

PHS Act. The notification provisions, including the definition of “emergency response employee,” were then removed from the Ryan White HIV/AIDS Treatment Modernization Act of 2006 and the PHS Act.<sup>4</sup> The term “emergency response employee,” however, continued to be used in a different part of the statutes pertaining to responsibilities assigned to the Health Resources and Services Administration (HRSA).<sup>5</sup> When Congress reinstated the notification provisions in Part G of the Ryan White HIV/AIDS Treatment Extension Act of 2009, a definition of ERE was not included.

NIOSH has interpreted the legislative history and the development of the Ryan White CARE Act of 1990 and subsequent reauthorizations to indicate that Congress’s failure to restore the original definition of ERE was unintentional and merely an oversight. Including the original statutory definition in the NIOSH list and guidelines would allow the notification provisions to be implemented as Congress originally intended.

Including the definition of “emergency response employee” in the definitions section of the list and guidelines is within NIOSH’s authority, pursuant to the August 27, 2018 re-delegation for the sec. 2695 duties. Implicit in this directive is the need to identify the types of EREs who transport or serve victims of emergencies taken to medical facilities, in order to improve the notification system allowing EREs to receive timely diagnosis and post-exposure medical treatment for infectious disease exposures. NIOSH therefore has the authority to include the definition of “emergency response employees” in the list and guidelines.

After consideration of public comment submitted to the docket for this action, NIOSH will update the guidelines and list with the ERE definition and re-publish them on the NIOSH Ryan White HIV/AIDS Treatment Extension Act of 2009 topic

page, at <https://www.cdc.gov/niosh/topics/ryanwhite/>.

**John J. Howard,**

*Director, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention.*

[FR Doc. 2018–22522 Filed 10–16–18; 8:45 am]

**BILLING CODE 4163–19–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

#### Breast and Cervical Cancer Early Detection and Control Advisory Committee (BCCEDCAC); Notice of Charter Renewal

**AGENCY:** Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

**ACTION:** Notice of charter renewal.

**SUMMARY:** This gives notice under the Federal Advisory Committee Act of October 6, 1972, that the Breast and Cervical Cancer Early Detection and Control Advisory Committee (BCCEDCAC), Centers for Disease Control and Prevention, Department of Health and Human Services, has been renewed for a 2-year period through September 12, 2020.

**FOR FURTHER INFORMATION CONTACT:** Ms. Jameka Blackmon, Designated Federal Officer, BCCEDCAC, CDC, 1600 Clifton Road NE, M/S K57, Atlanta, Georgia 30329, telephone (770) 488–4740; fax (770) 488–3230.

The Chief Operating Officer, Centers for Disease Control and Prevention, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

**Sherri Berger,**

*Chief Operating Officer, Centers for Disease Control and Prevention.*

[FR Doc. 2018–22561 Filed 10–16–18; 8:45 am]

**BILLING CODE 4163–18–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

#### Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP); Notice of Charter Renewal

**AGENCY:** Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

**ACTION:** Notice of charter renewal.

**SUMMARY:** This gives notice under the Federal Advisory Committee Act of October 6, 1972, that the Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP), Centers for Disease Control and Prevention, Department of Health and Human Services, has been renewed for a 2-year period through September 18, 2020.

**FOR FURTHER INFORMATION CONTACT:** Chris Langub, Ph.D., Designated Federal Officer, CDC, 1600 Clifton Road NE, Mailstop K48, Atlanta, Georgia 30329–4027, telephone (770) 488–3585; email [eeo6@cdc.gov](mailto:eeo6@cdc.gov).

