DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 413

[HCFA–1883–P]

RIN 0938–AI80

Medicare Program; Revision of the Procedures for Requesting Exceptions to Cost Limits for Skilled Nursing Facilities and Elimination of Reclassifications

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the procedures for granting exceptions to the cost limits for skilled nursing facilities (SNFs) and retain the current procedures for exceptions to the cost limits for home health agencies (HHAs). It also would remove the provision allowing reclassifications for all providers.

DATES: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5:00 p.m. on October 13, 1998.

ADDRESSES: Mail written comments (one original and three copies) to the following address:

Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1883–P, P.O. Box 31850, Baltimore, MD 21144–0517.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, DC 20201, or Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1883–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a 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) 690–7890).

FOR FURTHER INFORMATION CONTACT: Steve Raitzyk, (410) 786–4599.

SUPPLEMENTARY INFORMATION:

Copies: To order copies of the **Federal Register** containing this document, send your request to: Government Printing Office, New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order 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) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $8. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

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I. Background

Cost Limits

Section 223 of the Social Security Amendments of 1972 (Pub Law 92–603) amended section 1861(v)(1)(A) of the Social Security Act (the Act) to authorize the Secretary to establish ''* * * limits on the direct and indirect overall incurred costs or incurred costs of specific items or services or groups of items or services * * *'' as a presumptive estimate of reasonable costs. Under section 1861(v)(1)(A), a provider's cost in excess of its Medicare cost limit is deemed to be unreasonable for the efficient delivery of needed health care services under the Medicare program. The Congress, however, in the House Committee report ''H.R. Rep. No. 92–231, 92nd Congress, 1st Session 5071 (1971),'' stated that ''Providers would, of course, have the right to * * * obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception.''

On June 1, 1979, we published a final rule in the **Federal Register** at 44 FR 31802, revising 42 CFR 405.460 to implement more effectively and equitably section 223 of the Social Security Amendments of 1972. Section 405.460, which was subsequently redesignated as § 413.30, describes the general principles and procedures for establishing cost limits and the process by which providers may appeal the applicability of these cost limits. Under § 413.30(c), a provider may obtain relief from the effects of applying cost limits, either by requesting an exemption from its limit as a new provider of inpatient services, by requesting a reclassification, or by requesting an exception to the cost limit.

In the preamble of the June 1, 1979 final rule (44 FR 31806), we clarified the difference between an exemption and an exception. If a provider receives an exemption, it is not affected at all by the cost limits and it is paid under the standard rules for reasonable cost or customary charges. If a provider receives an exception, it is paid on the basis of the cost limit, plus an incremental sum for the reasonable costs warranted by the circumstances that justified the exception.

The cost limit is a presumptive estimate of reasonable costs, which excludes costs found to be unnecessary for the efficient delivery of needed health care services. We may establish limits for direct or indirect costs, for costs of specific services, or for groups of services. Medicare payable provider costs may not exceed the amounts, estimated by us, to be necessary for the efficient delivery of needed health care services furnished by a provider.

We imposed these limits prospectively and they may be calculated on a per admission, per discharge, per diem, per visit, or other basis. All SNFs and HHAs that are paid under the cost payment methodology are subject to these cost limits.

The routine service cost per diem limits are based on the average cost of furnishing services and are determined by the SNF's or HHA's geographical location classification (urban or rural) and type of facility classification (hospital-based or freestanding). We publish in the **Federal Register**, the schedule of limits that apply to the cost reporting periods beginning during the fiscal year indicated in the notice. This published ''Schedule of Limits'' outlines the methodology and data we use to determine the average cost of providing the routine services on which we base the cost limits.

The servicing intermediary notifies each SNF or HHA of its cost limit at

least 30 days before the start of a cost reporting period to which the cost limit applies. If there is a delay, we advise the intermediary of any alternate process to compute an interim cost limit. Each intermediary ''cost limit notification'' must contain the following:

- The provider's classification and calculation of the applicable limit.
- A statement that, if the provider believes it has been incorrectly classified, it is the provider's responsibility to furnish to the intermediary evidence that demonstrates the classification is incorrect.
- A statement that the provider may be entitled to an exemption from, or an exception to, the cost limits under the provisions of § 413.30.

This proposed rule focuses on two provisions of § 413.30 established in the June 1, 1979 final rule. First, we propose to change the approval process for granting exceptions to the cost limits for SNFs; second, we propose to delete the provision for obtaining a reclassification for all providers.

