§§ 52.2420(c)(117) and 52.2424 and the amendment to the table in § 81.347 are withdrawn.

[FR Doc. 97–11123 Filed 4–25–97; 11:54 pm]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 433

[MB–112–F]

Medicaid Program; Third Party Liability (TPL) Cost-Effectiveness Waivers

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

ACTION: Correcting amendment.

SUMMARY: This document makes technical corrections to final regulations published on July 10, 1995, at 60 FR 35498, concerning Medicaid agencies' actions where third party liability (TPL) may exist for expenditures for medical assistance covered under the State plan.

EFFECTIVE DATE: These amendments are effective as of September 8, 1995, the effective date of the final rule that contained the errors.

FOR FURTHER INFORMATION CONTACT: Deborah Helms, (410) 786–7132.

SUPPLEMENTARY INFORMATION: Final regulations published on July 10, 1995, at 60 FR 35498 amended 42 CFR part 433 to revise Medicaid regulations concerning Medicaid agencies' actions where third party liability (TPL) may exist for expenditures for medical assistance covered under the State plan. The regulations allow Medicaid agencies to request waivers from certain procedures in regulations that are not expressly required by the Social Security Act. In the regulations, we unintentionally deleted the entire text of § 433.139(b)(3) through an error in our amendatory language and presentation of the CFR text. Consequently, we need to restore the deleted text in § 433.139(b)(3). This document corrects the error by amending § 433.139, to reinstate the deleted language.

List of Subjects in 42 CFR Part 433

Administrative practice and procedure, Claims, Grant programs—health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 433 is corrected by making the following correcting amendments:

PART 433—STATE FISCAL ADMINISTRATION

1. The authority citation for Part 433 continues to read as follows:

Authority: Secs. 1102, 1137, 1902(a)(4), 1902(a)(18), 1902(a)(25), 1902(a)(45), 1902(t), 1903(a)(3), 1903(d)(2), 1903(d)(5), 1903(o), 1903(p), 1903(r), 1903(w), 1912, and 1919(e) of the Social Security Act (42 U.S.C. 1302, 1320b–7, 1396a(a)(4), 1396a(a)(18), 1396a(a)(25), 1396a(a)(45), 1396a(t), 1396b(a)(3), 1396b(d)(2), 1396a(d)(5), 1396b(i), 1396b(o), 1396b(p), 1396b(r), 1396b(w), and 1396k.

2. Section 433.139 is amended by adding paragraph (b)(3) to read as follows:

§ 433.139 Payment of claims.

* * * * *

(b) *Probable liability is established at the time claim is filed.* * * *

(3) The agency must pay the full amount allowed under the agency's payment schedule for the claim and seek reimbursement from any liable third party to the limit of legal liability (and for purposes of paragraph (b)(3)(ii) of this section, from a third party, if the third party liability is derived from an absent parent whose obligation to pay support is being enforced by the State title IV–D agency), consistent with paragraph (f) of this section if—

(i) The claim is prenatal care for pregnant women, or preventive pediatric services (including early and periodic screening, diagnosis and treatment services provided for under part 441, subpart B of this chapter), that is covered under the State plan; or

(ii) The claim is for a service covered under the State plan that is provided to an individual on whose behalf child support enforcement is being carried out by the State title IV–D agency. The agency prior to making any payment under this section must assure that the following requirements are met:

(A) The State plan specifies whether or not providers are required to bill the third party.

(B) The provider certifies that before billing Medicaid, if the provider has billed a third party, the provider has waited 30 days from the date of the service and has not received payment from the third party.

(C) The State plan specifies the method used in determining the provider's compliance with the billing requirements.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Programs)

Dated: April 17, 1997.

Neil J. Stillman,

Deputy Assistant Secretary for Information Resources Management.

[FR Doc. 97–11023 Filed 4–28–97; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

42 CFR Part 1004

RIN 0991–AA86

Health Care Programs: Fraud and Abuse; Revised PRO Sanctions for Failing To Meet Statutory Obligations

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

ACTION: Final rule.

