timely basis will be available for public inspection as they are received, beginning approximately 3 weeks after publication of this Notice, in Room 14–05 of the Health Resources and Services Administration's offices at 5600 Fishers Lane, Rockville, MD., on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 301–443–1785).

FOR FURTHER INFORMATION CONTACT: Director, HRSA Division of Policy Review and Coordination, at 301–443–1785.

SUPPLEMENTARY INFORMATION:

I. Negotiated Rulemaking Act

The Negotiated Rulemaking Act (Pub. L. 101–648, 5 U.S.C. 561–570) establishes a seven-point framework for agency determinations to conduct negotiated rulemaking to enhance the rulemaking process. However, Congress in Public 111–148 has mandated the use of this process for developing a new MUP–HPSA designation methodology.

In Negotiated Rulemaking (NR), negotiations are conducted by a committee, chartered under the Federal Advisory Committee Act (FACA) (5 U.S.C. App. 2), with members chosen to represent the various interests that will be significantly affected by the rule. Each NR committee includes an agency representative and is assisted by a neutral facilitator. The goal of the committee is to reach consensus on the treatment of the major issues involved in the rule, including key issues of language. If consensus is reached, it is to be used as the basis of the agency's proposed rule. The NR process does not affect otherwise applicable procedural requirements of FACA, the Administrative Procedures Act or other statutes.

II. Subject and Scope of the Rule

A. Need for the Rule

The current Health Professional Shortage Area (HPSA) criteria date back to 1978, when they were issued under Section 332 of the PHS Act, as amended in 1976; their predecessor, the Critical Health Manpower Shortage Area (CHMSA) criteria, date back to the 1971 legislation creating the National Health Service Corps. By statute, an area, population or facility must have a HPSA designation to be eligible to apply for placement of National Health Service Corps (NHSC) personnel.

The original CHMSA criteria simply required that a population-to-primary care physician ratio threshold be exceeded within a rational geographic service area to demonstrate shortage; the HPSA criteria kept this basic approach but expanded it to allow a lower threshold ratio for areas with unusually high needs, as indicated by high poverty, infant mortality or fertility rates, overutilization, or excessive waiting times, and to consider population groups with access barriers within areas where the general population has sufficient resources. Facility HPSA criteria were also included for prisons/correctional institutions and for other facilities serving designated areas or population groups.

The current Medically Underserved Population (MUP) criteria date back to 1975, when they were issued to implement legislation enacted in 1973 and 1974 establishing grants to support Health Maintenance Organizations (HMOs) and Community Health Centers (CHCs) serving medically underserved populations.

The original MUP criteria, still in effect, employ a four-variable Index of Medical Underservice (IMU), with those variables being: percent of the population with incomes below the poverty level; primary care physician-to-population ratio; infant mortality rate; and percent of the population aged 65 or over. Data on these four variables within a geographic service area can be used to compute an IMU score for the area; areas whose score is below an established threshold are identified as medically underserved areas (MUAs). There are also guidelines for applying the IMU to identify certain underserved population groups within adequately served areas, and additional provisions for designation of other underserved populations, including special provisions for migrant and homeless populations, and for designation in unique circumstances upon recommendation of a State Governor and local officials. The term MUP is defined to include both residents of geographic MUAs and population groups designated as MUPs through various means.

Since the time that designations of MUPs and HPSAs were first required by statute in connection with the NHSC and Community Health Center programs, additional programs have also been required by statute to use these designations. These include certification by the Centers for Medicare and Medicaid Services (CMS) of Rural Health Clinics (RHCs) located within rural areas that are HPSAs or MUPs, and the CMS Medicare Incentive Program, which provides higher reimbursement for physician services delivered in HPSAs. CMS also certifies as Federally Qualified Health Centers (FQHCs), organizations that do not receive HRSA grants but serve an MUP and otherwise

meet the definition of a Health Center under Section 330 of the PHS Act.

Over the years there has been an evolution, both in the types of requests for HPSA or MUP designation received, and in the methods for application of the established criteria. Beyond the relatively simple geographic area requests, such as for whole counties and rural subcounty areas, increasingly more requests have been made for urban neighborhood and population group designations. The availability of census data on poverty, race, and ethnicity at the census tract level has enabled the delineation of urban service areas based on their economic and race/ethnicity characteristics. Areas with concentrations of poor, minority and/or linguistically isolated populations have achieved area or population group HPSA designations based on their limited access to physicians adequately serving other parts of their metropolitan areas. As a result, the conceptual distinction between HPSA and MUP designations has become less apparent.

