(4) Dry bases for beverages, instant coffee, and instant tea.

(5) Dry bases for gelatins, puddings, and pudding desserts.

(6) Dry bases for dairy product analogs.

(d) If the food containing the additive is represented to be for special dietary uses, it shall be labeled in compliance with Part 105 of this chapter.

(e) The additive shall be used in accordance with current good manufacturing practice in an amount not to exceed that reasonably required to accomplish the intended effect.

Dated: July 19, 1988.

John M. Taylor,

Associate Commissioner for Regulatory Affairs.

[FR Doc. 88-16972 Filed 7-27-88; 8:45 am]

BILLING CODE 4160-01-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 185 and 186

[OPP-00264; FRL-3422-1]

Tolerances for Pesticides in Food and Animal Feeds; Transfer of Regulations; Correction

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule; correction.

SUMMARY: This document corrects a final rule that transferred former Parts 193 and 561 of Title 21 of the Code of Federal Regulations (CFR) regarding tolerances for pesticides in food and animal feeds into new Parts 185 and 186, respectively, of Title 40 of the CFR.

EFFECTIVE DATE: July 28, 1988.

FOR FURTHER INFORMATION CONTACT: John A. Richards, Chief, Federal Register Staff (TS-788B), Office of Pesticides and Toxic Substances, Environmental Protection Agency, Rm. NE-G009, 401 M St., SW., Washington, DC 20460, (202)-382-2253.

SUPPLEMENTARY INFORMATION: In FR Doc. 88-14718, published in the **Federal Register** of June 29, 1988 (53 FR 24666), EPA transferred former 21 CFR Parts 193 and 561 into new 40 CFR Parts 185 and 186, respectively. The following corrections are made to the document:

1. On page 24666, in the third column under the "old section-new section" table, in the entry for old section 193.80 change the new section entry from 185.375 to 185.410.

2. On page 24667, ir the first column, under the "old section-new section" table, in the entry for old section 193.470 change the new section entry from 185.5500 to 185.5550.

3. On page 24667, in the first column under the "old section-new section" table in the entry for old section 561.51 change the new section entry from 186.400 to 186.375.

4. On page 24667, in the first column, under the "old section-new section" table in the entry for old section 561.53 change the new section entry from 186.5050 to 186.4975.

5. On page 24667, in the first column, under the "old section-new section" table in the entry for old section 561.92 change the new section entry from 186.425 to 186.400.

PART 185—[CORRECTED]

6. On page 24667, in the third column, in the table of contents entry for section 185.375 1,1-Bis(*p*-chlorophenyl)-2,2,2-trichloroethanol, change the section number to 185.410 and reinsert the entry in numeric sequence.

PART 186—[CORRECTED]

7. On page 24668, in the third column, in the table of contents entry for section 186.400 Bentazon, change the section number to 186.375.

8. On page 24668, in the third column, in the table of contents entry for section 186.425 3,6-Bis(2-chlorophenyl)-1,2,4,5-tetrazine, change the section number to 186.400.

9. On page 24668, in the third column, in the table of contents entry for section 186.950, insert a hyphen after the first number 1 so that the entry reads "2-Chloro-1-(2,4,5-trichlorophenyl)vinyl dimethyl phosphate."

10. On page 24668, in the third column, in the table of contents entry for section 186.1850, remove the hyphen in the word "oxazolidine-dione" so that it reads "oxazolidinedione."

11. On page 26449, in the second column, in the table of contents entry for section 186.5050, change "Propenofos" to read "Profenofos" and change the section number to "186.4975" and reinsert the entry in numeric sequence.

(21 U.S.C. 348)

Dated: July 22, 1988.

Douglas D. Campt,

Director, Office of Pesticide Programs.

[FR Doc. 88-17105 Filed 7-27-88; 8:45 am]

BILLING CODE 6560-50-M

40 CFR Part 271

[FRL-3420-9]

Georgia; Final Authorization of State Hazardous Waste Management Program

AGENCY: Environmental Protection Agency.

ACTION: Immediate final rule.

SUMMARY: Georgia has applied for final authorization of revisions to its hazardous waste program under the Resource Conservation and Recovery Act (RCRA). EPA has reviewed Georgia's application and has made a decision, subject to public review and comment, that Georgia's hazardous waste program revision for the hazardous components of radioactive mixed wastes and for the closure, post-closure and financial responsibility requirements satisfies all of the requirements necessary to qualify for final authorization. Thus, EPA intends to approve Georgia's hazardous waste program revision for the hazardous components of radioactive mixed wastes and for the closure, post-closure, and financial responsibility requirements. Georgia's application for program revision is available for public review and comment.

