Provider No.	Wage index 4/1/2007–9/30/2007
230236	1.0797
230254	1.0602
230269	1.0602
230270	1.0440
230273	1.0440
230277	1.0602
250002	0.8461
250122	0.8461
270023	0.8956
270032	0.8956
270057	0.8956
310021	1.3113
310028	1.3113
310051	1.3113
310060	1.3113
310115	1.3113
310120	1.3113
330049	1.3113
330106	1.4779
330126	1.3113
330135	1.3113
330205	1.3113
330209	1.2730
330264	1.2730
340002	0.9413
350002	0.8367
350003	0.8367
350006	0.8367
350010	0.8367
350014	0.8367
350015	0.8367
350017	0.8367
350030	0.8367
380090	1.1162
390001	0.9990
390003	0.9990
390045*	0.9990
390054	0.9942
390072	0.9990
390095	0.9990
390119	0.9990
390137	0.9990
390169	0.9990
390185	0.9942
390192	0.9990
390237	0.9990
390270	0.9942
430005	0.8708
430015	0.9238
430048	0.9238
430060	0.9238
430064	0.9238
430077	0.9238
430091	0.9238
450010	0.8794
450072	1.0094
450591	1.0094
470003	1.1343
490001	0.8600
530015	1.0060

*This hospital is assigned a wage index value under a special exceptions policy (69 FR 49105).

III. Regulatory Impact Statement

We have examined the impact of this notice using the requirements of Executive Order 12866 (September 1993, Regulatory Planning and Review), 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). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This notice implements a statutory provision that would increase payments to hospitals by less than $100 million and is therefore not a major rule.

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. Again, although we do not consider this notice to be a rule subject to notice and comment rulemaking, we note that this notice does not impose any costs on State or local governments. Therefore, the requirements of Executive Order 13132 would not be applicable.

Section 106 of the Tax Relief and Health Care Act of 2006 extends any geographic reclassification that was set to expire on March 31, 2007 by six months until September 30, 2007. We estimate the impact of this provision will be to increase payments to hospitals by $80 million.

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

Authority: Section 106 of Public Law 109–432.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: March 8, 2007.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E7–5298 Filed 3–22–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4083–NR]

Medicare Program; Applicability of Part 405 Medicare Appeals Council Own Motion Review Provisions to the Part 423 Medicare Prescription Drug (Part D) Appeals Process

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

ACTION: Notice of CMS Ruling.

SUMMARY: This notice announces a CMS Ruling that establishes a process for own motion review of Medicare Prescription Drug Program (Part D) cases by the Medicare Appeals Council.

FOR FURTHER INFORMATION CONTACT: Arrah Tabe-Bedward, (410) 786–7129 or Kathryn McCann Smith, (410) 786–7623.

SUPPLEMENTARY INFORMATION: The CMS Acting Administrator signed Ruling CMS–4083–NR on March 15, 2007. The text of the CMS Ruling is as follows:

Implementation of a Process for Own Motion Review of Part D Cases by the Medicare Appeals Council

Summary: This Ruling establishes a process, consistent with the current Medicare fee-for-service (FFS) appeals rules in title 42 of the Code of Federal Regulations, part 405, subpart I, for own motion review of Part D cases by the Medicare Appeals Council. This Ruling is effective on the date the Acting Administrator signs the Ruling.

Citations: Sections 1852(g), 1860D–4(g)–(h), and 1869 of the Social Security Act (42 U.S.C. 1395w–22, 1395w–104 and 1395ff).

