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OFFICE OF PERSONNEL MANAGEMENT

5 CFR PART 930

RIN 3206–AL67

Programs for Specific Positions and Examinations (Miscellaneous)

AGENCY: U. S. Office of Personnel Management.

ACTION: Final rule.

SUMMARY: The U. S. Office of Personnel Management (OPM) is issuing a final rule to eliminate the licensure requirement for incumbent administrative law judges.

DATES: This rule is effective January 2, 2014.

FOR FURTHER INFORMATION CONTACT: Mike Gilmore by telephone at (202) 606–2429; by fax at (202) 606–2329; by TTY at (202) 418–3134; or by email at *michael.gilmore@opm.gov.*

SUPPLEMENTARY INFORMATION:

Background

On March 20, 2007, OPM published a final rule in the **Federal Register** at 72 FR 12947, codified in subpart B of part 930 of title 5, Code of Federal Regulations (CFR), to revise the Administrative Law Judge Program. These revisions included a requirement for incumbent administrative law judges (ALJs) to ''. . . possess a professional license to practice law and be authorized to practice law under the laws of a State, the District of Columbia, the Commonwealth of Puerto Rico, or any territorial court established under the United States Constitution. Judicial status is acceptable in lieu of 'active' status in States that prohibit sitting judges from maintaining 'active' status to practice law. Being in 'good standing' is also acceptable in lieu of 'active' status in States where the licensing authority considers 'good standing' as having a current license to practice law.'' (5 CFR 930.204(b)(1).) Under the Administrative Procedure Act (specifically, sections 556 and 557 of title 5, United States Code (U.S.C.), ALJs preside over formal proceedings requiring a decision on the record after an opportunity for a hearing. The licensure requirement was intended to ensure that ALJs, like attorneys, remain subject to a code of professional responsibility.

On July 18, 2008, OPM published an interim rule with request for comments in the **Federal Register** at 73 FR 41235 suspending the requirement in 5 CFR 930.204(b)(1) that incumbent ALJs must ''possess a professional license to practice law and be authorized to practice law. . . .'' OPM took this suspension action based on reconsideration of the comments received during the notice and comment period for the March 20, 2007, final rule. In response to the interim rule, OPM received written comments from three individuals and three professional organizations. These comments along with the comments received for the October 7, 2010, proposed rule, described below, are addressed in this final rule.

On October 7, 2010, OPM published a proposed rule in the **Federal Register** at 75 FR 61998 to eliminate the licensure requirement for incumbent ALJs. This final rule implements the proposed rule published on October 7, 2010.

During the comment period from October 7, 2010, through December 6, 2010, OPM received written comments from twelve individuals, two professional organizations, and a union. A total of 21 written comments were received in response to the issue of licensure requirements for incumbent ALJs. Of the written comments received, fourteen supported the elimination of the licensure requirement for incumbent ALJs and five opposed elimination. Two remaining comments addressed issues other than the topic of the proposed rule and are, therefore, outside the scope of the rulemaking.

With respect to the combined group of commenters, the majority supported the elimination of the licensure requirement for incumbent ALJs. Of the commenters in the majority, four identified existing mechanisms for regulating conduct, such as the Standards of Ethical Conduct for Employees of the Executive Branch promulgated by the Office of Government Ethics and codified at 5 CFR part 2635, agency-prescribed ethics standards, and the adverse action procedures for ALJs in 5 U.S.C. 7521, as sufficient to ensure that ALJs are held to a high standard of professional conduct. However, three of the commenters expressed a concern that even if a licensure requirement for incumbents is inappropriate, the other mechanisms for regulating conduct described above are inadequate to preserve the integrity and independence of the administrative judiciary. These commenters suggested that ALJs should be required to adhere to a code of judicial conduct such as the Code of Conduct for United States Judges (CCUSJ). The CCUSJ applies to Article I and Article III judges, and not, by its terms, to the Federal administrative judiciary. OPM did not adopt this recommendation because the commenters did not identify the authority under which OPM could make this code applicable to incumbent ALJs Governmentwide.

A professional organization supporting the proposed rule to eliminate the licensure requirement for incumbent ALJs requested that the requirement be eliminated for new appointments of Senior ALJs, arguing that, once appointed, Senior ALJs are subject to sufficient controls on their conduct. An individual inquired whether the licensure requirement applied to reemployed annuitants. OPM did not propose to amend section 930.209 governing the Senior ALJ Program, so the comments are beyond the scope of this rulemaking. OPM notes that the specific bar licensure requirement for appointment as a Senior ALJ has been in place since 1985. OPM explained in the Supplementary Information of the final rule published on April 18, 1985, that the purpose for requiring licensure for Senior ALJs was to give ''assurance to the public that retired ALJs . . . have maintained proficiency in their legal knowledge, skills, and abilities.'' (50 FR 15407)

By way of clarification, OPM notes that under section 930.209(b)(2), Senior ALJs must meet the licensure requirements in section 930.204(b). As amended by this final rulemaking, the licensure requirements in section 930.204(b) will apply only at the time of application (*including* while on the

Senior ALJ list pending reemployment) and at the time of appointment, not during the Senior ALJ's incumbency as a reemployed annuitant.

One commenter recommended eliminating the licensure requirement for new appointments. Again, because OPM did not propose to amend the licensure requirements for applicants, the comment is outside the scope of this rulemaking. As noted in the Supplementary Information accompanying the proposed rule published October 7, 2010, OPM remains convinced that active licensure at the time of application and appointment is vital as an indicator that the applicant presenting himself or herself for assessment and possible appointment has been subject to rigorous ethical requirements right up to the time of appointment. (75 FR 61998)

Another commenter recommended modifying the licensure requirement to allow as qualifying an attorney's authorization to practice before a Tribal court when he or she has not been authorized to practice before a court of a State, a Territory, or the District of Columbia. Because OPM did not propose to amend the licensure requirements for applicants, the comment is outside the scope of the rulemaking. However, OPM invites anyone with information concerning whether Tribal courts authorize the practice of law by licensed attorneys who are not authorized to practice before other courts, and whether such attorneys are subject to a code of ethical conduct and bar discipline, to provide such information to OPM's Employee Services so that OPM may consider it in determining what revisions might be appropriate in the future. Please email such information to Mike Gilmore at *Michael.gilmore@opm.gov.*

The same commenter recommended allowing, in lieu of bar licensure, an applicant's enrollment to represent clients before a specific administrative agency, or an applicant's experience in a technical non-legal discipline. OPM cannot accept this comment. Not only is it outside the scope of the rulemaking, but it is at odds with the legal experience and judicial competency requirements for ALJ applicants, as well as the requirement that applicants be subject to a code of ethical conduct.

