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 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 (CY).

II. Computing the Inpatient Hospital Deductible for CY 2016

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, adjusted 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 changes in 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)(XX) of the Act, the percentage increase used to update the payment rates for FY 2016 for hospitals paid under the inpatient prospective payment system is the market basket percentage increase, otherwise known as the market basket update, reduced by 0.2 percentage points and the MFP adjustment (see sections 1886(n)(3)(A) and 1886(m)(4)(E) of the Act).

The percentage increase for inpatient rehabilitation facilities is the market basket percentage increase reduced by 0.2 percentage points and the MFP adjustment (see sections 1886(j)(3)(C) and 1886(j)(3)(D)(iv) of the Act).

The percentage increase used to update the payment rate for inpatient psychiatric facilities is the market basket percentage increase reduced by 0.2 percentage points and the MFP adjustment (see sections 1886(s)(2)(A)(i), 1886(s)(2)(A)(ii), and 1886(s)(3)(D) of the Act).

The Inpatient Prospective Payment System market basket percentage increase for 2016 is 2.4 percent and the MFP adjustment is 0.5 percent, as announced in the final rule that appeared in the Federal Register on August 17, 2015 entitled, “Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates” (80 FR 49510). Therefore, the percentage increase for hospitals paid under the inpatient prospective payment system that submit quality data and are meaningful EHR users is 1.7 percent (that is, the FY 2016 market basket update of 2.4 percent less the MFP adjustment of 0.5 percentage point and less 0.2 percentage point).

The average payment percentage increase for hospitals excluded from the inpatient prospective payment system is 1.82 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 2016 is 1.72 percent.

To develop the adjustment to reflect changes in real case-mix, we first calculated an average case-mix for each hospital 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 2015 compared to FY 2014. (We excluded from this calculation hospitals whose payments are not based on the inpatient prospective payment system because their payments are based on alternate prospective payment systems or reasonable costs.) We used Medicare bills from prospective payment hospitals that we received as of July 2015. These bills represent a total of about 7.6 million Medicare discharges for FY 2015 and provide the most recent case-mix data available at this time. Based on these bills, the change in average case-mix in FY 2015 is 0.21 percent. Based on these bills and past experience, we expect the overall case-mix change to be 0.5 percent as the year progresses and more FY 2015 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. Real case-mix is that portion of case-mix that is due to changes in the mix of cases in the hospital and not due to coding optimization. We expect that all of the change in average case-mix will be real and estimate that this change will be 0.5 percent.

Thus as stated above, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 1.72 percent, and the real case-mix adjustment factor for the deductible is 0.5 percent. Therefore, using the statutory formula as stated in section 1813(b) of the Act, we calculate the inpatient hospital deductible for services furnished in CY 2016 to be $1,288. This deductible amount is determined by multiplying $1,260 (the inpatient hospital deductible for CY 2015 (79 FR 49854)) by the payment-weighted average increase in the payment rates of 1.0172 multiplied by the increase in real case-mix of 1.005, which equals $1,288.08 and is rounded to $1,288.

### III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for CY 2016

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. The increase in the deductible generates increases in the coinsurance amounts. For inpatient hospital and extended care services furnished in CY 2016, 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 $322 (one-fourth of the inpatient hospital deductible as stated in section 1813(a)(1)(A) of the Act); the daily coinsurance for lifetime reserve days will be $644 (one-half of the inpatient hospital deductible as stated in section 1813(a)(1)(B) of the Act); 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 $161 (one-eighth of the inpatient hospital deductible as stated in section 1813(a)(3) of the Act).

### IV. Cost to Medicare Beneficiaries

Table 1 below summarizes the deductible and coinsurance amounts for CYs 2015 and 2016, as well as the number of each that is estimated to be paid.

<table>
<thead>
<tr>
<th>Type of Cost Sharing</th>
<th>Value 2015</th>
<th>Value 2016</th>
<th>Number paid (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital deductible</td>
<td>$1260</td>
<td>$1288</td>
<td>7.73</td>
</tr>
<tr>
<td>Daily coinsurance for 61st – 90th Day</td>
<td>315</td>
<td>322</td>
<td>1.83</td>
</tr>
<tr>
<td>Daily coinsurance for lifetime reserve days</td>
<td>630</td>
<td>644</td>
<td>0.89</td>
</tr>
<tr>
<td>SNF coinsurance</td>
<td>157.50</td>
<td>161</td>
<td>41.47</td>
</tr>
</tbody>
</table>

The estimated total increase in costs to beneficiaries is about $610 million (rounded to the nearest $10 million) due to: (1) The increase in the deductible and coinsurance amounts, and (2) the increase in the number of deductibles and daily coinsurance amounts paid. We determine the increase in cost to beneficiaries by calculating the difference between the 2015 and 2016 deductible and coinsurance amounts multiplied by the increase in the number of deductible and coinsurance amounts paid.

### V. Waiver of Proposed Notice and Comment Period

Section 1813(b)(2) of the Act requires publication of the inpatient hospital deductible and all coinsurance amounts—the hospital and extended care services coinsurance amounts—between September 1 and September 15 of the year preceding the year to which they will apply. These amounts are determined according to the statute as discussed above. 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 here, 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 requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

VII. Regulatory Impact Analysis

A. Statement of Need

Section 1813(b)(2) of the Act requires the Secretary to publish, between September 1 and September 15 of each year, the amounts of the inpatient hospital deductible and hospital and extended care services coinsurance applicable for services furnished in the following calendar year (CY).

B. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C., Part I, Ch. 8).

Executive Orders 12866 and 13563 direct 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 notices 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 $610 million due to: (1) The increase in the deductible and coinsurance amounts, and (2) the increase in the number of deductibles and daily coinsurance amounts paid. As a result, this notice is economically significant under section 3(f)(1) of Executive Order 12866 and is a major action under the Congressional Review Act. In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than $7.5 million to $38.5 million in any 1 year (for details, see the Small Business Administration’s Web site at http://www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf). Individuals and states are not included in the definition of a small entity. As discussed above, this annual notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in CY 2016 under Medicare’s Hospital Insurance Program (Medicare Part A). As a result, we are not preparing an analysis for the RFA because the Secretary has determined that this notice will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Social Security 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 for Medicare payment regulations and has fewer than 100 beds. As discussed above, we are not preparing an analysis for section 1102(b) of the Act because the Secretary has determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. For 2015, that threshold accounting for inflation is approximately $144 million. This notice does not impose mandates that will have a consequential effect of $144 million or more 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 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. Since this notice does not impose any costs on state or local governments, preempt state law, or have Federalism implications, the requirements of Executive Order 13132 are not applicable.

Dated: November 6, 2015.

Andrew M. Slavitt,
Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: November 9, 2015.

Sylvia M. Burwell,
Secretary, Department of Health and Human Services.

[FR Doc. 2015–29207 Filed 11–10–15; 4:15 pm]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–2567 and CMS–10143]

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

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS’ intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the Federal Register concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the 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 collection.