SUMMARY: This final rule addresses revised procedures governing the imposition and adjudication of program sanctions, based on recommendations from State utilization and quality control peer review organizations (PROs), resulting from enactment of sections 214 and 231(f) of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

EFFECTIVE DATE: These regulations are effective on April 29, 1997.

FOR FURTHER INFORMATION CONTACT: Joel J. Schaer, Office of Counsel to the Inspector General, (202) 619–0089.

SUPPLEMENTARY INFORMATION:

I. Background

The PRO Sanctions Process

Section 1156 of the Social Security Act imposes specific statutory obligations on health care practitioners and other persons to furnish medically necessary services to Medicare and State health care program beneficiaries that meet professionally recognized standards of health care. The statute authorizes the Secretary—based on a PRO's recommendation—to impose sanctions on those who fail to comply with these statutory obligations.

Under the PRO sanctions process as originally established, no practitioner or other person was subject to a program exclusion or a momentary penalty until the practitioner or other person had received notice of the proposed sanction and had an opportunity to respond, including a discussion with the PRO. After the receipt of a recommendation from a PRO, the OIG, delegated the Secretary's authority, was authorized to impose an exclusion or a monetary penalty after a careful review of all

relevant documentation and upon making the determination that the practitioner or other person (1) Violated the statutory obligations to render medically necessary and appropriate care or failed to provide evidence of medical necessity and quality, and (2) was unwilling or unable to comply with these obligations. A practitioner or other person excluded from Medicare and any State health care program, or assessed a monetary penalty, on the basis of a PRO recommendation, was entitled to administrative and judicial review after such sanction was imposed.

Recent Revisions to the OIG PRO Sanction Regulations

As a result of various statutory changes to section 1156 of the Social Security Act resulting from section 6 of Public Law 100–93 (the Medicare and Medicaid Patient and Program Protection Act), section 4095 of Public Law 100–203 (the Omnibus Budget Reconciliation Act (OBRA) of 1987), section 4205 of Public Law 101–508 (OBRA of 1990) and section 156 Public Law 103–432 (the Social Security Amendments of 1994), on December 12, 1995 the OIG published final regulations (60 FR 63634) that set forth a comprehensive revision of 42 CFR part 1004, the regulations that govern the imposition and adjudication of sanctions against practitioners and other persons resulting from a PRO recommendation.

Among other revisions, the regulations (1) Eliminated the procedural distinction between ''substantial'' violations and ''gross and flagrant'' violations, (2) provided that any violations of the obligations identified during a corrective action plan would be used to support a PRO's recommendation regarding unwillingness or inability, and (3) allowed the OIG to consider any prior problems that a practitioner or other person had with any State health care program as a factor in determining an appropriate exclusion. In addition, the regulations also provided practitioners and other persons with the option of informing their patients directly of a sanction taken against them as an alternative to the current approach of published public notification by the OIG.

The Health Insurance Portability and Accountability Act of 1996

Sections 214 and 231(f) of HIPAA set forth a number of changes to section 1156 of the Act with regard to sanctioning practitioners and other persons for their failure to comply with statutory obligations.

1. Monetary Penalty

Prior to the enactment of HIPAA, section 1156(b)(3) of the Social Security Act authorized the imposition of a monetary penalty on a practitioner or other person as an alternative to exclusion from participation in the Medicare and State health care programs when it was determined, based on a PRO recommendation, that medically improper or unnecessary services were either provided or ordered. The penalty amount was not to be more than the ''actual or estimated cost of the medically improper or unnecessary services so provided'' (section 1156(b)(3) of the Act). The authority to impose a monetary penalty in lieu of exclusion from participation in Medicare and State health care programs was enacted prior to the establishment of the Medicare prospective payment system for hospitals, and it was often difficult to determine the ''actual or estimated cost'' of substandard or unnecessary services for purposes of imposing a monetary penalty. Further, the amount of such a penalty was frequently very small and therefore had little deterrent value. The penalty amount was also usually disproportionally small compared to the Government's costs in processing such a case.

Under section 231(f) of HIPAA, the penalty sanction amount against practitioners and other persons who fail to comply with the statutory obligations has now been changed from ''the actual or estimated cost'' to ''up to $10,000 for each instance of medically improper or unnecessary services provided.''

