Agenda items for these meetings are subject to change as priorities dictate.

Dated: September 15, 2008.

Carolyn M. Clancy,

Director.

[FR Doc. E8–22132 Filed 9–23–08; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Board of Scientific Counselors, National Center for Environmental Health/Agency for Toxic Substances and Disease Registry (BSC, NCEH/ATSDR)

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), CDC announces the following meetings for the aforementioned committee:

Times and Dates: 8:30 a.m.–4:30 p.m., November 6, 2008. 8:30 a.m.–12:00 p.m., November 7, 2008.

Place: Marriott Century Center Hotel, 2000 Century Boulevard, Chamblee, Georgia 30341.

Status: Open to the public, limited only by the space available. The meeting room accommodates approximately 75 people.

Purpose: The Secretary, Department of Health and Human Services (HHS) and by delegation, the Director, CDC, and Administrator, NCEH/ATSDR, are authorized under Section 301 (42 U.S.C. 241) and Section 311 (42 U.S.C. 243) of the Public Health Service Act, as amended, to: (1) Conduct, encourage, cooperate with, and assist other appropriate public authorities, scientific institutions, and scientists in the conduct of research, investigations, experiments, demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and other impairments; (2) assist states and their political subdivisions in the prevention of infectious diseases and other preventable conditions and in the promotion of health and well being; and (3) train state and local personnel in health work. The BSC, NCEH/ATSDR provides advice and guidance to the Secretary, HHS; the Director, CDC; the Administrator, ATSDR; and the Director, NCEH/ATSDR, regarding program goals, objectives, strategies, and priorities in fulfillment of the agency's mission to protect and promote people's health. The board provides advice and guidance that will assist NCEH/ATSDR in ensuring scientific quality, timeliness, utility, and dissemination of results. The board also provides guidance to help NCEH/ATSDR work more efficiently and effectively with its various constituents and to fulfill its mission in protecting America's health.

Matters To Be Discussed: An update on NCEH/ATSDR's Office of the Director; updates on NCEH/ATSDR work on Formaldehyde and FEMA Trailers; discussion of the findings on the BSC Program Peer Review of NCEH/ATSDR's internal clearance and external peer review processes and policies; a presentation of the response to the Preparedness and Emergency Response Peer Review Report from the Office of Terrorism Preparedness and Emergency Response; updates on public health issues: selenium poisoning associated with an over-the-counter dietary supplement; exercising the response capability of CDC and the Laboratory Response Network to test 10,000 clinical samples for nerve agent exposure; and vapor intrusion activities at hazardous waste sites.

Agenda items are tentative and subject to change.

Contact Person for More Information: Sandra Malcom, Committee Management Specialist, NCEH/ATSDR, 4770 Buford Highway, Mail Stop F–61, Chamblee, Georgia 30345; Telephone (770) 488–0575, Fax (770) 488–3377; *E-mail: smalcom@cdc.gov.* The deadline for notification of attendance is October 31, 2008.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: September 16, 2008.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. E8–22346 Filed 9–23–08; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Safety and Occupational Health Study Section (SOHSS), National Institute for Occupational Safety and Health (NIOSH)

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the following meetings for the aforementioned committee:

Times and Dates: 8 a.m.–5 p.m., October 14, 2008 (Closed). 8 a.m.–5 p.m., October 15, 2008 (Closed).

Place: Embassy Suites Hotel, 1900 Diagonal Road, Alexandria, Virginia 22314, Telephone (703) 684–5900, Fax (703)684–1403.

Status: This meeting will be closed to the public in accordance with provisions set forth in Section 552b(c)(4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, Centers for Disease Control and Prevention, pursuant to Section 10(d) Public Law 92–463.

Purpose: The Safety and Occupational Health Study Section will review, discuss, and evaluate grant application(s) received in response to the Institute's standard grants review and funding cycles pertaining to research issues in occupational safety and health, and allied areas.

It is the intent of NIOSH to support broad-based research endeavors in keeping with the Institute's program goals. This will lead to improved understanding and appreciation for the magnitude of the aggregate health burden associated with occupational injuries and illnesses, as well as to support more focused research projects, which will lead to improvements in the delivery of occupational safety and health services, and the prevention of work-related injury and illness. It is anticipated that research funded will promote these program goals.

Matters To Be Discussed: The meeting will convene to address matters related to the conduct of study section business and for the study section to consider safety and occupational health-related grant applications.

Agenda items are subject to change as priorities dictate.