DATES: Final authorization for Georgia shall be effective September 26, 1988 unless EPA publishes a prior **Federal Register** action withdrawing this immediate final rule. All comments on Georgia's program revision application must be received by the close of business August 29, 1988.

ADDRESSES: Copies of Georgia's program revision application are available during 8:00 a.m.-4:00 p.m. at the following addresses for inspection and copying: Georgia Department of Natural Resources, Land Protection Branch, Room 1154, 205 Butler Street SE., Floyd Towers East, Atlanta, Georgia 30334, Phone: 404/656-2833; U.S. EPA Headquarters Library, PM 211A, 401 M Street SW., Washington, DC 20460, Phone: 202/382-5926; U.S. EPA Region IV, Library, 345 Courtland Street NE., Atlanta, Georgia 30365, Phone: 404/347-4216. Written comments on the application should be sent to Otis Johnson, at the address listed below.

FOR FURTHER INFORMATION CONTACT: Otis Johnson, Jr., Chief, Waste Planning Section, U.S. Environmental Protection Agency, 345 Courtland Street NE., Atlanta, Georgia 30365, Phone: 404/347-3016.

SUPPLEMENTARY INFORMATION:

A. Background

States with final authorization under section 3006(b) of the Resource Conservation and Recovery Act ("RCRA" or "the Act"), 42 U.S.C. 6929(b), have a continuing obligation to maintain a hazardous waste program that is equivalent to, consistent with, and no less stringent than the Federal hazardous waste program. In addition, as an interim measure, the Hazardous and Solid Waste Amendments of 1984 (Pub. L. 98–616, November 8, 1984, hereinafter "HSWA") allows States to revise their programs to become substantially equivalent instead of equivalent to RCRA requirements promulgated under HSWA authority. States exercising the latter option receive "interim authorization" for the HSWA requirements under section 3006(g) of RCRA, 42 U.S.C. 6926(g), and later apply for final authorization for the HSWA requirements. Georgia received final authorization for HSWA provisions contained in the July 15, 1985 Codification Rule, 50 FR 28702 on September 18, 1986.

Revisions to State hazardous waste programs are necessary when Federal or State statutory or regulatory authority is modified or when certain other changes occur. Most commonly, State program revisions are necessitated by changes to EPA's regulations in 40 CFR Parts 260–266 and 124 and 270.

B. Georgia

Georgia initially received final authorization on August 21, 1984. Georgia received authorization for revisions to its program on September 18, 1986. On December 31, 1987, Georgia submitted a program revision application for additional program approval for the hazardous components of radioactive mixed wastes and for the closure, post-closure, and financial responsibility requirements. Today, Georgia is seeking approval of its program revision in accordance with 40 CFR 271.21(b)(3).

EPA has reviewed Georgia's application, and has made an immediate final decision that Georgia's hazardous waste program revision satisfies all of the requirements necessary to qualify for final authorization. Consequently, EPA intends to grant final authorization for the additional program modifications to Georgia. The public may submit written comments on EPA's immediate final decision up until August 29, 1988. Copies of Georgia's application for program revisions are available for inspection and copying at the locations indicated in the "**ADDRESSES**" section of this notice

Approval of Georgia's program revision shall be come effective in 60 days unless an adverse comment pertaining to the State's revision discussed in this notice is received by the end of the comment period. If an adverse comment is received EPA will publish either (1) a withdrawal of the immediate final decision, or (2) a notice containing a response to comments which either affirms that the immediate final decision takes effect or reverses the decision.

Georgia is not seeking authorization to operate in Indian lands.

C. Decision

I conclude that Georgia's application for program revisions meets all of the statutory and regulatory requirements established by RCRA. Accordingly, Georgia is granted final authorization to operate its hazardous waste program as revised. Georgia now has reponsibility for permitting treatment, storage, and disposal facilities within its borders and carrying out other aspects of the RCRA-program, subject to the limitation of its revised program application and previously approved authorities. Georgia also has primary enforcement responsibilities, although EPA retains the right to conduct inspections under section 3007 of RCRA and to take enforcement actions under sections 3008, 3013 and 7003 of RCRA.

Compliance With Executive Order 12291

The Office of Management and Budget has exempted this rule from the requirements of section 3 of Executive Order 12291.

Certification Under the Regulatory Flexibility Act

Pursuant to the provisions of 4 U.S.C. 605(b), I hereby certify that this authorization will not have a significant economic impact on a substantial number of small entities. This authorization effectively suspends the applicability of certain Federal regulations in favor of Georgia's program, thereby eliminating duplicative requirements for handlers of hazardous waste in the State. It does not impose any new burdens on small entities. This rule, therefore, does not require a regulatory flexibility analysis.