2. Determination of Unwillingness or Inability

Prior to the enactment of HIPAA, section 1156(b)(1) of the Social Security Act authorized the sanctioning of a practitioner or other person who was found, based on a PRO recommendation, to have violated certain statutory violations *and* was determined to ''have demonstrated an unwillingness or a lack of ability substantially to comply with such obligations.'' This provision created unnecessary obstacles to the sanctioning of practitioners and other persons who had failed to comply with the statutory obligations since it was often difficult to assess evidence on the separate issue of unwillingness or inability.

In accordance with section 214(b) of HIPAA, section 1156 of the Act has been now amended to state that in making a determination on whether to sanction a practitioner or other person for failure to comply with statutory obligations relating to quality and medical necessity of health care services, the Secretary will no longer be required to prove that the practitioner or other person was either unwilling or unable to comply with such obligations.

3. Minimum Exclusion Period

Section 1128 of the Social Security Act authorizes the Secretary to impose mandatory and permissive exclusions of individuals and entities from participation in the Medical and State health care programs. In the case of mandatory exclusions, minimum periods of exclusion are set forth. Section 1156 of the Act set forth no specified minimum period of exclusion from the programs.

Section 214(a) of HIPAA now mandates that the Secretary impose a minimum 1 year period of exclusion for all practitioners and other persons who fail to meet statutory obligations under section 1156 of the Act.

II. Revisions to 42 CFR Part 1004

As a result of Public Law 104–191, we are making a number of technical revisions to the OIG's PRO sanction regulations at 42 CFR part 1004, specifically amending §§ 1004.20, 1004.80, 1004.100 and 1004.110. The changes to § 1004.20, Sanctions, reflect the establishment of the 1 year minimum exclusion period and the revised monetary penalty amount. Sections 1004.80(b)(8) (regarding the corrective action plan contents), 1004.80(c)(6) (regarding the PRO report recommendations to the OIG), 1004.100(b)(3) (OIG review of the PRO report), and 1004.100(d)(7) (regarding the OIG's decision to sanction) are either being revised or deleted to address the deletion from the statute of the unwillingness and inability requirement.

An additional technical revision is also being made to §§ 1004.110 (d)(1)(i) and (d)(2)(i) with regard to public notice of a sanction. While the public notice of sanction will continue to identify the sanctioned practitioner or other person, the finding that the obligation has been violated, and the effective date of the sanction, we are deleting the word ''duration'' from these paragraphs. The duration of an exclusion is dependent upon the reinstatement of the practitioner or other person, which is not automatic and therefore not known in advance. This change is consistent with the content of public notices for exclusions under 42 CFR part 1001 that are currently published in the **Federal Register**.

III. Waiver of Proposed Rulemaking

In developing this final rule, we are waiving the usual notice of proposed rulemaking and public comment procedures set forth in the Administrative Procedure Act (APA) (5 U.S.C. 553). The APA provides an exception to the notice and comment procedures when an agency finds there is good cause for dispensing with such procedures on the basis that they are impracticable, unnecessary or contrary to the public interest. We have determined that under 5 U.S.C. 553(b)(3)(B) good cause exists for dispensing with the notice of proposed rulemaking and public comment procedures for this rule. Specifically, this rulemaking comports, for the most part, with the statutory requirements set forth in Public Law 104–191, with no issues of policy discretion. Accordingly, we believe that opportunity for prior comment is unnecessary and contrary to the public interest, and are issuing these revised regulations as a final rule that will apply to all future cases under this authority.

IV. Regulatory Impact Statement

As indicated above, the provisions contained in this final rulemaking set forth technical revisions to the OIG PRO sanctions process in compliance with statutory changes resulting from the Health Insurance Portability and Accountability Act of 1996. The great majority of individuals, organizations and entities addressed through these regulations do not engage in such prohibited activities and practices, and as a result, we believe that any aggregate economic impact of these revised regulations will be minimal, affecting only those limited few who may engage in prohibited behavior in violation of the statute. As such, the changes contained in this final rule should have no effect on Federal or State expenditures. The Office of Management and Budget (OMB) has reviewed this final rule in accordance with the provisions of Executive Order 12866.

