STATE CHILDREN'S HEALTH INSURANCE PROGRAM ALLOTMENTS FOR FEDERAL FISCAL YEAR—Continued

A	B	C	D	E	F	G
State	Number of children (000)	State cost factor	Product	Proportion of total [3] (percent)	Adjusted proportion of total [3] (percent)	Allotment [1]
VIRGIN ISLANDS	.....	.....	.....	2.6	.....	859,950
AMERICAN SAMOA	.....	.....	.....	1.2	.....	396,900
N. MARIANA ISLANDS	.....	.....	.....	1.1	.....	363,825
TOTAL COMMONWEALTHS AND TERRITORIES ONLY	.....	.....	.....	100.0	.....	33,075,000
TOTAL STATES AND COMMONWEALTHS AND TERRITORIES	.....	.....	.....	.....	.....	3,115,200,000

FOOTNOTES

The numbers in Columns B–F are rounded for presentation purposes, the actual numbers used in the allotment calculations are not rounded.

[1] Total amount available for allotment to the 50 States and the District of Columbia is $3,082,125,000; determined as the fiscal year appropriation ($3,150,000,000) reduced by the total amount available for allotment to the Commonwealths and Territories under section 2104(c) of the Act ($7,875,000) and amounts for Special Diabetes Grants under sections 4921 ($30,000,000) and 4922 ($30,000,000) of BBA.

[2] Total amount available for allotment to the Commonwealths and Territories is $7,875,000 (determined as 25 percent of $3,150,000,000, the fiscal year appropriation) plus $25,200,000, as specified in section 2104(c)(4)(B) of the Act.

[3] Percent share of total amount available for allotment to the Commonwealths and Territories is as specified in section 2104(c) of the Act.

IV. Impact Statement

We have examined the impact of this notice as required by Executive Order 12866. Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when rules are necessary, to select regulatory approaches that maximize net benefits (including potential economic environments, public health and safety, other advantages, distributive impacts, and equity). We believe that this notice is consistent with the regulatory philosophy and principles identified in the Executive Order. The formula for the allotments is specified in the statute. Since the formula is specified in the statute, we have no discretion in determining the allotments. This notice merely announces the results of our application of this formula, and therefore does not reach the economic significance threshold of $100 million in any one year.

The Unfunded Mandates Reform Act of 1995 requires that agencies prepare an assessment of anticipated costs and benefits before publishing any notice that may result in an annual expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted each year for inflation) in any one year. Because participation in the SCHIP program on the part of States is voluntary, any payments and expenditures States make or incur on behalf of the program that are not reimbursed by the Federal government are made voluntarily. This notice will not create an unfunded mandate on States, tribal, or local governments because it merely notifies states of their SCHIP allotment for FY 2002. Therefore, we are not required to perform an assessment of the costs and benefits of this notice.

Low-income children will benefit from payments under SCHIP through increased opportunities for health insurance coverage. We believe this notice will have an overall positive impact by informing States, the District of Columbia, and U.S. Territories and Commonwealths of the extent to which they are permitted to expend funds under their child health plans using their FY 2002 allotments.

Under Executive Order 13132, we are required to adhere to certain criteria regarding Federalism. We have reviewed this notice and determined that it does not significantly affect States' rights, roles, and responsibilities because it does not set forth any new policies.

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

(Section 1102 of the Social Security Act (42 U.S.C. 1302))

(Catalog of Federal Domestic Assistance Program No. 93.767, State Children's Health Insurance Program)

Dated: August 2, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: August 31, 2001.

Tommy G. Thompson,

Secretary.

[FR Doc. 01–26037 Filed 10–25–01; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8011–N]

RIN 0938–ZA19

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 2002

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 2002 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 $812. The daily coinsurance amounts will be: (a) $203 for the 61st through 90th day of hospitalization in a benefit period; (b) $406 for lifetime reserve days; and (c) $101.50 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, 2002.

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 2002

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, as amended by section 4401(a) of the Balanced Budget Act of 1997 (BBA '97) (Pub. L. 105–33) and section 301(a) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554, enacted on December 21, 2000), the percentage increase used to update the payment rates for fiscal year 2002 for hospitals paid under the prospective payment system is the market basket percentage increase minus 0.55 percentage points.

