

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by *November 10, 2014*.

ADDRESSES: When commenting on the proposed information collections, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be received by the OMB desk officer via one of the following transmissions: OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395-5806 OR Email: OIRA_submission@omb.eop.gov.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' Web site address at <http://www.cms.hhs.gov/PaperworkReductionActof1995>.
2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov.
3. Call the Reports Clearance Office at (410) 786-1326.

FOR FURTHER INFORMATION CONTACT: Reports Clearance Office at (410) 786-1326.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501-3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term "collection of information" is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice that summarizes the following proposed collection(s) of information for public comment:

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* State Medicaid HIT Plan, Planning Advance Planning Document, and Implementation Advance Planning Document for Section 4201 of the Recovery Act; *Use:* To assess the appropriateness of state

requests for the administrative Federal financial participation for expenditures under their Medicaid Electronic Health Record Incentive Program related to health information exchange, our staff will review the submitted information and documentation to make an approval determination of the state advance planning document. *Form Number:* CMS-10292 (OMB control number 0938-1088); *Frequency:* Once and occasionally; *Affected Public:* State, Local, and Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 56; *Total Annual Hours:* 896. (For policy questions regarding this collection contact Thomas Romano at 410-786-0465).

2. *Type of Information Collection Request:* Extension of currently approved collection; *Title of Information Collection:* Granting and Withdrawal of Deeming Authority to Private Nonprofit Accreditation Organizations and of State Exemption Under State Laboratory Programs and Supporting Regulations; *Use:* The information required is necessary to determine whether a private accreditation organization/State licensure program standards and accreditation/licensure process is at least equal to or more stringent than those of the Clinical Laboratory Improvement Amendments of 1988 (CLIA). If an accreditation organization is approved, the laboratories that it accredits are "deemed" to meet the CLIA requirements based on this accreditation. Similarly, if a State licensure program is determined to have requirements that are equal to or more stringent than those of CLIA, its laboratories are considered to be exempt from CLIA certification and requirements. The information collected will be used by HHS to: determine comparability/equivalency of the accreditation organization standards and policies or State licensure program standards and policies to those of the CLIA program; to ensure the continued comparability/equivalency of the standards; and to fulfill certain statutory reporting requirements. *Form No.:* CMS-R-185 (OMB control number: 0938-0686); *Frequency:* Occasionally; *Affected Public:* Private Sector—Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 12; *Total Annual Responses:* 96; *Total Annual Hours:* 384. (For policy questions regarding this collection contact Arlene Lopez at 410-786-6782.)

3. *Type of Information Collection Request:* Reinstatement without change of a previously approved collection; *Title of Information Collection:* Home

Office Cost Statement Form; *Use:* Providers of services participating in the Medicare program are required under sections 1815(a) and 1861(v)(1)(A) of the Social Security Act (42 U.S.C. 1395g) to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. In addition, regulations at 42 CFR 413.17, 413.20 and 413.24 require adequate cost data and cost reports from providers on an annual basis. The home office cost statement form is filed annually by chain organizations to report costs directly related to services furnished to individual providers that are related to patient care plus an appropriate share of indirect costs. *Form Number:* CMS-287-05 (OMB control number: 0938-0202); *Frequency:* Yearly; *Affected Public:* Private sector—Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 1,686; *Total Annual Responses:* 1,686; *Total Annual Hours:* 785,676. (For policy questions regarding this collection contact Yaakov Feinstein at 410-786-5834.)

Dated: October 7, 2014.

Martique Jones,

Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2014-24244 Filed 10-9-14; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-8056-N]

RIN 0938-AR94

Medicare Program; CY 2015 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) 2015 under Medicare's Hospital Insurance Program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts. For CY 2015, the inpatient hospital deductible will be \$1,260. The daily coinsurance amounts for CY 2015 will be: (1) \$315 for the 61st through 90th day of hospitalization in a benefit

period; (2) \$630 for lifetime reserve days; and (3) \$157.50 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, 2015.

