

SUPPLEMENTARY INFORMATION: The caption **ADDRESSES** on page 9223, column two, reads "The five meetings to conduct the negotiated rulemaking process will be held at the U.S. Department of Education, Barnard Auditorium, 400 Maryland Avenue, SW., Washington, DC 20202." It is corrected to read "The five meetings to conduct the negotiated rulemaking process will be held at the Sheraton Premiere At Tysons Corner, 8661 Leesburg Pike, Vienna, VA 22182." The published listing of individuals under the heading *Representing Principals and Teachers* on page 9224, column one, is corrected by adding to the list "David Sherman, Vice President, UFT, New York City (NY)". The published listing of individuals under the heading *Representing local Administrators and Local School Boards* on page 9224, column one, is corrected by removing from the list "Nelson Smith, charter schools, Washington, DC" and adding, in its place, "Nelson Smith, Managing Director for New School Services, New American Schools, Arlington (VA); formerly Executive Director of the DC Public Charter School Board". The published Web site under the heading *Topics Selected for Negotiation* on page 9224, column two, reads "www.ed.gov/nclb/". It is corrected to read "www.ed.gov/nclb/".

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Dated: February 28, 2002.

Susan B. Neuman,

Assistant Secretary for Elementary and Secondary Education.

[FR Doc. 02-5256 Filed 3-1-02; 11:21 am]

BILLING CODE 4001-01-U

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

42 CFR Part 457

[CMS-2127-P]

RIN 0938-AL37

State Children's Health Insurance Program; Eligibility for Prenatal Care for Unborn Children

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: In order to provide prenatal care and other health services, this proposed rule would revise the definition of "child" under the State Children's Health Insurance Program (SCHIP) to clarify that an unborn child may be considered a "targeted low-income child" by the State and therefore eligible for SCHIP if other applicable State eligibility requirements are met. Under this definition, the State may elect to extend eligibility to unborn children for health benefits coverage, including prenatal care and delivery, consistent with SCHIP requirements. **DATES:** We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on May 6, 2002.

ADDRESSES: In commenting, please refer to file code CMS-2127-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and three copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-2127-P, P.O. Box 8016, Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

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

Room 443-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5-16-03, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Kathleen Farrell, (410) 786-3285.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786-7195.

I. Background

Section 4901 of the Balanced Budget Act, (Public Law 105-33), as amended by Public Law 105-100, added title XXI to the Act. Title XXI authorizes the State Children's Health Insurance Program (SCHIP) to assist State efforts to initiate and expand the provision of child health assistance to uninsured, low-income children. Under title XXI, States may provide child health assistance primarily for obtaining health benefits coverage through (1) a separate child health program that meets the requirements specified under section 2103 of the Act; (2) expanding eligibility for benefits under the State's Medicaid plan under title XIX of the Act; or (3) a combination of the two approaches. To be eligible for funds under this program, States must submit a State child health plan (State plan), that meets the applicable requirements of title XXI and is approved by the Secretary.

The State Children's Health Insurance Program is jointly financed by the Federal and State governments and is administered by the States. Within broad Federal guidelines, each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. Under section 2102(b) of the Act, States have discretion to adopt eligibility standards that are related to age, and thus may extend SCHIP eligibility only to certain age groups of targeted low-income children (who must be under age 19). SCHIP provides a capped amount of funds to States on a matching basis for Federal fiscal years (FY) 1998 through 2007. Regulations implementing SCHIP are set forth at 42 CFR part 457.

II. Provisions of the Proposed Regulations

Section 2110 of the Act sets forth the definition of a targeted low-income child. In accordance with this section of

the Act, at § 457.310 we define a targeted low-income child as a child who meets the standards set forth at § 457.310 and the eligibility standards established by the State. The term "child" is defined at section 2110(c)(1) of the Act as an individual under 19 years of age. Under this framework and in accordance with the regulations promulgated by the Secretary, a State may elect the age groups of targeted low-income children under age 19 that will be eligible for SCHIP coverage under their State plans. For example, a State plan may permit eligibility of children only through age 12. This statutory definition is currently repeated in the regulations at § 457.10.