II. Skilled Nursing Facility and Home Health Agency Requests Regarding Applicability of Cost Limits

A. Current Regulations Regarding SNF and HHA Exceptions to Cost Limits

The current regulation at § 413.30(f) allows a provider that is subject to cost limits to request an exception to the cost limits if its costs exceed, or are expected to exceed, the limits as a result of one of the following unusual situations:

- Atypical services.
- Extraordinary circumstances.
- Providers in areas with fluctuating populations.
- Medical and paramedical education costs.
- Unusual labor costs.

An adjustment is made only to the extent that the costs are reasonable, attributable to the circumstance specified, separately identified by the provider, and verified by the intermediary.

The provider must file a request for an exception to the cost limits no later than 180 days from the date of the intermediary's notice of program reimbursement. The intermediary reviews the request with all supporting documentation. The intermediary also makes and submits to us a recommendation on the provider's request. We make a final determination and respond to the intermediary within 180 days from the date of the intermediary's recommendation. If we do not respond within 180 days, it is considered good cause for the granting of an extension of the time limit to apply for a Provider Reimbursement Review Board review.

In the past, Providers and intermediaries had raised many questions about the documentation needed to properly file SNF exception requests. In addition, we received many complaints from the SNFs about the length of time that it took to get a response to their exception requests, mainly because the regulation did not require a time limit for the intermediary's recommendation to us.

In order to address this situation and to clarify the exceptions process, we published, in July, 1994, section 2530 of HCFA Pub. 15–1 (Transmittal No. 378), which gives SNFs detailed instructions for requesting exceptions to the SNF cost limits. Under transmittal No. 378, intermediaries process SNF exceptions in a more expeditious manner. Section 2531.1 of Transmittal 378 requires intermediaries to submit to us their recommendations on a SNF's exception request within 90 days of the receipt of the request from the SNF. Also, under section 2531.1 of Transmittal 378, we notify the intermediary of our final determination on the exception within 90 days of the date that the request is received (the current regulation (§ 413.30(c)) allows us 180 days to make our final determination).

B. Provisions of this Rule Regarding Exceptions to the Cost Limits for SNFs and HHAs

After reviewing SNF exception requests submitted by intermediaries under the rules in Transmittal 378, we identified six intermediaries that were proficiently adjudicating SNF exceptions within 90 days of reviewing the SNF's requests. We gave the six intermediaries the additional responsibility in making the determination on SNF exception requests subject to our oversight and review. This has resulted in a substantial decrease in processing time and effort. The resulting increase in administrative efficiency has benefitted SNFs, fiscal intermediaries, and the Medicare program.

We propose to revise § 413.30(c) to give all intermediaries the authority to make final determinations on SNF exception requests. This would result in an increase in administrative efficiency that would benefit all SNFs that file SNF exception requests and fiscal intermediaries that process those exception requests.

In order to assure that all intermediaries will be able to adjudicate exception requests proficiently, we would work with the Blue Cross Association to perform additional training for all fiscal intermediaries. In addition, we would designate a single contact person to handle all inquiries from fiscal intermediaries regarding exception requests.

Under proposed § 413.30(c), if the intermediary determines that the SNF did not provide adequate documentation from which a proper determination can be made, the intermediary would notify the SNF that the request is denied. The intermediary would also notify the SNF that it has 45 days from the date on the intermediary's denial letter to submit a new exception request with the complete documentation, that we continue to allow the SNF to request a review by the Provider Reimbursement Review Board, and that the time we need to review the request (through the intermediary) is considered good cause for extending the time limit for the SNF to apply for the review. Otherwise, the denial is our final determination.

Section 4432 of the Balanced Budget Act of 1997, (Public Law 105–33) enacted August 5, 1997, mandates that a prospective payment system for SNFs be implemented effective for cost reporting periods beginning on or after July 1, 1998. This prospective payment system will replace the retrospective reasonable cost based system currently used by Medicare for payment of SNF services. Accordingly, exceptions will no longer be available to SNFs with cost reporting periods beginning on or after July 1, 1998. Fiscal intermediaries will continue to process, beyond July 1, 1998, SNF exception requests for cost reporting periods beginning before July 1, 1998.

Effective with cost reporting periods beginning on or after July 1, 1998, there will be a 3-year transition period to the prospective payment system. During the transition period, SNFs will be reimbursed a blended payment that is based partially on a facility-specific rate and a prospective payment rate. The base period for the facility-specific rate will be cost reporting periods beginning during the period October 1, 1994 and September 30, 1995. We recognize that providers might have questions about the relationship between the exceptions process and the calculation of the facility-specific rate under section 1888(e) of the Social Security Act, as added by the BBA. We are currently developing the regulation to implement the SNF prospective payment system enacted by the BBA and we will address those issues in that document.

