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

extended care services coinsurance amounts applicable for services furnished in the following calendar year (CY).

II. Computing the Inpatient Hospital Deductible for CY 2019

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 2019 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 2019, the applicable percentage increase for hospitals that do not submit quality data as specified by 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 100 percent for FY 2017 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 2019 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 a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, and further reduced by 0.75 percentage points in accordance with sections 1886(j)(3)(C)(ii)(II) 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 0.75 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 prospective payment system (for example, 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 2019 is 2.9 percent and the MFP adjustment is 0.8 percentage point, as announced in the final rule that appeared in the **Federal Register** on August 17, 2018 entitled, ''Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2019 Rates'' (83 FR 41144). Therefore, the percentage increase for hospitals paid under the inpatient prospective payment system that submit quality data and are meaningful EHR users is 1.35 percent (that is, the FY 2019 market basket update of 2.9 percent less the MFP adjustment of 0.8 percentage point and less 0.75 percentage point). The average payment percentage increase for hospitals excluded from the inpatient prospective payment system is 1.62 percent. This average includes long term care hospitals, inpatient rehabilitation facilities, and other hospitals excluded from the inpatient 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 2019 is 1.39 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 inpatient prospective payment system in FY 2018 compared to FY 2017. (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 2018. These bills represent a total of about 7.3 million Medicare discharges for FY 2018 and provide the most recent case-mix data available at this time. Based on these bills, the change in average case-mix in FY 2018 is 1.33 percent. Based on these bills and past experience, we expect the overall case mix change to be 1.8 percent as the year progresses and more FY 2018 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 observed total case mix increases of about 0.5 percent per year and have assumed that they are real. Thus, since we do not have further information at this time, we expect that 0.5 percent of the 1.8 percent change in average case-mix for FY 2018 will be real.

Thus as stated above, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 1.39 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 2019 to be $1,364. This deductible amount is determined by multiplying $1,340 (the inpatient hospital deductible for CY 2018 (82 FR 55367)) by the payment-weighted average increase in the payment rates of 1.0139 multiplied by the increase in real case-mix of 1.005, which equals $1,365.42 and is rounded to $1,364.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for CY 2019

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 2019, 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 $341 (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 $682 (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 (SNF) in a benefit period will be $170.50 (one-eighth of the inpatient hospital deductible as stated in section 1813(a)(3) of the Act).

IV. Cost to Medicare Beneficiaries

The Table below summarizes the deductible and coinsurance amounts for CYs 2018 and 2019, as well as the number of each that is estimated to be paid.

PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CALENDAR YEARS 2018 AND 2019

Type of cost sharing	Value		Number paid (in millions)	
	2018	2019	2018	2019
Inpatient hospital deductible	$1,340	$1,364	7.19	7.23
Daily coinsurance for 61st–90th Day	335	341	1.72	1.72
Daily coinsurance for lifetime reserve days	670	682	0.84	0.85
SNF coinsurance	167.50	170.50	33.15	33.34

The estimated total increase in costs to beneficiaries is about $390 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 2018 and 2019 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. We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment prior to a rule taking effect in accordance with section 553(b) of the Administrative Procedure Act (APA) and section 1871 of the Act. However, we believe that the policies being publicized in this document do not constitute agency rulemaking. Rather, the statute requires that the agency determine and publish the inpatient hospital deductible and hospital and extended care services coinsurance amounts for each calendar year in accordance with the statutory formulae, and we are simply notifying the public of the changes to the Medicare Part A deductible and coinsurance amounts for CY 2019. To the extent any of the policies articulated in this document constitute interpretations of the statute's requirements or procedures that will be used to implement the statute's directive, they are interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice, which are not subject to notice and comment rulemaking under the APA.

To the extent that notice and comment rulemaking would otherwise apply, we find good cause to waive this requirement. Under the APA, we may waive notice and public 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 this document does not propose to make any substantive changes to the policies or methodologies, but simply applies the formulae used to calculate the inpatient hospital deductible and hospital and extended care services coinsurance amounts as 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, so we also do not have any discretion in that regard. Therefore, we find good cause to waive notice and comment procedures, if such procedures are required at all.

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 impacts of this notice in accordance with 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), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

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). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) Having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). Although we do not consider this notice to constitute a substantive rule, this notice is economically significant under section 3(f)(1) of Executive Order 12866. As stated in section IV of this notice, we estimate that the total increase in costs to beneficiaries associated with this notice is about $390 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.

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 website at *http://www.sba.gov/content/small-business-size-standards*). Individuals and states are not included in the definition of a small entity. This annual notice announces the Medicare Part A deductible and coinsurance amounts for CY 2019 and will have an impact on the Medicare beneficiaries. 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 RIA 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. This annual notice announces the Medicare Part A deductible and coinsurance amounts for CY 2019 and will have an impact on the Medicare beneficiaries. As a result, 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 (UMRA) 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 2018, that threshold is approximately $150 million. This notice does not impose mandates that will have a consequential effect of $150 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. 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. 2018–22526 Filed 10–12–18; 11:15 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8070–N]

RIN 0938–AT35

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rates, and Annual Deductible Beginning January 1, 2019

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, 2019. In addition, this notice announces the monthly premium for aged and disabled beneficiaries, the deductible for 2019, 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 2019 are $264.90 for aged enrollees and $315.40 for disabled