List of Subjects in 40 CFR Part 271

Administrative practice and procedure, Confidential business information, Hazardous materials transportation, Hazardous waste, Indian lands, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Water pollution control, Water supply.

Authority: This notice is issued under the authority of sections 2002(a), 3006 and 7004(b) of the Solid Waste Disposal Act as amended 42 U.S.C. 6912(a), 6926, 6974(b).

Lee A. Dehihns,

Acting Regional Administrator.

Dated: June 28, 1988.

[FR Doc. 88–17027 Filed 7–27–88; 8:45 am]

BILLING CODE 6560–50–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 424

[BERC–300–F]

Medicare Program; Indirect Part B Payment Procedure

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

ACTION: Final rule.

SUMMARY: Section 1842(b)(6) of the Social Security Act, as amended by section 2339 of the Deficit Reduction Act of 1984, authorizes a Medicare carrier to pay Medicare Part B benefits under certain circumstances directly to an entity that provides a health benefits plan complementary to Medicare and that pays the physician or supplier in full for the service. This rule sets forth the requirements these entities must meet to receive payment directly from Medicare.

EFFECTIVE DATE: August 29, 1988.

FOR FURTHER INFORMATION CONTACT: Ed Roth, 301–966–4486.

SUPPLEMENTARY INFORMATION:

Background

Under Medicare's Supplementary Medical Insurance program (Part B), the payment for the services of a physician or supplier is generally 80 percent of reasonable charges in excess of an annual deductible amount. Upon submission of a properly executed claim, this payment is made to the beneficiary, or alternatively to the physician or supplier if he or she accepts assignment of the claim.

Some beneficiaries have complementary insurance coverage that pays the annual deductible, the 20 percent coinsurance, and any amount by which the approved charge of the insurer exceeds the Medicare reasonable charge. In 1969 we established a procedure that allows a complementary insurance plan meeting certain conditions to pay a physician or supplier an amount that the physician or

supplier accepts as full payment for his services and then bill the Medicare carrier for the Part B payment that would otherwise be made to the beneficiary (42 CFR 405.1685).

Until July 1985, we limited the actual use of this procedure, under Medicare Carriers Manual instructions, to employment-related group insurance plans, group practice prepayment plans and HMOs, and, in the case of the latter two types of organizations, we made the procedure available only for limited types of services. Moreover, between May 1979 and July 1985, we prohibited carriers from accepting new applications by employment-related group insurance plans to use the procedure. In July 1985, we issued revised Medicare Carrier Manual instructions removing many of these limitations.

On July 1, 1986 (51 FR 23792), we proposed to amend § 405.1685, as well as other rules that have an impact upon this payment procedure, to implement section 1842(b) of the Act, as amended by section 2339 of the Deficit Reduction Act of 1984 (Pub. L. 98–369) commonly referred to as "DRA". Section 1842(b)(6) now provides the authority for carriers to pay Medicare Part B benefits, for services that are reimbursable on a reasonable charge or fee schedule basis, to entities that meet the conditions specified below, if the beneficiary has agreed in writing for payment to such an entity. The entity must be one that—

- Provides coverage of the services under a complementary health services plan as described above; and
- Has paid the physician or supplier an amount that includes the amount payable under Medicare and is accepted by the physician or supplier as full payment for the service.

Under the broad language of amended section 1842(b)(6) of the Act, any entity that meets the stated requirements can use the indirect payment procedure. This includes employers, unions, insurance companies, and retirement homes. It also includes prepayment organizations such as HMOs, competitive medical plans, and other prepaid plans, when they deal with a carrier rather than directly with HCFA.

The procedure is available only for services paid on a reasonable charge or fee schedule basis, and only when Medicare is primary payer. It is not available for services of providers or of other entitites that are paid under prospective payment or cost basis systems and is not available when Medicare is secondary payer.

The Act sets forth the indirect payment procedure as an alternative to Medicare payment to the beneficiary on the basis of an itemized bill or to the physician or supplier on the basis of an assignment. Indirect payment is available even for services furnished by a participating physician or supplier, that is, one that has agreed to accept assignments.