Regulatory Flexibility Act

In addition, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (5 U.S.C. 601–612), unless we certify that a regulation will not have a significant economic impact on a substantial number of small business entities. While some penalties may have an impact on small entities, it is the nature of the violation and not the size of the entity that will result in an action by the OIG, and the aggregate economic impact of this rulemaking on small business entities should be minimal, affecting only those few who have chosen to engage in prohibited arrangements and schemes in violation of statutory intent. Therefore, we have concluded and certify, that this final rule will not have a significant economic impact on a substantial number of small business entities, and that a regulatory flexibility analysis is not required for this rulemaking.

Paperwork Reduction Act

Sections 1004.80 and 1004.110 of this rulemaking contain information collection requirements that require approval by OMB. We are required to solicit public comments under section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995. Specifically, we are inviting comments on (1) whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) the accuracy of the estimate of the burden of the collection of information; (3) ways to enhance the quality, utility and clarity of the information collected; and (4) ways to minimize the burden of the collection of information on practitioners and other persons, including through the use of automated collection techniques or other forms of information technology.

Title: PRO Sanction Process.

Summary of the collection of information: In conjunction with section 1156(b)(1) of the Social Security Act, § 1004.80 requires the PRO to submit a report and recommendation to the OIG if the violation(s) identified by the PRO have not been resolved. The report must include the following information—

- Identification of the practitioner or other person, and when applicable, the name of the director, administrator or owner of the entity involved;
- The type of health care services involved;
- A description of each failure to comply with an obligation;
- Pertinent documentary evidence;
- Copies of written correspondence and, if applicable, a copy of the verbatim transcript of the meeting with the practitioner or other person;
- The PRO's finding that an obligation has been violated and that the violation is substantial and has occurred in a substantial number of cases or is gross and flagrant;
- A case-by-case analysis and evaluation of any additional information provided by the practitioner or other person in response to the PRO's initial finding;
- A copy of the correction action plan that was developed and documentation of the results of such plan;
- The number of admissions by the practitioner or other person reviewed by the PRO during the period in which the violations(s) were identified;
- The professional qualifications of the PRO's reviewers; and
- The PRO's sanction recommendations.

The PRO must specify in its report the amount of monetary penalty and period of exclusion recommended, the availability of alternative sources in the community along with supporting information, and the county (or counties) in which the practitioner or other person furnishes services.

Section 1004.110 of these regulations set forth an alternative sanctions notification process that allows sanctioned practitioners or other persons the option of informing all their patients directly of the sanction action taken against them. If they select this option and comply with its requirements in a timely fashion, sanctioned practitioners and other persons will be exempted from the requirement of public notice. Practitioners or other persons are required to certify to the Department that they have taken action to inform all their patients of the sanction and, in the case of exclusion, that they will notify new patients before furnishing services. Each sanctioned practitioner or other person opting for this alternative notice procedure must alert both existing patients and all new patients through written notification based on a suggested, non-mandatory model provided by the OIG. The model patient notification letter indicates the effective date of the exclusion, the programs from which the practitioner or other person has been excluded, and the period of time for that exclusion. A copy of this model notification letter is available from the OIG upon request.

Respondents: The ''respondents'' for the collection of information described in § 1004.80 are the individual PROs recommending a sanction action. The ''respondents'' under § 1004.110 are those practitioners or other persons who have been sanctioned under section 1156 of the Act and who opt for the alternative notice procedure through written notification to their patients.

Estimated number of respondents: Over the last several years, the OIG has received less than ten PRO sanction recommendations for action. We believe that the number of PRO sanction cases and requests for the alternative notification process will remain low.

Estimated number of responses per respondent: 1

Estimated total annual burden on respondents: We believe that the burden on PROs of preparing the report to the OIG will vary widely because of the differences in the scope and type of information included and the complexity of the circumstances that have led to the PRO recommendation. We estimate that the average burden for each submitted report to the OIG will be in the range from 2 to 10 hours. We further believes that the burden for most PROs will be closer to the lower end of the range, with an average of 4 hours per respondent. The total burden for this information collection is estimated to be 28 hours.