Contact Person for More Information: Price Connor, Ph.D., NIOSH Health Scientist, 1600 Clifton Road, NE., Mailstop E–20, Atlanta, Georgia 30333, Telephone (404)498–2511, Fax (404)498–2571.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: September 16, 2008.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. E8–22344 Filed 9–23–08; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8034–N]

RIN 0938–AP03

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for Calendar Year 2009

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) 2009 under Medicare's Hospital Insurance

program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts. For CY 2009, the inpatient hospital deductible will be $1068. The daily coinsurance amounts for CY 2009 will be: (a) $267 for the 61st through 90th day of hospitalization in a benefit period; (b) $534 for lifetime reserve days; and (c) $133.50 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, 2009.

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

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 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 CY.

II. Computing the Inpatient Hospital Deductible for CY 2009

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 CY, adjusted 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 CY, 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 2009 for hospitals paid under the inpatient prospective payment system is the market basket percentage increase, otherwise known as the market basket update. 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. The market basket update for hospitals that do not submit this data is reduced by 2.0 percentage points. We are estimating that after accounting for those hospitals receiving the lower market basket 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 2009 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 2009 is 3.6 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 2009 Rates'' (73 FR 48434, August 19, 2008). Therefore, the percentage increase for hospitals paid under the prospective payment system is 3.6 percent. The average payment percentage increase for hospitals excluded from the prospective payment system is 3.5 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 2009 is 3.6 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 2008 compared to FY 2007. (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 2008. These bills represent a total of about 8.9 million Medicare discharges for FY 2008 and provide the most recent case-mix data available at this time. Based on these bills, the change in average case-mix in FY 2008 is 1.55 percent. Based on these bills and past experience, we expect the overall case mix change to be 1.75 percent as the year progresses and more FY 2008 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. In the FY 2008 IPPS final rule with comment period, we indicated that we believe the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for improved documentation and coding. In that final rule, we estimated that changes in coding or classification that do not reflect real change in case-mix would be 1.2 percent for FY 2008. Therefore, since we are expecting overall case mix to increase by 1.75 percent and 1.2 percent of that to be caused by coding changes, real case mix changes resulted in an increase of 0.55 percent for FY 2008.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 3.6 percent, and the real case-mix adjustment factor for the deductible is 0.55 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in CY 2009 is $1068. This deductible amount is determined by multiplying $1024 (the inpatient hospital deductible for CY 2008) by the payment-weighted average increase in the payment rates of 1.036 multiplied by the increase in real case-mix of 1.0055, which equals $1066.70 and is rounded to $1068.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for CY 2009

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 CY. Thus, the increase in the deductible generates increases in the coinsurance amounts. For inpatient hospital and extended care services furnished in CY 2009, 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 $267 (one-fourth of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be $534 (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 $133.50 (one-eighth of the inpatient hospital deductible).

IV. Cost to Medicare Beneficiaries

Table 1 summarizes the deductible and coinsurance amounts for CYs 2008 and 2009, as well as the number of each that is estimated to be paid.

TABLE 1—PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CALENDAR YEARS 2008 AND 2009

Type of cost sharing	Value		Number paid (in millions)	
	2008	2009	2008	2009
Inpatient hospital deductible	$1024	$1068	8.54	8.53
Daily coinsurance for 61st–90th day	256	267	2.22	2.22
Daily coinsurance for lifetime reserve days	512	534	1.06	1.06
SNF coinsurance	128	133.50	39.66	40.05

The estimated total increase in costs to beneficiaries is about $680 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 CY. 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 the 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. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

VII. Regulatory Impact Statement

We have examined the impact of this rule as required by Executive Order 12866 on regulatory planning and review (September 30 1993), as further amended, the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 (as amended by Executive Orders 13258 and 13422) 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). As stated in section IV of this notice, we estimate that the total increase in costs to beneficiaries associated with this notice is about $680 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 businesses, if a rule has a significant impact on a substantial number 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 $6.5 million to $31.5 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. Therefore, the Secretary has determined that this notice will not have a significant impact 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 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2008, that threshold is approximately $130 million. This notice has no consequential effect on State, local, or tribal governments or on the private sector. However, States may be required to pay the deductibles and coinsurance 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 will not have a substantial effect on State or local governments.

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

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

Dated: August 28, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: September 5, 2008.

Michael O. Leavitt,

Secretary.

[FR Doc. E8–22310 Filed 9–19–08; 9:00 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8036–N]

RIN 0938–APOO

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2009

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

ACTION: Notice.

