Proposed Project

Reframing How We Talk About Alcohol: Public Perceptions of Excessive Alcohol Use and Related Harms—NEW—National Center on Birth Defects and Developmental Disabilities (NCBDD), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Excessive alcohol consumption leads to a variety of negative health and social consequences. Those who drink heavily have an increased risk for certain chronic diseases, such as hypertension, psychological disorders, and various forms of cancer. Excessive alcohol use also can result in societal harms, such as unintentional injuries, violence, and high economic costs.

Fortunately effective prevention strategies are available to reduce excessive alcohol use and its related harms. However, it is difficult to craft public health messages and communication strategies to change alcohol-related attitudes and behaviors because the range of knowledge and beliefs about excessive alcohol use and its risks is not well understood. Despite the fact that public health experts recommend that alcohol screening and brief counseling be provided to adults in primary care settings, data indicate that only one of six U.S. adults reported ever discussing alcohol use with a health professional. To develop an effective, consistent messaging strategy, a deeper understanding of how the public thinks and talks about alcohol is required. The research will be used to inform the development of patient and provider materials and messages about excessive alcohol use and related harms.

The one-year study proposes a series of individual in-depth interviews and triads (small group discussions with three participants) with 54 participants identified by contractor staff and professional recruiting firms. Data will be collected through one-time, 90-minute in-depth interviews or triads. Up to 300 individuals will be screened to obtain 54 individuals who will participate in 90-minute in-depth interviews or triads. All data will be collected only one time. Respondents who will participate in these interviews and triads will be selected purposively to inform the development of a messaging strategy. Topics addressed may include alcohol and its related harms, language used when talking about alcohol, how people talk about alcohol with their health care providers, and sources of information about alcohol.

The information gathered through this data collection will allow CDC to develop an effective messaging strategy that reframes the way the public thinks and communicates about excessive alcohol use. Participation is voluntary, and there is no cost to respondents other than their time.

The total estimated annualized burden hours are 132.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden hours
Persons aged 21–55	Study screener	300	1	10/60	50
	In-depth interviews				
	Phase 1 (Descriptive)	9	1	1.5	14
	Phase 2 (Prescriptive)	9	1	1.5	14
	Triads				
	Phase 1 (Descriptive)	18	1	1.5	27
	Phase 2 (Prescriptive)	18	1	1.5	27
Total					132

Leroy A. Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8062–N]

RIN 0938–AS70

Medicare Program; CY 2017 Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts

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) 2017 under Medicare's Hospital Insurance Program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts. For CY 2017, the inpatient hospital deductible will be $1,316. The daily coinsurance amounts for CY 2017 will be: (1) $329 for the 61st through 90th day of hospitalization in a benefit period; (2) $658 for lifetime reserve days; and (3) $164.50 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, 2017.

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 2017

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 2017 for hospitals paid under the inpatient prospective payment system is the market basket percentage increase, otherwise known as the market basket update, reduced by 0.75 percentage points (see section 1886(b)(3)(B)(xii)(V) 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, for FY 2017, the applicable percentage increase for hospitals that do not submit quality data as specified by the Secretary of the Department of Health and Human Services (the Secretary) is reduced by one quarter of the market basket update. 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 not be affected, since the majority of hospitals submit quality data and receive the full market basket update. Section 1886(b)(3)(B)(ix) of the Act requires that any hospital that is not a meaningful electronic health record (EHR) user (as defined in section 1886(n)(3) of the Act) will have three-quarters of the market basket update reduced by 66⅔ percent for FY 2016, 100 percent for FY 2017, and 100 percent for FY 2018 and each subsequent fiscal year. We are estimating that after accounting for these hospitals receiving the lower market basket update, the calculated deductible will not be affected, since the majority of hospitals are meaningful EHR users and are expected to receive the full market basket update.

Under section 1886 of the Act, the percentage increase used to update the payment rates for FY 2017 for hospitals excluded from the inpatient prospective payment system is as follows:

- The percentage increase for long term care hospitals is the market basket percentage increase reduced by 0.75 percentage points and the MFP adjustment (see sections 1886(m)(3)(A) and 1886(m)(4)(F) of the Act). In addition, these hospitals may also be impacted by the quality reporting adjustments and the site-neutral payment rates (see sections 1886(m)(5) and 1886(m)(6) of the Act).
- The percentage increase for inpatient rehabilitation facilities is the market basket percentage increase reduced by 0.75 percentage points and the MFP adjustment (see sections 1886(j)(3)(C) and 1886(j)(3)(D)(v) of the Act). In addition, these hospitals may also be impacted by the quality reporting adjustments (see section 1886(j)(7) 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)(E) of the Act). In addition, these hospitals may also be impacted by the quality reporting adjustments (see section 1886(s)(4) of the Act).
- The percentage increase for other types of hospitals excluded from the inpatient hospital prospective payment system (cancer hospitals, children's hospitals, and hospitals located outside the 50 States, the District of Columbia, and Puerto Rico) is the market basket percentage increase (see section 1886(b)(3)(B)(ii)(VIII) of the Act).

