Medicare Provider #230019
Saint Joseph Medical Center
Creighton University Medical Center
601 North 30th Street
Omaha, NE 68131–2197
Medicare Provider #280030
Shasta Regional Medical Center
1100 Butte Street
Redding, CA 96001
Medicare Provider #050733
South Jersey Healthcare
1505 West Sherman Avenue
Vineland, NJ 08360
Medicare Provider #310032
St. Joseph's Hospital
69 West Exchange Street
St. Paul, MN 55102
Medicare Provider #240063
St. Mary's Hospital
1601 West St. Mary's Road
Tucson, AZ 85745
Medicare Provider #030010
Trident Medical Center
9330 Medical Plaza Drive
Charleston, SC 29406
Medicare Provider #420079
University of Iowa Hospitals and Clinics
Neurointerventional Radiology
Department of Radiology
200 Hawkins Drive
Iowa City, IA 52242
Medicare Provider #160058
Venice Regional Medical Center
540 The Rialto
Venice, FL 34285
Medicare Provider #100070
Virginia Mason Medical Center
1100 Ninth Avenue
P.O. Box 98111
Seattle, WA 98111
Medicare Provider #500005
WellStar Cobb Hospital
805 Sandy Plains Road
Marietta, GA 30060
Medicare Provider #110143
WellStar Kennestone Hospital
805 Sandy Plains Road
Marietta, GA 30060
Medicare Provider #110035

June 29, 2005

Arkansas Heart Hospital
1701 S. Shackleford Road
Little Rock, AR 72211
Medicare Provider #040134
Baptist Healthcare of Oklahoma, Inc.
d/b/a INTEGRIS Bass Baptist Health Center
600 S. Monroe
P.O. Box 3168
Enid, OK 73702
Medicare Provider #370016
Boca Raton Community Hospital
800 Meadows Road
Boca Raton, FL 33486
Medicare Provider #100168
Carolinas Medical Center
1000 Blythe Blvd
Charlotte, NC 28203
Medicare Provider #340113
Decatur Memorial Hospital
2300 North Edward Street
Decatur, IL 62526
Medicare Provider #140135
Doctors Community Hospital
8118 Good Luck Road
Lanham, MD 20706–3586
Medicare Provider #210051
Duke University Medical Center
Department of Radiology
P.O. Box 3808
Durham, NC 27710
Medicare Provider #340030
Heartland Health
5325 Faraon Street
St. Joseph, MO 64506–3398
Medicare Provider #260006
INTEGRIS Baptist Medical Center, Inc.
3300 Northwest Expressway
Oklahoma City, OK 73112
Medicare Provider #370028
Lehigh Valley Hospital
Muhlenberg Campus
2545 Schoenersville Road
Bethlehem, PA 18017
Medicare Provider #390263
McLaren Regional Medical Center
401 South Ballenger Highway
Flint, MI 48532–3685
Medicare Provider #230141
Mountain States Health Alliance
400 North State of Franklin Road
Johnson City, TN 37604–6094
Medicare Provider #440063
New York University Medical Center
550 First Avenue, HCC–15
New York, NY 10016–6481
Medicare Provider #330214
Overlook Hospital
99 Beauvoir Avenue
P.O. Box 220
Summit, NJ 07802–0220
Medicare Provider #310051
Saint Marys Hospital
1216 Second Street S.W.
Rochester, MN 55902
Medicare Provider #240010
Sarasota Memorial Hospital
1700 S. Tamiami Trail
Sarasota, FL 34239
Medicare Provider #100087
Shands Hospital at the University of Florida
P.O. Box 100326
Gainesville, FL 32610–0326
Medicare Provider #100113
Sisters of Charity Hospital
2157 Main Street
Buffalo, NY 14214
Medicare Provider #330078
St. Luke's Hospital
4202 Belfort Road
Jacksonville, FL 32216–5898
Medicare Provider #100151
University Medical Center
602 Indiana Avenue
Lubbock, TX 79415
Medicare Provider #450686
Vanderbilt University Medical Center
D–3300 Medical Center North
Nashville, TN 37232–2104
Medicare Provider #440039
West Virginia University Hospitals, Inc.
Medical Center Drive
P.O. Box 8059
Morgantown, WV 36506
Medicare Provider #510001

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BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8026–N]

RIN 0938–AO00

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for Calendar Year 2006

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) 2006 under Medicare's Hospital Insurance program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts.