I. Background on Part D Appeals

Sections 1860D–4(g) and (h) of the Social Security Act (the Act) and the implementing regulations at 42 CFR part 423, subpart M, establish a Part D enrollee's right to appeal an adverse coverage determination made by a Part D plan sponsor (''plan sponsor''), as defined at 42 CFR 423.4, that results in the denial of prescription drug coverage the enrollee believes he or she is entitled to receive under the Part D program. This includes a plan sponsor's decision not to provide or pay for a Part D drug, failure to provide a coverage determination in a timely manner when a delay would adversely affect the enrollee's health, a decision concerning a tiering or non-formulary exceptions request, and a decision on the amount

of cost sharing for a drug. The appeals process establishes that enrollees who are dissatisfied with a coverage determination have the right to request that the plan sponsor conduct a redetermination of its coverage determination. The enrollee then has the right to request a reconsideration by the Part D independent review entity (IRE) if the enrollee is dissatisfied with the plan sponsor's redetermination. If the enrollee is dissatisfied with the Part D IRE's decision, and the amount in controversy (AIC) requirement is satisfied, the enrollee has the right to request an administrative law judge (ALJ) hearing. An enrollee who is dissatisfied with the ALJ's decision has the right to file a request for review with the Medicare Appeals Council (MAC). If the enrollee is dissatisfied with the MAC's decision and the AIC requirement is satisfied, the enrollee has the right to file a civil action in Federal district court.

II. Background on MAC Own Motion Review Authority

Section 1860D–4(h) of the Act provides that plan sponsors follow appeals procedures in § 1852(g)(5) of the Act that are similar to those applicable to Medicare Advantage (MA) organizations for Part C appeals. Section 1860D–4(h) is silent with respect to own motion review by the MAC. Section 1852(g)(5) provides that enrollees in MA plans who are dissatisfied with determinations regarding their Part C benefits are entitled, if they meet the amount in controversy requirement, to a hearing before the Secretary to the same extent as is provided in § 205(b) of the Act and judicial review of the Secretary's final decision as provided in § 205(g) of the Act. Section 1869(b)(1)(A) of the Act, which sets forth the requirements for FFS appeals, contains similar language to that set forth in § 1852(g)(5) and also refers to § 205(b) and (g). Again, these sections of the Act do not discuss own motion review by the MAC.

These statutory concepts are reflected in the Part D regulations at 42 CFR part 423, subpart M and the Part C regulations at 42 CFR part 422, subpart M. The Part D regulations state that, unless otherwise provided, the Part C regulations regarding appeals will apply to Part D appeals ''to the extent they are appropriate.'' 42 CFR 423.562(c). The Part D regulations regarding MAC review do not provide any guidance on own motion review and, instead, at § 423.620, explicitly state that the regulations in part 422, subpart M, regarding MAC review apply to Part D appeals ''to the extent applicable.'' The Part C regulations governing appeals at the ALJ and MAC levels provide that adjudicators apply the FFS appeals procedures in 42 CFR part 405 ''to the extent that they are appropriate.'' 42 CFR 422.562(d). Like the Part D regulations, the Part C regulations governing MAC review are silent on own motion review and state that the FFS regulations ''regarding MAC review apply to matters addressed by this subpart to the extent that they are appropriate.'' 42 CFR 422.608.

Therefore, because there is no guidance on own motion review by the MAC in the existing Part C and Part D statutory and regulatory frameworks, we look to the FFS regulations. This Ruling is intended to establish the process for own motion review of Part D cases by the MAC using the process established under the FFS regulations, as appropriate. This Ruling does not limit the authority of the Secretary to issue future rulemaking or guidance documents addressing Part D appeals issues, including the MAC's own motion review authority.

III. MAC Own Motion Review Under Part 405 and Under This Ruling

We believe that it is appropriate to provide a process for making own motion referrals to the MAC for Part D appeals so that there is a means for seeking MAC review of ALJ decisions that may warrant review. Based on the existing statutory and regulatory frameworks, and for the limited purpose of this Ruling, we look to the FFS appeals process for MAC own motion review set out in 42 CFR part 405, subpart I to assist in developing this process and determining (1) who may refer cases to the MAC, (2) the standards of referral and review, and (3) other procedural requirements.

A. Who May Refer Part D Cases to the MAC for Own Motion Review

Under 42 CFR 405.1110(a), the MAC may decide on its own motion to review a decision or dismissal by an ALJ. In addition, CMS or its contractors may refer a case to the MAC for consideration under this own motion authority if the referral is made anytime within 60 days after the date of an ALJ's decision or dismissal.