One professional organization and one individual supported the elimination of the license requirement for incumbent ALJs and suggested that OPM add language to cover non-Federal judges who apply for Federal ALJ positions and whose licensure status is something other than ''active.'' Because OPM did not propose to change the qualification requirements for applicants, this comment is outside the scope of the rulemaking. OPM notes that non-Federal judges who apply for a Federal ALJ job are considered ''applicants'' and must meet the qualifications required by regulation for all applicants, including licensure requirements, at the time of application and appointment.

Two commenters opposing the elimination of the licensure requirement for incumbent ALJs expressed concern about the perceived inequity between Federal ALJs and Federal attorneys. The commenters believe that it is not appropriate to allow incumbent ALJs to be unlicensed when Federal attorneys must maintain an ''active'' bar status. OPM disagrees with this analogy. Attorneys are appointed in the excepted service, subject to qualification standards prescribed by their employing agencies. Except for certain classes of attorneys whose bar licensure is governed by statute, there is no uniform standard for licensure, and agencies have the discretion to establish appropriate standards for their incumbent attorneys. In contrast, ALJs are appointed in the competitive service and are subject to uniform qualification standards prescribed by OPM. OPM has determined that, in light of their unique function and role, incumbent ALJs should not be required to maintain an active bar license. OPM notes, however, that this rule only concerns the qualification requirements to serve as an incumbent ALJ in the Federal service. This rule is not intended to have any effect on an incumbent ALJ's status or responsibilities under state law.

In addition, one of these commenters urged that the bar licensure requirement for incumbent ALJs be reestablished so that ALJs will be subject to mandatory continuing legal education (MCLE) requirements. OPM does not believe this is a compelling justification to reestablish the licensure requirement. MCLE requirements are not uniform among licensing jurisdictions. MCLE offerings typically concern the advocacy and fiduciary responsibilities of lawyers rather than the adjudicative responsibilities of judges. Agencies already have the statutory authority—and the responsibility—to provide training tailored to the specific needs of their ALJ workforces. *See* 5 U.S.C. 1402 and 4103.

Another commenter suggested that a supervising ALJ who does not maintain an active bar license potentially could assign work that would jeopardize the staff attorney's adherence to the rules of professional responsibility, presumably due to the ALJ's unawareness of such rules. OPM believes this risk is speculative and remote, as the rules of professional responsibility are freely and easily accessible. Moreover, an attorney is obligated to know and follow the applicable rules of professional responsibility. If the attorney perceives a conflict he or she may bring it to the supervising ALJ's attention. The same commenter expressed concern that an unlicensed ALJ who supervises a staff attorney thereby engages in the unauthorized practice of law. OPM does not agree that it is an unauthorized practice of law for a sitting ALJ to review the work of an attorney whose job is to prepare draft judicial opinions.

A professional organization opposing the elimination of the licensure requirement for incumbent ALJs was concerned that removing the licensure requirement will remove an incentive for the ALJs to stay current in relevant areas of the law, will allow a public perception that ALJs are not qualified, and will unnecessarily expose their employing agencies to litigation risk. OPM does not agree that lack of licensure will result in the concerns the professional organization raises. OPM has determined that the bar licensure requirement is not necessary to guarantee the integrity and independence of incumbent ALJs, so there is no basis to impose the requirement solely on the commenter's speculative concerns. Moreover, as previously noted, OPM believes that the existing mechanisms are sufficient to ensure the adequacy of ALJs' training and conduct.

Another commenter's opposition to the elimination of the licensure requirement for incumbent ALJs was based on a belief that it is illogical to require an individual to be licensed at the time of application and appointment but not as an incumbent. OPM disagrees with the commenter's assertion. As noted in the Supplementary Information accompanying the proposed rule, OPM remains convinced that active licensure at the time of application and appointment is vital as an indicator that the applicant presenting himself or herself for assessment and possible appointment has been subject to rigorous ethical requirements right up to the time of appointment. This is no longer necessary after appointment because the ALJ employee becomes subject to the Standards of Ethical Conduct for Employees of the Executive Branch in 5 CFR part 2635 and adverse action procedures pursuant to 5 U.S.C. 7521.

The same commenter expressed a concern that this final rule would establish an inconsistent standard for

adjudicatory officers in the Federal service. OPM wishes to clarify that this rule only concerns the licensure status of incumbent ALJs (including reemployed annuitants) who, as noted above, are employed in the competitive service subject to uniform qualification standards. Members of the administrative judiciary who are not ALJs typically are classified as attorneys, and as such are appointed in the excepted service. *See* 5 CFR 302.101(c)(9). The excepted service by its nature consists of positions where qualification requirements may differ based on the requirements of each agency.

A final concern involved the integrity and objectivity of the administrative judiciary. The commenter believes that without an ''active'' license to practice law, ALJs would abandon their integrity and objectivity when certain parties appear before them. The commenter did not provide evidence of a causal link between active bar licensure and the ability to impartially and objectively adjudicate cases under the Administrative Procedure Act. OPM believes that the risk described by the commenter is speculative and remote.

Executive Order 13563 and Executive Order 12866

The Office of Management and Budget has reviewed this rule in accordance with E.O. 13563 and 12866.

Regulatory Flexibility Act

I certify that these regulations would not have a significant economic impact on a substantial number of small entities (including small businesses, small organizational units, and small governmental jurisdictions) because they would affect only Federal agencies and employees.

List of Subjects in 5 CFR Part 930

Administrative practice and procedure, Computer technology, Government employees, Motor vehicles.

U.S. Office of Personnel Management.

Katherine Archuleta,

Director.

Accordingly, OPM is revising 5 CFR part 930 as follows:

PART 930—PROGRAMS FOR SPECIFIC POSITIONS AND EXAMINATIONS (MISCELLANEOUS)

Subpart B—Administrative Law Judge Program

■ 1. The authority citation for subpart B continues to read as follows:

Authority: 5 U.S.C. 1104(a), 1302(a), 1305, 3105, 3301, 3304, 3323(b), 3344, 4301(2)(D), 5372, 7521, and E.O. 10577, 3 CFR, 1954–1958 Comp., p. 219.

