

regarding this collection contact Matt Klischer at 410-786-7488. For all other issues call 410-786-1326.)

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Report of a Hospital Death Associated with Restraint or Seclusion; *Use:* Executive Order 13563, Improving Regulation and Regulatory Review, was signed on January 18, 2011. The order recognized the importance of a streamlined, effective, and efficient regulatory framework designed to promote economic growth, innovation, job creation, and competitiveness. Each agency was directed to establish an ongoing plan to reduce or eliminate burdensome, obsolete, or unnecessary regulations to create a more efficient and flexible structure.

The regulation that was published on May 16, 2012 (77 FR 29034) included a reduction in the reporting requirement related to hospital deaths associated with the use of restraint or seclusion, § 482.13(g). Hospitals are no longer required to report to CMS those deaths where there was no use of seclusion and the only restraint was 2-point soft wrist restraints. It is estimated that this will reduce the volume of reports that must be submitted by 90 percent for hospitals. In addition, the final rule replaced the previous requirement for reporting via telephone to CMS, which proved to be cumbersome for both CMS and hospitals, with a requirement that allows submission of reports via telephone, facsimile or electronically, as determined by CMS. Finally, the amount of information that CMS needs for each death report in order for CMS to determine whether further on-site investigation is needed has been reduced.

The Child Health Act (CHA) of 2000 established in Title V, Part H, Section 591 of the Public Health Service Act (PHSA) minimum requirements concerning the use of restraints and seclusion in facilities that receive support with funds appropriated to any Federal department or agency. In addition, the CHA enacted Section 592 of the PHSA, which establishes minimum mandatory reporting requirements for deaths in such facilities associated with use of restraint or seclusion. Provisions implementing this statutory reporting requirement for hospitals participating in Medicare are found at 42 CFR 482.13(g), as revised in the final rule that published on May 16, 2012 (77 FR 29034). *Form Number:* CMS-10455 (OCN: 0938-New); *Frequency:* Occasionally; *Affected Public:* Private Sector. *Number of Respondents:* 4,900. *Number of*

Responses: 24,500. *Total Annual Hours:* 8,085. (For policy questions regarding this collection contact Danielle Miller at 410-786-8818. For all other issues call 410-786-1326.)

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.cms.hhs.gov/PaperworkReductionActof1995>, or Email your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office on (410) 786-1326.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by *January 22, 2013*:

1. *Electronically.* You may submit your comments electronically to <http://www.regulations.gov>. Follow the instructions for "Comment or Submission" or "More Search Options" to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number _____, Room C4-26-05, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Dated: November 16, 2012.

Martique Jones,

Director, Regulations Development Group, Division B, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2012-28381 Filed 11-20-12; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-8046-N]

RIN 0938-AR14

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for CY 2013

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) 2013 under Medicare's Hospital Insurance Program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts. For CY 2013, the inpatient hospital deductible will be \$1,184. The daily coinsurance amounts for CY 2013 will be: \$296 for the 61st through 90th day of hospitalization in a benefit period; \$592 for lifetime reserve days; and \$148 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

DATES: This notice is effective on January 1, 2013.

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 calendar year (CY).

II. Computing the Inpatient Hospital Deductible for CY 2013

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 2013 for hospitals paid under the inpatient prospective payment system is the market basket percentage increase, otherwise known as the market basket update, reduced by 0.1 percentage points (see section 1886(b)(3)(B)(xii)(II) of the Act), and an adjustment based on changes in the economy-wide productivity (the multifactor productivity (MFP) adjustment (see section 1886(b)(3)(B)(xi)(II) of the Act). 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, as the majority of hospitals submit quality data and receive the full market basket update.

Under section 1886(b)(3)(B)(ii)(VIII) of the Act, the percentage increase used to update the payment rates for FY 2013 for hospitals excluded from the inpatient prospective payment system is as follows:

- For FY 2013, the percentage increase for long term care hospitals is the market basket percentage increase reduced by 0.1 percentage points and the MFP adjustment (see sections 1886(m)(3)(A) and 1886(m)(4)(C) of the Act).
- For FY 2013, the percentage increase for inpatient rehabilitation facilities is the market basket percentage increase reduced by 0.1 percentage points and the MFP adjustment (see sections 1886(j)(3)(C) and 1886(j)(3)(D)(ii) of the Act).
- For FY 2013, the percentage increase used to update the payment rate for psychiatric hospitals is the market basket percentage increase reduced by 0.1 percentage points and the MFP adjustment (see sections

1886(s)(2)(A)(ii) and 1886(s)(3)(B) of the Act).

The market basket percentage increase for 2013 is 2.6 percent and the MFP adjustment is 0.7 percent, as announced in the final rule with comment period published in the **Federal Register** on August 31, 2012 entitled, “Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and FY 2013 Rates and to the Long Term Care Hospital PPS and FY 2013 Rates” (77 FR 53257). Therefore, the percentage increase for hospitals paid under the inpatient prospective payment system is 1.8 percent. The average payment percentage increase for hospitals excluded from the inpatient prospective payment system is 2.05 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 2013 is 1.84 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 2012 compared to FY 2011. (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 2012. These bills represent a total of about 8.2 million Medicare discharges for FY 2012 and provide the most recent case-mix data available at this time. Based on these bills, the change in average case-mix in FY 2012 is 0.33 percent. Based on these bills and past experience, we expect the overall case mix change to be 0.7 percent as the year progresses and more FY 2012 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 will be 0.7 percent.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 1.84 percent, and the real case-mix adjustment factor for the deductible is 0.7 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in CY 2013 is \$1,184. This deductible amount is determined by multiplying \$1,156 (the inpatient hospital deductible for CY 2012) by the payment-weighted average increase in the payment rates of 1.0184 multiplied by the increase in real case-mix of 1.007, which equals \$1,185.51 and is rounded to \$1,184.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for CY 2013

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 2013, 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 \$296 (one-fourth of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be \$592 (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 \$148 (one-eighth of the inpatient hospital deductible).

IV. Cost to Medicare Beneficiaries

Table 1 below summarizes the deductible and coinsurance amounts for CYs 2012 and 2013, as well as the number of each that is estimated to be paid.

TABLE 1—PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CALENDAR YEARS 2012 AND 2013

Type of cost sharing	Value		Number paid (in millions)	
	2012	2013	2012	2013
Inpatient hospital deductible	\$1,156	\$1,184	8.19	8.44
Daily coinsurance for 61st–90th Day	289	296	2.11	2.17
Daily coinsurance for lifetime reserve days	578	592	1.04	1.08
SNF coinsurance	144.50	148	43.82	45.72

The estimated total increase in costs to beneficiaries is about \$1,030 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.

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 impact of this notice 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 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 \$1,030 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. Therefore, this notice is a major action as defined in Title 5, United States Code, Part I, Ch. 8), and is an economically significant action 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 small governmental jurisdictions. 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 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. 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 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. In 2012, that threshold is approximately \$139 million. This notice will have 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: November 6, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: November 15, 2012.

Kathleen Sebelius,

Secretary.

[FR Doc. 2012–28273 Filed 11–16–12; 11:15 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8048–N]

RIN 0938–AR16

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2013

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