Section 1860D–4(h)(1) of the Act establishes that only a ''Part D eligible individual shall be entitled to bring such an appeal.'' Moreover, existing regulations do not provide plan sponsors with the ability to bring an appeal or afford plan sponsors party status to an appeal. Thus, plan sponsors do not have a direct right of appeal to the MAC. Similarly, the existing Part D statute and regulations do not explicitly allow either CMS or its contractors to participate in or be parties to ALJ hearings.

For purposes of this Ruling, we believe it is appropriate for the MAC to decide on its own motion to review a decision or dismissal by an ALJ. In addition, we believe that it is appropriate that only CMS or the Part D IRE make referrals to the MAC for own motion review. As a procedural matter and for efficiency, we expect that most of the referrals will be made through the Part D IRE, because it is the entity responsible for monitoring plan effectuation of favorable decisions and serves as a repository for all completed Part D ALJ cases and associated files. The Part D IRE has neither a business nor a financial interest in the outcome of a case. As such, the Part D IRE is generally in the best position to objectively examine whether a particular case meets the standard for referral. While the process established by this Ruling does not permit a plan sponsor to refer a Part D case to the MAC for own motion review, plan sponsors will continue to have the opportunity to communicate with the Part D IRE about cases that may warrant such a referral. Thus, we consider it appropriate, and consistent with part 405, subpart I, to allow the MAC to review an ALJ decision or dismissal on its own motion, and to allow only CMS or the Part D IRE to refer cases to the MAC to consider review under its own motion authority.

B. Standards for Referral and Review of Part D Cases for Own Motion Review by the MAC

With respect to the standards for referral of cases, the regulations at § 405.1110 distinguish between cases in which CMS or its contractor participated or appeared as a party in the appeal at the ALJ level and cases in which CMS or its contractor did not participate. Where CMS or its contractor did not participate or appear as a party, § 405.1110(b)(1) and (c)(2) establish that CMS or any of its contractors may refer a case to the MAC if the ALJ decision or dismissal contains an error of law material to the outcome of the claim or presents a broad policy or procedural issue that may affect the public interest. In addition to the referral standards that apply when CMS or its contractor did not participate or appear as a party, for cases in which CMS or its contractor participated or was a party at the ALJ level, § 405.1110(b)(1)(ii) and (c)(1) provide that CMS or its contractor may also refer cases for own motion review by the MAC if, in CMS' view, the ALJ

decision or dismissal is not supported by the preponderance of evidence in the record or the ALJ abused his or her discretion. Since CMS and its contractor do not have explicit authority under the existing statutes and regulations to participate in or be parties to ALJ hearings in Part D cases, we believe it is appropriate and consistent with part 405, subpart I, to allow CMS or the Part D IRE to refer Part D cases to the MAC to consider review under its own motion authority based on the standards for referral that apply when CMS or its contractor did not participate in the ALJ proceedings or appear as a party.

Similar to how § 405.1110 sets forth different referral standards depending on whether or not CMS or its contractor participate in the ALJ hearing, the regulations provide differing standards for review. Section 405.1110(c)(1) provides that when a referral is made in instances where CMS or its contractor participated or appeared as a party, the MAC exercises its own motion authority if there is an error of law material to the outcome of the case, an abuse of discretion by the ALJ, the decision is not consistent with the preponderance of the evidence of record, or there is a broad policy or procedural issue that may affect the public interest. In deciding whether to accept review under this standard, the MAC will limit its consideration of the ALJ's action to those exceptions raised by CMS.

Section 405.1110(c)(2) provides that when referral is made in instances where CMS or its contractor did not participate or appear as a party, the MAC will accept review if the decision or dismissal contains an error of law material to the outcome of the case, or presents a broad policy or procedural issue that may affect the public interest. In deciding whether to accept review, the MAC will limit its consideration of the ALJ's action to those exceptions raised by CMS.