■ 2. Revise § 930.204(b) to read as follows:

§ 930.204 Appointments and conditions of employment.

* * * * *

(b) *Licensure.* At the time of application and any new appointment, the individual must possess a professional license to practice law and be authorized to practice law under the laws of a State, the District of Columbia, the Commonwealth of Puerto Rico, or any territorial court established under the United States Constitution. Judicial status is acceptable in lieu of ''active'' status in States that prohibit sitting judges from maintaining ''active'' status to practice law. Being in ''good standing'' is also acceptable in lieu of ''active'' status in States where the licensing authority considers ''good standing'' as having a current license to practice law.

* * * * *

[FR Doc. 2013–28289 Filed 11–29–13; 8:45 am]

BILLING CODE P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2013–0976; Directorate Identifier 2013–NM–198–AD; Amendment 39–17686; AD 2013–24–12]

RIN 2120–AA64

Airworthiness Directives; The Boeing Company Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule; request for comments.

SUMMARY: We are adopting a new airworthiness directive (AD) for all The Boeing Company Model 747–8 and 747–8F series airplanes. This AD requires repetitive ultrasonic or dye penetrant inspections for cracking of the barrel nuts and bolts, as applicable, on each forward engine mount, and related investigative and corrective actions if necessary. This AD was prompted by a report of cracked barrel nuts found on a forward engine mount. We are issuing this AD to detect and correct cracked barrel nuts on a forward engine mount, which could result in reduced load capacity of the forward engine mount, and could result in separation of an engine under power from the airplane, and consequent loss of control of the airplane.

DATES: This AD is effective December 17, 2013.

The Director of the Federal Register approved the incorporation by reference of a certain publication listed in this AD as of December 17, 2013.

We must receive comments on this AD by January 16, 2014.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590.
- *Hand Delivery:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this AD, contact Boeing Commercial Airplanes, Attention: Data & Services Management, P. O. Box 3707, MC 2H–65, Seattle, WA 98124–2207; telephone 206–544–5000, extension 1; fax 206–766–5680; Internet *https://www.myboeingfleet.com*. You may view this referenced service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington. For information on the availability of this material at the FAA, call 425–227–1221.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov;* or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this AD, the regulatory evaluation, any comments received, and other information. The street address for the Docket Office (phone: 800–647–5527) is in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Bill Ashforth, Aerospace Engineer, Airframe Branch, ANM–120S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue SW., Renton, WA 98057–3356; phone: (425) 917–6432; fax: (425) 917–6590; email: *bill.ashforth@faa.gov*.

SUPPLEMENTARY INFORMATION:

Discussion

We received a report that during the replacement of the No. 2 engine, an operator conducted a non-destructive test (NDT) inspection of the barrel nuts on the forward engine mount and found cracks on two of the four barrel nuts. The operator also discovered one cracked barrel nut on the No. 1 engine. Boeing did a NDT on the No. 2 engine of a flight test airplane and discovered two barrel nuts with cracks. The barrel nuts are located at the forward end of the strut box and are used to fasten the forward engine mount to the strut. A barrel nut with a crack on one side is still able to carry ultimate load. A crack on both sides of a barrel nut will cause complete failure of the barrel nut. Complete failure of two or more barrel nuts on the same forward engine mount reduces the load capacity of the forward engine mount and could result in separation of an engine from the airplane. Cracked barrel nuts on a forward engine mount, if not detected and corrected, could result in reduced load capacity of the forward engine mount, and could result in separation of an engine under power from the airplane, and consequent loss of control of the airplane.

Relevant Service Information

We reviewed Boeing Alert Service Bulletin 747–71A2329, dated September 27, 2013. For information on the procedures and compliance times, see this service information at *http://www.regulations.gov* by searching for Docket No. FAA–2013–0976.

FAA's Determination

We are issuing this AD because we evaluated all the relevant information and determined the unsafe condition described previously is likely to exist or develop in other products of the same type design.

AD Requirements

This AD requires accomplishing the actions specified in the service information described previously. This AD also requires sending the inspection results and any cracked bolts and barrel nuts to the manufacturer. The root cause of the cracking has not been determined and inspection data from the fleet needs to be gathered and analyzed.

The FAA worked in conjunction with industry, under the Airworthiness Directives Implementation Aviation Rulemaking Committee, to enhance the AD system. One enhancement was a new process for annotating which steps in the service information are required for compliance with an AD. Differentiating these steps from other tasks in the service information is expected to improve an owner's/operator's understanding of crucial AD requirements and help provide consistent judgment in AD compliance. The actions specified in the service information described previously include steps that are labeled as ''RC'' (required for compliance) because these steps have a direct effect on detecting, preventing, resolving, or eliminating an identified unsafe condition.

As noted in the specified service information, steps labeled as ''RC'' must be done to comply with the AD. However, steps that are not labeled as ''RC'' are recommended. Those steps that are not labeled as ''RC'' may be deviated from, done as part of other actions, or done using accepted methods different from those identified in the service information without obtaining approval of an alternative method of compliance (AMOC), provided the steps labeled as ''RC'' can be done and the airplane can be put back in a serviceable condition. Any substitutions or changes to steps labeled as ''RC'' will require approval of an AMOC.

The phrase ''related investigative actions'' is used in this AD. ''Related investigative actions'' are follow-on actions that (1) are related to the primary actions, and (2) further investigate the nature of any condition found. Related investigative actions in an AD could include, for example, inspections.

In addition, the phrase ''corrective actions'' is used in this AD. ''Corrective actions'' are actions that correct or address any condition found. Corrective actions in an AD could include, for example, repairs.

Interim Action

This AD is considered to be interim action. The inspection reports and return of cracked parts that are required by this AD will enable the manufacturer to obtain better insight into the nature, cause, and extent of the cracking, and eventually to develop final action to address the unsafe condition. Once final action has been identified, we might consider further rulemaking.

FAA's Justification and Determination of the Effective Date

An unsafe condition exists that requires the immediate adoption of this AD. The FAA has found that the risk to the flying public justifies waiving notice and comment prior to adoption of this rule because cracked barrel nuts on a forward engine mount could result in reduced load capacity of the forward engine mount, and could result in separation of an engine under power from the airplane and consequent loss of the control of the airplane. Therefore, we find that notice and opportunity for prior public comment are impracticable and that good cause exists for making this amendment effective in less than 30 days.