For reasons set forth below, in interest of providing necessary pre-natal care to children, we propose in this regulation to clarify and expand the definition of the term "child" so that a State may elect to make individuals in the period between conception and birth eligible for coverage as well under their State plan. Specifically, we would expand and revise the definition to clarify that "child" means an individual under the age of 19 and may include any period of time from conception to birth through age 19. This clarification of the definition of child will provide States with the option to consider an unborn child to be a targeted low-income child and therefore eligible for SCHIP if other applicable State eligibility requirements are met. This clarification would be consistent with the general statutory flexibility given States to elect the age groups of targeted low income children who must be under 19 years of age. Absent this clarification, under SCHIP there is a significant population of children who would be eligible at birth but who would not have had the benefit of needed prenatal care and delivery services. Currently, a pregnant woman under age 19 could be eligible as a targeted low income child and her child would benefit from needed prenatal care and delivery services by virtue of the mother's eligibility status. Absent this clarification, a pregnant woman over age 19 could not be eligible as a targeted low income child, and her child thus would not necessarily have the benefit of needed prenatal care and delivery services. This clarification would permit States to ensure that these needed services are available to benefit unborn children independent of the mother's eligibility status.

It is anticipated that the children covered by this regulation will become eligible for the SCHIP program after birth. By establishing eligibility prior to birth, the proposed change would improve continuity of care and simply

allow states to establish eligibility at an earlier but medically critical point in time.

It is well established that access to prenatal care can improve health outcomes during infancy as well as over a child's life. Prenatal care includes monitoring the health of both the mother and the unborn child. The importance of prenatal care is widely accepted for the reasons summarized in the Department's 1999 report, *Trends in the Well-Being of America's Children and Youth*, "Receiving prenatal care late in a pregnancy, or receiving no prenatal care at all, can lead to negative health outcomes for mother and child." This 1999 report shows that while the percentage of women who receive late prenatal care (defined as seventh month or later) has declined for women in all racial and ethnic groups and ages, there are still significant differences by race and ethnicity and age. For example, five percent of women aged 20 to 24 receive late or no prenatal care compared to 3.9 percent of all women. This proposed rule change would allow states to provide coverage under SCHIP to the unborn children of those pregnant women if other eligibility criteria are met. Since low-income women are less likely to receive prenatal care, this rule would allow states to provide those needed services to a segment of the population that otherwise may not receive them.

The report explains,

Adequate prenatal care is determined by both the early receipt of prenatal care (within the first trimester) and the receipt of an appropriate number of prenatal care visits for each stage of a pregnancy. Women whose prenatal care fails to meet these standards are at a greater risk for pregnancy complications and negative birth outcomes.

In the 2000 *Trends in the Well-Being of America's Children and Youth*, the Department states,

Early prenatal care allows women and their health care providers to identify, and when possible, treat or correct health problems and health-compromising behaviors that can be particularly damaging during the initial stages of fetal development. Increasing the percentage of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth.

The 2000 Report explains,

Babies born weighing less than 2,500 grams face an increased risk of physical and developmental complications and death. These babies account for four-fifths of all neonatal deaths (deaths under 28 days of age) and are 24 times more likely to die during the first year than are heavier infants.

According to the Report, low birthweight infants account for 7.6 percent of all infants born to mothers age 20 to 24 years.

Medical care is continually advancing and offers opportunities for services specifically targeted to the care of the unborn child. "Fetal medicine" or "fetology" is emerging as a distinct and important medical specialty which includes: obstetrics, maternal-fetal medicine, neonatology, pediatrics and fetal/neonatal pediatric surgery. Physicians specializing in fetal medicine use the pre-partum period to diagnosis potentially life threatening conditions in utero (e.g. congenital cystic adenomatoid malformation, congenital diaphragmatic hernia, congenital heart disease, gastroschisis, giant neck masses, hydrocephalus, obstructive uropathy omphalocele, spina bifida, sacrococcygeal teratoma). Once detected, such conditions can often be surgically or medically treated in utero, with beneficial consequences which can include: saving the life of the child; elimination of long neo-natal, post-partum medical care for the child; and ultimately lower post-partum medical care costs for the child and therefore the SCHIP plan. The Secretary would like to permit the States the flexibility to pay for the medical expenses related to unborn children because the Secretary has determined that provision of such services before birth should result in healthier infants, better long-term child growth and development and ultimate cost savings to the SCHIP plans (and the federal government through the SCHIP contribution process) through reduced expenditures for high cost neo-natal care.