SUMMARY: This notice announces the monthly actuarial rates for aged (age 65 and over) and disabled (under age 65) beneficiaries enrolled in Part B of the Medicare Supplementary Medical Insurance (SMI) program beginning January 1, 2009. In addition, this notice announces the monthly premium for aged and disabled beneficiaries as well as the income-related monthly adjustment amounts to be paid by beneficiaries with modified adjusted gross income above certain threshold amounts. The monthly actuarial rates for 2009 are $192.70 for aged enrollees and $224.20 for disabled enrollees. The standard monthly Part B premium rate for 2009 is $96.40, which is equal to 50 percent of the monthly actuarial rate for aged enrollees or approximately 25 percent of the expected average total cost of Part B coverage for aged enrollees. (The 2008 standard premium rate was also $96.40.) The Part B deductible for 2009 is $135.00 for all Part B beneficiaries. If a beneficiary has to pay an income-related monthly adjustment, they may have to pay a total monthly premium of about 35, 50, 65, or 80 percent of the total cost of Part B coverage.

DATES: *Effective Date:* January 1, 2009.

FOR FURTHER INFORMATION CONTACT: M. Kent Clemens, (410) 786–6391.

SUPPLEMENTARY INFORMATION:

I. Background

Part B is the voluntary portion of the Medicare program that pays all or part of the costs for physicians' services, outpatient hospital services, certain home health services, services furnished by rural health clinics, ambulatory surgical centers, comprehensive outpatient rehabilitation facilities, and certain other medical and health services not covered by Medicare Part A, Hospital Insurance. Medicare Part B is available to individuals who are entitled to Medicare Part A, as well as to U.S. residents who have attained age 65 and are citizens, and aliens who were lawfully admitted for permanent residence and have resided in the United States for 5 consecutive years. Part B requires enrollment and payment of monthly premiums, as provided for in 42 CFR part 407, subpart B, and part 408, respectively. The difference between the premiums paid by all enrollees and total incurred costs is met by payments from the Supplementary Medical Insurance Fund.

The Secretary of the Department of Health and Human Services (the Secretary) is required by section 1839 of the Social Security Act (the Act) to announce the Part B monthly actuarial rates for aged and disabled beneficiaries as well as the monthly Part B premium. The Part B annual deductible is included because its determination is directly linked to the aged actuarial rate.

The monthly actuarial rates for aged and disabled enrollees are used to determine the correct amount of general revenue financing per beneficiary each month. These amounts, according to actuarial estimates, will equal, respectively, one-half the expected average monthly cost of Part B for each aged enrollee (age 65 or over) and one-half the expected average monthly cost of Part B for each disabled enrollee (under age 65).

The Part B deductible to be paid by enrollees is also announced. Prior to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173), the Part B deductible was set in statute. After setting the 2005 deductible amount at $110.00, section 629 of the MMA (amending section 1833(b) of the Act) requires that the Part B deductible be indexed beginning in 2006. The inflation factor to be used each year is the annual percentage increase in the Part B actuarial rate for enrollees age 65 and over. Specifically, the 2009 Part B deductible is calculated by multiplying the 2008 deductible by the ratio of the 2009 aged actuarial rate over the 2008 aged actuarial rate. The amount determined under this formula is then rounded to the nearest $1.

The monthly Part B premium rate to be paid by aged and disabled enrollees is also announced. (Although the costs to the program per disabled enrollee are different than for the aged, the statute provides that they pay the same premium amount.) Beginning with the passage of section 203 of the Social Security Amendments of 1972 (Pub. L. 92–603), the premium rate, which was determined on a fiscal year basis, was limited to the lesser of the actuarial rate for aged enrollees, or the current monthly premium rate increased by the same percentage as the most recent general increase in monthly Title II social security benefits.

However, the passage of section 124 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) suspended this premium determination process. Section 124 of TEFRA changed the premium basis to 50 percent of the monthly actuarial rate for aged enrollees (that is, 25 percent of program costs for aged enrollees). Section 606 of the Social Security Amendments of 1983 (Pub. L. 98–21), section 2302 of the Deficit Reduction Act of 1984 (DEFRA 84) (Pub. L. 98–369), section 9313 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 85) (Pub. L. 99–272), section 4080 of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) (Pub. L. 100–203), and section 6301 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) (Pub. L. 101–239) extended the provision that the premium be based on 50 percent of the monthly actuarial rate for aged enrollees (that is, 25 percent of program costs for aged enrollees). This extension expired at the end of 1990.

The premium rate for 1991 through 1995 was legislated by section 1839(e)(1)(B) of the Act, as added by section 4301 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) (Pub. L. 101–508). In January 1996, the premium determination basis would have reverted to the method established by the 1972 Social Security Act Amendments. However, section 13571