over the amount that they paid in CY 2006.

V. Waiver of Proposed Notice and Comment Period

We are not using notice and comment rulemaking in this notification of Part A premiums for CY 2007, as that procedure is unnecessary because of the lack of discretion in the statutory formula that is used to calculate the premium and the solely ministerial function that this notice serves. The Administrative Procedure Act (APA) permits agencies to waive notice and comment rulemaking when notice and public comment thereon are unnecessary. On this basis, we waive publication of a proposed notice and a solicitation of public comments.

VI. Regulatory Impact Statement

We have examined the impacts of this notice 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 Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

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). As stated in section IV of this notice, we estimate that the overall effect of these changes in the Part A premium will be a cost to voluntary enrollees (section 1818 and section 1818A of the Act) of about $114 million. Therefore, this notice is a major rule as defined in Title 5, United States Code, section 804(2) and is an economically significant rule under Executive Order 12866.

The RFA requires agencies to analyze options for regulatory relief of small entities. 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. We have determined that this notice will not have a significant economic impact on a substantial number of small entities. Therefore, we are not preparing an analysis for the RFA.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area (MSA) and has fewer than 100 beds.

We have determined that this notice will not have a significant effect on the operations of a substantial number of small rural hospitals. Therefore, we are not preparing an analysis for section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $120 million. This notice has no consequential effect on State, local, or tribal governments or on the private sector. However, States are required to pay premiums for dually-eligible beneficiaries.

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes 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. This notice will not have a substantial effect on State or local governments.

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

Authority: Sections 1818(d)(2) and 1818A(d)(2) of the Social Security Act (42 U.S.C. 1395i–2(d)(2) and 1395i–2a(d)(2)).

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

Dated: September 11, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 12, 2006.

Michael O. Leavitt,

Secretary.

[FR Doc. 06–7710 Filed 9–12–06; 4:00 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8029–N]

RIN 0938–AO19

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for Calendar Year 2007

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

ACTION: Notice.

SUMMARY: This notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in calendar year (CY) 2007 under Medicare's Hospital Insurance program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts.

For CY 2007, the inpatient hospital deductible will be $992. The daily coinsurance amounts for CY 2007 will be: (a) $248 for the 61st through 90th day of hospitalization in a benefit period; (b) $496 for lifetime reserve days; and (c) $124 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

DATES: *Effective Date:* This notice is effective on January 1, 2007.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786–6390. For case-mix analysis only: Gregory J. Savord, (410) 786–1521.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1813 of the Social Security Act (the Act) provides for an inpatient hospital deductible to be subtracted from the amount payable by Medicare for inpatient hospital services furnished to a beneficiary. It also provides for certain coinsurance amounts to be subtracted from the amounts payable by Medicare for inpatient hospital and extended care services. Section 1813(b)(2) of the Act requires us to determine and publish, between September 1 and September 15 of each year, the amount of the inpatient hospital deductible and the hospital and extended care services coinsurance amounts applicable for services furnished in the following calendar year.

II. Computing the Inpatient Hospital Deductible for CY 2007

Section 1813(b) of the Act prescribes the method for computing the amount of the inpatient hospital deductible. The inpatient hospital deductible is an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by our best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B) of the Act) used for updating the payment rates to hospitals for discharges in the fiscal year (FY) that begins on October 1 of the same preceding calendar year, and adjusted to reflect real case-mix. The adjustment to reflect real case-mix is determined on the basis of the most recent case-mix data available. The amount determined under this formula is rounded to the nearest multiple of $4 (or, if midway between two multiples of $4, to the next higher multiple of $4).

Under section 1886(b)(3)(B)(i) of the Act, the percentage increase used to update the payment rates for FY 2007 for inpatient hospitals paid under the prospective payment system is the market basket percentage increase. Under section 1886(b)(3)(B)(viii) of the Act, hospitals will receive the full market basket update only if they submit quality data as specified by the Secretary. Those hospitals that do not submit data will receive an update of market basket minus 2.0 percentage points. We are estimating that after including the impact of those hospitals receiving the lower update in the payment-weighted average update, the calculated deductible will remain the same.

Under section 1886(b)(3)(B)(ii) of the Act, the percentage increase used to update the payment rates for FY 2007 for hospitals excluded from the prospective payment system is the market basket percentage increase, defined according to section 1886(b)(3)(B)(iii) of the Act.

The market basket percentage increase for 2007 is 3.4 percent, as announced in the final rule published in the **Federal Register** entitled ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates'' (71 FR 47870). Therefore, the percentage increase for hospitals paid under the prospective payment system is 3.4 percent. The average payment percentage increase for hospitals excluded from the prospective payment system is 3.4 percent. Weighting these percentages in accordance with payment volume, our best estimate of the payment-weighted average of the increases in the payment rates for FY 2007 is 3.4 percent.

To develop the adjustment for real case-mix, we first calculated for each hospital an average case-mix that reflects the relative costliness of that hospital's mix of cases compared to those of other hospitals. We then computed the change in average case-mix for hospitals paid under the Medicare prospective payment system in FY 2006 compared to FY 2005. (We excluded from this calculation hospitals excluded from the prospective payment system because their payments are based on reasonable costs.) We used Medicare bills from prospective payment hospitals that we received as of July 2006. These bills represent a total of about 9.1 million Medicare discharges for FY 2006 and provide the most recent case-mix data available at this time. Based on these bills, the change in average case-mix in FY 2006 is 0.68 percent. Based on past experience, we expect the overall case-mix change to be 0.8 percent as the year progresses and more FY 2006 data become available.