The Chief Operating Officer, Centers for Disease Control and Prevention, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

**Sherri Berger,**

*Chief Operating Officer, Centers for Disease Control and Prevention.*

[FR Doc. 2018–22616 Filed 10–16–18; 8:45 am]

**BILLING CODE 4163–18–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

[CMS–8069–N]

RIN 0938–AT34

#### Medicare Program; CY 2019 Part A Premiums for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

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

**ACTION:** Notice.

**SUMMARY:** This annual notice announces Medicare’s Hospital Insurance (Part A) premium for uninsured enrollees in

<sup>4</sup> The notification provisions now included in Part G were formerly found in Part E, which was deleted because the intent of the 2006 reauthorization was, in part, to eliminate programs “which had never been funded or re-examined in the last two reauthorizations.” Congress then “deleted definitions which were no longer relevant (e.g., designated officer of emergency response employees, emergency, emergency response employee, employer of emergency response employees, and exposed),” which were located in Part D of the original statute. See H.R. REP. NO. 109–695, at 12 (2006).

<sup>5</sup> 42 U.S.C. 300ff–62.

calendar year (CY) 2019. This premium is paid by enrollees age 65 and over who are not otherwise eligible for benefits under Medicare Part A (hereafter known as the “uninsured aged”) and by certain disabled individuals who have exhausted other entitlement. The monthly Part A premium for the 12 months beginning January 1, 2019 for these individuals will be \$437. The premium for certain other individuals as described in this notice will be \$240.

**DATES:** *Effective Date:* This notice is effective on January 1, 2019.

**FOR FURTHER INFORMATION CONTACT:** Yaminee Thaker, (410) 786-7921.

**SUPPLEMENTARY INFORMATION:**

**I. Background**

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in the Medicare Hospital Insurance Program (Medicare Part A), subject to payment of a monthly premium, of certain persons aged 65 and older who are uninsured under the Old-Age, Survivors, and Disability Insurance (OASDI) program or the Railroad Retirement Act and do not otherwise meet the requirements for entitlement to Medicare Part A. These “uninsured aged” individuals are uninsured under the OASDI program or the Railroad Retirement Act, because they do not have 40 quarters of coverage under Title II of the Act (or are/were not married to someone who did). (Persons insured under the OASDI program or the Railroad Retirement Act and certain others do not have to pay premiums for Medicare Part A.)

Section 1818A of the Act provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium for certain disabled individuals who have exhausted other entitlement. These are individuals who were entitled to coverage due to a disabling impairment under section 226(b) of the Act, but who are no longer entitled to disability benefits and free Medicare Part A coverage because they have gone back to work and their earnings exceed the statutorily defined “substantial gainful activity” amount (section 223(d)(4) of the Act).

Section 1818A(d)(2) of the Act specifies that the provisions relating to premiums under section 1818(d) through section 1818(f) of the Act for the aged will also apply to certain disabled individuals as described above.

Section 1818(d)(1) of the Act requires us to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services incurred in the upcoming calendar year (CY) (including the

associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Medicare Part A. We must then determine the monthly actuarial rate for the following year (the per capita amount estimated above divided by 12) and publish the dollar amount for the monthly premium in the succeeding CY. If the premium is not a multiple of \$1, the premium is rounded to the nearest multiple of \$1 (or, if it is a multiple of 50 cents but not of \$1, it is rounded to the next highest \$1).

Section 13508 of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103-66) amended section 1818(d) of the Act to provide for a reduction in the premium amount for certain voluntary enrollees (section 1818 and section 1818A of the Act). The reduction applies to an individual who is eligible to buy into the Medicare Part A program and who, as of the last day of the previous month:

- Had at least 30 quarters of coverage under Title II of the Act;
- Was married, and had been married for the previous 1 year period, to a person who had at least 30 quarters of coverage;
- Had been married to a person for at least 1 year at the time of the person’s death if, at the time of death, the person had at least 30 quarters of coverage; or
- Is divorced from a person and had been married to the person for at least 10 years at the time of the divorce if, at the time of the divorce, the person had at least 30 quarters of coverage.

Section 1818(d)(4)(A) of the Act specifies that the premium that these individuals will pay for CY 2019 will be equal to the premium for uninsured aged enrollees reduced by 45 percent.