The Inpatient Prospective Payment System market basket percentage increase for FY 2017 is 2.7 percent and the MFP adjustment is −0.3 percentage point, as announced in the final rule that appeared in the **Federal Register** on August 22, 2016 entitled, ''Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2017 Rates'' (81 FR 56762). Therefore, the percentage increase for hospitals paid under the inpatient prospective payment system that submit quality data and are meaningful EHR users is 1.65 percent (that is, the FY 2017 market basket update of 2.7 percent less the MFP adjustment of 0.3 percentage point and less 0.75 percentage point). The average payment percentage increase for hospitals excluded from the inpatient prospective payment system is 2.0 percent. This average includes long term care hospitals, inpatient rehabilitation facilities, and other hospitals excluded from the inpatient hospital prospective payment system. 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 2017 is 1.70 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 2016 compared to FY 2015. (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 2016. These bills represent a total of about 7.4 million Medicare discharges for FY 2016 and provide the most recent case-mix data available at this time. Based on these bills, the change in average case-mix in FY 2016 is 2.61 percent. Based on these bills and past experience, we expect the overall case mix change to be 2.7 percent as the year progresses and more FY 2016 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. Over the past several years, we have seen case mix increases of about 0.5 percent per year. (In some years there were larger increases in case mix due to much lower discharges for that year.) For 2016, we expect the increase in real case mix to continue to be 0.5 percent. Most of the observed FY 2016 case mix increase is likely due to artifacts of the implementation of ICD–10 which affects the calculated case mix level, but does not measure the actual increase in real case mix. Therefore, we expect that much of the change in average case-mix will not be real and estimate that this real 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 1.70 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 2017 to be $1,316. This deductible amount is determined by multiplying $1,288 (the inpatient hospital deductible for CY 2016 (81 FR 56762)) by the payment-weighted average increase in the payment rates of 1.017 multiplied by the increase in real case-mix of 1.005, which equals $1,316.45 and is rounded to $1,316.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for CY 2017

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 2017, 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 $329 (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 $658 (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 $164.50 (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 2016 and 2017, as well as the number of each that is estimated to be paid.

TABLE 1—PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CALENDAR YEARS 2016 AND 2017 TYPE OF COST SHARING

	Value		Number paid (in millions)	
	2016	2017	2016	2017
Inpatient hospital deductible	$1288	$1316	7.15	7.26
Daily coinsurance for 61st–90th Day	322	329	1.77	1.80
Daily coinsurance for lifetime reserve days	644	658	0.87	0.88
SNF coinsurance	161	164.50	40.56	41.83

The estimated total increase in costs to beneficiaries is about $740 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 2016 and 2017 deductible and coinsurance amounts multiplied by the estimated 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 CY.

B. Overall Impact

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 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 $740 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 2017 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 2016, that threshold accounting for inflation is approximately $146 million. This notice does not impose mandates that will have a consequential effect of $146 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: September 23, 2016.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: November 8, 2016.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

[FR Doc. 2016–27389 Filed 11–10–16; 4:15 pm]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8064–N]

RIN 0938–AS72

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2017

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 Insurance (SMI) program beginning January 1, 2017. In addition, this notice announces the monthly premium for aged and disabled beneficiaries, the deductible for 2017, and the income-related monthly adjustment amounts to be paid by beneficiaries with modified adjusted gross income above certain threshold amounts. The monthly actuarial rates for 2017 are $261.90 for aged enrollees and $254.20 for disabled enrollees. The standard monthly Part B premium rate for all enrollees for 2017 is $134.00, which is equal to 50 percent of the monthly actuarial rate for aged enrollees (or approximately 25 percent of the expected average total cost of Part B coverage for aged enrollees) plus $3.00. (The 2016 standard premium rate was $121.80, which includes the $3.00 repayment amount.) The Part B deductible for 2017 is $183.00 for all Part B beneficiaries. If a beneficiary has to pay an income-related monthly adjustment, they will have to pay a total monthly premium of about 35, 50, 65, or 80 percent of the total cost of Part B coverage plus $4.20, $6.00, $7.80, or $9.60.

DATES: *Effective Date:* January 1, 2017.

FOR FURTHER INFORMATION CONTACT: M. Kent Clemens, (410) 786–6391.

SUPPLEMENTARY INFORMATION:

I. Background

Part B is the voluntary portion of the Medicare program that pays all or part of the costs for physicians' services, outpatient hospital services, certain 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 Medicare Part A, Hospital Insurance. Medicare Part B