and Supporting Regulations in 42 CFR 411.25, 489.2, and 489.20; *Form Number:* HCFA–250 through HCFA–254 (OMB approval #: 0938–0214); *Use:* Medicare Secondary Payer (MSP) refers to those situations where Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary. Medicare intermediaries and carriers must collect information to perform various tasks to detect MSP cases, develop and disseminate tools to enable them to better perform their tasks, and monitor their performance in achievement of their assigned MSP functions. These information collection requirements describe the MSP requirements and consist of the following:

1. Initial enrollment questionnaire
2. MSP claims investigation, which consists of first claim development, trauma code development, self-reporting MSP liability development, notice to responsible third party development (411.25 notice), secondary claims development, and ''08'' development (involving claims where information cannot be obtained from the beneficiary)
3. Provider MSP development, which requires the provider to request information from the beneficiary or representative during admission and other encounters; *Frequency:* On occasion; *Affected Public:* Individuals or households, Business or other for-profit, and Not-for-profit institutions; *Number of Respondents:* 14,204,000; *Total Annual Responses:* 116,394,528; *Total Annual Hours Requested:* 3,305,814.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access HCFA'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 HCFA document identifier, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326.

Public Meeting

HCFA will be holding a public meeting to permit interested parties an opportunity to give their views on how the content and use of the MSP collection requirements may need to be revised. Representatives of the hospital industry, health care consumer advocacy groups, and provider groups who wish to participate in the public meeting are asked to notify the Agency in advance of their interest in attending. At this meeting, the Health Care Financing Administration will solicit comments on the topics listed in the first paragraph of this notice and as referenced in the supporting statement, which may be obtained as described above.

The public meeting will be held on Friday, November 3, 2000, from 1:00–4:00 p.m., in the Multipurpose Room (Capacity: 100 persons) of the Health Care Financing Administration, 7500 Security Boulevard, Baltimore, Maryland 21244. Interested parties should provide notification of their planned attendance to Tom Bouchat or Joan Fowler, either via telephone (410) 786–4621 or (410) 786–0922, fax (410) 786–9963, or e-mail: Tbouchat@hcfa.gov or Jfowler@hcfa.gov by no later than 3 p.m., Monday, October 30, 2000.

Interested persons are invited to send comments regarding the burden or any other aspect of these collections of information requirements. However, as noted above, comments on these information collection requirements must be mailed and/or faxed to the designees referenced below by November 23, 2000:

Health Care Financing Administration, Office of Information Services, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850, Fax Number: (410) 786–0262, Attn: Julie Brown HCFA–250 through HCFA–254 and,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Fax Number: (202) 395–6974 or (202) 395–5167, Attn: Wendy Taylor, HCFA Desk Officer.

Dated: October 17, 2000.

John P. Burke, III,

HCFA Reports Clearance Officer, HCFA, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards.

[FR Doc. 00–27028 Filed 10–17–00; 3:06 pm]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–8007–N]

RIN 0938–AK27

Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 2001

AGENCY: Health Care Financing Administration (HCFA), 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 2001 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 $792. The daily coinsurance amounts will be: (a) $198 for the 61st through 90th day of hospitalization in a benefit period; (b) $396 for lifetime reserve days; and (c) $99 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, 2001.

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 2001

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 the same preceding calendar year, and adjusted to reflect 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) of the Act, as amended by section 4401(a) of the Balanced Budget Act of 1997 (BBA '97) (Public Law 105–33), the percentage increase used to update the payment rates for fiscal year 2001 for hospitals paid under the prospective payment system is the market basket percentage increase minus 1.1 percentage points.

Under section 1886(b)(3)(B)(ii) of the Act, as amended by section 4411(a) of the BBA '97, the percentage increase used to update the payment rates for fiscal year 2001 for hospitals excluded from the prospective payment system depends on the hospital's allowable operating costs of inpatient hospital services. If the hospital's allowable operating costs of inpatient hospital services for the most recent cost reporting period for which information is available—

(1) Are equal to or exceed 110 percent of the hospital's target amount for that cost reporting period, the applicable percentage increase is the market basket percentage;

(2) Exceed 100 percent but are less than 110 percent of the hospital's target amount for that cost reporting period, the applicable percentage increase is the market basket percentage minus 0.25 percentage points for each percentage point by which the hospital's allowable operating costs are less than 110 percent of the target amount for that cost reporting period (but not less than 0 percent);

(3) Are equal to or less than 100 percent of the hospital's target amount for that cost reporting period, but exceed two-thirds of the target amount, the applicable percentage increase is 0 percent or, if greater, the market basket percentage minus 2.5 percentage points; or

(4) Do not exceed two-thirds of the hospital's target amount for that cost reporting period, the applicable percentage increase is 0 percent.

