Information Collection: Procedures for Making National Coverage Decisions; *Form No.:* CMS–R–0290 (OMB# 0938–0776); *Use:* These information collection requirements provide the process CMS will use to make a national coverage decision for a specific item or service under sections 1862 and 1871 of the Social Security Act. This will streamline our decision making process and will increase the opportunities for public participation in making national coverage decisions; *Frequency:* Other (as needed); *Affected Public:* Business or other for-profit, Not-for-profit institutions; *Number of Respondents:* 200; *Total Annual Responses:* 200; *Total Annual Hours:* 8,000.

(3) *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Request for Retirement Benefit Information; *Form No.:* CMS–R–0285 (OMB# 0938–0769); *Use:* This information is needed to determine whether a beneficiary meets the requirements for reduction of the Part A premium to zero.; *Frequency:* On occasion.; *Affected Public:* State, Local or Tribal Government; *Number of Respondents:* 1,500; *Total Annual Responses:* 1,500; *Total Annual Hours:* 208.

(4) *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* End Stage Renal Disease Medical Information System ESRD Facility Survey; *Form No.:* CMS–2744 (OMB# 0938–0447); *Use:* The ESRD Facility Survey form is completed annually by Medicare approved providers of dialysis and transplant services. The CMS–2744 is designed to collect information concerning treatment trends, utilization of services and patterns of practice in treating ESRD patients.; *Frequency:* Annually; *Affected Public:* Business or other for-profit, Not-for-profit institutions; *Number of Respondents:* 4,225; *Total Annual Responses:* 4,225; *Total Annual Hours:* 33,800.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS's Web site address at *http://www.hcfa.gov/regs/prdact95.htm,* or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@hcfa.gov,* or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the CMS Paperwork Clearance Officer designated at the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development and Issuances, Attention: Dawn Willinghan, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: October 10, 2002.

John P. Burke, III,

Paperwork Reduction Act Team Leader, CMS Reports Clearance Officer, Office of Strategic Operations and Strategic Affairs, Division of Regulations Development and Issuances.

[FR Doc. 02–26652 Filed 10–18–02; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS–R–21]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare and Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (HCFA), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated 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.

Type of Information Collection Request: Extension of a currently approved collection; *Title of Information Collection:* Withholding Medicare Payments to Recover Medicaid Overpayments and Supporting Regulations in 42 CFR 447.31; *Form No.:* CMS–R–21 (OMB# 0938–0287); *Use:* Overpayments may occur in either the Medicare and Medicaid program, at times resulting in a situation where an institution or person that provides services owes a repayment to one program while still receiving reimbursement from the other. Certain Medicaid providers that are subject to offsets for the collection of Medicaid overpayments may terminate or substantially reduce their participation in Medicaid, leaving the State Medicaid Agency unable to recover the amounts due. These information collection requirements give CMS the authority to recover Medicaid overpayments by offsetting payments due to a provider under the program; *Frequency:* On occasion; *Affected Public:* State, Local, or Tribal Government; *Number of Respondents:* 54; *Total Annual Responses:* 27; *Total Annual Hours:* 81.

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.hcfa.gov/regs/prdact95.htm*, or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@hcfa.gov*, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Brenda Aguilar, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: October 10, 2002.

John P. Burke, III,

Paperwork Reduction Act Team Leader, CMS Reports Clearance Officer, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development and Issuances.

[FR Doc. 02–26653 Filed 10–18–02; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8013–N]

RIN 0938–AL56

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 2003

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 2003 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 $840. The daily coinsurance amounts will be: (a) $210 for the 61st through 90th day of hospitalization in a benefit period; (b) $420 for lifetime reserve days; and (c) $105.00 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, 2003.

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 2003

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 such preceding calendar year, and adjusted to reflect changes in real case mix. The adjustment to reflect changes in 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 2003 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, the percentage increase used to update the payment rates for fiscal year 2003 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 fiscal year 2003 is 3.5 percent, as announced in the final rule titled ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates; Final Rule'' published in the **Federal Register** on August 1, 2002 (67 FR 49982). Therefore, the percentage increase for hospitals paid under the prospective payment system is 2.95 percent. The average payment percentage increase for hospitals excluded from the prospective payment system is 3.5 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 2003 is 3.0 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 2002 compared to fiscal year 2001. (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 2002. These bills represent a total of about 8.8 million discharges for fiscal year 2002 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 2002 is 0.17 percent. Based on past experience, we expect the overall case mix change to be 0.5 percent as the year progresses and more fiscal year 2002 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 fiscal year 2002 is 0.5 percent.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 3.0 percent, and the real case mix adjustment factor for the deductible is 0.5 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in calendar year 2003 is $840. This deductible amount is determined by multiplying $812 (the inpatient hospital deductible for 2002) by the payment-weighted average increase in the payment rates of 1.03 multiplied by the increase in real case mix of 1.005, which equals $840.54 and is rounded to $840.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for 2003

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 2003, 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 $210 (one-fourth of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be $420 (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 $105.00 (one-eighth of the inpatient hospital deductible).

IV. Cost to Beneficiaries

We estimate that in 2003 there will be about 8.95 million deductibles paid at $840 each, about 2.31 million days subject to coinsurance at $210 per day (for hospital days 61 through 90), about 1.03 million lifetime reserve days subject to coinsurance at $420 per day, and about 26.50 million extended care days subject to coinsurance at $105.00 per day. Similarly, we estimate that in 2002 there will be about 8.78 million deductibles paid at $812 each, about 2.27 million days subject to coinsurance at $203 per day (for hospital days 61

through 90), about 1.01 million lifetime reserve days subject to coinsurance at $406 per day, and about 25.99 million extended care days subject to coinsurance at $101.50 per day. Therefore, the estimated total increase in cost to beneficiaries is about $580 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 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 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security 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 $580 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 considered small entities. 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 $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 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 notice was reviewed by the Office of Management and Budget.

Authority: Secs. 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 4, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 20, 2002.

Tommy G. Thompson,

Secretary.

[FR Doc. 02–26674 Filed 10–18–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8014–N]

RIN 0938–AL63

Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Rate Beginning January 1, 2003

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

ACTION: Notice.

SUMMARY: In accordance with section 1839 of the Social Security Act (the Act), this notice announces the monthly actuarial rates for aged (age 65 and over) and disabled (under age 65) enrollees in the Medicare Supplementary Medical Insurance (SMI) program for 2003. It also announces the monthly SMI premium to be paid by all enrollees during 2003. The monthly actuarial rates for 2003 are $118.70 for aged enrollees and $141.00 for disabled enrollees. The monthly SMI premium rate for 2003 is $58.70. (The 2002 premium rate was $54.00). This compares to projections of the 2003 SMI premium of $57.00 in the 2002 Trustees Report and $63.30 in the 2001 Trustees Report. The 2003 Part B premium is not equal to 50 percent of the monthly actuarial rate because of the differential between the amount of home health that is transferred into Part B in 2003 (the