the **Federal Register**. This rule is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Hydrocarbons, Intergovernmental relations, New source review, Nitrogen dioxide, Particulate matter, Reporting, and recordkeeping requirements, Sulfur dioxide, Volatile organic compounds.

Authority: 42 U.S.C. 7401, *et seq.*

Dated: November 14, 1997.

David A. Ullrich,

Acting Regional Administrator, Region 5.

[FR Doc. 97–31280 Filed 12–9–97; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 63

[FRL–5932–2]

Approval of Section 112(l) Authority for Hazardous Air Pollutants; Perchloroethylene Air Emission Standards for Dry Cleaning Facilities; State of California; San Luis Obispo County Air Pollution Control District

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: Pursuant to section 112(l) of the Clean Air Act (CAA) and through the California Air Resources Board, San Luis Obispo County Air Pollution Control District (SLOCAPCD) requested approval to implement and enforce its ''Rule 432: Perchloroethylene Dry Cleaning Operations'' (Rule 432) in place of the ''National Perchloroethylene Air Emission Standards for Dry Cleaning Facilities'' (dry cleaning NESHAP) for area sources under SLOCAPCD's jurisdiction. In the Rules section of this **Federal Register**, EPA is granting SLOCAPCD the authority to implement and enforce Rule 432 in place of the dry cleaning NESHAP for area sources under SLOCAPCD's jurisdiction as a direct final rule without prior proposal because the Agency views this as a noncontroversial action and anticipates no adverse comments. A detailed rationale for this approval is set forth in the direct final rule. If no adverse comments are received in response to this proposed rule, no further activity is contemplated in relation to this rule. If EPA receives adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule based on this proposed rule. The EPA will not institute a second comment period on this document. Any parties interested in commenting on this action should do so at this time.

DATES: Comments on this proposed rule must be received in writing by January 9, 1998.

ADDRESSES: Written comments on this action should be addressed to: Andrew Steckel, Rulemaking Office (AIR–4), Air Division, U.S. Environmental Protection Agency, Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901.

Copies of the submitted request are available for public inspection at EPA's Region IX office during normal business hours.

FOR FURTHER INFORMATION CONTACT: Mae Wang, Rulemaking Office (AIR–4), Air Division, U.S. Environmental Protection Agency, Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901, Telephone: (415) 744–1200.

SUPPLEMENTARY INFORMATION: This document concerns SLOCAPCD Rule 432, Perchlorothylene Dry Cleaning Operations, adopted on November 13, 1996. For further information, please see the information provided in the direct final action which is located in the Rules section of this **Federal Register**.

Authority: This action is issued under the authority of Section 112 of the Clean Air Act, as amended, 42 U.S.C. Section 7412.

Dated: November 23, 1997.

Felicia Marcus,

Regional Administrator.

[FR Doc. 97–32330 Filed 12–9–97; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

42 CFR Part 1001

Solicitation of New Safe Harbors and Special Fraud Alerts

AGENCY: Office of Inspector General (OIG), HHS.

ACTION: Notice of intent to develop regulations.

SUMMARY: In accordance with section 205 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, this notice solicits proposals and recommendations for developing new and modifying existing safe harbor provisions under the Federal and State health care programs' anti-kickback statute, as well as developing new OIG Special Fraud Alerts. The purpose of developing these documents is to clarify OIG enforcement policy with regard to program fraud and abuse.

DATES: To assure consideration, public comments must be delivered to the address provided below by no later than 5 p.m. on February 9, 1998.

ADDRESSES: Please mail or deliver your written comments to the following address: Office of Inspector General, Department of Health and Human Services, Attention: OIG–21–N, Room 5246, Cohen Building, 330 Independence Avenue, S.W., Washington, D.C. 20201. We do not accept comments by facsimile (FAX) transmission. In commenting, please refer to file code OIG–21–N. 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 5541 of the Office of Inspector General at 330 Independence Avenue, S.W., Washington, D.C., on Monday through Friday of each week from 8:00 a.m. to 4:30 p.m.

FOR FURTHER INFORMATION CONTACT: Joel Schaer, (202) 619–0089, OIG Regulations Officer.

SUPPLEMENTARY INFORMATION:

I. Background

A. The OIG Safe Harbor Provisions

Section 1128B(b) of the Social Security Act (the Act) (42 U.S.C. 1320a–7b(b)) provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit or receive remuneration in order to induce business reimbursed under the Federal or State health care programs. The offense is classified as a felony, and is punishable by fines of up to $25,000 and imprisonment for up to 5 years.

