burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Recognition of pass-through payment for additional (new) categories of devices under the Outpatient Prospective Payment System and Supporting Regulations in 42 CFR, Part 4 19; *Use:* Section 20 1 (b) of the Balanced Budget Act of 1999 amended section 1833(t) of the Social Security Act (the Act) by adding new section 1833(t)(6). This provision requires the Secretary to make additional payments to hospitals for a period of 2 to 3 years for certain drugs, radiopharmaceuticals, biological agents, medical devices and brachytherapy devices. Section 1833(t)(6)(A)(iv) establishes the criteria for determining the application of this provision to new items. Section 1833(t)(6)(C)(ii) provides that the additional payment for medical devices be the amount by which the hospital's charges for the device, adjusted to cost, exceed the portion of the otherwise applicable hospital outpatient department fee schedule amount determined by the Secretary to be associated with the device. Section 402 of the Benefits Improvement and Protection Act of 2000 made changes to the transitional pass-through provision for medical devices. The most significant change is the required use of categories as the basis for determining transitional pass-through eligibility for medical devices, through the addition of section 1833(t)(6)(B) of the Act.

Interested parties such as hospitals, device manufacturers, pharmaceutical companies, and physicians apply for transitional pass-through payment for certain items used with services covered in the outpatient prospective payment system. After CMS receives all requested information, CMS will evaluate the information to determine if the creation of an additional category of medical devices for transitional pass-through payments is justified. *Form Number:* CMS–10052 (OMB#: 0938–0857); *Frequency:* Reporting: Yearly; *Affected Public:* Business or other for-profit; *Number of Respondents:* 10; *Total Annual Responses:* 10; *Total Annual Hours:* 160.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Hospice Cost and Data Report and supporting regulations 42 CFR 413.20 and 42 CFR 413.24; *Use:* In accordance with sections 1815(a), 1833(e), 1861(v)(A)(ii) and 1881 (b)(2)(B) of the Social Security Act, providers of services in the Medicare program are required to submit annual information to receive reimbursement for health care services provided to Medicare beneficiaries. In addition, 42 CFR 413.20(b) requires that cost reports be filed with the provider's fiscal intermediary/Medicare Administrative Contractor (FI/MAC). The functions of the FI/MAC are described in section 1816 of the Social Security Act. The Center for Medicare and Medicaid Services will use the information from providers for rate evaluations for the Prospective Payment System. *Form Number:* CMS–R–249 (OMB#: 0938–0758); *Frequency:* Reporting: Yearly; *Affected Public:* Business or other for-profit; *Number of Respondents:* 1938; *Total Annual Responses:* 1938; *Total Annual Hours:* 341,088.

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships and Supporting Regulations in 42 CFR, Sections 411.352 through 411.361; *Use:* The collection of information contained in 42 CFR sections 411.352(d), 411.354(d), 411.355(e), 411.357(a), (b), (d), (e), (h), (l), (p), and (s), and 411.361 is necessary to allow CMS to implement section 1877 of the Social Security Act. This collection has been revised to eliminate the requirement in section 411.357(s) to notify insurance companies that an entity has a professional courtesy policy. CMS issued these regulations to comply with the provisions of section 1877 of the Social Security Act that prohibit a physician from referring a patient to an entity for a designated health service for which Medicare might otherwise pay, if the physician or an immediate family member has a financial relationship with the entity, unless an exception applies. *Form Number:* CMS–10047 (OMB#: 0938–0846); *Frequency:* Yearly; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 154,404 *Total Annual Responses:* 154,404; *Total Annual Hours:* 116,035.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web Site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995*, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*, or call the Reports Clearance Office on (410) 786–1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on November 5, 2007.

OMB Human Resources and Housing Branch, Attention: Carolyn Lovett, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: (202) 395–6974.

Dated: September 27, 2007.

Michelle Shortt,

Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. E7–19506 Filed 10–4–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8032–N]

RIN 0938–AO61

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for Calendar Year 2008

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) 2008 under Medicare's Hospital Insurance program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts.

For CY 2008, the inpatient hospital deductible will be $1024. The daily coinsurance amounts for CY 2008 will be: (a) $256 for the 61st through 90th day of hospitalization in a benefit period; (b) $512 for lifetime reserve days; and (c) $128 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, 2008.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786–6390. For case-mix analysis: 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 CY.

II. Computing the Inpatient Hospital Deductible for CY 2008

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, 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 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 2008 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 2008 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 2008 is 3.3 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 2008 Rates'' 72 FR 47130. Therefore, the percentage increase for hospitals paid under the prospective payment system is 3.3 percent. The average payment percentage increase for hospitals excluded from the prospective payment system is 3.3 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 2008 is 3.3 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 2007 compared to FY 2006. (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 2007. These bills represent a total of about 8.9 million Medicare discharges for FY 2007 and provide the most recent case-mix data available at this time. Based on these bills, the change in average case-mix in FY 2007 is −0.48 percent. Based on these bills and past experience, we estimate that the change in real case-mix for FY 2007 will be 0 percent.

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.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 3.3 percent, and the real case-mix adjustment factor for the deductible is 0 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in CY 2008 is $1024. This deductible amount is determined by multiplying $992 (the inpatient hospital deductible for CY 2007) by the payment-weighted average increase in the payment rates of 1.033 multiplied by the increase in real case-mix of 1.00, which equals $1024.74 and is rounded to $1024.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for CY 2008

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 2008, 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 $256 (one-fourth of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be $512 (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 $128 (one-eighth of the inpatient hospital deductible).

IV. Cost to Medicare Beneficiaries

Table 1 summarizes the deductible and coinsurance amounts for CYs 2007 and 2008, as well as the number of each that is estimated to be paid.

TABLE 1.—PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CALENDAR YEARS 2007 AND 2008

Type of cost sharing	Value		Number paid (in millions)	
	2007	2008	2007	2008
Inpatient hospital deductible	$992	$1,024	8.57	8.81
Daily coinsurance for 61st–90th Day	248	256	2.23	2.30
Daily coinsurance for lifetime reserve days	496	512	1.01	1.04
SNF coinsurance	124	128	39.42	40.40

The estimated total increase in costs to beneficiaries is about $870 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 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). 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 $870 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 $6.5 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. 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 the 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.

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 26, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: September 26 2007.

Michael O. Leavitt,

Secretary.

[FR Doc. 07–4911 Filed 10–1–07; 11:18 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8031–N]

RIN 0938–AO62

Medicare Program; Part A Premium for Calendar Year 2008 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

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

ACTION: Notice.

SUMMARY: This annual notice announces Medicare's Hospital Insurance (Part A) premium for uninsured enrollees in calendar year (CY) 2008. This premium is to be paid by enrollees age 65 and over who are not otherwise eligible for benefits under Medicare Part A (hereafter known as the ''uninsured aged'') and by certain disabled individuals who have exhausted other entitlement. The monthly Part A premium for the 12 months beginning January 1, 2008 for these individuals will be $423. The reduced premium for