Under section 1886(b)(3)(B)(ii) of the Act, as amended by section 4411(a) of the BBA '97, the percentage increase used to update the payment rates for fiscal year 2002 for hospitals excluded from the prospective payment system depends on the hospital's allowable operating costs of inpatient hospital services. If the hospital's allowable operating costs of inpatient hospital services for the most recent cost reporting period for which information is available—

(1) Are equal to or exceed 110 percent of the hospital's target amount for that cost reporting period, the applicable percentage increase is the market basket percentage;

(2) Exceed 100 percent but are less than 110 percent of the hospital's target amount for that cost reporting period, the applicable percentage increase is the market basket percentage minus 0.25 percentage points for each percentage point by which the hospital's allowable operating costs are less than 110 percent of the target amount for that cost reporting period (but not less than 0 percent);

(3) Are equal to or less than 100 percent of the hospital's target amount for that cost reporting period, but exceed two-thirds of the target amount, the applicable percentage increase is 0 percent or, if greater, the market basket percentage minus 2.5 percentage points; or

(4) Do not exceed two-thirds of the hospital's target amount for that cost reporting period, the applicable percentage increase is 0 percent.

The market basket percentage increase for fiscal year 2002 is 3.3 percent, as announced in the final rule titled ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Rates and Costs of Graduate Medical Education: Fiscal Year 2002 Rates; Provisions of the Balanced Budget Refinement Act of 1999; and Provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000'' published in the **Federal Register** on August 1, 2001 (66 FR 39828). Therefore, the percentage increase for hospitals paid under the prospective payment system is 2.75 percent. The average payment percentage increase for hospitals excluded from the prospective payment system is 0.88 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 2002 is 2.54 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 2001 compared to fiscal year 2000. (We excluded from this calculation hospitals excluded from the prospective payment system because their payments are based on reasonable costs and are affected only by real changes in case mix.) We used bills from prospective payment hospitals received in CMS as of July 2001. These bills represent a total of about 8.6 million discharges for fiscal year 2001 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 2001 is −1.0 percent. Based on past experience, we expect the overall case mix change to be −0.8 percent as the year progresses and more fiscal year 2001 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. There is a negligible change in overall case mix for fiscal year 2001. We estimate that there is no change in real case mix; that is, we estimate that the change in real case mix for fiscal year 2001 is 0.0 percent.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 2.54 percent, and the real case mix adjustment factor for the deductible is 0.0 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in calendar year 2002 is $812. This deductible amount is determined by multiplying $792 (the inpatient hospital deductible for 2001) by the payment-weighted average increase in the payment rates of 1.0254 multiplied by the increase in real case mix of 1.00, which equals $812.12 and is rounded to $812.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for 2002

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 2002, 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 $203 (one-fourth of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be $406 (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 $101.50 (one-eighth of the inpatient hospital deductible).

IV. Cost to Beneficiaries

We estimate that in 2002 there will be about 8.67 million deductibles paid at $812 each, about 2.14 million days subject to coinsurance at $203 per day (for hospital days 61 through 90), about 0.99 million lifetime reserve days subject to coinsurance at $406 per day, and about 26.28 million extended care days subject to coinsurance at $101.50 per day. Similarly, we estimate that in 2001 there will be about 8.53 million deductibles paid at $792 each, about 2.11 million days subject to coinsurance at $198 per day (for hospital days 61 through 90), about 0.97 million lifetime reserve days subject to coinsurance at $396 per day, and about 25.84 million extended care days subject to coinsurance at $99 per day. Therefore, the estimated total increase in cost to beneficiaries is about $430 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 is 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 and the Regulatory Flexibility Act (RFA) (Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). The RFA requires agencies to analyze options for regulatory relief for small businesses. 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.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any notice that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we consider 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 one 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.

As stated in section IV of this notice, we estimate that the total increase in costs to beneficiaries associated with this notice is about $430 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.

We have reviewed this notice under the threshold criteria of Executive Order 13132, Federalism. We have determined that it does not significantly affect the rights, roles, and responsibilities of States.

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 7, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 27, 2001.

Tommy G. Thompson,

Secretary.

[FR Doc. 01–26701 Filed 10–19–01; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMSR–3080–NR]

Medicare Program; the National and Local Coverage Determination Review Process for an Individual With Standing as Defined in Section 522 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protections Act of 2000

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

ACTION: Notice of CMS Ruling.[1]

SUMMARY: This notice announces a CMS Ruling concerning the appropriate actions to be taken upon receipt of a complaint seeking review of a national or local coverage determination under section 522 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106–554. The Ruling establishes the interim administrative procedures that CMS contractors, and Administrative Law Judges (ALJs) are to follow in processing such complaints until final regulations are published regarding the adjudication of the complaints and the effectuation of ALJ and Departmental Appeals Board decisions with respect to complaints.

FOR FURTHER INFORMATION CONTACT: Jim Bossenmeyer, (410) 786–9317.

[1] **EDITORIAL NOTE:** Future CMS Rulings may appear in the Rules Section of the **Federal Register** if they are interpretations of or general policy statements concerning CMS rules (See 1 CFR 5.9(b)).