The types of remuneration covered specifically include kickbacks, bribes, and rebates, whether made directly or indirectly, overtly or covertly, or in cash or in kind. In addition, prohibited conduct includes not only remuneration intended to induce referrals of patients, but remuneration intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by Federal or State health care programs.

Since the statute on its face is so broad, concern has been expressed for many years that some relatively innocuous commercial arrangements are technically covered by the statute and are, therefore, subject to criminal prosecution. As a response to the above concern, the Medicare and Medicaid Patient and Program Protection Act of 1987, section 14 of Public Law 100–93,

specifically required the development and promulgation of regulations, the so-called ''safe harbor'' provisions, designed to specify various payment and business practices which, although potentially capable of inducing referrals of business under the Federal and State health care programs, would not be treated as criminal offenses under the anti-kickback statute (section 1128B(b) of the Act; 42 U.S.C. 1320a–7b(b)) and would not serve as a basis for a program exclusion under section 1128(b)(7) of the Act; 42 U.S.C. 1320a–7(b)(7). The OIG safe harbor provisions have been developed ''to limit the reach of the statute somewhat by permitting certain non-abusive arrangements, while encouraging beneficial and innocuous arrangements'' (56 FR 35952, July 29, 1991). Health care providers and others may voluntarily seek to comply with these provisions so that they have the assurance that their business practices are not subject to any enforcement action under the anti-kickback statute or program exclusion authority.

To date, the OIG has developed and codified in 42 CFR 1001.952 a total of 13 final safe harbors that describe practices that are sheltered from liability, and is continuing to finalize 8 additional safe harbor provisions (see the OIG notice of proposed rulemaking at 58 FR 49008, September 21, 1993).

B. OIG Special Fraud Alerts

In addition, the OIG has also periodically issued Special Fraud Alerts to give continuing guidance to health care providers with respect to practices the OIG regards as unlawful. These Special Fraud Alerts serve to notify the health care industry that the OIG has become aware of certain abusive practices that the OIG plans to pursue and prosecute, or to bring civil and administrative action, as appropriate. The Special Fraud Alerts also serve as a tool to encourage industry compliance by giving providers an opportunity to examine their own practices. The OIG Special Fraud Alerts are intended for extensive distribution directly to the health care provider community, as well as those charged with administering the Medicare and Medicaid programs.

In developing these Special Fraud Alerts, the OIG has relied on a number of sources and has consulted directly with experts in the subject field, including those within the OIG, other agencies of the Department, other Federal and State agencies, and those in the health care industry. To date, eight individual Special Fraud Alerts have been issued by the OIG and subsequently reprinted in the **Federal Register** on December 19, 1994 (59 FR 65372), August 10, 1995 (60 FR 40847) and June 17, 1996 (61 FR 30623).

C. Section 205 of Public Law 104–191

In accordance with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191), the Department is now required to provide additional formal guidance regarding the application of the anti-kickback statute and the safe harbor provisions, as well as other OIG health care fraud and abuse sanctions. In addition to accepting and responding to requests for advisory opinions to outside parties regarding the interpretation and applicability of certain statutes relating to the Federal and State health care programs, section 205 of Public Law 104–191 requires the Department to develop and publish an annual notice in the **Federal Register** formally soliciting proposals for (1) modifying existing safe harbors, and (2) developing new safe harbors and OIG Special Fraud Alerts. After considering such proposals and recommendations, the Department, in consultation with the Department of Justice, will consider the issuance of new or modified safe harbor regulations, as appropriate. In addition, the OIG will consider the issuance of additional Special Fraud Alerts.

On December 31, 1996, the Department published the first of these annual **Federal Register** notice solicitations (61 FR 69060) addressing proposals and recommendations for developing new and modifying existing safe harbor provisions under the Federal and State health care programs' anti-kickback statute, as well as developing new OIG Special Fraud Alerts. As a result, the OIG received a total of 32 timely-filed public comments from a cross-section of organizations, associations and other outside entities. In response to that solicitation, respondents raised a number of issues and comments on a variety of areas, including general comments concerning application of the existing safe harbor provisions, and specific concerns over the existing safe harbors presently codified in 42 CFR 1001.952 and those proposed in our September 1993 notice of proposed rulemaking. Respondents also recommended new safe harbors for, among other practices and arrangements: (1) physician ownership of hospitals; (2) provider sponsorship or support of continuing education programs for health care practitioners and facilities; (3) provision of cataract surgery-related prosthetic devices; (4) loans between parties in a position to refer or arrange for the referral of Medicare covered items; (5) *de minimis* gifts to beneficiaries for recommending new patients; (6) intercorporate transfers among entities delivering health care through integrated delivery systems; and (7) payments for purposes of physician retention.