In addition, we estimate that the alternative notification procedure selected by sanctioned practitioners or other persons will be minimal, averaging from 1 to 2 hours per respondent. Total burden for this activity is estimated not to exceed 10 hours.

Comments on these information collection activities should be sent to both:

Cynthia Agens Bauer, OS Reports Clearance Officer, ASMB Budget Office, Room 503–H Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201, FAX: (202) 690–6352;

Allison Herron Eydt, OIG Desk Officer, Office of Management and Budget, Room 10235, New Executive Office Building, 725 17th Street, N.W., Washington, D.C. 20053, FAX: (202) 395–6974.

Comments on these paperwork reduction requirements should be submitted to the above individuals within 30 days following the **Federal Register** publication of this final rule. The information collection requirements will not be in effect until approval by OMB. Public notice will be provided when OMB approval is obtained.

List of Subjects in 42 CFR Part 1004

Administrative practice and procedure, Health facilities, Health professions, Medicare, Peer Review Organizations, Penalties, Reporting and recordkeeping requirements.

Accordingly, 42 CFR part 1004 is amended as set forth below:

PART 1004—IMPOSITION OF SANCTIONS ON HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES BY A PEER REVIEW ORGANIZATION

1. The authority citation for part 1004 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1320c–5.

2. Section 1004.20 is revised to read as follows:

§ 1004.20 Sanctions.

In addition to any other sanction provided under the law, a practitioner or other person may be—

(a) Excluded from participating in programs under titles V, XVIII, XIX, and XX of the Social Security Act for a period of no less than 1 year; or

(b) In lieu of exclusion and as a condition for continued participation in titles V, XVIII, XIX, and XX of the Act, if the violation involved the provision or ordering of health care services (or services furnished at the medical direction or on the prescription of a physician) that were medically improper or unnecessary, required to pay an amount of up to $10,000 for each instance in which improper or unnecessary services were furnished or ordered (or prescribed, if appropriate). The practitioner or other person will be required either to pay the monetary assessment within 6 months of the date of notice or have it deducted from any sums the Federal Government owes the practitioner or other person.

3. Section 1004.80 is amended by republishing the introductory text of paragraphs (b) and (c), revising paragraphs (b)(8), (c)(4), and (c)(5), and removing paragraph (c)(6) to read as follows:

§ 1004.80 PRO report to the OIG.

* * * * *

(b) *Content of report.* The PRO report must include the following information—

* * * * *

(8) A copy of the CAP that was developed and documentation of the results of such plan;

* * * * *

(c) *PRO recommendation.* The PRO must specify in its report—

* * * * *

(4) The availability of alternative sources of services in the community, with supporting information; and

(5) The county or counties in which the practitioner or other person furnishes services.

4. Section 1004.100 is amended by republishing the introductory text of paragraph (d), revising paragraphs (b), (d)(6), and (d)(7), and removing paragraph (d)(8) to read as follows:

§ 1004.100 Acknowledgement and review of report.

* * * * *

(b) *Review.* The OIG will review the PRO report and recommendation to determine whether—

(1) The PRO has followed the regulatory requirements of this part; and

(2) A violation has occurred.

* * * * *

(d) *Decision to sanction.* If the OIG decides that a violation of obligations has occurred, it will determine the appropriate sanction by considering—

* * * * *

(6) Any prior problems the Medicare or State health care programs have had with the practitioner or other person; and

(7) Any other matters relevant to the particular case.

* * * * *

5. Section 1004.110 is amended by revising paragraphs (d)(1)(i) and (d)(2) to read as follows:

§ 1004.110 Notice of sanction.