The procedures for HHA exception requests would remain unchanged but would be set forth at § 413.30(c)(1).

III. Reclassification of Providers

A. Current Regulations Regarding Reclassifications

Section 413.30(d) states that a provider may obtain a reclassification if the provider can show that its classification is at variance with the criteria specified in promulgating the limits.

When cost limits were first developed, we manually arrayed the data collected from the providers' cost reports and classified them by type (hospital-based or freestanding) and location (metropolitan area or nonmetropolitan area). There were instances when providers were misclassified. Accordingly, we allowed providers to file reclassification requests under § 413.30(d) if they could show that the data we used for the classification were incorrect.

B. Provisions of this Rule To Remove the Regulation Allowing Reclassifications

We propose to remove § 413.30(d) to discontinue the use of reclassifications. HHAs and SNFs are now filing specific cost reports, and metropolitan and nonmetropolitan area designations have become linked, through automation, to the county and State where each provider is located. As a result, there is no chance that a SNF or HHA can be misclassified.

Hospitals now file for reclassifications with the Medicare Geographic Review Board. These reclassifications are specific to hospitals and are governed under subpart L of part 412. Hospitals no longer apply for reclassifications under § 413.30.

IV. Technical Changes

A. We would remove paragraph (h), pertaining to hospital cost report adjustments, as it is obsolete.

B. We would make minor editorial changes to § 413.30.

V. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments that we receive by the date and time specified in the ''DATES'' section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments, in the preamble to that document.

VI. Regulatory Impact Statement

Consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, all SNFs and HHAs are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a 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 that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds. The proposed rule to eliminate reclassifications for HHAs and SNFs would have no effect, since they no longer need reclassifications. Hospitals can obtain any needed reclassifications and exceptions under subpart L of part 412. The proposed rule to change the method of processing requests for exceptions to cost limits would have no economic impact on either the providers or the Medicare program.

For these reasons, we are not preparing an analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule would not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

VII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirements discussed below.

§ 413.30 Limitations on Payable Costs

(e) *Exceptions.* Limits established under this section may be adjusted upward for a SNF or HHA under the circumstances specified in paragraphs (e)(1) through (e)(5) of this section. An adjustment is made only to the extent that the costs are reasonable, attributable to the circumstances specified, separately identified by the SNF or HHA, and verified by the intermediary.

The current regulation at § 413.30(f) allows a provider that is subject to cost limits to request an exception to the cost limits if its costs exceed, or are expected to exceed, the limits as a result of one of the following unusual situations:

- Atypical services.
- Extraordinary circumstances.
- Providers in areas with fluctuating populations.
- Medical and paramedical education costs.
- Unusual labor costs.

An adjustment is made only to the extent that the costs are reasonable, attributable to the circumstance specified, separately identified by the provider, and verified by the intermediary.

The provider must file a request for an exception to the cost limits no later than 180 days from the date of the intermediary's notice of program reimbursement. The intermediary reviews the request with all supporting documentation. The intermediary also makes and submits to us a recommendation on the provider's request. We make a final determination and respond to the intermediary within 180 days from the date of the intermediary's recommendation. If we do not respond within 180 days, it is considered good cause for the granting of an extension of the time limit to apply for a Provider Reimbursement Review Board review.

We propose to revise § 413.30(c) to give all intermediaries the authority to make final determinations on SNF exception requests. This would result in an increase in administrative efficiency that would benefit all SNFs that file SNF exception requests and fiscal intermediaries that process those exception requests.

Under proposed § 413.30(c), if the intermediary determines that the SNF did not provide adequate

documentation from which a proper determination can be made, the intermediary would notify the SNF that the request is denied. The intermediary would also notify the SNF that it has 45 days from the date on the intermediary's denial letter to submit a new exception request with the complete documentation, that we continue to allow the SNF to request a review by the Provider Reimbursement Review Board, and that the time we need to review the request (through the intermediary) is considered good cause for extending the time limit for the SNF to apply for the review. Otherwise, the denial is our final determination.

Section 4432 of the Balanced Budget Act of 1997, (Public Law 105–33) enacted August 5, 1997, mandates that a prospective payment system for SNFs be implemented effective for cost reporting periods beginning on or after July 1, 1998. Accordingly, exceptions will no longer be available to SNFs with cost reporting periods beginning on or after July 1, 1998.