However, while the HPSAs are required by statute to be updated on a regular basis, no such statutory requirement exists for MUPs, with the result that many MUP designations are now significantly outdated. It is important that the list of designated MUPs, which is used by a variety of Federal programs, be reasonably current, and that the criteria used for these designations reflect underservice indicators currently relevant and available (and the currently prevailing range of values of those indicators), rather than being limited to those indicators that were available in the 1970s (and the range of indicator values then prevailing).

For these reasons, consideration has been given to the development of a revised, more coordinated MUP and HPSA designation methodology and procedure that would, at a minimum, define consistently the indicators used for both designation types; clarify the distinctions between MUPs and HPSAs; and update both types of designation on a regular, simultaneous basis. Given the extensive numbers of comments received during the previous two attempts to do this using standard rulemaking procedures, Congress has now mandated the use of negotiated rulemaking.

B. Issues and Questions To Be Resolved

Issues that HRSA anticipates will require resolution through the NR process are outlined below. HRSA also invites public comment on whether there are other issues important to this rulemaking and within the scope of the rule.

1. Are the objectives of the MUP designations and the HPSA designations clearly different, therefore justifying two separate processes? Or are the objectives so closely related that a single designation approach should be used both for MUPs and for HPSAs?

2. The MUP and HPSA statutes (PHS Act Sec. 330(b) and 332 respectively) require the inclusion of factors indicative of health status, ability to pay for services, the accessibility of services, and the availability of health professionals, as well as other indicators of a need for health services (including infant mortality rates). What specific underservice/shortage indicators should be included, for either or both designation types, and how should they be defined/measured? To what extent should national data sources be used, versus State and local sources? What existing data sources are accurate and reliable enough to use, at the appropriate level?

(a) What provider availability measures should be used?

(b) What economic factors may influence access and how can they be measured?

(c) What health status indicators should be included?

(d) What measures of utilization should be included?

(e) What demographic indicators should be included, if any?

3. What methodology or methodologies should be used to incorporate/combine the impact of these various underservice indicators on access? Should indicators be combined in the same way or in different ways for use in MUP and HPSA designations?

4. Within provider availability measures (such as population-to-clinician ratios), which clinicians/providers should be included? How do we define full-time-equivalents (FTEs), as opposed to "head counts"?

5. In counting the clinicians available within an area (or to a population group) for designation update purposes, should those clinicians placed in the designated area under a Federal program be included?

6. How should "Rational Service Areas" or RSAs be defined for designation purposes?

7. What types of Population Groups should be considered for designation?

8. What is the role of Facility designations, which are included under the HPSA authority (in Sec. 332 of the PHS Act)?

9. How should appropriate threshold levels of various underservice/shortage indicators incorporated in the method be identified to separate those areas, population groups and facilities found to qualify for designation from all others?

10. How can the revised methodology and procedures be designed so as to reduce the burden of the designation application and update process on States and local entities?

11. How should the Committee assess the potential impact of revised MUP/HPSA methodologies, versus continued use of the current methods? How can the impact of various options and methodologies best be summarized and displayed?

12. How can the new methodology be implemented in a manner that minimizes disruption and assures equity to the various areas affected?

III. Affected Interests and Potential Participants

We are proposing to include representatives of the following interest groups and/or organizations as negotiation participants.

(1) Up to 3 State Primary Care Offices (PCOs) representing a range of States in terms of size, rural/urban, and different regions of the country, including at least one which is also a State Office of Rural Health (SORH). These PCO representatives would be requested to consult with their fellow PCOs between meetings.

(2) National Organization of State Offices of Rural Health (NOSOHR).

(3) Association of State and Territorial Health Officers (ASTHO) or National Academy for State Health Policy (NASHP).

(4) Up to 3 State Primary Care Associations (PCAs) from different types of States.

(5) National Association of Community Health Centers (NACHC).

(6) National Association of Rural Health Clinics (NARHC).

(7) National Rural Health Association.

(8) Representatives of the Native American community, such as the National Indian Health Board (NIHB), or the National Council of Urban Indian Health (NCUIH).

(9) Dartmouth Institute. It has expertise in rational service areas for primary care and hospital services, and the use of Medicare data for health systems analysis.

(10) American Academy of Family Physicians, Robert Graham Center. It has expertise in health center service areas analysis and maintains "Health Landscape" on-line data base of health care data for geographical analysis.

(11) Representatives of primary care providers and training programs with expertise on supply and demand

analysis and issues of underservice. Representatives from some of these groups would be asked to represent a larger group's interests, including coordinating with sister organizations between NR meetings.

(12) Representative(s) of organizations and institutions with expertise in complex data analysis, as well as expertise in measuring access to care and underservice.

(13) Representatives of organizations representing State, territorial and local government elected officials to ensure their views are reflected in the process. Representatives from some of these groups would be asked to represent a larger group's interests, including coordinating with sister organizations between NR meetings.