Section 1818(g) of the Act requires the Secretary, at the request of a state, to enter into a Part A buy-in agreement with a state to pay Medicare Part A premiums for Qualified Medicare Beneficiaries (QMBs). Under the QMB program, state Medicaid agencies must pay the Medicare Part A premium for those not eligible for premium-free Part A. (Entering into a Part A buy-in agreement would permit a state to avoid late enrollment penalties and enroll persons in Part A at any time of the year (without regard to Medicare enrollment periods)).

**II. Monthly Premium Amount for CY 2019**

The monthly premium for the uninsured aged and certain disabled individuals who have exhausted other entitlement for the 12 months beginning January 1, 2019, is \$437. The monthly premium for the individuals eligible

under section 1818(d)(4)(B) of the Act, and therefore, subject to the 45 percent reduction in the monthly premium, is \$240.

**III. Monthly Premium Rate Calculation**

As discussed in section I of this notice, the monthly Medicare Part A premium is equal to the estimated monthly actuarial rate for CY 2019 rounded to the nearest multiple of \$1 and equals one-twelfth of the average per capita amount, which is determined by projecting the number of Medicare Part A enrollees aged 65 years and over as well as the benefits and administrative costs that will be incurred on their behalf.

The steps involved in projecting these future costs to the Federal Hospital Insurance Trust Fund are:

- Establishing the present cost of services furnished to beneficiaries, by type of service, to serve as a projection base;
- Projecting increases in payment amounts for each of the service types; and
- Projecting increases in administrative costs.

We base our projections for CY 2019 on—(1) current historical data; and (2) projection assumptions derived from current law and the Mid-Session Review of the President’s Fiscal Year 2019 Budget.

We estimate that in CY 2019, 51,601,049 people aged 65 years and over will be entitled to (enrolled in) benefits (without premium payment) and that they will incur about \$270.703 billion in benefits and related administrative costs. Thus, the estimated monthly average per capita amount is \$437.17 and the monthly premium is \$437. Subsequently, the full monthly premium reduced by 45 percent is \$240.

**IV. Costs to Beneficiaries**

The CY 2019 premium of \$437 is approximately 3.6 percent higher than the CY 2018 premium of \$422. We estimate that approximately 679,000 enrollees will voluntarily enroll in Medicare Part A, by paying the full premium. We estimate that over 90 percent of these individuals will have their Part A premium paid for by states, since they are enrolled in the QMB program. Furthermore, the CY 2019 reduced premium of \$240 is approximately 3.4 percent higher than the CY 2018 premium of \$232. We estimate an additional 75,000 enrollees will pay the reduced premium. Therefore, we estimate that the total aggregate cost to enrollees paying these premiums in CY 2019, compared to the

amount that they paid in CY 2018, will be about \$129 million.

#### V. Waiver of Proposed Notice and Comment Period

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 the applicable premium amount for each calendar year in accordance with the statutory formula, and we are simply notifying the public of the changes to the Medicare Part A premiums 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 believe that notice and comment rulemaking for this notification of Medicare Part A premiums for CY 2019 is unnecessary because of the lack of CMS discretion in the statutory formula that is used to calculate the premium and the solely ministerial function that this notice serves. 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 1818(d) of the Act requires the Secretary of the Department of

Health and Human Services (the Secretary) during September of each year to determine and publish the amount to be paid, on an average per capita basis, from the Federal Hospital Insurance Trust Fund for services incurred in the impending CY (including the associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Medicare Part A.

##### 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 overall effect of the changes in the Part A premium will be a cost to voluntary enrollees (section 1818 and section 1818A of the Act) of about \$129 million.

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 less than \$7.5 million to \$38.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. This annual notice announces the Medicare Part A premiums 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 Act requires us to prepare an 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 for Medicare payment regulations and has fewer than 100 beds. This annual notice announces the Medicare Part A premiums 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 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. 2018–22529 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 21244–8016.

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