Section 1842(h)(1) of the Act, as amended by section 2306 of the DRA (and as further amended by section 9301(d)(2)(A)(ii) of Pub. L. 99–272), permits a participating physician or other supplier to accept payment under the indirect payment procedure in lieu of accepting Medicare assignment. Indirect payment is also available for clinicial diagnostic laboratory tests furnished by a physician or independent laboratory. Section 1833(h)(5)(C) of the Act, as amended by section 2303 of the DRA, permits a physician or independent laboratory to accept payment for clinical diagnostic laboratory tests under the indirect payment procedure in lieu of accepting Medicare assignment for those tests. Until December 22, 1987, when a physician or laboratory used this procedure for clinical diagnostic laboratory tests, Medicare payment for those tests was subject to deductible and coinsurance and was not 100 percent of the fee schedule amount or the actual charge (whichever is less) as it was when Medicare paid for the tests under assignment. This was changed by section 4085(i)(1) of the Omnibus Budget Reconciliation Act of 1987 Pub. L. 100–203), effective for services furnished on or after the date of enactment, December 22, 1987. Deductible and coinsurance no longer apply to clinical diagnostic laboratory tests for which payment is made under the indirect payment procedure.

Provisions of the Proposed Regulations

Since the amendments did not change the essential conditions for use of the procedure as set forth in the existing rules, we proposed primarily technical changes to conform the rules more closely to the language of the law, with minor revisions and clarifications. Specifically, we proposed to amend §§ 405.1672, 405.1679, 405.1685, and 405.1686, as discussed below.

A. Section 405.1672, Individual's Request For Direct Payment—General Provisions

A parenthetical statement at the end of § 405.1672(c) indicated that "for payment to organizations that pay bills on behalf of enrollees, see § 405.1685." In line with proposed changes in § 405.1685 discussed below, we proposed to change this statement to read: "For payment to entities that pay for services on behalf of entitled individuals, see § 405.1685."

B. Section 405.1679, Execution of Claim For Payment

This section made no reference to the indirect payment procedure. It discussed who could execute a claim for an individual. We proposed to add a new paragraph (e) to clarify that an entity that provides complementary health insurance and meets the requirements of the indirect payment procedure could execute a claim on behalf of the beneficiary under that procedure. The beneficiary would authorize the entity to receive his or her Part B payments. Section 1842(b)(3)(B) of the Act (following clause (ii)), requires that a Part B bill be submitted in such form as is provided by regulations. Section 1835(a)(1) of the Act requires (in the case of services furnished by certain "providers of services") that the beneficiary submit a written request for payment "except in cases in which the Secretary finds it impracticable for the beneficiary to do so". Since the main purpose of the indirect payment procedure is to simplify the billing process, for beneficiaries and for physicians and other suppliers, and since the beneficiary must give written authorization for the complementary coverage plan to receive the Part B payments, we believe that a request for payment signed by the beneficiary, or a written statement authorizing the plan to submit claims on his or her behalf, is unnecessary.

C. Section 405.1685, Payment to Organizations That Pay Bills on Behalf of Enrollees.

We proposed to change the title of this section to "The indirect payment procedure." All the proposed special requirements for payment under the indirect payment procedure would be set forth in the revised § 405.1685(a). We proposed that Medicare Part B payment for the services of a physician or supplier otherwise payable to a beneficiary or to his or her legal representative or representative payee could be made to an entity that provides coverage to the beneficiary under a complementary health benefits plan. (This was to make it clear that payment under the indirect payment procedure is an exception to the rule that benefits that are not assigned to the physician or supplier must be paid to the beneficiary or to his or her legal representative or representative payee.) Paragraphs (a)(1) through (a)(6) and (b), discussed below, would specify the requirements the entity must meet to receive the payment.

To improve technical accuracy, we also proposed to change references

throughout paragraphs (a) and (b) from "organization" to "entity," and from "bills" to "services."

Any entity using the indirect payment procedure would have to meet the general criterion set forth in a new § 405.1685(a)(1). This provision provided explanatory language to indicate that the plan would have to be complementary to Medicare, in line with current practice.

In paragraph (a)(2) of the proposed regulations we proposed to continue the current requirement that the entity must have made full payment to the person furnishing the service. Editorial changes were to be made to follow the language of the law more closely.

In paragraph (a)(3), we proposed to clarify the role of an "authorized representative" of a beneficiary in executing an agreement for Medicare Part B payment to the entity. (We proposed also to revise § 405.1672(c) to provide that any of the persons specified in § 405.1679 could execute a claim on behalf of the beneficiary.)

We proposed to redesignate current paragraph (a)(3) as paragraph (a)(4) and revise it editorially, and to combine the contents of the current paragraphs (a)(4) and (a)(5) in paragraph (a)(5), requiring that the entity submit any information the carrier needs to meet requirements of the Medicare program.

In paragraph (a)(6) we proposed to require an entity to have in place a process that would identify and exclude from its requests for payment all services for which Medicare is the secondary payer. This is called for by the provision that the entity may request payment only in cases in which it pays for the service under a plan complementary to Part B. Section 1862(b) of the Act and 42 CFR 405.316–405.329 indicate when Medicare is secondary payer.