Special Fraud Alerts were also suggested to address such areas as: (1) financial arrangements between hospitals and hospital-based physicians; (2) billing management consultants; (3) hospital discharges and transfers; (4) food vendor ''value added'' services; and (5) demands for discounts by Medigap insurers.

The array of proposals and recommendations received for new safe harbors and Special Fraud Alerts are summarized below, and are still under review within the OIG. When the OIG has fully assessed the merits of these recommendations, we will consider the promulgation of formal proposed regulations to create new safe harbors for those proposals deemed appropriate.

II. Summary of Previously Submitted Recommendations for New Safe Harbors and OIG Special Fraud Alerts

Set forth below is a summary of the major topics previously submitted for consideration in the OIG development of new safe harbors and Fraud Alerts. This listing serves to outline the major concepts and specific proposals received by this office as a result of the December 1996 solicitation notice. The OIG is currently taking these recommendations under advisement, and is *not seeking* additional public comment on *these* proposals at this time.

A. Proposed New Safe Harbors

Interface With the Stark Law

Commenters indicated that physician groups are closely regulated by both the anti-kickback statute and the physician self-referral laws, i.e., the Stark provisions. Since many existing safe harbors are similar but not identical to the statutory exceptions under the Stark law, commenters indicated that physician groups are forced to analyze much of what they do under two separate bodies of law, and are left with regulatory uncertainty. As a result, they recommended that the OIG conform safe harbors to the statutory and regulatory exceptions applicable under the Stark provisions, thus protecting any payment arrangement that meets an exception under the Stark provisions. We intend specifically to address this issue in the final regulations that are being developed in response to the September 1993 proposed rule.

Physician Ownership of Hospitals

Since physician investment in hospitals is expressly recognized under the Stark provisions, a recommendation was made for a companion safe harbor for physicians and group practices that hold ownership interests in hospitals to which they refer.

ASCs, CORFs and Similar Entities

Commenters recommended expanded safe harbors to cover ambulatory surgical centers (ASCs) owned by a group practice (even if not all members of the group are surgeons), and for ASCs that are owned in part by physicians and in part by hospitals or other non-physician investors, as long as the physician's return on investment is based on the performance of the ASC as a whole. A commenter also requested protection for physician ownership in other facilities where they practice, such as comprehensive outpatient rehabilitation facilities. We expect to address these issues in the final regulations being developed in response to our earlier safe harbor proposed rule.

Services Provided by Federally-Funded Community Health Centers

A safe harbor was suggested to allow Federally-funded community health centers to take advantage of opportunities to improve their services to disadvantaged patients, for example, by arranging for discounted services where the arrangement will produce a substantial benefit to a medically underserved population.

Continuing Education

One commenter recommended a safe harbor delineating the circumstances under which manufacturers, commercial laboratories and other providers can sponsor or provide continuing education programs to health care facilities and practitioners. This commenter believed that many educational opportunities may be foregone by practitioners who, at the request of the provider, may have to notify other local practitioners about the presentation to avoid the appearance of impropriety. The commenter was concerned that the OIG may consider a presentation to a single hospital, for example, as an inducement for Medicare referrals.

Cataract Surgery-Related Prosthetic Devices

A recommendation was made for a safe harbor addressing the referral of patients for eyeglasses, contact lenses and intraocular lenses. A commenter stated that eyeglasses and contact lenses sold by optical stores, regardless of who owns the establishment, are consumer items that are subject to specific controls by the Federal Trade Commission, as well as by State regulation and free market competition. With respect to a safe harbor for the provision of intraocular lenses during cataract surgery, the commenter indicated that patients during an operation are not in a position to shop elsewhere for these items, and the selection of these lenses is based on operative techniques and often cannot be done prior to surgery.