For CY 2006, the inpatient hospital deductible will be $952. The daily coinsurance amounts for CY 2006 will be: (a) $238 for the 61st through 90th day of hospitalization in a benefit period; (b) $476 for lifetime reserve days; and (c) $119.00 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, 2006.

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 2006

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 2006 for inpatient hospitals paid under the prospective payment system is the market basket percentage increase. Under section 501 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 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 .4 percentage points. In determining the payment-weighted average of the updates to payment rates to hospitals in FY 2006, we are estimating that the payment to hospitals not submitting quality data will be insignificant.

Under section 1886(b)(3)(B)(ii) of the Act, the percentage increase used to update the payment rates for FY 2006 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 2006 is 3.7 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 2006 Rates'' (70 FR 47278). Therefore, the percentage increase for hospitals paid under the prospective payment system is 3.7 percent. The average payment percentage increase for hospitals excluded from the prospective payment system is 3.8 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 2006 is 3.7 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 2005 compared to FY 2004. (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 2005. These bills represent a total of about 9.5 million Medicare discharges for FY 2005 and provide the most recent case-mix data available at this time. Based on these bills, the change in average case-mix in FY 2005 is 0.15 percent. Based on past experience, we expect the overall case-mix change to be 0.45 percent as the year progresses and more FY 2005 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 2005 is .45 percent.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 3.7 percent, and the real case-mix adjustment factor for the deductible is .45 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in CY 2006 is $952. This deductible amount is determined by multiplying $912 (the inpatient hospital deductible for CY 2005 by the payment-weighted average increase in the payment rates of 1.037 multiplied by the increase in real case-mix of 1.0045, which equals $950 and is rounded to $952.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for 2006

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 2006, 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 $238 (one-fourth of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be $476 (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 $119.00 (one-eighth of the inpatient hospital deductible).

IV. Cost to Medicare Beneficiaries

Table 1 summarizes the deductible and coinsurance amounts for CYs 2005 and 2006, as well as the number of each that is estimated to be paid.

TABLE 1.—PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CALENDAR YEARS 2005 AND 2006

Type of cost sharing	Value		Number paid (in millions)	
	2005	2006	2005	2006
Inpatient hospital deductible	$912	$952	8.91	8.70
Daily coinsurance for 61st-90th Day	228	238	2.28	2.23
Daily coinsurance for lifetime reserve days	456	476	1.06	1.04
SNF coinsurance	114.00	119.00	32.84	31.92

The estimated total increase in costs to beneficiaries is about $230 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, which merely reassigns responsibility of duties) 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 $230 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 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 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 12, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 15, 2005.

Michael O. Leavitt,

Secretary.

[FR Doc. 05–18838 Filed 9–16–05; 4:00 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1307–GNC]

RIN 0938–ZA74

Medicare Program; Criteria and Standards for Evaluating Intermediary, Carrier, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Regional Carrier Performance During Fiscal Year 2006

AGENCY: Centers for Medicare and Medicaid Services (CMS), Health and Human Services (HHS).

ACTION: General notice with comment period.

SUMMARY: This notice describes the criteria and standards to be used for evaluating the performance of fiscal intermediaries (FIs), carriers, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) regional carriers in the administration of the Medicare program beginning on the first day of the first month following publication of this notice in the **Federal Register**. The results of these evaluations are considered whenever we enter into, renew, or terminate an intermediary agreement, carrier contract, or DMEPOS regional carrier contract or take other contract actions, for example, assigning or reassigning providers or services to an intermediary or designating regional or national intermediaries. We are requesting public comment on these criteria and standards.

DATES: *Effective Date:* The criteria and standards are effective on October 24, 2005.

Comment Date: To be assured consideration, comments must be received at one of the addresses