Comments Invited

This AD is a final rule that involves requirements affecting flight safety and was not preceded by notice and an opportunity for public comment. However, we invite you to send any written data, views, or arguments about this AD. Send your comments to an address listed under the **ADDRESSES** section. Include the docket number FAA–2013–0976 and Directorate Identifier 2013–NM–198–AD at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this AD. We will consider all comments received by the closing date and may amend this AD because of those comments.

We will post all comments we receive, without change, to *http://www.regulations.gov,* including any personal information you provide. We will also post a report summarizing each substantive verbal contact we receive about this AD.

Costs of Compliance

We estimate that this AD affects 8 airplanes of U.S. registry.

We estimate the following costs to comply with this AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Inspections	Up to 24 work-hours × $85 per hour = $2,040 per inspection cycle.	None	Up to $2,040 per inspection cycle.	Up to $16,320 per inspection cycle.

We estimate the following costs to do any necessary replacements that would be required based on the results of the inspection. We have no way of determining the number of aircraft that might need these replacements:

ON-CONDITION COSTS

Action	Labor cost	Parts cost	Cost per product
Replacement of barrel nuts and bolts.	16 × $85 per hour = $1,360	Up to $480	Up to $1,840.

According to the manufacturer, some of the costs of this AD may be covered under warranty, thereby reducing the cost impact on affected individuals. We do not control warranty coverage for affected individuals. As a result, we have included all costs in our cost estimate.

Paperwork Reduction Act

A federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB control number. The control number for the collection of information required by this AD is 2120–0056. The paperwork cost associated with this AD has been detailed in the Costs of Compliance section of this document and includes time for reviewing instructions, as well as completing and reviewing the collection of information. Therefore, all reporting associated with this AD is mandatory. Comments concerning the accuracy of this burden and suggestions for reducing the burden should be directed to the FAA at 800 Independence Ave. SW., Washington, DC 20591. ATTN: Information Collection Clearance Officer, AES–200.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. ''Subtitle VII: Aviation Programs'' describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701: ''General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

This AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979),

(3) Will not affect intrastate aviation in Alaska, and

(4) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new airworthiness directive (AD):

2013–24–12 The Boeing Company: Amendment 39–17686; Docket No. FAA–2013–0976; Directorate Identifier 2013–NM–198–AD.

(a) Effective Date

This AD is effective December 17, 2013.

(b) Affected ADs

None.

(c) Applicability

This AD applies to all The Boeing Company Model 747–8 and 747–8F series airplanes, certificated in any category.

(d) Subject

Joint Aircraft System Component (JASC)/ Air Transport Association (ATA) of America Code 71, Powerplant.

(e) Unsafe Condition

This AD was prompted by a report of cracked barrel nuts found on a forward engine mount. We are issuing this AD to detect and correct cracked barrel nuts on a forward engine mount, which could result in reduced load capacity of the forward engine mount, and could result in separation of an engine under power from the airplane, and consequent loss of control of the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Repetitive Inspections and Corrective Actions

Except as required by paragraph (h)(1) of this AD, at the time specified in paragraph 1.E., ''Compliance,'' of Boeing Alert Service Bulletin 747–71A2329, dated September 27, 2013: Do the inspection specified in paragraph (g)(1) or (g)(2) of this AD, and do all applicable related investigative and corrective actions, in accordance with the Accomplishment Instructions of Boeing Alert Service Bulletin 747–71A2329, dated September 27, 2013. Do all applicable related investigative and corrective actions before further flight. Repeat the inspection thereafter at the times specified in paragraph 1.E., ''Compliance,'' of Boeing Alert Service Bulletin 747–71A2329, dated September 27, 2013.

(1) Ultrasonic inspection for cracking of the barrel nuts on each forward engine mount, except as required by paragraph (h)(2) of this AD.

(2) Dye penetrant inspection for cracking of the bolts and barrel nuts. Whenever a dye penetrant inspection is done, all the bolts and barrel nuts on that engine mount must be removed and replaced with new or serviceable parts.

(h) Exceptions to Service Information Specifications

(1) Where Boeing Alert Service Bulletin 747–71A2329, dated September 27, 2013, specifies a compliance time ''after the original issue date of this service bulletin,'' this AD requires compliance within the specified compliance time after the effective date of this AD.

(2) Where Appendix B of Boeing Alert Service Bulletin 747–71A2329, dated September 27, 2013, states alternate instruments and transducers can be used, this AD requires that only equivalent instruments and transducers can be used.

(3) Where Appendix A of Boeing Alert Service Bulletin 747–71A2329, dated September 27, 2013, states to record flight hours and flight cycles, record the flight hours and flight cycles on the airplane and the flight hours and flight cycles for each engine since change or removal.

(i) Reporting and Sending Parts

After any inspection required by paragraph (g) of this AD: Submit a report of the inspection results (both positive and negative), and return all cracked bolts and barrel nuts, at the applicable time specified in paragraph (i)(1) or (i)(2) of this AD. The report must include the information requested in Appendix A of Boeing Alert Service Bulletin 747–71A2329, dated September 27, 2013, except as required by paragraph (h)(3) of this AD. Both the report and all cracked bolts and barrel nuts must be sent to the address specified in Appendix A of Boeing Alert Service Bulletin 747–71A2329, dated September 27, 2013.

(1) For airplanes on which an ultrasonic inspection was done and no cracking was found, do the required actions at the time specified in paragraph (i)(1)(i) or (i)(1)(ii) of this AD, as applicable.

(i) If the inspection was done on or after the effective date of this AD: Submit the report within 10 days after the inspection.

(ii) If the inspection was done before the effective date of this AD: Submit the report within 10 days after the effective date of this AD.

(2) For airplanes on which a dye penetrant inspection was done, do the required actions at the time specified in paragraph (i)(2)(i) or (i)(2)(ii) of this AD, as applicable.

(i) If the inspection was done on or after the effective date of this AD: Submit the report and return all cracked bolts and barrel nuts within 10 days after replacing the bolts and barrel nuts with new or serviceable bolt and barrel nuts in accordance with Part 2 of the Accomplishment Instructions of Boeing Alert Service Bulletin 747–71A2329, dated September 27, 2013.

(ii) If the inspection was done before the effective date of this AD: Submit the report and return all cracked bolts and barrel nuts within 10 days after the effective date of this AD.