As previously noted, since neither the Part D statute nor the current Part D regulations explicitly allow a Part D plan sponsor, CMS, or a CMS contractor to participate in or be parties to appeals at the ALJ level, we consider it appropriate to implement the standard of referral and review in § 405.1110 that applies when CMS and its contractor do not participate in or are not parties to the ALJ hearing. Accordingly, under this Ruling, CMS or the Part D IRE may refer a Part D case to the MAC and the MAC will accept review of a Part D case if the ALJ's decision or dismissal contains an error of law material to the outcome of the case or presents a broad policy or procedural issue that may affect the general public interest. In deciding whether to accept review, the MAC will limit its consideration of the ALJ's action to those exceptions raised by CMS or the Part D IRE.

C. Other Issues Regarding MAC Own Motion Review of Part D Cases

For the most part, the other provisions set forth under § 405.1110 apply appropriately to Part D cases. The requirements related to the 60-day time frame for filing the written referral and for providing notice to other interested parties set forth in § 405.1110(b)(2) are processes that are appropriate to apply to Part D cases. See also 42 CFR 405.1110(a). Written referrals must state the reasons why CMS or its contractors believe the MAC must review the case on its own motion. CMS or its contractors will send a copy of its referral to all parties to the ALJ's action and to the ALJ. Similarly, the requirements in § 405.1110(b)(2) regarding the filing of exceptions to the referral by submitting written comments to the MAC within 20 days of the referral notice, and sending such comments to CMS, appropriately apply to Part D cases.

We also believe it is appropriate to apply to Part D cases those requirements in § 405.1110(d) regarding the MAC's action. This provision states that if the MAC decides to review a decision or dismissal on its own motion, it will mail the results of its action to all the parties to the hearing and to CMS if it is not already a party to the hearing. The notice of the referral in § 405.1110(b)(2) requires that the enrollee will be notified that the ALJ's decision may not be the final action in the case. If the MAC accepts review, it may adopt, modify, or reverse the decision or dismissal, may remand the case to an ALJ for further proceedings or may dismiss a hearing request. The MAC must issue its action no later than 90 days after receipt of the CMS referral, unless the 90-day period has been extended as provided in 405 CFR subpart I. The MAC may not, however, issue its action before the 20-day comment period has expired, unless it determines that the agency's referral does not provide a basis for reviewing the case. If the MAC does not act within the applicable adjudication deadline, the ALJ's decision or dismissal remains the final action in the case. We believe it is appropriate to apply these procedures to Part D cases that the MAC reviews on its own motion.

As described in this section, the provisions in § 405.1110 are procedural rules that apply appropriately to Part D appeals. Further, applying these regulatory processes to Part D appeals does not conflict with existing Part D requirements.

Authority: Sections 1852, 1860D–4(g)–(h), and 1869 of the Social Security Act (42 U.S.C. 1395w–22, 1395w–104 and 1395ff).

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: March 15, 2007.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E7–5304 Filed 3–22–07; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1481–N3]

Medicare Program; Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group (TAG) Meeting—May 3–4, 2007

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

ACTION: Notice of meeting.

SUMMARY: This notice announces the sixth meeting of the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group (TAG). The purpose of the EMTALA TAG is to review regulations affecting hospital and physician responsibilities under EMTALA to individuals who come to a hospital seeking examination or treatment for medical conditions. The primary purpose of the sixth meeting is to enable the EMTALA TAG to hear additional testimony and further consider written responses from medical societies and other organizations on specific issues considered by the EMTALA TAG at previous meetings. The public is permitted to attend this meeting and, to the extent that time permits and at the discretion of the Chairperson, the EMTALA TAG may hear comments from the floor.

DATES: *Meeting Date:* The meetings of the EMTALA TAG announced in this notice are as follows:

Thursday, May 3, 2007, 9 a.m. to 5 p.m.
Friday, May 4, 2007, 9 a.m. to 5 p.m.

Registration Deadline: All individuals must register in order to attend this meeting. Individuals who wish to attend the meeting but do not wish to present testimony must register by April 26,