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 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 $640 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 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 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. 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 11, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 12, 2006.

Michael O. Leavitt,

Secretary.

[FR Doc. 06–7711 Filed 9–12–06; 4:00 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5042–N]

RIN 0938–ZA90

Medicare Program: Solicitation for Proposals To Participate in the Medicare Hospital Gainsharing Demonstration Program Under Section 5007 of the Deficit Reduction Act

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

ACTION: Notice.

SUMMARY: This notice is to inform interested parties of an opportunity to apply to participate in the Medicare Hospital Gainsharing Demonstration being implemented by CMS. The Medicare Hospital Gainsharing Demonstration authorized under Section 5007 of the Deficit Reduction Act (DRA) of 2005 was established to test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work. The purpose of this demonstration is to improve the quality and efficiency of care provided to Medicare beneficiaries and to develop improved operational and financial hospital performance with the sharing of remuneration payments between hospitals and physicians in six projects, each project consisting of one hospital. Two projects must be rural. This demonstration will be limited in scope: we intend to focus on the short-term impacts of gainsharing programs.

DATES: Applications will be considered timely if we receive them no later than 5 p.m., Eastern Standard Time (E.S.T.), on November 17, 2006.

FOR FURTHER INFORMATION CONTACT: Lisa Waters at (410) 786–6615 or *GAINSHARING@cms.hhs.gov.* Interested parties can obtain a complete solicitation, application, and supporting information on the following CMS Web sites at *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1186805* or

http://www.cms.hhs.gov/DemoProjectsEvalRpts/.

Paper copies can be obtained by writing to Lisa Waters at the address listed in the **ADDRESSES** section of this notice.

ADDRESSES: Mail or deliver applications to the following address: Centers for Medicare & Medicaid Services, Attention: Lisa Waters, Mail Stop: C4–17–27, 7500 Security Boulevard, Baltimore, Maryland 21244.

Because of staff and resource limitations, we cannot accept applications by facsimile (fax) transmission or by e-mail.

Eligible Organizations: Section 5007 of the DRA provides that hospitals receiving payment under section 1886(d) of the Social Security Act are eligible to apply.

For the purpose of this demonstration, hospitals may provide gainsharing payments to physicians (as defined in 1861(r)(1) or (3) and practitioners (as described in 1842(b)(18)(C)). Section 5007(g)(4) permits practitioners as described in section 1842(b)(18)(C) to participate in this demonstration. We believe that the reference to section 1842(e)(18)(C) in DRA section 5007(g) is a scrivener's error, and that the reference should be to section 1842(b)(18)(C). Section 5007(g) explicitly provides that the reference to physicians who are permitted to participate in the demo is deemed to include certain practitioners, which we believe is clear evidence of Congress' intent to include such practitioners in the demo. We also note the Conference Report language specifically refers to the inclusion of practitioners as part of the gainsharing arrangement. Since section 1842(e)(18)(C) does not exist, and since section 1842(b)(18)(C) is, with the exception of substituting (b) for (e), identical to that section], specifically defines practitioners, we believe that section 1842(b)(18)(C) is the one that Congress actually intended to reference, and that the substitution of the (e) for the (b) is a scrivener's error. We do not believe that this typographical error impedes any authority to otherwise implement this demonstration. Furthermore, a comprehensive list of all eligibility requirements can be found in the ''Eligible Organizations'' section of the solicitation.

SUPPLEMENTARY INFORMATION:

I. Background

Section 5007 of the Deficit Reduction Act of 2005 (DRA) requires the establishment of a qualified gainsharing demonstration program that will test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work to improve the quality and efficiency of care provided to beneficiaries and to develop improved operational and financial hospital performance with the sharing of remuneration as specified in the project. It will have a short-term focus given the limited size of the demonstration.

II. Provisions of the Notice

This notice solicits applications to participate in the DRA Section 5007 Medicare Hospital Gainsharing Demonstration that will assist in determining if gainsharing can align incentives between hospitals and physicians to improve the quality and efficiency of care provided to beneficiaries, which will promote improved operational and financial performance of hospitals. The focus of each demonstration will be to link physician incentive payments to improvements in quality and efficiency. Each demonstration will provide measures to ensure that the quality and efficiency of care provided to beneficiaries is monitored and improved.

Overall, we seek demonstration models that result in savings to Medicare. We will assure the demonstration is budget neutral.

III. Collection of Information Requirements

This information collection requirement is subject to the Paperwork Reduction Act of 1995 (PRA); however, the collection is currently approved under OMB control number 0938–0880 entitled ''Medicare Demonstration Waiver Application.''

Authority: Section 5007 of the Deficit Reduction Act of 2005, Pub. L. 109–171.

(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: August 7, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 06–7738 Filed 9–13–06; 3:58 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8030–N]

RIN 0938–A023

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rates, and Annual Deductible for Calendar Year 2007

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

ACTION: Notice.

SUMMARY: This notice announces the monthly actuarial rates for aged (age 65 and over) and disabled (under age 65) beneficiaries enrolled in Part B of the Medicare Supplementary Medical Insurance (SMI) program beginning January 1, 2007. In addition, this notice announces the standard monthly premium for aged and disabled beneficiaries, as well as the income-related monthly adjustment amounts to be paid by beneficiaries with modified adjusted gross income above certain threshold amounts, as required by section 811 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as modified by the Deficit Reduction Act of 2005. It also announces the annual deductible to be paid by all beneficiaries during 2007.

The standard monthly Part B premium is equal to 50 percent of the monthly actuarial rate for aged enrollees or approximately 25 percent of the expected average total cost of Part B coverage for aged enrollees, plus any applicable income-related monthly adjustment amount. If a beneficiary has to pay an income-related monthly adjustment amount, they may have to pay a total monthly premium equal to 35, 50, 65, or 80 percent of the total cost of Part B coverage, by the end of the 3-year transition period. However, for 2007, the beneficiary is only responsible for one-third of any applicable income-related monthly adjustment amount.

The monthly actuarial rates for 2007 are $187.00 for aged enrollees and $197.30 for disabled enrollees. The monthly Part B premium rates to be paid in 2007, including the income-related monthly adjustment amounts, are $93.50 (the standard premium), $106.00, $124.70, $143.40, and $162.10. The specific amount payable by beneficiaries depends on their income level and income tax filing status. (The 2006 premium rate paid by all beneficiaries was $88.50.)

The Part B deductible for 2007 is $131.00 for all beneficiaries.