Section 1813 of the Act requires that the inpatient hospital deductible be adjusted only by that portion of the case-mix change that is determined to be real. We estimate that the change in real case-mix for FY 2006 is 0.8 percent.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 3.4 percent, and the real case-mix adjustment factor for the deductible is 0.8 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in CY 2007 is $992. This deductible amount is determined by multiplying $952 (the inpatient hospital deductible for CY 2006) by the payment-weighted average increase in the payment rates of 1.034 multiplied by the increase in real case-mix of 1.008, which equals $992.24 and is rounded to $992.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for 2007

The coinsurance amounts provided for in section 1813 of the Act are defined as fixed percentages of the inpatient hospital deductible for services furnished in the same calendar year. Thus, the increase in the deductible generates increases in the coinsurance amounts. For inpatient hospital and extended care services furnished in CY 2007, in accordance with the fixed percentages defined in the law, the daily coinsurance for the 61st through 90th day of hospitalization in a benefit period will be $248 (one-fourth of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be $496 (one-half of the inpatient hospital deductible); and the daily coinsurance for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period will be $124 (one-eighth of the inpatient hospital deductible).

IV. Cost to Medicare Beneficiaries

Table 1 summarizes the deductible and coinsurance amounts for CYs 2006 and 2007, as well as the number of each that is estimated to be paid.

TABLE 1.—PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CALENDAR YEARS 2006 AND 2007

Type of cost sharing	Value		Number paid (in millions)	
	2006	2007	2006	2007
Inpatient hospital deductible	952	992	8.91	8.85
Daily coinsurance for 61st–90th Day	238	248	2.31	2.30
Daily coinsurance for lifetime reserve days	476	496	1.08	1.08
SNF coinsurance	119	124	37.08	38.03

The estimated total increase in costs to beneficiaries is about $640 million (rounded to the nearest $10 million), due to: (1) The increase in the deductible and coinsurance amounts and (2) the change in the number of deductibles and daily coinsurance amounts paid.

V. Waiver of Proposed Notice and Comment Period

The Medicare statute, as discussed previously, requires publication of the

Medicare Part A inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services for each calendar year. The amounts are determined according to the statute. As has been our custom, we use general notices, rather than notice and comment rulemaking procedures, to make the announcements. In doing so, we acknowledge that, under the Administrative Procedure Act (APA), interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice are excepted from the requirements of notice and comment rulemaking.

We considered publishing a proposed notice to provide a period for public comment. However, we may waive that procedure if we find good cause that prior notice and comment are impracticable, unnecessary, or contrary to the public interest. We find that the procedure for notice and comment is unnecessary because the formulae used to calculate the inpatient hospital deductible and hospital and extended care services coinsurance amounts are statutorily directed, and we can exercise no discretion in following those formulae. Moreover, the statute establishes the time period for which the deductible and coinsurance amounts will apply and delaying publication would be contrary to the public interest. Therefore, we find good cause to waive publication of a proposed notice and solicitation of public comments.

VI. Regulatory Impact Statement

We have examined the impacts of this notice 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 Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

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). As stated in Section IV of this notice, we estimate that the total increase in costs to beneficiaries associated with this notice is about $640 million due to: (1) The increase in the deductible and coinsurance amounts and (2) the change in the number of deductibles and daily coinsurance amounts paid. Therefore, this notice is a major rule as defined in Title 5, United States Code, section 804(2), and is an economically significant rule under Executive Order 12866.

The RFA requires agencies to analyze options for regulatory relief of small entities. 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. We have determined that this notice will not have a significant economic impact on a substantial number of small entities. Therefore we are not preparing an analysis for the RFA.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We have determined that this notice will not have a significant effect on the operations of a substantial number of small rural hospitals. Therefore, we are not preparing an analysis for section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $120 million. This notice has no consequential effect on State, local, or tribal governments or on the private sector. However, States are required to pay premiums for dually-eligible beneficiaries.

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. This notice has no consequential effect on State or local governments.

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

Authority: Sections 1813(b)(2) of the Social Security Act (42 U.S.C. 1395e–2(b)(2)).

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

Dated: September 11, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 12, 2006.

Michael O. Leavitt,

Secretary.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5042–N]

RIN 0938–ZA90

Medicare Program: Solicitation for Proposals To Participate in the Medicare Hospital Gainsharing Demonstration Program Under Section 5007 of the Deficit Reduction Act

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

ACTION: Notice.

SUMMARY: This notice is to inform interested parties of an opportunity to apply to participate in the Medicare Hospital Gainsharing Demonstration being implemented by CMS. The Medicare Hospital Gainsharing Demonstration authorized under Section 5007 of the Deficit Reduction Act (DRA) of 2005 was established to test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work. The purpose of this demonstration is to improve the quality and efficiency of care provided to Medicare beneficiaries and to develop improved operational and financial hospital performance with the sharing of remuneration payments between hospitals and physicians in six projects, each project consisting of one hospital. Two projects must be rural. This demonstration will be limited in scope: we intend to focus on the short-term impacts of gainsharing programs.

DATES: Applications will be considered timely if we receive them no later than 5 p.m., Eastern Standard Time (E.S.T.), on November 17, 2006.

FOR FURTHER INFORMATION CONTACT: Lisa Waters at (410) 786–6615 or *GAINSHARING@cms.hhs.gov.* Interested parties can obtain a complete solicitation, application, and supporting information on the following CMS Web sites at *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1186805* or