As referenced above, a SNF or HHA may request an exception based on the information provided in its cost report, as submitted to the appropriate HCFA intermediary. Accordingly, HCFA believes that the supplemental information submitted by the provider is not subject to the PRA, as stipulated in 5 CFR 1320.3(h)(6) and 5 CFR 1320.3(h)(9). In particular, on an individual basis, providers are given an opportunity to submit additional information designed to clarify the responses disclosed in a currently approved collection, e.g., HHA/SNF cost reports (OMB #0938–0022 & 0938–0463), to demonstrate an exception.

We have submitted a copy of this rule to OMB for its review of the information collection requirements above. If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850. Attn: John Burke HCFA–1883.

And,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503,

List of Subjects in 42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set out in the preamble, 42 CFR Chapter IV, Subchapter B, part 413, subpart C would be amended as follows:

PART 413—[AMENDED]

1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 413.30 is revised to read as follows:

§ 413.30 Limitations on payable costs.

(a) *Introduction*—(1) *Scope.* This section implements section 1861(v)(1)(A) of the Act, by setting forth the general rules under which HCFA may establish limits on SNF and HHA costs recognized as reasonable in determining Medicare program payments. It also sets forth rules governing exemptions and exceptions to limits established under this section that HCFA may make as appropriate in consideration of special needs or situations.

(2) *General principle.* Payable SNF and HHA costs may not exceed the costs HCFA estimates to be necessary for the efficient delivery of needed health services. HCFA may establish estimated cost limits for direct or indirect overall costs or for costs of specific services or groups of services. HCFA imposes these limits prospectively and may calculate them on a per admission, per discharge, per diem, per visit, or other basis.

(b) *Procedure for establishing limits.* (1) In establishing limits under this section, HCFA may classify SNFs and HHAs by factors that HCFA finds appropriate and practical, including the following:

(i) Type of services furnished.

(ii) Geographical area where services are furnished, allowing for grouping of noncontiguous areas having similar demographic and economic characteristics.

(iii) Size of institution.

(iv) Nature and mix of services furnished.

(v) Type and mix of patients treated.

(2) HCFA bases its estimates of the costs necessary for efficient delivery of health services on cost reports or other data providing indicators of current costs. HCFA adjusts current and past period data to arrive at estimated costs for the prospective periods to which limits are applied.

(3) Before the beginning of a cost period to which revised limits will be applied, HCFA will publish a notice in the **Federal Register**, establishing cost limits and explaining the basis on which they are calculated.

(4) In establishing limits under paragraph (b)(1) of this section, HCFA may find it inappropriate to apply particular limits to a class of SNFs or HHAs due to the characteristics of the SNF or HHA class, the data on which HCFA bases those limits, or the method by which HCFA determines the limits. In these cases, HCFA may exclude that class of SNFs or HHAs from the limits, explaining the basis of the exclusion in the notice setting forth the limits for the appropriate cost reporting periods.

(c) *Requests regarding applicability of cost limits.* A SNF may request an exception or exemption to the cost limits imposed under this section. An HHA may request only an exception to the cost limits. The SNF's or HHA's request must be made to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement.

(1) *Home health agencies.* The intermediary makes a recommendation on the HHA's request to HCFA, which makes the decision. HCFA responds to the request within 180 days from the date HCFA receives the request from the intermediary. The intermediary notifies the HHA of HCFA's decision. The time required by HCFA to review the request is considered good cause for the granting of an extension of the time limit for the HHA to apply for a Provider Reimbursement Review Board review, as specified in § 405.1841 of this chapter. HCFA's decision is subject to review under subpart R of part 405 of this chapter.

(2) *Skilled nursing facilities.* The intermediary makes the final determination on the SNF's request within 90 days from the date that the intermediary receives the request from the SNF. If the intermediary determines that the SNF did not provide adequate documentation from which a proper determination can be made, the intermediary notifies the SNF that the request is denied. The intermediary also notifies the SNF that it has 45 days from the date on the intermediary's denial letter to submit a new exception request with the complete documentation and that otherwise, the denial is the final determination. The time required by the intermediary to review the request is considered good cause for the granting of an extension of the time limit for the SNF to apply for a Provider Reimbursement Review Board review, as specified in § 405.1841 of this

chapter. The intermediary's determination is subject to review under subpart R of part 405 of this chapter.

(d) *Exemptions.* Exemptions from the limits imposed under this section may be granted to a new SNF. A new SNF is a provider of inpatient services that has operated as the type of SNF (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than 3 full years. An exemption granted under this paragraph, expires at the end of the SNF's first cost reporting period beginning at least 2 years after the provider accepts its first inpatient.

(e) *Exceptions.* Limits established under this section may be adjusted upward for a SNF or HHA under the circumstances specified in paragraphs (e)(1) through (e)(5) of this section. An adjustment is made only to the extent that the costs are reasonable, attributable to the circumstances specified, separately identified by the SNF or HHA, and verified by the intermediary.