This regulatory clarification is intended to benefit both the unborn children and their mothers by promoting continuity of important medical care. Healthy pregnancies should also result in significant savings in public expenditures over a child's lifetime.

In order to protect against the substitution of Title XXI enhanced payments for Medicaid payments, we have added a new subparagraph in section 457.626(a) Prevention of duplicate payments. This subparagraph would clarify that payment is not available under Title XXI when payment may be reasonably expected to be made under Medicaid on the basis of the Medicaid eligibility or enrollment of the pregnant woman. Under section 2105(c)(6)(B) of the SCHIP statute, payment under SCHIP is not available if payment can be reasonably expected under another federally financed health

benefits program. To permit shifting of claims for services that could be covered under Medicaid to the SCHIP program would not be consistent with this provision. The intent of this regulation is to provide prenatal services for unborn children who would otherwise not be covered by Medicaid or other coverage. We want to ensure that Title XXI funds do not substitute for Medicaid funds.

The purpose of the enhanced match in Title XXI is to encourage states to increase eligibility for health insurance coverage. So too is the purpose of this proposed rule. Consistent with congressional intent, the Department will work with states which seek to adopt this definition to ensure that coverage will be expanded beyond current Title XIX and Title XXI levels.

To the extent that a state elects to include unborn children in the SCHIP definition of children, as permitted by this rule, we believe that the state must also apply that same interpretation in assessing compliance with the Medicaid maintenance of effort provision of section 2105(d)(1). Since unborn children receive medical assistance under the Medicaid program through their mothers' status as pregnant women, more restrictive eligibility standards or methodologies for pregnant women in Medicaid would violate this maintenance of effort requirement. This requirement will be considered when state plan amendments to adopt the expanded definition are submitted. For the same reasons, a state that defines children under SCHIP to include unborn children would need to apply the same definition in the screen-and-enroll process described in SCHIP regulations at 42 CFR 457.350. We are proposing to modify these requirements to clarify that, for purposes of the screen and enroll process, individuals are properly enrolled in the appropriate program.

States will continue to have the authority to set eligibility requirements under their State plans, including age limits so long as the age limit is under 19 years of age, and hence States would not be required to extend coverage to this population. States that opt to extend eligibility to unborn children will submit a State plan amendment in accordance with § 457.60.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 30-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. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comments on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Section 457.60 requires a State to submit to CMS for approval an amendment to its approved State plan, whenever necessary, to reflect any changes in: (1) Federal law, regulations, policy interpretations, or court decisions, (2) State law, organization, policy or operation of the program, or (3) the source of the State share of funding. The burden associated with this requirement is the time and effort for a State to prepare and submit any necessary amendments to its State plan to CMS for approval. Based upon CMS's previous experiences with State plan amendments we estimate that on average, it will take a State 8 hours to complete and submit an amendment. We estimate that 13 States/territories will submit an amendment on an annual basis for a total burden of 104 hours.

IV. 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 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.

V. Regulatory Impact Statement

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health

and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more annually).

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$25 million or less annually. 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. This 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 100 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million.

This proposed rule would revise and clarify the definition of "child" under the State Children's Health Insurance Program (SCHIP) to provide that an unborn child may be considered a "targeted low-income child" by the State and therefore eligible for SCHIP if other applicable State eligibility requirements are met. We estimate that 13 states will elect to include this definition in their State plans. We also estimate that an additional 30,000 unborn children will benefit by this change. In States that adopt this option, the health status of children will improve to the extent that their mothers receive prenatal care. We estimate that the budget impact will be \$320 million over a five-year period. Therefore, the provisions set forth in this proposed rule will not have an impact of \$110 million or more annually. These are the best estimates available. However, we are interested in seeking comment from the public on estimates of the impact of this rule. Neither is this rule expected to impose an unfunded mandate on States exceeding \$110 million annually. Therefore, we have not prepared an analysis of cost and benefits as required by E.O. 12866 and the Unfunded

Mandates Act for rules with significant economic impacts or that impose significant unfunded mandates on States. Also, we believe the changes being promulgated in this document will have very little direct impact on small entities as defined under the RFA or on small rural hospitals as defined under section 1102(b) of the Social Security Act. Therefore, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule will 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.

Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has federalism implications. The option for States to extend coverage to unborn children promulgated in this proposed rule does not meet the criteria for having Federalism implications. This provision would not impose direct costs on states or local governments, nor does it preempt State laws. This new option only increases State flexibility and, therefore, prior consultation is not required. However, we welcome input from State and local governments through the notice and comment process.

List of Subjects in 42 CFR Part 457

Administrative practice and procedure, Grant programs—health, Children's Health Insurance Program, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR part 457 is proposed to be amended as set forth below:

PART 457—ALLOTMENTS AND GRANTS TO STATES

1. The authority citation for part 457 continues to read as follows:

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

Subpart A—Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

2. In § 457.10, the definition of "Child" is revised to read as follows:

§ 457.10 Definitions and use of terms.

* * * * *

Child means an individual under the age of 19 including the period from conception to birth.

* * * * *

Subpart C—State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

3. Amend § 457.350 as follows:
 A. Redesignate the text of paragraph (b) following the heading as paragraph (b)(1).
 B. Add paragraph (b)(2) to read as follows:

§ 457.350 Eligibility screening and facilitation of Medicaid enrollment.

* * * * *

(b) Screening objectives. (1) * * *
 (2) Screening procedures must also identify any applicant or enrollee who would be potentially eligible for Medicaid services based on the eligibility of his or her mother under one of the poverty level groups described in 1902(l) of the Act, section 1931 of the Act or a Medicaid demonstration project approved under section 1115 of the Act.

* * * * *

Subpart F—Payment to States

4. Revise § 457.622(c)(5) to read as follows:

§ 457.622 Rate of FFP for State expenditures.

* * * * *

(c) * * *
 (5) The state does not adopt eligibility standards and methodologies for purposes of determining a child's eligibility under the Medicaid State plan that were more restrictive than those applied under policies of the State plan in effect on June 1, 1997. This limitation applies also to more restrictive standards and methodologies for determining eligibility for services for a child based on the eligibility of a pregnant woman.

* * * * *

5. Amend § 457.626 to add a new paragraph (a)(3) to read as follows:

§ 457.626 Prevention of duplicate payments.

(a) * * *
 (3) Services are for an unborn child and are payable under Medicaid as a service to an eligible pregnant woman under that program.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.767, State Children's Health Insurance Program)

Dated: February 18, 2002.

Thomas A Scully,
Administrator, Centers for Medicare & Medicaid Services.

Approved: February 22, 2002.

Tommy G. Thompson,
Secretary.

[FR Doc. 02-5217 Filed 3-1-02; 2:00 pm]

BILLING CODE 4120-01-P

DEPARTMENT OF TRANSPORTATION

Coast Guard

46 CFR Parts 28, 109, 122, 131, 169, 185, and 199

[USCG-2001-11118]

RIN 2115-AG28

Liferaft Servicing Intervals

AGENCY: Coast Guard, DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Coast Guard proposes to amend its commercial vessel regulations to provide consistency in the requirements for servicing of inflatable liferafts and inflatable buoyant apparatus (IBA). We are proposing this rule to eliminate an unnecessary burden on vessel operators and to eliminate confusion among the public and Coast Guard field personnel. The proposed rule would defer the first servicing of a new liferaft or IBA to two years after initial packing on all commercial vessels not certificated under the International Convention for the Safety of Life at Sea (SOLAS).

DATES: Comments and related material must reach the Docket Management Facility on or before May 6, 2002.

ADDRESSES: To make sure that your comments and related material are not entered more than once in the docket, please submit them by only one of the following means:

(1) By mail to the Docket Management Facility (USCG-2001-11118), U.S. Department of Transportation, room PL-401, 400 Seventh Street SW., Washington, DC 20590-0001.

(2) By delivery to room PL-401 on the Plaza level of the Nassif Building, 400 Seventh Street SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The telephone number is 202-366-9329.

(3) By fax to the Docket Management Facility at 202-493-2251.

(4) Electronically through the Web Site for the Docket Management System at <http://dms.dot.gov>.

The Docket Management Facility maintains the public docket for this