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 direct effect on state or local governments, preempt state law, or otherwise have Federalism implications.

Executive Order 13771, titled ''Reducing Regulation and Controlling Regulatory Costs,'' was issued on January 30, 2017 (82 FR 9339, February 3, 2017). It has been determined that this notice is a transfer notice that does not impose more than de minimis costs and thus is not a regulatory action for the purposes of E.O. 13771.

Consistent with the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*), this notice has been transmitted to the Congress and the Comptroller General for review.

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

Although this notice does not constitute a substantive rule, we nevertheless prepared this Impact Analysis in the interest of ensuring that the impacts of this notice are fully understood.

Dated: October 3, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 11, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2018–22529 Filed 10–12–18; 11:15 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3370–PN]

Medicare and Medicaid Program; Application from the Accreditation Association for Hospitals/Health Systems-Healthcare Facilities Accreditation Program (AAHHS–HFAP) for Approval of its Hospital Accreditation Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice with request for comment.

SUMMARY: This proposed notice acknowledges the receipt of an application from the Accreditation Association for Hospitals/Health Systems-Healthcare Facilities Accreditation Program (AAHHS–HFAP) for recognition as a national accrediting organization for hospitals that wish to participate in the Medicare or Medicaid programs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on November 16, 2018.

ADDRESSES: In commenting, refer to file code CMS–3370–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3370–PN, P.O. Box 8016, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3370–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Monda Shaver, (410) 786–3410, Mary Ellen Palowitch, (410) 786–4496, or Renee Henry, (410) 786–7828.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a hospital, provided that certain requirements are met. Section 1861(e) of the Social Security Act (the Act), establishes distinct criteria for facilities seeking designation as a hospital. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488. The regulations at 42 CFR part 482 specify the minimum conditions that a hospital must meet to participate in the Medicare program.

Generally, to enter into an agreement, a hospital must first be certified by a state survey agency as complying with the conditions or requirements set forth in part 482 of our regulations. Thereafter, the hospital is subject to regular surveys by a state survey agency to determine whether it continues to meet these requirements. There is an alternative; however, to surveys by state agencies.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accrediting organization that all applicable Medicare conditions are met or exceeded, we may deem those provider entities as having met the requirements. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

If an accrediting organization is recognized by the Secretary of the Department of Health and Human Services (the Secretary) as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program may be deemed to meet the Medicare conditions. A national accrediting organization applying for approval of its accreditation program under part 488, subpart A, must provide the Centers for Medicare and Medicaid Services (CMS) with reasonable assurance that the accrediting organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of accrediting organizations are set forth at § 488.5. The regulations at § 488.5(e)(2)(i) require accrediting organizations to reapply for continued approval of its accreditation program every 6 years or sooner as determined by CMS.

II. Provisions of the Proposed Notice

A. Approval of Deeming Organizations

Section 1865(a)(2) of the Act and our regulations at § 488.5 require that our

findings concerning review and approval of a national accrediting organization's requirements consider, among other factors, the applying accrediting organization's requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide us with the necessary data for validation.

Section 1865(a)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accrediting body making the request, describing the nature of the request, and providing at least a 30-day public comment period. We have 210 days from the receipt of a complete application to publish notice of approval or denial of the application.

The purpose of this proposed notice is to inform the public of AAHHS–HFAP's request for approval of its hospital accreditation program. This notice also solicits public comment on whether AAHHS–HFAP's requirements meet or exceed the Medicare conditions of participation (CoPs) for hospitals.

B. Evaluation of Deeming Authority Request

AAHHS–HFAP submitted all the necessary materials to enable us to make a determination concerning its request for continued approval of its hospital accreditation program. This application was determined to be complete on August 17, 2018. Under section 1865(a)(2) of the Act and our regulations at § 488.5 (Application and re-application procedures for national accrediting organizations), our review and evaluation of AAHHS–HFAP will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of AAHHS–HFAP's standards for hospitals as compared with CMS' hospital CoPs.
- AAHHS–HFAP's survey process to determine the following:

++ The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

++ The comparability of AAHHS–HFAP's processes to those of state agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ AAHHS–HFAP's processes and procedures for monitoring a hospital found out of compliance with the AAHHS–HFAP's program requirements. These monitoring procedures are used only when the AAHHS–HFAP identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the state survey agency monitors corrections as specified at § 488.9(c).

++ AAHHS–HFAP's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

++ AAHHS–HFAP's capacity to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ The adequacy of AAHHS–HFAP's staff and other resources, and its financial viability.

++ AAHHS–HFAP's capacity to adequately fund required surveys.

++ AAHHS–HFAP's policies with respect to whether surveys are announced or unannounced, to assure that surveys are unannounced.

++ AAHHS–HFAP's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as we may require (including corrective action plans).

C. Notice Upon Completion of Evaluation

Upon completion of our evaluation, including evaluation of public comments received as a result of this notice, we will publish a final notice in the **Federal Register** announcing the result of our evaluation.

III. 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. Chapter 35).

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Dated: October 10, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2018–22546 Filed 10–16–18; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8068–N]

RIN 0938–AT33

Medicare Program; CY 2019 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) 2019 under Medicare's Hospital Insurance Program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts. For CY 2019, the inpatient hospital deductible will be $1,364. The daily coinsurance amounts for CY 2019 will be: $341 for the 61st through 90th day of hospitalization in a benefit period; $682 for lifetime reserve days; and $170.50 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, 2019.

FOR FURTHER INFORMATION CONTACT: Yaminee Thaker, (410) 786–7921 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 the Secretary of the Department of Health and Human Services (the Secretary) to determine and publish each year the amount of the inpatient hospital deductible and the hospital and