Paragraph (b) of § 405.1685 indicated that the entity could choose not to pay and claim reimbursement for all Part B bills on behalf of a beneficiary; the entity could establish criteria to determine at its discretion which bills it would pay. We proposed to revise the paragraph to show that the entity has discretion to determine which services, rather than which bills, it will pay. In addition, to prevent possible double billing (when the entity and the beneficiary bill the carrier for the same service), we proposed to require that the entity undertake to cover, and to pay and claim reimbursement for, either one or more well defined general categories of services, or all Part B services.

D. Section 405.1686, Organizations Qualified To Receive Payment on Behalf of Enrollee

This section described the types of organizations that could qualify to receive payment under the indirect payment procedure. Since the availability of the indirect payment procedure no longer would be limited to the types of organizations specified in § 405.1686, we proposed to delete this section.

Response to Comments

We received timely comments from a Medicare carrier, a State Medicaid Agency, and a private health benefits plan on the proposed regulations. Because there were so few comments and because each commenter's comments are so distinct from the others, we discuss them individually.

The carrier raised a number of issues regarding the administration of the indirect payment provision. These questions and our responses are as follows:

Question: Will the carrier be required to make programming changes to make deductible and coinsurance applicable to the charges for clinical diagnostic laboratory tests furnished by independent laboratories?

Response: Carriers should not make these programming changes. Under section 4085(i)(1) of the Omnibus Budget Reconciliation Act of 1987, the Part B deductible and coinsurance no longer apply to charges for clinical diagnostic laboratory tests for which payment is made under the indirect payment procedure.

Question: Will there be carrier involvement to ascertain that an entity using the indirect payment procedure meets the requirements of the final regulations?

Response: Yes. The entity will submit its request to use the procedure to the carrier to which it expects to submit the most claims. The carrier will determine whether the entity meets the requirements and notify HCFA.

Question: What mechanism will be developed to inform the carrier of the status of the entity?

Response: HCFA will add the entity to a list of approved entities in the Medicare Carriers Manual and assign it a national identification number ("approval number") to show on its claim.

Question: How will the carrier determine whether or not a private insurance plan should receive Medicare reimbursement, since the plan might be obligated by its terms to pay for the service in full regardless of Medicare?

Response: In applying to use the indirect payment procedure, the entity must agree to claim payment for a service only when it covers the service under a plan complementary to Medicare Part B and meets the requirements for reimbursement for that service. Medicare beneficiaries who are members of the plan receive from the carrier an explanation of medical benefits detailing the services Medicare paid for and we anticipate that they would soon complain to the carrier or HCFA if Medicare payment is made to a plan for services for which the plan is obligated to pay in full regardless of Medicare.

The State Medicaid agency's comment on the regulations and our response are as follows:

Comment: The State Medicaid agency provides payment for medical services as a payer of benefits complementary to Medicare. In addition, the agency covers only the amount by which a Part B payment falls short of the charge approved for the service or the State's fee, whichever is less. Accordingly, the agency believes it should be considered an entity entitled to use the indirect payment procedure.

Response: While State Medicaid plans are similar in some respects to health benefits plans complementary to Medicare, we do not regard them as such plans for purposes of using the indirect payment procedure. Unlike private insurance plans, State Medicaid plans generally pay fees lower than the fees usually charged in the community. Under the indirect payment procedure, the amount the entity pays the physician or supplier for a service goes into his customary charge profile. If this amount is less than his usual charges, the physician's payment level may be penalized. The indirect payment procedure is designed for use by entities that pay physicians' and suppliers' usual charges.

Moreover, State agencies generally pay no more than (if as much as) the Medicare approved charge. There is no disadvantage, therefore, to a physician or supplier who participates in Medicaid in accepting Medicare assignments and submitting Medicare claims directly to the Medicare carrier. State agencies have procedures for obtaining Medicare claims information for purposes of making the supplementary Medicaid payment on these claims. Thus, it would merely create an administrative complication for the Medicare program to authorize the use of the indirect payment procedure by States.

The health benefits plan made a number of comments objecting to the

prohibition in the proposed regulations against the imposition of any copayment in connection with the indirect payment procedure. These comments and our responses to them are as follows:

Comment: There is no prohibition in the statute against imposing a copayment.