We invite comment on this list of negotiation participants. The intent in establishing the negotiating committee is that all relevant types of interests are represented, not necessarily all parties with similar interests. We believe this proposed list of participants represents all types of interests likely to be affected by the rule to be negotiated. If comments suggest that other interests should perhaps be included, the procedure described in section V.C below will be followed.

IV. Schedule for the Negotiation

Public Law 111–148, the Patient Protection and Affordable Health Care Act of 2010, requires that this Notice be published within 45 days of enactment (*i.e.,* by May 7, 2010), followed by a 30-day comment period (*i.e.,* comments due approximately June 7, 2010). The Committee is to be appointed by the Secretary of Health and Human Services (HHS) within 30 days after the expiration of the comment period, or by approximately July 7, 2010. Within 10 days thereafter, the Secretary of HHS will nominate her choice of a facilitator. The facilitator will be subject to consensus approval by the NR Committee.

Once the Committee membership is selected, a Notice regarding the meeting schedule will be published; it is anticipated that the meetings will begin in August or September. The first day's meeting will include discussion in detail on how the negotiations will proceed and how the Committee will function. The Committee will agree to ground rules for committee operation, will approve a facilitator, and discuss how best to address the principal issues (*i.e.,* which issues to address first, and a tentative schedule for consideration of the rest of the issues). The Committee will then begin to address those issues.

Subsequent meetings of the Committee will be held approximately monthly until all issues are resolved, allowing for members to report to and confer with their respective interest groups between meetings. We anticipate approximately six meetings, with each meeting lasting for 2 to 3 days. If more meetings are required in order to resolve fractious issues, or to avoid slipping the target date, additional face-to-face meetings may be scheduled (up to a total of two per month), or detailed discussions on specific issues may be handled with conference telephone calls among identified subgroups of the Committee. The next key action is the submission of a preliminary committee report on the Committee's progress towards achieving consensus and the likelihood of achieving such a consensus by July 2011.

If the preliminary report indicates that consensus is likely by July 1, 2011, HRSA would then help the Committee develop appropriate regulatory wording to implement the Committee's decisions. The Committee would submit a final report to the Secretary, including the draft version of the interim final rule (as required by the legislation). The target date for the final report would be July 1, 2011. Actual publication would follow Departmental and Office of Management and Budget (OMB) review.

If the preliminary committee report indicates a need for some additional time to achieve consensus, with corresponding postponement of the target date, the Secretary may grant a reasonable amount of additional time (such as 60 days). If the preliminary report indicates that the Committee has failed to make significant progress toward consensus and is unlikely to do so by the target date, the Secretary may terminate the activities of the Committee, and the Committee may submit to the Secretary a report specifying any areas of consensus and including any other information, recommendations or materials that the Committee considers appropriate. The Secretary will pursue publication of an interim-final rule by the target date, taking into account any areas of consensus, recommendations, and materials provided by the Committee.

V. Formation of the Negotiated Committee

A. Procedure for Establishing an Advisory Committee

An agency of the Federal government is required to comply with the requirements of FACA when it establishes or uses a group that includes non-federal members as a source of advice. Under FACA, an advisory committee becomes established only after approval of an agreed-upon charter. We have prepared a draft charter and initiated the requisite consultation process. Following review of public comments on this Notice and upon successful completion of the approved charter, we will form the Committee and begin negotiations.

B. Participants

The total number of individuals who will be asked to participate in this effort as NR Committee members is estimated to be about 20, and should not exceed 25. (A number larger than this would make it extremely difficult to conduct effective negotiations.) Each member will be asked to designate an Alternate in case the member is unable to attend one or more meetings, or wishes to share the responsibility with a close associate. (Alternates may attend any meeting with the Lead member, but in general the Lead member will be expected to do most of the talking when both are present.)

One purpose of this Notice is to determine whether the proposed rule might significantly affect additional interests not adequately represented by the list of proposed participants included above. Each potentially affected organization or group of individuals does not necessarily need its own representative, since groups of organizations can work together to see that their collective interests are adequately represented. (See groupings of interest groups suggested above.) However, each identifiably separate interest must be adequately represented. Moreover, HRSA must be satisfied that the group as a whole reflects a proper balance and mix of the various interests.

C. Requests for Additional Representation

Persons who wish to apply for membership on the Committee may submit an application or nomination, which shall include the following:

(1) The name of the applicant or nominee and a description of the interests such person shall represent;

(2) Evidence that the applicant or nominee is authorized to represent parties related to the interests the person proposes to represent;

(3) A written commitment that the applicant or nominee shall actively participate in good faith in the development of the rule under consideration; and

(4) The reasons that the persons specified in the notice under Section III do not adequately represent the interests

of the person submitting the application or nomination.