FOR FURTHER INFORMATION: 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 2015

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 2015 for hospitals paid under the inpatient prospective payment system is the market basket percentage increase, otherwise known as the market basket update, reduced by 0.2 percentage points (see section 1886(b)(3)(B)(xii)(IV) 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, beginning with fiscal year 2015, 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. Beginning with FY 2015, 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 33⅓ percent for FY 2015, 66⅔ percent for FY 2016, and 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(b)(3)(B)(ii)(VIII) of the Act, the percentage increase used to update the payment rates for FY 2015 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 0.2 percentage points and the MFP adjustment (see sections 1886(m)(3)(A) and 1886(m)(4)(E) of the Act).
- The percentage increase for inpatient rehabilitation facilities is the market basket percentage increase reduced by 0.2 percentage points and the MFP adjustment (see sections 1886(j)(3)(C) and 1886(j)(3)(D)(iv) of the Act).
- The percentage increase used to update the payment rate for psychiatric hospitals is the market basket percentage increase reduced by 0.3 percentage points and the MFP adjustment (see sections 1886(s)(2)(A)(i), 1886(s)(2)(A)(ii), and 1886(s)(3)(C) of the Act).

The Inpatient Prospective Payment System market basket percentage increase for 2015 is 2.9 percent and the MFP adjustment is 0.5 percent, as announced in the final rule that appeared in the **Federal Register** on

August 22, 2014 entitled, “Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents” (79 FR 49854). Therefore, the percentage increase for hospitals paid under the inpatient prospective payment system that submit quality data and are meaningful EHR users is 2.2 percent (that is, the FY 2015 market basket update of 2.9 percent less the MFP adjustment of 0.5 percentage point and less 0.2 percentage point). The average payment percentage increase for hospitals excluded from the inpatient prospective payment system is 2.3 percent. Weighting these percentages in accordance with payment volume, our best estimate of the payment-weighted average of the increases in the payment rates for FY 2015 is 2.22 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 2014 compared to FY 2013. (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 2014. These bills represent a total of about 7.4 million Medicare discharges for FY 2014 and provide the most recent case-mix data available at this time. Based on these bills, the change in average case-mix in FY 2014 is 1.48 percent. Based on these bills and past experience, we expect the overall case mix change to be 1.5 percent as the year progresses and more FY 2014 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. We expect that all of the change in average case-mix will be real and estimate that this change will be 1.5 percent.

Thus as stated above, the estimate of the payment-weighted average of the applicable percentage increases used for

updating the payment rates is 2.22 percent, and the real case-mix adjustment factor for the deductible is 1.5 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 2015 to be \$1,260. This deductible amount is determined by multiplying \$1,216 (the inpatient hospital deductible for CY 2014 (78 FR 64953)) by the payment-weighted average increase in the payment rates of 1.0222 multiplied by the increase in real case-mix of 1.015, which equals \$1,261.64 and is rounded to \$1,260.

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for CY 2015

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 2015, 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 \$315 (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 \$630 (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 \$157.50 (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 2014 and 2015, as well as the number of each that is estimated to be paid.

TABLE 1—PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CALENDAR YEARS 2014 AND 2015 TYPE OF COST SHARING

	Value		Number paid (in millions)	
	2014	2015	2014	2015
Inpatient hospital deductible	\$1,216	\$1,260	7.23	7.39
Daily coinsurance for 61st–90th Day	304	315	1.87	1.91
Daily coinsurance for lifetime reserve days	608	630	0.93	0.95
SNF coinsurance	152	157.50	41.80	43.73

The estimated total increase in costs to beneficiaries is about \$1,120 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 2014 and 2015 deductible and coinsurance amounts multiplied by the 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.

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 calendar year (CY).

B. Overall Impact

We have examined the impacts of this rule 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 \$1,120 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 thus, 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 2015 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 2014, that threshold accounting for inflation is approximately \$141 million. This notice does not impose mandates that will have a consequential effect of \$141 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 12, 2014.

Marilyn Tavenner,
Administrator, Centers for Medicare & Medicaid Services.

Dated: September 26, 2014.

Sylvia M. Burwell,
Secretary.

[FR Doc. 2014-24257 Filed 10-9-14; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-8057-N]

RIN 0938-AR96

Medicare Program; CY 2015 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 calendar year (CY) 2015. 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, 2015, for these individuals will be \$407. The premium for certain other individuals as described in this notice will be \$224.

DATES: *Effective Date:* This notice is effective on January 1, 2015.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786-6390.

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) 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