Response: While it is true that the prohibition is not stated explicitly in the statute, it is the most supportable interpretation of that part of section 1842(b)(6) of the Act that requires a physician (or supplier) to accept the plan payment as full payment. This part of the statutory language could mean either: (1) That the plan must be the entire ultimate source of payment for the service (exclusive of Medicare Part B); or (2) that the plan must merely be the entire immediate source of payment. The first interpretation would prohibit the billing of a copayment by either the plan or the physician; the second would merely prohibit the billing of a copayment by the physician. The first interpretation is more consistent with the objectives of the legislation that we stated in our recommendation that legislation in this area be initiated. In recommending the indirect payment provision to Congress, we stated that the provision should be designed to permit the physician to submit a single claim, relieve the beneficiary of any need to file a claim, and protect the beneficiary against any financial liability for the service, if Medicare and the plan together fully cover the services.

We believe that Congress fully agreed with out recommendation and did not contemplate the collection of a copayment by a plan under the indirect payment procedure. Congress did not provide guidance in the statute or in the legislative committee reports on determining the permissible amount of any copayment.

Comment: Prohibiting a copayment limits the availability of the indirect payment procedure and disadvantages carrier-dealing health benefits plans relative to HMOs that enter into contracts with HCFA and may impose copayments.

Response: In the case of a health benefits plan that uses the indirect payment procedure (unlike a health benefits plan that has a contract with HCFA as an HMO or competitive medical plan), we do not regulate the amount of premiums the plan may charge. For a plan that pays physicians on a fee-for-service basis, this makes the indirect payment procedure an attractive alternative to entering into a risk-capitation contract with HCFA (i.e., a contract under which HCFA pays the plan, as an HMO or competitive medical plan, a capitation rate with the plan assuming the financial risk of providing services covered under Part A or Part B of Medicare). Permitting the imposition of a copayment would make the indirect payment procedure an even more attractive alternative to a risk-capitation contract if the plan believes that a copayment would help it to reduce utilization and other costs. Making the indirect payment procedure this attractive, however, conflicts with our initiative encouraging plans to enter into risk-capitation contracts. We find little basis for permitting such a disincentive to risk capitation contracts without an explicit statutory requirement to do so.

Comment: This prohibition precludes use of a copayment as a utilization control mechanism.

Reponse: Copayments are certainly one form of utilization control. However, other control exist, such as careful review of claims, partial refund of premiums to plan members, etc. The indirect payment procedure was basically intended for Medigap plans that ordinarily do not charge a copayment and that assume full responsibility for the difference between the Medicare payment and the approved charge of the plan.

Final Rule

While the final rule was under development, HCFA undertook to redesignate all rules on conditions for Medicare payment (including Subpart P of Part 405) as a new Part 424. Accordingly, the section numbers of Part 424 are substituted in the final rule, as shown in the following discussion.

We are adopting the proposed rule as final without substantive changes. For clarity and precision we are making the following editorial revisions in § 405.1685, which is now § 424.66:

1. Provide a more descriptive heading;

2. Revise paragraph (a)(6) to require that the entity "identify and exclude from its requests for payment all services for which Medicare is secondary payer * * *." (The wording of the proposed rule appeared to emphasize the process leading to identification rather than exclusion as such.)

3. Clarify (in paragraph (b)) that an entity that does not pay and claim reimbursement for all Part B services must establish in advance precise criteria for determining the services for which it will pay.

Language in the proposed rule was misleading.

By referring to "cover" and "pay and claim reimbursement for" in the same sentence, we created the erroneous impression that the entity must pay and claim reimbursement for any service that it covers. Actually, an entity's health benefit plans might have copayment requirements or approved charge limitations that would prevent it from claiming reimbursement for some services. Also, an entity might choose to use the indirect payment procedure for some of its plans but not others.

By stating that an entity must determine which well-defined categories of services for which it would pay, we created the erroneous impression that there are HCFA-defined categories from which the entity can choose.

The paragraph (e) that we proposed to add to § 405.1679, redesignated as § 424.36, under which an entity authorized to use the indirect payment procedure could execute a claim on behalf of the beneficiary, appears in the final rule as paragraph (d).

Other proposed changes to § 405.1672 (paragraphs (c) and (d)) became inappropriate or unnecessary as we simplified our rules in a final rule published March 2, 1988 (53 FR 6629). The content of these paragraphs is found in new § 424.34(a) and § 424.54. In that regard, paragraph (a) of new § 424.66, which includes the content of former § 405.1686 is being removed, as we proposed and as it is inconsistent with current law.

