

IV. Waiver of Proposed Notice

The statute requires publication of the monthly actuarial rates and the Part B premium amounts. We ordinarily use general notices, rather than notice and comment rulemaking procedures, to make such announcements. In doing so, we note 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, for 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 formulas used to calculate the Part B premiums are statutorily directed, and we can exercise no discretion in applying those formulas. Moreover, the statute establishes the time period for which the premium rates will apply, and delaying publication of the Part B premium rate such that it would not be published before that time would be contrary to the public interest. Therefore, we find good cause to waive publication of a proposed notice and solicitation of public comments.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 14, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: October 16, 2009.

Kathleen Sebelius,

Secretary.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-8037-N]

RIN 0938-AP42

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for Calendar Year 2010

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) 2010 under Medicare's Hospital Insurance Program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts. For CY 2010, the inpatient hospital deductible will be \$1,100. The daily coinsurance amounts for CY 2010 will be—(a) \$275 for the 61st through 90th day of hospitalization in a benefit period; (b) \$550 for lifetime reserve days; and (c) \$137.50 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, 2010.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786-6390 for general information. Gregory J. Savord, (410) 786-1521 for case-mix analysis.

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 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 2010

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 2010 for hospitals paid under the inpatient prospective payment system is the market basket percentage increase, otherwise known as the market basket update. 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. The market basket update for hospitals that do not submit this data is reduced by 2.0 percentage points. We are estimating that after accounting for those hospitals receiving the lower market basket update in the payment-weighted average update, the calculated deductible will remain the same.

Under section 1886(b)(3)(B)(ii)(VIII) of the Act, the percentage increase used to update the payment rates for FY 2010 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 2010 is 2.1 percent, as announced in the final rule with comment period published in the *Federal Register* on August 27, 2009 entitled, “Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates; and Changes to the Long-Term Care Hospital Prospective Payment System and Rate Years 2010 and 2009 Rates (IPPS/RY 2010 LTCH PPS) (74 FR 43754).” Therefore, the percentage increase for hospitals paid under the prospective payment system is 2.1 percent. The average payment percentage increase for hospitals excluded from the prospective payment system is 2.5 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 FY 2010 is 2.15 percent.

To develop the adjustment to reflect changes in 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 2009 compared to FY 2008. (We excluded from this calculation hospitals whose payments are not based on the Acute care 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 June 2009. These bills represent a total of about 9.0 million Medicare discharges for FY 2009 and provide the most recent case-mix data available at this time. Based on these bills, the change in average case-mix in FY 2009 is 2.5 percent. Based on these bills and past experience, we expect the overall case mix change to be 3.1 percent as the year progresses and more FY 2009 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. In the FY 2010 IPPS/RY 2010 LTCH PPS final rule with comment period, we indicated that we believe the adoption of the Medicare severity-based diagnosis-related groups (MS-DRGs) led to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for improved documentation and coding. In that final rule with comment period, we estimated that changes in coding or classification

that do not reflect real change in case-mix would be 2.3 percent for FY 2009. Therefore, since we are expecting overall case mix to increase by 3.1 percent and 2.3 percent of that to be caused by coding changes, real case-mix changes resulted in an increase of 0.8 percent for FY 2009.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 2.15 percent, and the real case-mix adjustment factor for the deductible is 0.8 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in CY 2010 is \$1,100. This deductible amount is determined by multiplying \$1,068 (the inpatient hospital deductible for CY 2009) by the payment-weighted average increase in the payment rates of 1.0215 multiplied by the increase in real case-mix of 1.008, which equals \$1,099.69 and is rounded to \$1,100.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for CY 2010

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 2010, 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 \$275 (one-fourth of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be \$550 (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 \$137.50 (one-eighth of the inpatient hospital deductible).

IV. Cost to Medicare Beneficiaries

Table 1 below summarizes the deductible and coinsurance amounts for CYs 2009 and 2010, as well as the number of each that is estimated to be paid.

TABLE 1—PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CALENDAR YEARS 2009 AND 2010

Type of cost sharing	Value		Number paid (in millions)	
	2009	2010	2009	2010
Inpatient hospital deductible	\$1068	\$1100	8.70	8.80
Daily coinsurance for 61st–90th day	267	275	2.27	2.30
Daily coinsurance for lifetime reserve days	534	550	1.12	1.13
SNF coinsurance	133.50	137.50	40.79	41.74

The estimated total increase in costs to beneficiaries is about \$730 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 final rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), 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 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the

Congressional Review Act (5 U.S.C. 804(2)).

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 \$730 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 businesses, 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 government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$7.0 million to \$34.5 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 under 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. The Secretary has determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals. Therefore, we are not preparing an analysis under section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) 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. In 2009, that threshold is approximately \$133 million. This notice has no consequential effect on State, local, or Tribal governments or on the private sector. However, States may be required to pay the deductibles and coinsurance 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 will not have a substantial 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.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: September 1, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: September 17, 2009.

Kathleen Sebelius,

Secretary.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-8038-N]

RIN 0938-AP43

Medicare Program; Part A Premium for Calendar Year 2010 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) 2010. This premium is 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, 2010 for

these individuals will be \$461. The reduced premium for certain other individuals as described in this notice will be \$254.

DATES: *Effective Date:* This notice is effective on January 1, 2010.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786-6390.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in the Medicare Hospital Insurance Program (Medicare Part A), subject to payment of a monthly premium, of certain persons aged 65 and older who are uninsured under the Old-Age, Survivors, and Disability Insurance (OASDI) program or the Railroad Retirement Act and do not otherwise meet the requirements for entitlement to Medicare Part A. (Persons insured under the OASDI program or the Railroad Retirement Act and certain others do not have to pay premiums for Medicare Part A.)

Section 1818A of the Act provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium of certain disabled individuals who have exhausted other entitlement. These are individuals who were entitled to coverage due to a disabling impairment under section 226(b) of the Act, but are no longer entitled to disability benefits and free Medicare Part A coverage because they have gone back to work and their earnings exceed the statutorily defined "substantial gainful activity" amount (section 223(d)(4) of the Act).

Section 1818A(d)(2) of the Act specifies that the provisions relating to premiums under section 1818(d) through section 1818(f) of the Act for the aged will also apply to certain disabled individuals as described above.

Section 1818(d) of the Act requires us to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services incurred in the following calendar year (CY) (including the associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Medicare Part A. We must then determine, during September of each year, the monthly actuarial rate for the following year (the per capita amount estimated above divided by 12) and publish the dollar amount for the monthly premium in the succeeding CY. If the premium is not a multiple of \$1, the premium is rounded to the nearest multiple of \$1 (or, if it is a multiple of