

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-8040-N]

RIN 0938-AP86

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for CY 2011

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) 2011 under Medicare's Hospital Insurance Program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts. For CY 2011, the inpatient hospital deductible will be \$1132. The daily coinsurance amounts for CY 2011 will be--(a) \$283 for the 61st through 90th day of hospitalization in a benefit period; (b) \$566 for lifetime reserve days; and (c) \$141.50 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, 2011.

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 2011

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 2011 for hospitals paid under the inpatient prospective payment system is the market basket percentage increase, otherwise known as the market basket update, reduced by .25 percentage points. Under section 1886(b)(3)(B)(viii) of the Act, hospitals will receive this update only if they submit quality data as specified by the Secretary. The 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 2011 for hospitals excluded from the inpatient prospective payment system is the market basket percentage increase reduced by .5 percentage points for Long Term Care Hospitals and reduced by .25 percentage points for Inpatient Rehabilitation facilities and Psychiatric Hospitals, defined according to section 1886(b)(3)(B)(iii) of the Act.

The market basket percentage increase for 2011 is 2.6 percent, as announced in the final rule with comment period published in the **Federal Register** on August 16, 2010 entitled, "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2011 Rates; and Changes to the Long-Term Care Hospital Prospective Payment System and Rate Years 2011 and 2010 Rates (IPPS/R Y 2011 LTCH PPS) (75 FR 50042-50677)." Therefore, the percentage increase for hospitals paid under the inpatient prospective payment system is 2.35 percent. The

average payment percentage increase for hospitals excluded from the inpatient prospective payment system is 2.73 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 2011 is 2.40 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 2010 compared to FY 2009. (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 2010. These bills represent a total of about 8.5 million Medicare discharges for FY 2010 and provide the most recent case-mix data available at this time. Based on these bills, the change in average case-mix in FY 2010 is 0.3 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 2010 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 2011 IPPS/RY 2011 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 0.0 percent for FY 2010. Therefore, since we are expecting overall case mix to increase by 0.5 percent and 0.0 percent of that to be caused by coding changes, real case mix changes resulted in an increase of 0.5 percent for FY 2010.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 2.40 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 CY 2011 is \$1132. This deductible amount is determined by multiplying \$1100 (the inpatient hospital deductible for CY 2010) by the payment-weighted average increase in the payment rates of 1.0240 multiplied by the increase in real case-mix of 1.005, which equals \$1132.03 and is rounded to \$1132.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for CY 2011

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 2011, 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 \$283 (one-fourth of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be \$566 (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 \$141.50 (one-eighth of the inpatient hospital deductible).

IV. Cost to Medicare Beneficiaries

Table 1 below summarizes the deductible and coinsurance amounts for CYs 2010 and 2011, as well as the number of each that is estimated to be paid.

Table 1. Part A Deductible and Coinsurance Amounts for Calendar Years 2010 and 2011

Type of Cost Sharing	Value		Number paid (in millions)	
	2010	2011	2010	2011
Inpatient hospital deductible	\$1100	\$1132	8.40	8.59
Daily coinsurance for 61 st -90 th Day	\$275	\$283	2.25	2.30
Daily coinsurance for lifetime reserve days	\$550	\$566	1.13	1.16
SNF coinsurance	\$137.50	\$141.50	42.41	43.66

The estimated total increase in costs to beneficiaries is about \$900 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 \$900 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

2010, that threshold is approximately \$135 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.

CMS-8040-N

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

Dated: September 9, 2010

Donald M. Berwick,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: October 29, 2010

Kathleen Sebelius,

Secretary.

BILLING CODE 4120-01-P

[FR Doc. 2010-28251 Filed 11/04/2010 at 2:15 pm; Publication Date: 11/09/2010]