Board of Governors of the Federal Reserve System, October 20, 2003.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc.03–26913 Filed 10–23–03; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Grant Award to Promote Reverse Mortgages for Long-Term Care

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

ACTION: Notice of grant award.

SUMMARY: The Centers for Medicare & Medicaid Services has awarded a grant entitled ''A Public-Private Partnership to Promote Reverse Mortgages for Long-Term Care'' to the National Council on the Aging (NCOA), 300 D Street SW., Suite 801, Washington, DC 20024, in response to an unsolicited application. The NCOA proposes to work with leaders from the private sector and government to develop a national blueprint for increasing the use of reverse mortgages for long-term care. The total amount of the award is $295,000 for the period September 30, 2003 through May 30, 2004. The encouragement of reverse mortgages as a means of private sector financing of long-term care expenses for the elderly is a priority issue for DHHS, CMS. Funding of this unsolicited proposal will result in a desirable public benefit based on NCOA's extensive specialized expertise in evaluating long-term care services and financing. The NCOA has a professional staff that is dedicated to understanding the myriad of state and Federal regulations that affect long-term care. NCOA also has many years of experience in defining and developing long-term care issues.

FOR FURTHER INFORMATION CONTACT: Tom Kornfield, Project Officer, Department of Health and Human Services, Centers for Medicare & Medicaid Services, DHSR/ORDI, C3–20–17, 7500 Security Boulevard, Baltimore, Maryland, 21244, (410) 786–8263, or Judith Norris, Grants Officer, Department of Health and Human Services, OICS/AGG/CMS, C2–21–15, 7500 Security Boulevard, Baltimore, Maryland, 21244, (410) 786–5130.

Authority: (Catalog of Federal Domestic Assistance Program No. 93.779, Center for Medicare & Medicaid Services, Research, Demonstrations and Evaluations) Section 110 of the Social Security Act.

Dated: October 2, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 03–26458 Filed 10–23–03; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8016–N]

RIN 0938–AM31

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 2004

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 2004 under Medicare's Hospital Insurance program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts.

The inpatient hospital deductible will be $876. The daily coinsurance amounts will be: (a) $219 for the 61st through 90th day of hospitalization in a benefit period; (b) $438 for lifetime reserve days; and (c) $109.50 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

EFFECTIVE DATE: This notice is effective on January 1, 2004.

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 2004

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 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 fiscal year 2004 for hospitals paid under the prospective payment system is the market basket percentage increase.

Under section 1886(b)(3)(B)(ii) of the Act, the percentage increase used to update the payment rates for fiscal year 2004 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 fiscal year 2004 is 3.4 percent, as announced in the final rule titled ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates,'' published in the **Federal Register** on August 1, 2003 (68 FR 45346). 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 fiscal year 2004 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 fiscal year 2003 compared to fiscal year 2002. (We excluded from this calculation hospitals excluded from the prospective payment system because their payments are based on reasonable costs. We used bills from prospective payment hospitals received in CMS as of July 2003. These bills represent a total of about 9.0 million discharges for fiscal year 2003 and provide the most recent case mix data available at this time. Based on these bills, the change in average case mix in fiscal year 2003 is 0.87 percent. Based on past experience, we expect the overall case mix change to be 1 percent as the year progresses and more fiscal year 2003 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 fiscal year 2003 is 1 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 1 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in calendar year 2004 is $876. This deductible amount is determined by multiplying $840 (the inpatient hospital deductible for 2003) by the payment-weighted average increase in the payment rates of 1.034 multiplied by the increase in real case mix of 1.01, which equals $877 and is rounded to $876.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for 2004

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 2004, 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 $219 (one-fourth of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be $438 (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 $109.50 (one-eighth of the inpatient hospital deductible).

IV. Cost to Beneficiaries

Table 1 summarizes the deductible and coinsurance amounts for 2003 and 2004, as well as the number of each that is estimated to be paid.

TABLE 1.—PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CALENDAR YEARS 2003 AND 2004

Type of Cost Sharing	Value		Number paid (in millions)	
	2003	2004	2003	2004
Inpatient hospital deductible	$840	$876	9.22	9.40
Daily coinsurance for 61st–90th Day	210	219	2.46	2.50
Daily coinsurance for lifetime reserve days	420	438	1.14	1.16
SNF coinsurance	105.00	109.50	27.73	28.18

The estimated total increase in cost to beneficiaries is about $720 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, 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 16, 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 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, we estimate that the total increase in costs to beneficiaries associated with this notice is about $720 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. For purposes of the RFA, States and individuals are not considered small entities. 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 notice 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 expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This notice has no consequential effect on State, local, or tribal governments or on the 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. This notice has no consequential 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.

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 12, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 3, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–26455 Filed 10–16–03; 10:06 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8017–N]

RIN 0938–AM91

Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Beginning January 1, 2004

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

ACTION: Notice.

SUMMARY: In accordance with section 1839 of the Social Security Act (the Act), this notice announces the monthly actuarial rates for aged (age 65 and over) and disabled (under age 65) enrollees in the Medicare Supplementary Medical Insurance (SMI) (Medicare Part B) program for 2004. It also announces the monthly SMI premium to be paid by all enrollees during 2004. The monthly actuarial rates for 2004 are $133.20 for aged enrollees and $175.50 for disabled enrollees. The monthly SMI premium for 2004 is $66.60. (The 2003 premium was $58.70.) The 2004 Part B premium is equal to 50 percent of the monthly actuarial rate. Included in the monthly premium is $3.02 for home health services transferred into Part B.

EFFECTIVE DATE: January 1, 2004.

FOR FURTHER INFORMATION CONTACT: Carter S. Warfield, (410) 786–6396.

SUPPLEMENTARY INFORMATION:

I. Background

The Medicare Supplementary Medical Insurance (SMI) (Medicare Part B) program is the voluntary program that pays all or part of the costs for physicians' services, outpatient hospital services, 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 hospital insurance (HI) (Medicare Part A). The SMI program is available to individuals who are entitled to HI and to U.S. residents who have attained age 65 and are citizens, or aliens who were lawfully admitted for permanent residence and have resided in the United States for 5 consecutive years. This program requires enrollment and payment of monthly premiums, as provided 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 from the general revenues of the Federal Government.

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 issue two annual notices relating to the SMI program.

One notice announces two amounts that, according to actuarial estimates, will equal respectively, one-half the expected average monthly cost of SMI for each aged enrollee (age 65 or over) and one-half the expected average monthly cost of SMI for each disabled enrollee (under age 65) during the year beginning the following January. These amounts are called ''monthly actuarial rates.''

The second notice announces the monthly SMI premium to be paid by aged and disabled enrollees for the year beginning the following January. (Although the costs to the program per disabled enrollee are different than for the aged, the law 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, 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 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