If, in response to this notice, representatives of additional interest groups request membership or representation in the negotiating group, HRSA will determine whether that representative should be added to the NR Committee or simply asked to submit its comments and concerns to us and to another Committee member. HRSA will make that decision based on whether the interest group:

- Would be significantly affected by the rule; and
- Is or is not already adequately represented on the proposed NR Committee.

D. Establishing the Committee

After reviewing any public comments on this Notice and any requests for additional representation, HRSA will take the final steps required to form the Committee.

VI. Negotiation Procedures

If and when this NR Committee is formed, the following procedures and guidelines will apply, unless they are modified as a result of comments received on this notice or during the negotiating process.

A. Facilitator

HRSA will use a neutral facilitator. The facilitator will not be involved with advocating for substantive aspects of the regulation. The facilitator's role is to:

- Chair negotiating sessions, assuring equal opportunity among the various members to present their points of view;
- Help the negotiation process to run smoothly; and
- Help participants define and reach consensus.

B. Good Faith Negotiations

Participants must be willing to negotiate in good faith, and must be authorized to so negotiate by the leaders of the organizations/groups/interests they represent. This may best be accomplished by the selection of senior officials of the affected organizations or groups as participants, and/or by the selection of experienced individuals in such organizations/groups who have expertise in the issues subsumed by this rule and who have access to such senior officials, allowing them to obtain concurrence at each stage of the NR process. This applies to HRSA as well, and HRSA will appoint an appropriate representative, to represent HRSA/HHS when the committee is appointed. (Representatives of components of HRSA and CMS which use the MUP and HPSA designations will also be invited to attend the NR meetings as resources on how their programs relate to the designations, but the HRSA/HHS representative will be the spokesperson for HRSA and HHS interests in this NR effort and will meet with other HHS component representatives between NR Committee meetings to maximize coordination.)

C. Administrative Support

HRSA will supply logistical, administrative and management support. HRSA will also provide technical support to the Committee in gathering and analyzing appropriate indicator data, methodologies and other information relevant to the Committee's work, and conduct appropriate impact analyses, with contractual support from John Snow, Inc. (JSI).

D. Meetings

Meetings will typically be held in the DC metropolitan area or, if necessary, in another location, at the convenience of the Committee. HRSA will announce scheduled Committee meetings and agendas either in the **Federal Register** or on a committee Web site, yet to be established, whose location will be published in the **Federal Register**. Unless announced otherwise, meetings are open to the public.

E. Committee Procedures

Under the general guidance and direction of the facilitator, and subject to any applicable legal requirements, the members will establish at the first meeting the detailed procedures for committee meetings which they consider most appropriate.

F. Defining Consensus

The goal of the negotiating process is consensus. Under the Negotiated Rulemaking Act, consensus generally means that each interest group represented concurs in the result, unless the term is defined otherwise by the Committee. HRSA expects the participants to agree upon their working definition of this term at the first meeting.

G. Failure of Advisory Committee to Reach Consensus

Parties to the NR effort may withdraw at any time. If this happens, the remaining Committee members and HRSA will evaluate whether the Committee should continue.

If the Committee is unable to reach consensus, HRSA will proceed to develop a proposed/interim final rule on its own, as described above.

H. Record of Meetings

In accordance with FACA's requirements, minutes of all Committee meetings will be kept. The minutes will be placed on the Committee's Web site and a copy kept in the public rulemaking record.

Dated: May 6, 2010.

Mary Wakefield,

Administrator, Health Resources and Services Administration.

Dated: May 6, 2010.

Kathleen Sebelius,

Secretary.

[FR Doc. 2010–11214 Filed 5–7–10; 11:15 am]

BILLING CODE 4165–15–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Chapter I

[PS Docket No. 10–93; FCC 10–63]

Cyber Security Certification Program

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: This document seeks comment on whether the Commission should establish a voluntary program under which participating communications service providers would be certified by the FCC or a yet to be determined third party entity for their adherence to a set of cyber security objectives and/or practices. The Commission also seeks comment on other actions it should take, if any, to improve cyber security and to improve education on cyber security issues. The Commission's goals in this proceeding are to increase the security of the nation's broadband infrastructure, promote a culture of more vigilant cyber security among participants in the market for communications services, and offer end users more complete information about their communication service providers' cyber security practices.

DATES: Comments are due on or before July 12, 2010 and reply comments are due on or before September 8, 2010.

ADDRESSES: You many submit comments, identified by PS Docket No. 10–93 and/or rulemaking FCC 10–63, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Federal Communications Commission's Web Site: http://fjallfoss.fcc.gov/ecfs2/.* Follow the instructions for submitting comments.