New Managed Care Safe Harbors

A new safe harbor was suggested to apply broadly to all Medicare and Medicaid contracting managed care plans that are in compliance with the applicable requirements under Medicare, and plans that are participating in the Health Care Financing Administration (HCFA) managed care demonstrations. A recommendation was also made to establish comparable safe harbor protection for managed care plans that are licensed or regulated by HCFA or State regulatory bodies, involving non-contracting organizations and their activities involved in providing and arranging care for Medicare beneficiaries. Further, a recommendation for new safe harbors was also received that would protect other managed care financial relationships, such as (i) payment arrangements between managed care organizations and manufacturers that relate to usage of the manufacturer's products by the managed care organization's enrollees and (ii) protection for preferred provider organizations that charge administrative fees to providers.

Intercorporate Transfers

Commenters recommended that a new safe harbor be created for integrated delivery systems that would address payments between related entities, including, among others, parent companies and wholly-owned subsidiaries. This safe harbor would serve to clarify permissible transfers of ''remuneration'' between and among physicians, hospitals, health plans and others who are delivering health care through integrated delivery systems.

Offering Flat Rates for Outpatient Surgery by Hospitals

With regard to outpatient surgeries, a commenter stated that providers should be able to charge Medicare patients in the same fashion as other patients, without fear of sanctions. As a result, they recommended a new safe harbor for flat fees for outpatient surgeries. The commenter suggested that this would enhance access to health services to the extent that the beneficiary would have a greater comfort level knowing the coinsurance charge at the time a procedure is scheduled rather than dealing with uncertainty of not knowing the precise amount of the coinsurance obligation until after the procedure has been billed.

Physician Retention

A new safe harbor was recommended for all physician retention efforts by hospitals, regardless of a hospital's location. The safe harbor would protect payments or benefits offered by hospitals and other entities to retain physicians and other practitioners in the service area.

Investments by Ambulatory Surgical Center (ASC) Administrators and Family Members

A commenter suggested a safe harbor to protect investment interests by certain non-practitioners who are actively involved with the delivery of health care services at an ASC in an administrative or managerial capacity. Since many ASCs are owned, in part, by facility administrators who have a vested interest in the success of the ASC, it was believed that these individuals should be allowed to invest in ASCs and participate in any profits generated by the facility at which they work with the protection of a safe harbor, much like surgeons would be allowed to invest in the ASC even if passive investors. The commenter also believed that a safe harbor should allow investment interests in ASCs to be held by family members of those individuals whose investment interests are protected by the safe harbor so long as those family members are not able to make or influence referrals to the facility. We expect to address this issue in the OIG's final regulations being developed in response to our earlier safe harbors proposal.

ASCs Located in Underserved Rural Areas

To encourage efficient and less-costly medical care delivery, it was recommended that all investments in an ASC in an area where there was previously no ASC or hospital, regardless of their source, should receive protection as long as the investments meet specific criteria set forth in the proposed safe harbor for investments in entities in rural areas. (Proposed revisions to § 1001.952(a)(4) were set forth in the OIG proposed

rulemaking of September 21, 1993 (58 FR 49008).)

Loans

A commenter indicated that loans between a provider and practitioner are often the only available source of necessary capital in a community, and recommended protection for loans between parties who may be in a position to refer, recommend or arrange for the referral or recommendation of Medicare or Medicaid covered items or services.

Investments

Although there is a safe harbor under the anti-kickback statute for investment interests, a commenter believed that it expressly protects only payments in the form of ''return paid to investors'' on investments that comply with the safe harbor's requirement, but not expressly the investments themselves. They indicated that health care providers and practitioners often enter into legitimate business ventures in which the investors are potential recipients of referrals from the venture in which they are investing. As a result, the commenter recommended a new safe harbor to protect legitimate investments from the anti-kickback statute.

De Minimis Gifts

A commenter suggested a new safe harbor addressing *de minimis* gifts to beneficiaries for recommending a new customer to the provider. For purposes of this proposal, *de minimis* gifts would be small tokens of a provider's gratitude given to customers and community members who suggest the provider's services or products to other potential customers, consistent with the Internal Revenue Service's definition on limitation on all allowable business gifts. No safe harbor protection would be afforded where gifts, even if *de minimis,* were made to physicians and other practitioners in a position to influence patients.