(j) Paperwork Reduction Act Burden Statement

A federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2120–0056. Public reporting for this collection of information is estimated to be approximately 5 minutes per response, including the time for reviewing instructions, completing and reviewing the collection of information. All responses to this collection of information are mandatory. Comments concerning the accuracy of this burden and suggestions for reducing the burden should be directed to the FAA at: 800 Independence Ave. SW., Washington, DC 20591, Attn: Information Collection Clearance Officer, AES–200.

(k) Alternative Methods of Compliance (AMOCs)

(1) The Manager, Seattle Aircraft Certification Office (ACO), FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the manager of the ACO, send it to the attention of the person identified in paragraph (l) of this AD. Information may be emailed to: *9-ANM-Seattle-ACO-AMOC-Requests@faa.gov.*

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(3) An AMOC that provides an acceptable level of safety may be used for any repair required by this AD if it is approved by the Boeing Commercial Airplanes Organization Designation Authorization (ODA) that has been authorized by the Manager, Seattle ACO, to make those findings. For a repair method to be approved, the repair must meet the certification basis of the airplane and the approval must specifically refer to this AD.

(4) If the service information contains steps that are labeled as ''RC'' (Required for Compliance), those steps must be done to comply with this AD; any steps that are not labeled as ''RC'' are recommended. Those steps that are not labeled as ''RC'' may be deviated from, done as part of other actions, or done using accepted methods different from those identified in the specified service information without obtaining approval of an AMOC, provided the steps labeled as ''RC'' can be done and the airplane can be put back in a serviceable condition. Any substitutions or changes to steps labeled as ''RC'' require approval of an AMOC.

(l) Related Information

For more information about this AD, contact Bill Ashforth, Aerospace Engineer, Airframe Branch, ANM–120S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue SW., Renton, WA 98057–3356; phone: (425) 917–6432; fax: (425) 917–6590; email: *bill.ashforth@faa.gov.*

(m) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference (IBR) of the service information listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this service information as applicable to do the actions required by this AD, unless the AD specifies otherwise.

(i) Boeing Alert Service Bulletin 747–71A2329, dated September 27, 2013.

(ii) Reserved.

(3) For service information identified in this AD, contact Boeing Commercial Airplanes, Attention: Data & Services Management, P. O. Box 3707, MC 2H–65, Seattle, WA 98124–2207; telephone 206–544–5000, extension 1; fax 206–766–5680; Internet *https://www.myboeingfleet.com.*

(4) You may view this service information at FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, Washington. For information on the availability of this material at the FAA, call 425–227–1221.

(5) You may view this service information that is incorporated by reference at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal-register/cfr/ibr-locations.html.*

Issued in Renton, Washington, on November 19, 2013.

Jeffrey E. Duven,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2013–28616 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2013–0698; Directorate Identifier 2012–NM–136–AD; Amendment 39–17682; AD 2013–24–08]

RIN 2120–AA64

Airworthiness Directives; Airbus Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Final rule.

SUMMARY: We are superseding airworthiness directive (AD) 2006–06–14 for certain Airbus Model A318–100 and A319–100 series airplanes, A320–111 airplanes, A320–200 series airplanes, and A321–100 and A321–200 series airplanes. AD 2006–06–14 required operators to review the airplane's maintenance records to determine the part numbers of the magnetic fuel level indicators (MFLIs) of the wing fuel tanks, and perform related investigative and corrective actions if necessary. This new AD also requires an inspection (improved method) to determine the part numbers of the MFLIs, and, if necessary, replacement of the MFLI or repair. This AD was prompted by information that the related investigative actions of AD 2006–06–14 are not fully effective and that an affected MFLI could still be installed on airplanes on which the

related investigative actions were accomplished. We are issuing this AD to prevent an ignition source in the wing fuel tank in the event of a lightning strike, which could result in a fire or explosion.

DATES: This AD becomes effective January 6, 2014.

The Director of the Federal Register approved the incorporation by reference of a certain publication listed in this AD as of January 6, 2014.

The Director of the Federal Register approved the incorporation by reference of a certain other publication listed in this AD as of May 1, 2006 (71 FR 15023, March 27, 2006).

ADDRESSES: You may examine the AD docket on the Internet at *http://www.regulations.gov/#!docketDetail;D=FAA-2013-0698;* or in person at the U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC.

For service information identified in this AD, contact Airbus, Airworthiness Office—EIAS, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France; telephone +33 5 61 93 36 96; fax +33 5 61 93 44 51; email *account.airworth-eas@airbus.com*; Internet http://www.airbus.com. You may view this referenced service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221.

FOR FURTHER INFORMATION CONTACT: Sanjay Ralhan, Aerospace Engineer, International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue SW., Renton, WA 98057–3356; telephone (425) 227–1405; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION:

Discussion

We issued a notice of proposed rulemaking (NPRM) to amend 14 CFR part 39 by adding an AD that would apply to the specified products. The NPRM published in the **Federal Register** on August 20, 2013 (78 FR 51117), and proposed to supersede AD 2006–06–14, Amendment 39–14523 (71 FR 15023, March 27, 2006). The NPRM proposed to correct an unsafe condition for the specified products.

The European Aviation Safety Agency (EASA), which is the Technical Agent for the Member States of the European Community, has issued EASA Airworthiness Directive 2012–0119, dated July 4, 2012 (referred to after this as the Mandatory Continuing Airworthiness Information, or ''the MCAI''), to correct an unsafe condition for the specified products. The MCAI states:

> In 2005, several in-service occurrences were reported of finding wear and/or detachment of the top stop of magnetic fuel level indicators (MFLI), either observed during tank maintenance activities, or on MFLI returned to the MFLI manufacturer. The investigation results indicated that the wear of the top stop retaining 'S' shaped wire had been caused by repetitive impact with the float, resulting in complete detachment of the top stop.
>
> This condition, if not detected and corrected, could lead an MFLI top stop to come into contact with a probe, which could, in the event of a lightning strike, create an ignition source in the fuel tank vapour space, possibly resulting in a fuel tank explosion and consequent loss of the aeroplane.
>
> DGAC France issued AD F–2005–108 (EASA approval 2005–6026) [*http://ad.easa.europa.eu/ad/F-2005-108*] [corresponding FAA AD 2006–06–14] to require identification (by inspection) and replacement of the affected metallic MFLI (3508802–xx series with the 'S' shaped retaining wire) with a metallic MFLI with the top stop retained by a 'trapped wire', or with a composite MFLI.
>
> Since that [French] AD was issued, it has been identified that the inspection procedure (visual check) detailed in Airbus Service Bulletin (SB) A320–28–1138 was not fully effective, and that affected MFLI could still be fitted on aeroplanes which have passed the inspection in accordance with the instructions of this SB.
>
> For the reasons described above, this [EASA] AD, which supersedes DGAC France AD F–2005–108, requires a one-time inspection (improved method) to identify the type of MFLI installed and, depending on findings, replacement or repair, as applicable. This [EASA] AD also prohibits the installation of the affected MFLI on any aeroplane as replacement parts.