(1) *Atypical services.* The SNF or HHA can show that the—

(i) Actual cost of services furnished by a SNF or HHA exceeds the applicable limit because the services are atypical in nature and scope, compared to the services generally furnished by SNFs or HHAs similarly classified; and

(ii) Atypical services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care.

(2) *Extraordinary circumstances.* The SNF or HHA can show that it incurred higher costs due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to, strikes, fire, earthquake, flood, or other unusual occurrences with substantial cost effects.

(3) *Areas with fluctuating populations.* The SNF or HHA meets the following conditions:

(i) Is located in an area (for example, a resort area) that has a population that varies significantly during the year.

(ii) Is furnishing services in an area for which the appropriate health planning agency has determined does not have a surplus of beds or services and has certified that the beds or services furnished by the SNF or HHA are necessary.

(iii) Meets occupancy or capacity standards established by the Secretary.

(4) *Medical and paramedical education.* The SNF or HHA can demonstrate that, if compared to other SNFs or HHAs in its group, it incurs increased costs for items or services covered by limits under this section because of its operation of an approved education program specified in § 413.85.

(5) *Unusual labor costs.* The SNF or HHA has a percentage of labor costs that varies more than 10 percent from that included in the promulgation of the limits.

(f) *Operational review.* Any SNF or HHA that applies for an exception to the limits established under paragraph (e) of this section must agree to an operational review at the discretion of HCFA. The findings from this review may be the basis for recommendations for improvements in the efficiency and economy of the SNF's or the HHA's operations. If recommendations are made, any future exceptions are contingent on the SNF's or HHA's implementation of these recommendations.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: December 8, 1997.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: April 6, 1998.

Donna E. Shalala,

Secretary.

[FR Doc. 98–21423 Filed 8–10–98; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL MARITIME COMMISSION

46 CFR Part 514

[Docket No. 98–10]

Inquiry into Automated Tariff Filing Systems as Proposed by the Pending Ocean Shipping Reform Act of 1998

AGENCY: Federal Maritime Commission.

ACTION: Notice of inquiry; Extension of time.

SUMMARY: Upon consideration of a request from counsel for various carrier agreements and ocean common carriers a limited extension of time to comment on the Notice of Inquiry in this matter is granted.

DATES: Comments due on or before August 25, 1998.

ADDRESSES: Send comments (original and 20 copies) to: Joseph C. Polking, Secretary, Federal Maritime Commission, 800 North Capitol Street, NW, Washington DC 20573–0001, (202) 523–5725.

FOR FURTHER INFORMATION CONTACT:

Bryant L. VanBrakle, Director, Bureau of Tariffs, Certification and Licensing, Federal Maritime Commission, 800 North Capitol Street, NW, Washington, DC 20573–0001, (202) 523–5796

Thomas Panebianco, General Counsel, Federal Maritime Commission, 800 North Capitol Street, NW, Washington, DC 20573–0001, (202) 523–5740.

SUPPLEMENTARY INFORMATION: The Commission on July 9, 1998, (63 FR 37088) published a Notice of Inquiry (''NOI'') to help determine an approach that will produce automated tariff publication systems and service contract filings that best comport with the directives of S. 414, the Ocean Shipping Reform Act of 1998, and its legislative history. The Commission directed comments to be filed by August 10, 1998, recognizing that S. 414 was awaiting action in the House of Representatives and that passage there before adjournment could leave a very short time period to adopt final implementing rules by the March 1, 1999, deadline contained in S. 414.

Counsel for numerous carrier agreements and ocean common carriers now have requested a 30-day extension of the comment period to September 11, 1998. As justification therefore counsel refer to the fact that S. 414 has not yet been passed by the House and it would be ''premature and speculative to offer comments on how it should be implemented.'' Counsel further suggest that because of the uncertainty of the legislative process they have been ''reluctant to devote much time'' to the matter and ''have not had an opportunity to meet and discuss these issues.''

The Commission, in establishing the August 10 comment deadline, recognized that enactment of S. 414 in its current form was not a certainty, but nevertheless determined that time constraints required that the NOI go forward. Nothing has changed in this regard although the House of Representatives on August 4 passed a slightly modified version of S. 414. Given the S. 414 time constraints, the Commission must continue to proceed expeditiously and cannot accommodate a 30-day extension request. Nevertheless, a 15-day extension to August 25, 1998, will be granted in the interest of maximizing public participation in the NOI. The demands inherent in meeting the proposed statutory timetable may preclude comments received after that date from