Physician/Provider Sponsored Organizations

Commenters requested that a new safe harbor be created for physician/provider sponsored organizations (PSOs). The proposed safe harbor would protect payments to or by any provider, provider sponsor or provider service network for services to beneficiaries enrolled by an eligible organization under section 1876 of the Act in accordance with a full-risk or partial-risk contract. The commenter suggested that protection for PSOs would increase patient access to health care services and increase the health care options available to program beneficiaries.

B. Proposed New OIG Special Fraud Alerts

Limitation on use of Fraud Alerts

A recommendation was made to limit the use of Special Fraud Alerts to circumstances that raise concerns about serious and clear violations, rather than merely ''questionable'' practices.

Financial Arrangements Between Hospitals and Hospital-Based Physicians

A commenter stated that an increasing number of hospital-based physician agreements with hospitals compensate physicians for less than the fair market value of management and supervisory services they provide to hospitals, or require physicians to pay more than the fair market value for certain services provided by the hospital as a condition for entering into or renewing contracts. As a result, a Fraud Alert was recommended to discuss financial arrangements between hospitals and hospital-based physicians. A second commenter raised concern about the appropriate compensation for hospital-based physicians and physicians serving as medical directors. They recommended a new OIG Fraud Alert addressing services considered integral and not ''incident to'' physician services, and the proper use of nonphysician practitioners accompanied by the appropriate billing for their services.

Ambiguity in Billing Practices

A suggestion was made to provide clear direction regarding covered and non-covered services and appropriate billing practices and, in conjunction with section 231 of the HIPAA, define the term ''pattern of billing for services'' that the provider knew or should have known was not medically necessary. The commenter indicated that any Fraud Alert should specify that no sanctions would be taken for a pattern of billing for services considered to be medically unnecessary until the provider has been given written notice of the problem and an opportunity to desist from the billing practice.

Barring Demands by Medicare Supplemental Carriers for Discounts from Providers

Since Medigap carriers other than Medicare SELECT plans continue to seek discounts or waivers of copayment amounts from providers, it was recommended that the OIG clarify that is improper for Medigap insurers (other than Medicare SELECT in connection with Part A services covered by existing safe harbors) to seek discounts and waivers of Medicare coinsurance or deductible amounts.

Payment Arrangements Between Hospice Providers and Nursing Homes

Concern was voiced over certain compensation arrangements between hospices and nursing facilities, including skilled nursing facilities, that suggested suspect incentive arrangements that disguise referral fees as payments for services to such nursing facilities. A Fraud Alert was suggested to address the fact that when a hospice pays a nursing facility more than 95 percent of the Standard Medicaid Per Diem Reimbursement Rate, such arrangements may violate the anti-kickback statute.

Clinical Laboratory Personnel Within an ESRD Facility

A commenter recommended an amendment to the phlebotomy section of the OIG Special Fraud Alert—''Arrangements for the Provision of Clinical lab Services''—that was issued in October 1994. Under that section, a clinical laboratory's placement of a phlebotomist in a physician's office does not in and of itself serve as an inducement prohibited by the anti-kickback statute. However, the commenter indicated that certain tasks could implicate the statute if those functions that benefit the physician are performed by the phlebotomist. As a result, they proposed that the OIG highlight a similar practice of providing a clinical laboratory employee, or processor, to an ESRD facility on a full-time basis to relieve the facility of these duties.

Laboratory Contracting with Billing Management Consultants

It was suggested that a Fraud Alert be developed outlining the potential issues related to contracting with billing management consultants, the appropriate relationship between the facility and the consultants, and the liability of all parties involved in the contract.

Discounted Copayments and Deductibles

In light of new civil money penalty authority for Medicare providers who offer incentives to induce Medicare referrals, it was recommended that a Fraud Alert be developed addressing situations in which a copayment or deductible can be discounted.

Home Health Issues

With regard to the proper certification of Medicare beneficiaries for home health services, a recommendation was made to develop a Fraud Alert defining what is considered ''home bound'' and what actions should be taken to ensure that the beneficiary is appropriately certified and is eligible for home health services. The commenter also recommended that a Fraud Alert address home health agency procedures related to contacting patients upon discharge from the hospital, and claims for home health visits that occur prior to physician authorization for the visit.

Medicare as Secondary Payer

A commenter indicated that if primary coverage is not identified, Medicare may be billed inappropriately, thus leading to allegations of fraudulent billing. The commenter recommended a new Fraud Alert setting forth the appropriate process to determine primary coverage, and the level of diligence a facility must use to verify primary coverage.