The repair may also include locating and removing any missing top stop, and inspecting for any damage caused to the fuel tank by a missing top stop. You may examine the MCAI in the AD docket on the Internet at *http://www.regulations.gov/#!documentDetail;D=FAA-2013-0698-0002.*

Comments

We gave the public the opportunity to participate in developing this AD. We received no comments on the NPRM (78 FR 51117, August 20, 2013) or on the determination of the cost to the public.

Change to ''Applicability,'' Paragraph (c) of This Final Rule

We have removed Airbus Model A320–215 and A320–216 airplanes from paragraph (c) of this final rule. These airplane models are not listed on a U.S. type certificate data sheet (TCDS). If those airplane models are later certificated in the U.S. and listed on a U.S. TCDS, we may consider further action then.

Conclusion

We reviewed the available data and determined that air safety and the public interest require adopting this AD as proposed except for minor editorial changes. We have determined that these minor changes:

- Are consistent with the intent that was proposed in the NPRM (78 FR 51117, August 20, 2013) for correcting the unsafe condition; and
- Do not add any additional burden upon the public than was already proposed in the NPRM (78 FR 51117, August 20, 2013).

Costs of Compliance

We estimate that this AD affects 755 airplanes of U.S. registry.

We estimate the following costs to comply with this AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Part numbers review [retained actions from AD 2006–06–14, Amendment 39-14523 (71 FR 15023, March 27, 2006)].	Between 1 and 8 work-hours × $85 per hour = Between $85 and $680.	None	Between $85 and $680.	Between $64,175 and $513,400

ESTIMATED COSTS—Continued

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Inspection for part numbers [new action].	21 work-hours × $85 per hour = $1,785	$0	$1,785	$1,347,675.

We estimate the following costs to do any necessary replacement or repair that would be required based on the results of the inspection. We have no way of determining the number of aircraft that might need the replacement or repair:

ON-CONDITION COSTS

Action	Labor cost	Parts cost	Cost per product
Replacement or repair	4 work-hours × $85 per hour = $340	$0	$340

According to the manufacturer, some of the costs of this AD may be covered under warranty, thereby reducing the cost impact on affected individuals. We do not control warranty coverage for affected individuals. As a result, we have included all costs in our cost estimate.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. ''Subtitle VII: Aviation Programs,'' describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in ''Subtitle VII, Part A, Subpart III, Section 44701: General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

1. Is not a ''significant regulatory action'' under Executive Order 12866;

2. Is not a ''significant rule'' under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979);

3. Will not affect intrastate aviation in Alaska; and

4. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

Examining the AD Docket

You may examine the MCAI in the AD docket on the Internet at *http://www.regulations.gov/#!documentDetail;D=FAA-2013-0698-0002*; or in person at the Docket Operations office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this AD, the regulatory evaluation, any comments received, and other information. The street address for the Docket Operations office (telephone (800) 647–5527) is in the **ADDRESSES** section.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by removing airworthiness directive (AD) 2006–06–14, Amendment 39–14523 (71 FR 15023, March 27, 2006), and adding the following new AD:

2013–24–08 Airbus: Amendment 39–17682. Docket No. FAA–2013–0698; Directorate Identifier 2012–NM–136–AD.

(a) Effective Date

This airworthiness directive (AD) becomes effective January 6, 2014.

(b) Affected ADs

This AD supersedes AD 2006–06–14, Amendment 39–14523 (71 FR 15023, March 27, 2006).

(c) Applicability

This AD applies to Airbus Model A318–111, A318–112, A318–121, A318–122, A319–111, A319–112, A319–113, A319–114, A319–115, A319–131, A319–132, A319–133, A320–111, A320–211, A320–212, A320–214, A320–231, A320–232, A320–233, A321–111, A321–112, A321–131, A321–211, A321–212, A321–213, A321–231, and A321–232 airplanes; certificated in any category; all manufacturer serial numbers.

(d) Subject

Air Transport Association (ATA) of America Code 28: Fuel.

(e) Reason

This AD was prompted by a report of several in-service incidents of wear and detachment of the top-stops from magnetic fuel level indicators (MFLI) in a wing fuel tank. We are issuing this AD to prevent an ignition source in the wing fuel tank in the event of a lighting strike, which could result in a fire or explosion.

(f) Compliance

You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

(g) Retained Review of Airplane Maintenance Records/Investigative and Corrective Actions

This paragraph restates the requirements of paragraph (f) of AD 2006–06–14, Amendment 39–14523 (71 FR 15023, March 27, 2006). For Model A318–111 and –112 airplanes; Model

A319–111, –112, –113, –114, –115, –131, –132, and –133 airplanes; A320–111 airplanes; Model A320–211, –212, –214, –231, –232, and –233 airplanes; Model A321–111, –112, and –131 airplanes; and Model A321–211, –212, –213, –231, and –232 airplanes; on which Airbus Modification 27496 has not been installed in production: Within 65 months or 6,500 flight hours after May 1, 2006 (the effective date of AD 2006–06–14), whichever is first, review the airplane's maintenance records to determine the part number (P/N) of each MFLI of the wing fuel tanks in accordance with the Accomplishment Instructions of Airbus Service Bulletin A320–28–1138, dated March 18, 2005. If the P/N cannot be identified, or the P/N is identified in the ''old P/N'' column of the table in paragraph 1.L., ''Interchangeability/Mixability,'' of Airbus Service Bulletin A320–28–1138, dated March 18, 2005, before further flight, do the applicable related investigative and corrective actions by accomplishing all of the actions in accordance with the Accomplishment Instructions of Airbus Service Bulletin A320–28–1138, dated March 18, 2005.