The market basket percentage increase for fiscal year 2001 is 3.4 percent, as announced in the final rule titled ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2001 Rates,'' published in the **Federal Register** on August 1, 2000 (65 FR 47054). Therefore, the percentage increase for hospitals paid under the prospective payment system is 2.3 percent. The average payment percentage increase for hospitals excluded from the prospective payment system is 1.4 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 2001 is 2.21 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 2000 compared to fiscal year 1999. (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 HCFA as of June 2000. These bills represent a total of about 7.3 million discharges for fiscal year 2000 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 2000 is −0.95 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 2000 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. There is a negligible change in overall case mix for fiscal year 2000. We estimate that there is no change in real case mix; that is, we estimate that the change in real case mix for fiscal year 2000 is 0.0 percent.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 2.21 percent, and the real case mix adjustment factor for the deductible is 0.0 percent. Therefore, under the statutory formula, the inpatient hospital deductible for services furnished in calendar year 2001 is $792. This deductible amount is determined by multiplying $776 (the inpatient hospital deductible for 2000) by the payment-weighted average increase in the payment rates of 1.0221 multiplied by the increase in real case mix of 1.000, which equals $793.15 and is rounded to $792.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for 2001

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 2001, 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 $198 (one-fourth of the inpatient hospital deductible); the daily coinsurance for lifetime reserve days will be $396 (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 $99 (one-eighth of the inpatient hospital deductible).

IV. Cost to Beneficiaries

We estimate that in 2001 there will be about 8.56 million deductibles paid at $792 each, about 2.10 million days subject to coinsurance at $198 per day (for hospital days 61 through 90), about 0.97 million lifetime reserve days subject to coinsurance at $396 per day, and about 30.08 million extended care days subject to coinsurance at $99 per day. Similarly, we estimate that in 2000 there will be about 8.42 million deductibles paid at $776 each, about 2.06 million days subject to coinsurance at $194 per day (for hospital days 61 through 90), about 0.95 million lifetime reserve days subject to coinsurance at $388 per day, and about 28.64 million extended care days subject to coinsurance at $97 per day. Therefore, the estimated total increase in cost to beneficiaries is about $480 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 these 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 and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). The RFA requires agencies to analyze options for regulatory relief for small businesses. For purposes of the RFA, States and individuals are not considered small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any notice that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we consider a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 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.

As stated in section IV of this notice, we estimate that the total increase in costs to beneficiaries associated with this notice is about $480 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.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

We have reviewed this notice under the threshold criteria of Executive Order 13132, Federalism. We have determined that it does not significantly affect the rights, roles, and responsibilities of States.

Authority: Sections 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 5, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: September 26, 2000.

Donna E. Shalala,

Secretary.

[FR Doc. 00–26846 Filed 10–18–00; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–8009–N]

Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Rate Beginning January 1, 2001

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice.

SUMMARY: In accordance with section 1839 of the Social Security Act, this notice announces the monthly actuarial rates for aged (aged 65 and over) and disabled (under age 65) enrollees in the Medicare Supplementary Medical Insurance (SMI) program for 2001. It also announces the monthly SMI premium to be paid by all enrollees during 2001. The monthly actuarial rates for 2001 are $101.00 for aged enrollees and $132.00 for disabled enrolless. The monthly SMI premium rate for 2001 is $50.00. This compares to projections of the 2001 SMI premium of $49.90 in the 2000 Trustees Report and $57.00 in the 1998 Trustees Report. The 2000 premium rate was $45.50 and a good portion of the increase for 2001 is due to additional amounts of home health being transferred into Part B (the 2001 monthly premium includes $3.09 for home health services being transferred into Part B). The 2001 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 2001 (four-sixths) and the amount in Part B that is included in the premium calculation (four-sevenths).

EFFECTIVE DATE: January 1, 2001.

FOR FURTHER INFORMATION CONTACT: Carter S. Warfield, (410) 786–6396.

SUPPLEMENTARY INFORMATION:

I. Background

The Medicare Supplementary Medical Insurance (SMI) program is the voluntary Medicare Part B program that pays all or part of the costs for physicians' services, outpatient hospital services, home health services, services furnished by rural health clinics, ambulatory surgical centers, comprehensive outpatient rehabilitation facilities, and certain other medical and health services not covered by hospital insurance (HI) (Medicare Part A). The SMI program is available to individuals who are entitled to HI and to U.S. residents who have attained age 65 and are citizens, or aliens who were lawfully admitted for permanent residence and have resided in the United States for 5 consecutive years. This program requires enrollment and payment of monthly premiums, as provided in 42 CFR part 407, subpart B, and part 408, respectively. The difference between the premiums paid by all enrollees and total incurred costs is met from the general revenues of the Federal government.

The Secretary of Health and Human Services is required by section 1839 of the Social Security Act (the Act) to issue two annual notices relating to the SMI program.

One notice announces two amounts that, according to actuarial estimates, will equal respectively, one-half the expected average monthly cost of SMI for each aged enrollee (age 65 or over) and one-half the expected average monthly cost of SMI for each disabled enrollee (under age 65) during the year beginning the following January. These amounts are called ''monthly actuarial rates.''

The second notice announces the monthly SMI premium rate to be paid by aged and disabled enrollees for the year beginning the following January. (Although the costs to the program per disabled enrollee are different than for the aged, the law provides that they pay the same premium amount.) Beginning with the passage of section 203 of the Social Security Amendments of 1972 (Public Law 92–603), the premium rate, which was determined on a fiscal year basis, was limited to the lesser of the actuarial rate for aged enrollees, or the