Hospice Care

A new Fraud Alert was recommended outlining the appropriate method for determining life expectancy to meet hospice eligibility criteria, and the responsibility if a patient is subsequently found ineligible for hospice benefits due to an incorrect determination of life expectancy. It was also suggested that the Fraud Alert address billing issues associated with a hospice patient who is transferred to a hospital, and the instances when a hospital should bill the hospice instead of Medicare to avoid duplicate bills to Medicare for the same patient.

Hospital Issues

It was suggested that problems have occurred with PPS hospitals billing Medicare for discharging a patient when the patient was actually transferred to another PPS hospital or unit, and that the OIG develop a Fraud Alert outlining instances in which a hospital may bill Medicare for a patient discharge and when the hospital must file a claim as a transfer.

Value Added Services

A new Fraud Alert was recommended to address concerns about vendors in the food service industry offering ''value added services'' to their institutional customers. The commenter stated that many of these practices, intended to induce the initiation or maintenance of a business relationship between parties, raised concerns under the anti-kickback statute since food service sold to health care institutions is reimbursed in part by Medicare and the State health care programs.

Further public comments on the proposals summarized above are *not* being solicited at this time.

III. Solicitation of Additional New Recommendations and Proposals

In accordance with the requirements of section 205 of Public Law 104–191, we are seeking additional recommendations from affected provider, practitioner, supplier and beneficiary representatives regarding the development of proposed or modified safe harbor regulations and new Special Fraud Alerts beyond those summarized above.

Criteria for Modifying and Establishing Safe Harbor Provisions

In accordance with the statute, we will consider a number of factors in reviewing proposals for new or modified safe harbor provisions, such as the extent to which the proposals would effect an increase or decrease in—

- Access to health care services;
- The quality of care services;
- Patient freedom of choice among health care providers;
- Competition among health care providers;
- The cost to Federal health care programs;
- The potential overutilization of the health care services; and
- The ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

In addition, we will also take into consideration the existence (or nonexistence) of any potential financial benefit to health care professionals or providers that may vary based on their decisions of whether to (1) order a health care item or service, or (2) arrange for a referral of health care items or services to a particular practitioner or provider.

Criteria for Developing Special Fraud Alerts

In determining whether to issue additional Special Fraud Alerts, we will also consider whether, and to what extent, those practices that would be identified in new Fraud Alerts may result in any of the consequences set forth above, and the volume and frequency of the conduct that would be identified in these Special Fraud Alerts.

A detailed explanation of justification or empirical data supporting the suggestion, and sent to the address indicated above, would prove helpful in our considering and drafting new or modified safe harbor regulations and Special Fraud Alerts.

Dated: December 1, 1997.

June Gibbs Brown,

Inspector General.

[FR Doc. 97–32150 Filed 12–9–97; 8:45 am]

BILLING CODE 4150–04–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 32

[CC Docket No. 97–212; FCC 97–355]

Uniform System of Accounts for Interconnection

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: In this document, we propose rules for the accounting treatment of transactions related to interconnection and shared infrastructure. Specifically, we propose new Part 32 accounts and subsidiary recordkeeping requirements to record the revenues and expenses related to providing and obtaining interconnection. We tentatively conclude that new accounts are not necessary to record the revenues and expenses associated with sharing infrastructure.

DATES: Interested parties may file comments on or before December 10, 1997, and reply comments on or before January 26, 1998. Written comments by the public on the proposed and/or modified information collections are due December 10, 1997. Written comments must be submitted by the Office of Management and Budget (OMB) on the proposed and/or modified information collections on or before February 9, 1998.

ADDRESSES: Parties should send their comments or reply comments to Office of the Secretary, Federal Communications Commission, 1919 M Street, NW., Room 222, Washington, DC 20554. Parties should also send a paper copy, and a copy on 3.5 inch diskette formatted in an IBM compatible form using, if possible, WordPerfect 5.1 for Windows software, to Matthew Vitale of the Common Carrier Bureau's Accounting and Audits Division, 2000 L Street, NW., Room 200F, Washington, DC 20554. Commenters should also provide one copy of any documents filed in this proceeding to the Commission's copy contractor, International Transcription Service, 1231 20th Street, NW., Washington, DC 20036.