(h) Retained Parts Installation Prohibition

This paragraph restates the requirements paragraph (g) of AD 2006–06–14, Amendment 39–14523 (71 FR 15023, March 27, 2006). For Model A318–111 and –112 airplanes; Model A319–111, –112, –113, –114, –115, –131, –132, and –133 airplanes; A320–111 airplanes; Model A320–211, –212, –214, –231, –232, and –233 airplanes; Model A321–111, –112, and –131 airplanes; and Model A321–211, –212, –213, –231, and –232 airplanes; on which Airbus Modification 27496 has not been installed in production: As of May 1, 2006 (the effective date of AD 2006–06–14), no person may install on any airplane any MFLI of the wing fuel tanks with a P/N identified in the ''old P/N'' column of the table in paragraph 1.L., ''Interchangeability/Mixability,'' of Airbus Service Bulletin A320–28–1138, dated March 18, 2005.

(i) New Requirement of This AD: Inspection

For all airplanes, except as provided by paragraph (k) of this AD: At the next scheduled fuel tank entry after the effective date of this AD, or within 49,000 flight hours after May 1, 2006 (the effective date of AD 2006–06–14, Amendment 39–14523 (71 FR 15023, March 27, 2006)), whichever occurs first, perform a special detailed inspection of the wing tank to determine which type of magnetic fuel level indicators (MFLI) are installed, in accordance with the Accomplishment Instructions of Airbus Service Bulletin A320–28–1209, dated December 12, 2011. A review of airplane maintenance records is acceptable in lieu of this inspection, if the part number and the type of the installed MFLI can be conclusively determined from that review. Paragraphs (i)(1) through (i)(11) of this AD identify the affected MLFI part numbers.

(1) 3508802–24.
(2) 3508802–25.
(3) 3508802–26.
(4) 3508802–27.
(5) 3508802–28.
(6) 3508802–34.
(7) 3508802–39.
(8) 3508802–74.
(9) 3508802–75.
(10) 3508802–76.
(11) 3508802–91.

Note 1 to paragraph (i) of this AD: The affected MFLI have the 'S'-shaped lock-wire design.

(j) New Requirement of This AD: Replacement or Repair

If, during the inspection required by paragraph (i) of this AD, a MFLI with the 'S' shaped lock-wire design (Part Number (P/N) listed in paragraphs (i)(1) through (i)(11) of this AD) is found, then at the next scheduled fuel tank entry after the effective date of this AD, or within 49,000 flight hours after May 1, 2006 (the effective date of AD 2006–06–14, Amendment 39–14523 (71 FR 15023, March 27, 2006)), whichever occurs first, replace the affected MFLI with a serviceable part and accomplish the corrective actions (repair), as applicable, in accordance with the Accomplishment Instructions of Airbus Service Bulletin A320–28–1209, dated December 12, 2011. For the purpose of this AD, a serviceable part is a composite MFLI, or a metallic MFLI with the top stop retained by a 'trapped wire,' as applicable to the location identified in Table 1 of paragraph (j) of this AD.

TABLE 1 OF PARAGRAPH (J) OF THIS AD—METALLIC MFLI WITH THE TOP STOP RETAINED BY A 'TRAPPED WIRE,' INCLUDING APPLICABLE LOCATION (FIN)

MFLI P/N	Applicable Location (FIN)
3508802–35	56/57QM
3508802–36	58/59QM
3508802–37	60/61QM
3508802–38	62/63QM

(k) New Requirement of This AD: Exception for Paragraph (i) of This AD

Airplanes on which Airbus Modification (mod) 27496 has been embodied in production, and on which no wing tank MFLI replacement with a part number listed in paragraphs (i)(1) through (i)(11) of this AD has been made since first flight, are not affected by the requirement of paragraph (i) of this AD.

(l) New Requirement of This AD: Parts Installation Prohibition

As of the effective date of this AD, do not install on any airplane a MFLI with a part number listed in paragraphs (i)(1) through (i)(11) of this AD.

(m) Other FAA AD Provisions

The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, International Branch, ANM–116, Transport Airplane Directorate, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the International Branch, send it to ATTN: Sanjay Ralhan, Aerospace Engineer, International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue SW., Renton, WA 98057–3356; telephone (425) 227–1405; fax (425) 227–1149. Information may be emailed to: *9–ANM–116–AMOC–REQUESTS@faa.gov.* Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office. The AMOC approval letter must specifically reference this AD.

(2) *Airworthy Product:* For any requirement in this AD to obtain corrective actions from a manufacturer or other source, use these actions if they are FAA-approved. Corrective actions are considered FAA-approved if they are approved by the State of Design Authority (or its delegated agent, or by the Design Approval Holder with a State of Design Authority's design organization approval). For a repair method to be approved, the repair approval must specifically refer to this AD. You are required to assure the product is airworthy before it is returned to service.

(n) Special Flight Permits

Special flight permits, as described in Section 21.197 and Section 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199), are not allowed.

(o) Related Information

Refer to Mandatory Continuing Airworthiness Information (MCAI) European Aviation Safety Agency (EASA) Airworthiness Directive 2012–0119, dated July 4, 2012, for related information. You may examine the MCAI in the AD docket on the Internet at *http://www.regulations.gov/#!documentDetail;D=FAA-2013-0698-0002.*

(p) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference (IBR) of the service information listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this service information as applicable to do the actions required by this AD, unless this AD specifies otherwise.

(3) The following service information was approved for IBR on January 6, 2014.

(i) Airbus Service Bulletin A320–28–1209, dated December 12, 2011.

(ii) Reserved.

(4) The following service information was approved for IBR on May 1, 2006 (71 FR 15023, March 27, 2006).

(i) Airbus Service Bulletin A320–28–1138, dated March 18, 2005.

(ii) Reserved.

(5) For service information identified in this AD, contact Airbus, Airworthiness Office—EIAS, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France; telephone +33 5 61 93 36 96; fax +33 5 61 93 44 51; email *account.airworth-eas@airbus.com;* Internet *http://www.airbus.com.*

(6) You may view this service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221.

(7) You may view this service information that is incorporated by reference at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal-register/cfr/ibr-locations.html.*

Issued in Renton, Washington, on November 15, 2013.

John Piccola,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2013–28192 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2013–0096; Directorate Identifier 2012–NM–143–AD; Amendment 39–17566; AD 2013–17–02]

RIN 2120–AA64

Airworthiness Directives; Airbus Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Final rule.