Regulatory Impact Statement

A. Executive Order 12291

Executive Order (E.O.) 12291 requires us to prepare and publish a final regulatory impact analysis for any final regulation that meets one of the E.O. criteria for a "major rule"; that is, that would be likely to result in: An annual effect on the economy of $100 million or more; a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or, significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets. While this rule may result in administrative savings because it will permit the physician or supplier to file a single claim and receive payment in a single check, the overall effect will be negligible. Coverage and payment amounts will not be affected. Therefore, because no threshold criteria under E.O. 12291 will be exceeded, this rule is not considered a major rule and an impact analysis is not required.

B. Regulatory Flexibility Act

We generally prepare a final regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that a final regulation will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, States and individuals are not small entites, but we treat all physicians or suppliers as small entities. While, in some cases, physicians or suppliers may benefit slightly because a single claim will be permitted for a given service, the overall impact on the physician or supplier will be minimal.

For these reasons, we have determined, and the Secretary certifies, that this final rule will not have a significant economic impact on a substantial number of small entities, and we have therefore not prepared a regulatory flexibility analysis.

C. Paperwork Reduction Act

These changes will not impose paperwork collection requirements. Consequently, they need not be reviewed by the Executive Office of Management and Budget (EOMB) under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*).

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 424

Administrative practice and procedure, Conditions for payment, Medicare claims, Physician certification, Plan of treatment, Request for payment.

42 CFR Part 424 is amended as set forth below:

PART 424—[AMENDED]

1. The authority citation continues to read as follows:

Authority: Secs. 216(j), 1102, 1814, 1815(c), 1935, 1842(b), 1861, 1866(d), 1870 (e) and (f), 1871, and 1872 of the Social Security Act (42 U.S.C. 416(j), 1302, 1395f, 1395g, 1395n, 1395u, 1395x, 1395cc, 1395gg, 1395hh, and 1395ii).

2. Section 424.36 is amended to redesignate paragraph (d) as (e) and add a new paragraph (d) to read as follows:

§ 424.36 Signature requirements.

* * * * *

(d) *Claims by entities that provide coverage complementary to Medicare.* A claim by an entity that provides coverage complementary to Medicare Part B may be signed by the entity on the beneficiary's behalf.

(e) *Acceptance of other signatures for good cause.* * * *

3. Section 424.60 is amended by revising paragraph (a) to read as follows:

§ 424.60 Scope.

(a) This subpart sets forth provisions applicable to payment after the beneficiary's death and payment to entities that provide coverage complementary to Medicare Part B.

* * * * *

4. Section 424.66 is amended to revise the section heading, remove paragraphs (a) and (b), redesignate paragraph (c) as (a) and revise it, and add a new paragraph (b). As amended, § 424.66 reads as follows:

§ 424.66 Payment to entities that provide coverage complementary to Medicare Part B.

(a) *Conditions for payment.* Medicare may pay an entity for Part B services furnished by a physician or other supplier if the entity meets all of the following requirements:

(1) Provides coverage of the service under a complementary health benefit plan (this is, the coverage that the plan provides is complementary to Medicare benefits and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).

(2) Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.

(3) Has the written authorization of the beneficiary (or of a person authorized to sign claims on his behalf under § 405.1679) to receive the Part B payment for the services for which the entity pays.

(4) Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, his or her survivors or estate.

(5) Submits any information HCFA or the carrier may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.

(6) Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

(b) *Services paid by the entity.* An entity is not required to pay and claim reimbursement for all Part B services furnished to members of its plans. However, if it does not pay and claim reimbursement for all those services, it must establish in advance precise criteria for identifying the services for which it will pay and claim reimbursement.

(Catalog of Fedral Domestic Assistance Program No. 13.774, Medicare—Supplementary Medical Insurance)

Dated: August 18, 1988.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: June 10, 1988.

Otis R. Bowen,

Secretary.

[FR Doc. 88-16995 Filed 7-27-88 8:45 am]

BILLING CODE 4120-01-M

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 65

[Docket No. FEMA-6931]

Changes in Flood Elevation Determinations; Arkansas et al.

AGENCY: Federal Emergency Management Agency.

ACTION: Interim rule.

SUMMARY: This rule lists those communities where modification of the base (100-year) flood elevations is appropriate because of new scientific or technical data. New flood insurance premium rates will be calculated from the modified base (100-year) elevations for new buildings and their contents and for second layer insurance on existing buildings and their contents.

DATES: These modified elevations are currently in effect and amend the Flood Insurance Rate Map (FIRM) in effect prior to this determination. From the date of the second publication of notice of these changes in a prominent local newspaper, any person has ninety (90) days in which he can request through the community that the Administrator, reconsider the changes. These modified elevations may be changed during the 90-day period.

ADDRESSES: The modified base (100-year) flood elevation determinations are available for inspection at the office of the Chief Executive Officer of the community, listed in the fifth column of the table. Send comments to that address also.

FOR FURTHER INFORMATION CONTACT: Mr. John L. Matticks, Chief, Risk Studies Division, Federal Insurance

Administration, Federal Emergency Management Agency, Washington, DC 20472, (202) 646–2767.

SUPPLEMENTARY INFORMATION: The numerous changes made in the base (100-year) flood elevations on the FIRM(s) make it administratively infeasible to publish in this notice all of the modified base (100-year) flood elevations contained on the map. However, this rule includes the address of the Chief Executive Officer of the community where the modified base (100-year) flood elevation determinations are available for inspection.

Any request for reconsideration must be based on knowledge of changed conditions, or new scientific or technical data.

These modifications are made pursuant to section 206 of the Flood Disaster Protection Act of 1973 (Pub. L. 93–234) and are in accordance with the National Flood Insurance Act of 1968, as amended, (Title XIII of the Housing and Urban Development Act of 1968 (Pub. L. 90–448)), 42 U.S.C. 4001–4128, and 44 CFR Part 65.4.

For rating purposes, the revised community number is listed and must be used for all new policies and renewals.

These base (100-year) flood elevations are the basis for the floodplain management measures that the community is required to either adopt or show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program.

These elevations, together with the floodplain management measures required by 60.3 of the program regulations are the minimum that are required. They should not be construed to mean the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time, enact stricter requirements on its own, or pursuant to policies established by other Federal, State or regional entities.

The changes in the base (100-year) flood elevations listed below are in accordance with 44 CFR 65.4.

Pursuant to the provisions of 5 U.S.C. 605(b), the Administrator, to whom authority has been delegated by the Director, Federal Emergency Management Agency, hereby certifies that this rule if promulgated will not have a significant economic impact on a substantial number of small entities. This rule provides routine legal notice of technical amendments made to designated special flood hazard areas on the basis of updated information and imposes no new requirements or regulations on participating communities.

List of Subjects in 44 CFR Part 65

Flood insurance, Floodplains.

PART 65—[AMENDED]

The authority citation for Part 65 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, E.O. 12127.

§ 65.4 [Amended]

Section 65.4 is amended by adding in alphabetical sequence new entries to the table.

State	County	Location	Date and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Arkansas	Crawford	City of Van Buren	Mar. 17, 1988, Mar. 24, 1988 *Press Argus Courier.*	The Honorable Robert E. Bell, Mayor of the city of Van Buren, P.O. Box 668, Van Buren, Arkansas 72956.	Mar. 4, 1988	050053
Georgia	DeKalb	Unincorporated areas.	June 23, 1988, June 30, 1988, *Decatur-DeKalb News/ERA.*	The Honorable Manuel J. Maloof, Chief Executive Officer, DeKalb County, 556 North McDonough, Decatur, Georgia 30030.	June 14, 1988	130065
Illinois	Cook	Village of Westchester.	July 21, 1988, July 28, 1988, *Westchester News.*	The Honorable John J. Sinde, Village President, village of Westchester, 10240 Roosevelt Road, Westchester, Illinois 60153.	Oct. 28, 1988	170170
Massachusetts.	Essex	City of Methuen	June 24, 1988, July 1, 1988, *Lawrence Eagle-Tribune.*	Mr. William F. Gallagher, Manager of the city of Methuen, 90 Hampshire Street, Methuen, Massachusetts 01844.	June 14, 1988	250093C
Texas	Montgomery	Unincorporated areas.	June 29, 1988, July 6, 1988, *The Courier.*	The Honorable Alvin Stahl, Montgomery County Judge, 326½ N. Main, Conroe, Texas 77301.	June 17, 1988	480483
Vermont	Windsor	Town of Royalton	June 16, 1988, June 23, 1988, *White River Valley Herald.*	The Honorable David I. Lyman, Chairman of the town of Royalton Board of Selectmen, P.O. Box 680, South Royalton, Vermont 05068.	June 8, 1988	500153B

Issued: July 20, 1988.

Harold T. Duryee,

Administrator, Federal Insurance Administration.

[FR Doc. 88–16985 Filed 7–27–88; 8:45 am]

BILLING CODE 6718-03-M

44 CFR Part 65

Changes in Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency.

ACTION: Final rule.

SUMMARY: Modified base (100-year) flood elevations are finalized for the communities listed below.

These modified elevations will be used in calculating flood insurance premium rates for new buildings and their contents and for second layer coverage on existing buildings and their contents.

DATES: The effective dates for these modified base flood elevations are indicated on the following table and amend the Flood Insurance Rate Map(s) (FIRM) in effect for each listed community prior to this date.