* * * * *

(d) *Patient notification.* (1)(i) The OIG will provide a sanctioned practitioner or other person an opportunity to elect to inform each of their patients of the sanction action. In order to elect this option, the sanctioned practitioner or other person must, within 30 calendar days from receipt of the OIG notice, inform both new and existing patients through written notice—based on a suggested (non-mandatory) model provided to the sanctioned individual by the OIG—of the sanction and, in the case of an exclusion, its effective date. Receipt of the OIG notice is presumed to be 5 days after the date of the notice, unless there is a reasonable showing to the contrary. Within this same period, the practitioner or other person must also sign and return the certification that the OIG will provide with the notice. For purposes of this section, the term ''all existing patients'' includes all patients currently under active treatment with the practitioner or other person, as well as all patients who have been treated by the practitioner or other person within the last 3 years. In addition, the practitioner or other person must notify all prospective patients orally at the time such persons request an appointment. If the sanctioned party is a hospital, it must notify all physicians who have privileges at the hospital, and must post a notice in its emergency room, business office and in all affiliated entities regarding the exclusion. In addition, for purposes of this section, the term ''in all affiliated entities'' encompasses all entities and properties in which the hospital has a direct or indirect ownership interest of 5 percent or more and any management, partnership or control of the entity.

* * * * *

(2) If the sanctioned practitioner or other person does not inform his, her or its patients *and* does not return the required certification within the 30-day period, or if the sanctioned practitioner or other person returns the certification within the 30-day period but the OIG obtains reliable evidence that such person nevertheless has not adequately informed new and existing patients of the sanction, the OIG—

(i) Will see that the public is notified directly of the identity of the sanctioned practitioner or other person, the finding that the obligation has been violated, and the effective date of any exclusion; and

(ii) May consider this failure to adhere to the certification obligation as an adverse factor at the time the sanctioned practitioner or other person requests reinstatement.

* * * * *

Dated: December 12, 1996.

June Gibbs Brown,

Inspector General, Department of Health and Human Services.

Approved: December 27, 1996.

Donna E. Shalala,

Secretary.

[FR Doc. 97–11024 Filed 4–28–97; 8:45 am]

BILLING CODE 4150–04–M

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 65

Changes in Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, FEMA.

ACTION: Final rule.

SUMMARY: Modified base (1% annual chance) flood elevations are finalized for the communities listed below. These modified elevations will be used to calculate flood insurance premium rates for new buildings and their contents.

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

ADDRESSES: The modified base flood elevations for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the following table.

FOR FURTHER INFORMATION CONTACT: Frederick H. Sharrocks, Jr., Chief, Hazard Identification Branch, Mitigation Directorate, 500 C Street SW., Washington, DC 20472, (202) 646–2796.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency makes the final determinations listed below of modified base flood elevations for each community listed. These modified elevations have been published in newspapers of local circulation and ninety (90) days have elapsed since that publication. The Executive Associate Director has resolved any appeals resulting from this notification.

The modified base flood elevations are not listed for each community in this notice. However, this rule includes the address of the Chief Executive Officer of the community where the modified base flood elevation determinations are available for inspection.

The modifications are made pursuant to section 206 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 *et seq.*, and with 44 CFR part 65.

For rating purposes, the currently effective community number is shown and must be used for all new policies and renewals.

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

These modified elevations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that 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 of its own, or pursuant to policies established by other Federal, state or regional entities.

These modified elevations are used to meet the floodplain management requirements of the NFIP and are also used to calculate the appropriate flood insurance premium rates for new buildings built after these elevations are made final, and for the contents in these buildings.

The changes in base flood elevations are in accordance with 44 CFR 65.4.

National Environmental Policy Act

This rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. No environmental impact assessment has been prepared.

Regulatory Flexibility Act

The Executive Associate Director, Mitigation Directorate, certifies that this rule is exempt from the requirements of the Regulatory Flexibility Act because modified base flood elevations are required by the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are required to maintain community eligibility in the National Flood Insurance Program. No regulatory flexibility analysis has been prepared.

Regulatory Classification

This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 12612, Federalism

This rule involves no policies that have federalism implications under Executive Order 12612, Federalism, dated October 26, 1987.

Executive Order 12778, Civil Justice Reform

This rule meets the applicable standards of section 2(b)(2) of Executive Order 12778.

List of Subjects in 44 CFR Part 65

Flood insurance, Floodplains, Reporting and recordkeeping requirements.

Accordingly, 44 CFR part 65 is amended to read as follows:

PART 65—[AMENDED]

1. 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, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 65.4 [Amended]

2. The tables published under the authority of § 65.4 are amended as follows: