this **Federal Register** for detailed instructions on how to submit comments.

**FOR FURTHER INFORMATION CONTACT:** Stacy DiFrank, Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. The telephone number is (404) 562–9042. Ms. DiFrank can also be reached via electronic mail at *difrank.stacy@epa.gov*.

**SUPPLEMENTARY INFORMATION:** For additional information, see the direct final rule which is published in the Rules section of this **Federal Register**.

Dated: April 19, 2006.

**A. Stanley Meiburg,**

*Acting Regional Administrator, Region 4.*

[FR Doc. 06–4022 Filed 4–27–06; 8:45 am]

**BILLING CODE 6560–50–P**

## ENVIRONMENTAL PROTECTION AGENCY

### 40 CFR Part 271

**[EPA–R07–RCRA–2006–0026; FRL–8163–5]**

### Missouri: Final Authorization of State Hazardous Waste Management Program Revisions

**AGENCY:** Environmental Protection Agency (EPA).

**ACTION:** Proposed rule.

**SUMMARY:** Missouri has applied to EPA for Final authorization of the changes to its hazardous waste program under the Resource Conservation and Recovery Act (RCRA). EPA proposes to grant final authorization to Missouri.

**DATES:** Send your written comments by May 30, 2006.

**ADDRESSES:** Submit your comments, identified by Docket ID No. EPA–R07–RCRA–2006–0026 by one of the following methods:

1. *http://www.regulations.gov:* Follow the on-line instructions for submitting comments.

2. E-mail: *haugen.lisa@epa.gov*.

3. Mail: Lisa Haugen, Environmental Protection Agency, RCRA Enforcement and State Programs Branch, 901 North 5th Street, Kansas City, Kansas 66101.

4. Hand Delivery or Courier: Deliver your comments to: Lisa Haugen, Environmental Protection Agency, RCRA Enforcement and State Programs Branch, 901 North 5th Street, Kansas City, Kansas 66101. Such deliveries are only accepted during the Regional Office's normal hours of operation. The Regional Office's official hours of business are Monday through Friday, 8 to 4:30, excluding legal holidays.

Please see the direct final rule which is located in the Rules section of this **Federal Register** for detailed instructions on how to submit comments.

**FOR FURTHER INFORMATION CONTACT:** Lisa Haugen at the above address and phone number, or by e-mail at *haugen.lisa@epa.gov*.

**SUPPLEMENTARY INFORMATION:** In the ''Rules and Regulations'' section of this **Federal Register**, EPA is authorizing the changes by an immediate final rule. EPA did not make a proposal prior to the immediate final rule because we believe this action is not controversial and do not expect comments that oppose it. We have explained the reasons for this authorization in the preamble to the immediate final rule. Unless we get written comments which oppose this authorization during the comment period, the immediate final rule will become effective on the date it establishes, and we will not take further action on this proposal. If we receive comments that oppose this action, we will withdraw the immediate final rule and it will not take effect. We will then respond to public comments in a later final rule based on this proposal. If you want to comment on this action, you must do so at this time.

For additional information, please see the immediate final rule published in the ''Rules and Regulations'' section of this **Federal Register**.

Dated: April 17, 2006.

**James B. Gulliford,**

*Regional Administrator, Region 7.*

[FR Doc. 06–4024 Filed 4–27–06; 8:45 am]

**BILLING CODE 6560–50–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Indian Health Service

### Centers for Medicare & Medicaid Services

### 42 CFR Parts 136 and 489

**[CMS–2206–P]**

**RIN 0917–AA02**

### Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003—Limitation on Charges for Services Furnished by Medicare Participating Inpatient Hospitals to Indians

**AGENCY:** Indian Health Service (IHS)/ Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Proposed rule.

**SUMMARY:** This proposed rule would establish regulations required by section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), (Pub. L. 108–173). Section 506 of the MMA amended section 1866(a)(1) of the Social Security Act to add subparagraph (U) which requires hospitals that furnish inpatient hospital services payable under Medicare to participate in the contract health services program funded by the Indian Health Service (IHS) whether operated by the IHS, tribes or tribal organizations and any health program operated by Urban Indian organizations that are funded by IHS with respect to any medical care furnished under those programs. Section 506 also requires such participation to be in accordance with the admission practices, payment methodology, and payment rates set forth in regulation established by the Secretary, including acceptance of no more than the payment rate as payment in full.

**DATES:** Comments are due June 27, 2006. Send your written comments to: Betty Gould, Regulations Officer, Division of Regulatory Affairs, Records Access, and Policy Liaison, Indian Health Service (IHS), 801 Thompson Avenue, Suite 450, Rockville, Maryland 20852. Telephone (301) 443–7899. (This is not a toll free number.) Comments received will be available for inspection at the address above from 9 a.m. to 3 p.m., Monday through Friday, beginning approximately two weeks after publication.

**FOR FURTHER INFORMATION CONTACT:** Carl Harper, Director, Office of Resource Access and Partnerships, IHS, 801 Thompson Avenue, Rockville, Maryland

20852, Telephone (301) 443–3024; or Dorothy Dupree, Senior Policy Advisor for American Indian and Alaska Natives, CMS, Telephone (410) 786–1942. (These are not toll free numbers.)

**SUPPLEMENTARY INFORMATION:**

## I. Background

The Indian healthcare system is comprised of the IHS, and health programs operated by Indian Tribes or Tribal Organizations, and Urban Indian Organizations (I/T/U). The I/T/Us provide, to the extent possible, primary, preventive and chronic health care services to eligible IHS beneficiaries in I/T/U operated facilities.

In accordance with IHS regulations at 42 Code of Federal Regulations (CFR) part 136, the Indian Health Service and Tribes (I/Ts) are authorized to pay for medical care provided to IHS beneficiaries by non-I/T public or private providers as contract health services. Payment may be authorized by an I/T under the contract health services (CHS) program for non-I/T services for either non-emergency or emergency care. For non-emergency care, an advance referral from the I/T is usually required and, for emergency care, timely notification is required. Authorization for CHS program payment is subject to the availability of funding and the exhaustion of alternative resources. Payment for medical services furnished is made through a purchase order issued to the non I/T public or private providers. While recent efforts have been more successful in negotiating reasonable rates, historically, purchase orders for CHS services have been for amounts at full billed charges that substantially exceeded the Medicare allowable rates and this problem could recur in the future.

Under section 503 of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. 1660a, *et seq.*), urban Indian programs are authorized to provide referral services to eligible urban Indians (as defined in section 4 of the IHCIA). The urban programs are authorized to refer eligible urban Indian patients to non I/T/U public and private providers with whom the program has a signed agreement or contract. When an urban Indian program refers an eligible urban Indian to a non I/T/U public or private provider, the urban program may elect to either provide the referral service only or, dependent upon the availability of funds, to provide a referral service and cover the cost of care. Similar to the I/T programs, urban programs have historically had to pay full billed charges that exceed the Medicare allowable rates.

The small market share of individual I/T/U programs has made it difficult for these programs to negotiate discounted rates, and these programs historically have had to pay full billed charges that substantially exceed the rates paid by the Medicare program. Partly as a result of these high costs, the need for contract health services in the population served by I/T/U programs routinely exceeds funding available to these programs.

Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) requires the Secretary to issue regulations to describe admission practices, payment methodology and rates of payment applicable to Medicare-participating hospitals that furnish inpatient services when such hospitals provide medical care to eligible American Indian/Alaskan Native (AI/AN) beneficiaries and such care is authorized by the I/T/U.

In the development of this proposed rule, the IHS consulted with the Centers for Medicare & Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG). The CMS TTAG operates under the authority of section 204 of the Unfunded Mandates Reform Act of 1995, 2 U.S.C. 1534 and consists of elected Tribal leaders of Tribal governments, or their designated employees acting on their behalf, as well as representatives of the National Indian Health Board, the National Congress of American Indians, and the Tribal Self-Governance Advisory Committee which are national Washington DC based Indian associations designated by Tribal leaders to act on their behalf. The CMS TTAG was established to enhance the Government to Government relationship and serves as an advisory body to CMS providing expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for AI/ANs. One of the responsibilities of the TTAG is to provide advice and input into the development of CMS regulations.

A subcommittee of the TTAG was established for the purpose of exchanging information and providing advice and input as to the financial and systematic impact different Medicare-like rate payment methodology options would have on tribal programs. The subcommittee of the TTAG held four meetings from May through September 2004. After independent consideration by the IHS of the Tribal input of the CMS TTAG and in collaboration with CMS, IHS developed these rules proposing a Medicare-like payment methodology suitable for I/T/Us. Tribal leaders will be mailed a copy of the proposed rule after its publication in the **Federal Register** with an opportunity to review and provide comments within the comment period.

### *Medicare-Like Rate Payment Methodology*

The term ''Medicare-like'' rate describes the rate at which the Medicare-participating hospitals will be reimbursed by I/T/Us as established by these regulations. For purposes of this regulation, the term ''Medicare-participating hospitals'' includes hospitals, as defined in 1861(e) of the Social Security Act (SSA), and Critical Access Hospitals (CAR), as defined in 1861(mm)(1) of the Social Security Act (SSA). As proposed by these regulations, the IHS is interpreting section 506 to apply to any level of care furnished by such Medicare-participating hospitals as an institution, including all hospital departments and provider-based entities. The TRICARE program of the Department of Defense has similar statutory authority and uses rates similar to those of Medicare for hospital-based inpatient, outpatient, and skilled nursing facility (SNF) care. Accordingly, IHS anticipates that Medicare-participating hospitals will not face any major problems under the approach proposed.

Because the payment methodology proposed to be used by I/T/Us is slightly different from the current Medicare methodology used by CMS for services provided to Medicare beneficiaries, the payment rates under section 506 will not be identical. Thus, it is necessary that the IHS issue specific regulations that describe the payment methodology and rates of payment under section 506.

In 1983, CMS implemented the prospective payment system (PPS) for hospital inpatient services provided to Medicare beneficiaries. Since then, CMS has implemented PPS for other provider services provided to Medicare beneficiaries for any services that an inpatient hospital provides including services of a subunit or distinct part of a hospital. The CMS does not publish the dollar amount that will be paid to each hospital for every inpatient admission or outpatient service. On an annual basis, CMS publishes in the **Federal Register** the PPS methodology and payment rates for the various types of provider services. Other hospitals, such as cancer and children's hospitals, continue to be exempt from PPS and are reimbursed on a cost basis.

In 1997, CMS created a new class of Medicare providers designated as Critical Access Hospitals (CAH). CAHs receive cost based reimbursement for inpatient and outpatient services

delivered to Medicare beneficiaries. However, under PPS or cost based reimbursement systems, the hospitals and CAHs are paid an interim rate and receive retrospective settlements from Medicare for the difference between the interim payment and final payment rate.

The IHS is proposing in these regulations that when Medicare-participating hospitals provide services to IHS beneficiaries authorized by I/T/Us pursuant to the IHS CHS regulations at 42 CFR part 136 or section 503 of the IHCIA for urban Indian programs, the ''Medicare-like rate'' payment methodology and maximum rates paid to these Medicare-participating hospitals, including CAHs or other hospitals reimbursed on a cost basis, will be no greater than the interim rates for applicable services as calculated in the same manner as CMS Medicare Fiscal Intermediaries in accordance with 42 CFR part 413, subpart E, without adjustments or retrospective settlements. Adjustments will be made only to correct billing or claims processing errors, including when fraud is detected.

The I/T/U programs operate with discretionary appropriations. IHS facilities are subject to the Anti-Deficiency Act. Because of the annual cap on IHS' appropriations, the I/T/Us cannot accommodate retrospective settlements where payment obligations may not be fully quantified until one or more years after the services are provided. Thus, the Medicare-like rates payment methodology established by these regulations will not include retrospective settlements of final payments under Medicare payment methodologies for these providers.

The IHS has in the past negotiated contracts with some hospitals at rates based on the hospital's final settled cost reports that are similar to or in some cases lower than the Medicare-like rates. These rules are not intended to preclude I/T/Us from negotiating rates that are lower than the Medicare rates. However, in the event the I/T/Us are not able to negotiate a contract with non-I/T/U providers, the Medicare-like rates established by this rule will serve as a ceiling on the amount the I/T/U will pay for services.

According to section 222 of the IHCIA, patients who receive authorized CHS services are not liable for the payment of any charges or costs associated with the provision of such services. If an I/T/U has authorized payment for CHS services provided to an individual who is eligible for benefits under Medicare, Medicaid, or another third party payor, the I/T/U shall be the payor of last resort under 42 CFR 136.61. When payment is made by Medicaid, it is considered payment in full and there will be no additional payment made by the I/T/U beyond the amount paid by Medicaid, (except for applicable cost sharing, if any). If there are any other third party payors, the I/T/U will coordinate benefits to pay the amount for which the patient is being held responsible after all other alternative resources have been considered and paid, including applicable copayments, deductibles, and coinsurance that are owed by the patient. The I/T/U payment will not exceed the rate calculated in accordance with § 136.30(a) basic determination and (b) basic payment calculation or the contracted amount (plus applicable cost sharing), whichever is less. For purposes of the basic payment calculation specified in section 136.30(b), required copayments, deductibles and coinsurance are those that would have been owed by a Medicare beneficiary under the proposed methodology. However, because IHS is barred under the IHCIA from imposing any cost sharing on CHS patients, the I/T/U will assume these costs.

In order for a hospital or CAH to be eligible for payment under this section, the I/T/Us have adopted the standard Medicare requirements for filing of claims. Medicare-participating hospitals are required to submit their claims for medical services provided to patients who have been approved for payment by the I/T/U in accordance with the guidelines established by Medicare. All claims must be submitted to the I/T/U agent or FI within a period of time equivalent to the timely filing period under 42 CFR 424.44, and must be filed on a UB92 paper claim form (until abolished, or on an officially adopted successor form) or the HIPAA 837 electronic claims format ANSI X12N, version 4010AI (until abolished, or on an officially adopted successor form) with the hospital's Medicare provider number/National Provider Identifier included (**Note:** Section 3 of the Administrative Simplification Compliance Act, Public Law 107–105 (ASCA), and the implementing regulation at 42 CFR 424.32 require that all initial claims for reimbursement under Medicare, except from small providers, be submitted electronically as of October 16, 2003, with limited exceptions).

## II. Provisions of the Proposed Rule

This proposed rule amends the IHS regulation at 42 CFR part 136, by adding a new subpart D to describe the ''Medicare-like rate'' payment methodology and other requirements for Medicare-participating hospitals or CAHs who furnish inpatient or outpatient services, either directly or under arrangement, to AI/ANs who are authorized to receive such services by the Indian Health Service, Tribe or Tribal organization, or Urban Indian organization (I/T/U).

The proposed rule also amends CMS regulations at 42 CFR part 489 to require Medicare-participating hospitals or CAHs that furnish inpatient hospital services to AI/AN patients who are authorized for services by the Indian Health Service, Tribe or Tribal organization, or Urban Indian organization (I/T/U) to accept the payment methodology pursuant to 42 CFR part 136, subpart D. The IHS has chosen not to provide additional regulation of admission practices here because American Indians and Alaska Natives already receive protection against discrimination under existing regulations at 45 CFR part 80, administered and enforced by the HHS Office for Civil Rights.

## III. Collection of Information Requirements

These regulations do not impose any new information collection requirements. The burden of the requirements in § 136.30(e), for submitting a claim form, are currently approved under OMB approval number 0938–0279.

## IV. Response to Comments

Because of the large number of public comments the IHS normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. The IHS will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

## V. Regulatory Impact Statement

The IHS has examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health

and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This action is not a significant regulatory action under Executive Order 12866. Because the economic impact should be minimal, further regulatory evaluation is not necessary.

The RFA requires agencies to analyze options for regulatory relief of small 1184 businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity.

The I/T/Us have entered into contracts with many public and private non-I/T Medicare-participating hospitals at rates similar to the rate proposed in this rule. The IHS intends to continue existing contracts with these hospitals; however, to the extent that I/T/Us are not able to negotiate a contract with a hospital, the payment rate established by this rule will apply. This action will alleviate the need and administrative burden of the IHS as well as the Medicare-participating hospital to negotiate rates through individual contracts.

The IHS conducted a study to determine the financial impact the interim payment rates, as proposed by this regulation, would have on public and private non-I/T/U hospitals. As part of this study, the IHS compared the interim rates to the rates that the IHS has negotiated per contracts with public and private non-I/T/U hospitals. For FY 2003, of the 387 hospitals that IHS does business with, the IHS has negotiated contracts with 48% of these hospitals. Based on IHS data, the [findings revealed the overall negative impact to these public and private non-I/T/U hospitals would be less than 1 %. Of the 387 hospitals in the study, 105 are rural hospitals and 84 of these are small rural hospitals (less than 100 beds). By comparing the interim rate to full billed charges, [i.e. what the IHS pays if a contract is not negotiated] revealed a negative financial impact of 8% to these rural hospitals. Further analysis of the inpatient bed utilization by hospital revealed the IHS represents less than 2% of the rural and small rural hospitals total business meaning that 98% of the hospitals' income comes from other sources. For these reasons, the IHS has determined that the rates proposed by these regulations will not have a significant economic impact on a substantial number of small entities within the meaning of the Regulatory Flexibility Act, 5 U.S.C. 601, *et seq.*

In addition, section 1102(b) of the Act requires IHS to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, IHS defines a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. For the reasons provided above, IHS has determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose requirements mandate expenditure in any 1 year by State, local, or Tribal governments, in the aggregate, or by the private sector, of $120 million. This proposal would not impose substantial Federal mandates on State, local, or Tribal governments or private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. It has been determined that this action would not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government, and therefore would not have federalism implications.

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

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

**List of Subjects**

*42 CFR Part 136*

American Indian, Alaskan Natives, Health, Medicare.

*42 CFR Part 489*

Health facilities, Medicare, Reporting and recordkeeping requirements.

Dated: April 27, 2005.

**Phyllis Eddy,**

*Deputy Director for Management Operations, Indian Health Service.*

Dated: April 29, 2005.

**Mark B. McClellan,**

*Administrator, Centers for Medicare & Medicaid Services.*

Dated: January 24, 2006.

**Michael O. Leavitt,**

*Secretary.*

**Editorial Note:** This document was received at the Office of the Federal Register April 24, 2006.

For the reasons set forth in the preamble, the Indian Health Service proposes to amend 42 CFR chapter I as set forth below:

## PART 136—INDIAN HEALTH

1. The authority citation for part 136 continues to read as follows:

**Authority:** 25 U.S.C. 13; 42 U.S.C. 1395cc(a)(1)(U), 42 U.S.C. 2001 and 2003, unless otherwise noted.

2. Add new subpart D consisting of §§ 136.30 and 136.31, to read as follows:

## Subpart D—Limitation on Charges for Services Furnished by Medicare-participating Hospitals to Indians

Sec.



### § 136.30 Payment to Medicare-participating hospitals for authorized Contract Health Services.

Except as otherwise provided in this section, payment to Medicare-participating hospitals, which are defined for purposes of these regulations to include all departments and provider-based entities of hospitals (as defined in 1861(e) of the Social Security Act) and Critical Access Hospitals (as defined in 1861(mm)(1) of the Social Security Act), for any level of care authorized under part 136, subpart C by a contract health service (CHS) program of the Indian Health Service (IHS) or a Tribe or Tribal organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act, as amended, Public Law 93–638, 25 U.S.C. 450 *et seq.;* or by referral from an urban Indian organization (as that term is defined in 25 U.S.C. 1603(h)) under § 136.31 (hereafter ''I/T/U'') shall be based on payment methodologies used in the Medicare program for paying for those hospital services as follows:

(a) *Basic determination.* Payment to Medicare-participating hospitals or CAHs for services authorized by an I/T/U, whether provided as inpatient, outpatient, skilled nursing facility care, or other services of a department, subunit or distinct part of a hospital, shall be paid consistent with the methodology to determine interim rate payments in accordance with 42 CFR part 413, subpart E.

(b) *Basic payment calculation.* The calculation of the payment by I/T/Us will be based on determinations made under paragraph (a) of this section consistent with CMS instructions to its fiscal intermediaries at the time the claim is processed, provided that no retrospective calculations will be performed. Adjustments will be made only to correct billing or claims processing errors. Any payments made by the I/T/U to the Medicare-participating hospital or CAH shall include any beneficiary copayments, deductibles, or coinsurance that the patient would be required to pay under Medicare.

(c) *Exceptions to payment calculation.* Notwithstanding paragraphs (a) and (b) of this section, if an amount has been negotiated with the hospital or its agent by the I/T/U, the I/T/U will pay the lesser amount determined under paragraphs (a) and (b) of this section or the amount negotiated with the hospital or its agent; including but not limited to capitated contracts or contracts per Federal law requirements;

(d) *Coordination of benefits and limitation on recovery.* If an I/T/U has authorized payment for CHS services provided to an individual who is eligible for benefits under Medicare, Medicaid, or another third party payor:

(1) The I/T/U shall be the payor of last resort under § 136.61;

(2) If there are any third party payors, the I/T/U will coordinate benefits to pay the amount for which the patient is being held responsible after all other alternative resources have been considered and paid, including applicable copayments, deductibles, and coinsurance that are owed by the patient; and

(3) The maximum payment by the I/T/U will be only that portion of the payment amount determined under this section not covered by any other payor; and

(4) The I/T/U payment will not exceed the rate calculated in accordance with paragraphs (a) and (b) of this section or the contracted amount (plus applicable cost sharing), whichever is less; and

(5) When payment is made by Medicaid it is considered payment in full and there will be no additional payment made by the I/T/U for the amount paid by Medicaid, (except for applicable cost sharing).

(e) *Claims processing.* For a hospital to be eligible for payment under this section, the hospital or its agent must submit the claim for authorized services—

(1) On a UB92 paper claim form (until abolished, or on an officially adopted successor form) or the HIPAA 837 electronic claims format ANSI X12N, version 4010A1 (until abolished, or on an officially adopted successor form) and include the hospital's Medicare) provider number/National Provider Identifier; and

(2) To the I/T/U, agent, or fiscal intermediary identified by the I/T/U in the agreement between the I/T/U and the hospital or in the authorization for services provided by the I/T/U; and

(3) Within a time period equivalent to the timely filing period for Medicare claims under § 424.44 of this title and provisions of the Medicare Intermediary Manual applicable to the type of service provided.

(f) *Authorized services.* Payment shall be made only for those services authorized by an I/T/U consistent with part 136 of this title or section 503(a) of the IHCIA.

(g) *No additional charges.* A payment made in accordance with this section shall constitute payment in full and the hospital or its agent may not impose any additional charge—

(1) On the individual for I/T/U authorized services; or

(2) For information requested by the I/T/U or its agent or fiscal intermediary for the purposes of payment determinations or quality assurance.

**§ 136.31 Authorization by Urban Indian Organization.**

Subject to availability of funds, when an urban Indian organization purchases items and services for an eligible urban Indian (as defined in section 4 of the IHCIA) according to section 503 of the IHCIA and applicable regulations, the Medicare-like rates as described in § 136.30 shall apply.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter V, as set forth below:

## PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

3. The authority citation for part 489 continues to read as follows:

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

### Subpart B—Essentials of Provider Agreements

4. A new § 489.29 is added to subpart B to read as follows:

**§ 489.29 Special requirements concerning beneficiaries served by the Indian Health Service, Tribal health programs, or Urban Indian health programs.**

Hospitals and Critical Access Hospitals that participate in the Medicare program must meet the following requirements:

(a) 42 CFR 136, subpart D of this title concerning payment methodology and amounts.

(b) Must participate in the following programs:

(1) A contract health service (CHS) program under 42 CFR part 136, subpart C, of the Indian Health Service (IHS).

(2) A Tribe or Tribal Organization carrying out a CHS program under 42 CFR part 136, subpart C, pursuant to the Indian Self-Determination and Education Assistance Act, as amended, Public Law 93–638, 25 U.S.C 450 *et seq.*

(3) A program funded through a grant or contract by the IHS and operated by an urban Indian organization (in accordance with the terms defined in 25 U.S.C. 1603(f) and (h)) under which admission or treatment is authorized.

[FR Doc. 06–3976 Filed 4–27–06; 8:45 am]

**BILLING CODE 4165–16–M**

## DEPARTMENT OF TRANSPORTATION

### Federal Motor Carrier Safety Administration

### 49 CFR Part 392

**[Docket No. FMCSA–1998–4202]**

**RIN 2126–AA18**

### Railroad Grade Crossing Safety; Withdrawal

**AGENCY:** Federal Motor Carrier Safety Administration (FMCSA), DOT.

**ACTION:** Withdrawal of notice of proposed rulemaking.

**SUMMARY:** FMCSA withdraws a July 30, 1998, Notice of Proposed Rulemaking (NPRM) that would have prohibited the driver of a commercial motor vehicle (CMV) from driving onto a highway-railroad grade crossing without sufficient space to drive completely through the crossing without stopping. The NPRM was issued in response to section 112 of the Hazardous Materials Transportation Authorization Act of 1994.

After careful analysis and review of the comments, FMCSA has concluded