SUMMARY: We are adopting a new airworthiness directive (AD) for certain Airbus Model A318–112, A319–111, A319–112, A319–115, A319–132, and A319–133 airplanes. This AD was prompted by a report that a fastener, which connects the cargo door keel beam foot to the circumferential butt-strap and the section 13–14 lower shell panel, was not installed on airplanes during production. This AD requires inspecting forward fuselage frame 24, stringer 39, right hand, to determine if the fastener is missing; measuring the hole dimensions of the five holes surrounding the missing fastener if necessary; and doing related investigative and corrective actions if necessary. We are issuing this AD to detect and correct the missing fastener, which could result in reduced structural integrity of the airplane.

DATES: This AD becomes effective January 6, 2014.

The Director of the Federal Register approved the incorporation by reference of a certain publication listed in this AD as of January 6, 2014.

ADDRESSES: You may examine the AD docket on the Internet at *http://www.regulations.gov* or in person at the U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC.

FOR FURTHER INFORMATION CONTACT: Sanjay Ralhan, Aerospace Engineer, International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue SW., Renton, Washington 98057–3356; telephone (425) 227–1405; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION:

Discussion

We issued a notice of proposed rulemaking (NPRM) to amend 14 CFR part 39 by adding an AD that would apply to the specified products. The NPRM was published in the **Federal Register** on March 4, 2013 (78 FR 14029). The NPRM proposed to correct an unsafe condition for the specified products.

The European Aviation Safety Agency (EASA), which is the Technical Agent for the Member States of the European Community, has issued Airworthiness Directive 2012–0132, dated July 19, 2012 (referred to after this as the Mandatory Continuing Airworthiness Information, or ''the MCAI''), to correct an unsafe condition for the specified products. The MCAI states:

> During a ground inspection of an A319 aeroplane in production, it was discovered that one fastener was missing at stringer (STGR) 39 on the right-hand (RH) side of FR [forward fuselage frame] 24 (Section 13–14 side). The hole of the missing fastener was not drilled. The missing fastener, a 4.8 mm [millimeter] diameter titanium bolt, Part Number (P/N) EN 6114 V3–7, should connect the cargo door keel beam foot to the circumferential butt-strap and the section 13–14 lower shell panel. Further investigations have revealed that the affected fastener has not been installed on a limited number of aeroplanes in production, due to incorrect production instructions.
>
> This condition, if not corrected, could impair the structural integrity of the affected aeroplanes.
>
> * * * * *

The required actions include doing a detailed inspection to determine if the fastener is missing, measuring the hole dimensions of the five holes surrounding the missing fastener if necessary, and doing related investigative and corrective actions if necessary. The related investigative actions include a rototest inspection of the five holes for cracking. The corrective actions include repairing any holes with diameter values that exceed the specified dimensions, repairing any cracking found, and installing new fasteners. You may obtain further information by examining the MCAI in the AD docket on the Internet at *http://www.regulations.gov/#!documentDetail;D=FAA-2013-0096-0002.*

Comments

We gave the public the opportunity to participate in developing this AD. We have considered the comments received.

Request To Refer to Revised EASA AD

Airbus requested that paragraph (j) of the NPRM (78 FR 14029, March 4, 2013) be revised to refer to revised EASA AD 2012–0132R1, dated March 1, 2013 (*http://ad.easa.europa.eu/blob/easa_ad_2012_0132_R1.pdf*).

We do not agree with the commenter's request. EASA AD 2012–0132R1, dated March 1, 2013, was revised to clarify the configurations of the Airbus Model A318 and A319 airplanes included in table 1 of EASA AD 2012–0132R1, dated March 1, 2013. The clarifying text that EASA included in EASA AD 2012–0132R1, dated March 1, 2013, was designated in the NPRM (78 FR 14029, March 4, 2013) as ''Table 1 to Paragraphs (g) and (h) of this AD.''

We have re-designated the material in table 1 to paragraphs (g) and (h) of the NPRM (78 FR 14029, March 4, 2013) as paragraphs (g)(1), (g)(2), and (g)(3) in this final rule. This change does not affect the intent of this AD. In addition, we revised references to ''Table 1 to Paragraphs (g) and (h) of this AD'' that appeared in paragraphs (g) and (h) of the NPRM to instead refer to paragraphs (g)(1), (g)(2), and (g)(3) of this AD. No change was made to this final rule with respect to the commenter's request to revise paragraph (j) of this final rule.

Request To Allow Credit for Actions Previously Accomplished Using Previous Revisions of the Service Information

Airbus requested that table 1 to paragraphs (g) and (h) of the NPRM (78 FR 14029, March 4, 2013) be revised to provide credit for actions that are accomplished before the effective date of this AD using Airbus Service Bulletin A320–00–1219 dated November 9, 2010; Revision 01, dated December 8, 2010; Revision 02, dated September 6, 2011; or Revision 03, dated March 28, 2012.

We do not agree with the commenter's request. As stated previously, the material in table 1 to paragraphs (g) and (h) of the NPRM (78 FR 14029, March 4, 2013) has been re-designated as paragraphs (g)(1), (g)(2), and (g)(3) of this final rule. Those paragraphs do not mandate accomplishing any actions using Airbus Service Bulletin A320–00–

1219. That service information is only referenced to provide guidance to operators regarding certain configurations of Model A318 and A319 airplanes. No change was made to this final rule with regard to the commenter's request.

Request To Revise Airbus Contact Information

Airbus requested that we revise the contact information for the Airbus office of airworthiness from EAS to EIAS.

We agree with the request and have included the revised contact information in paragraph (k)(3) of this final rule.

Conclusion

We reviewed the available data, including the comments received, and determined that air safety and the public interest require adopting this AD with the changes described previously and minor editorial changes. We have determined that these changes:

- Are consistent with the intent that was proposed in the NPRM (78 FR 14029, March 4, 2013) for correcting the unsafe condition; and
- Do not add any additional burden upon the public than was already proposed in the NPRM (78 FR 14029, March 4, 2013).

Costs of Compliance

We estimate that this AD affects about 3 products of U.S. registry. We also estimate that it takes about 26 work hours per product to comply with the basic requirements of this AD. The average labor rate is $85 per work hour. Required parts cost $1,904 per product. Where the service information lists required parts costs that are covered under warranty, we have assumed that there will be no charge for these parts. As we do not control warranty coverage for affected parties, some parties may incur costs higher than estimated here. Based on these figures, we estimate the cost of this AD on U.S. operators to be up to $12,342, or $4,114 per product.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. ''Subtitle VII: Aviation Programs,'' describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in ''Subtitle VII, Part A, Subpart III, Section 44701: General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

1. Is not a ''significant regulatory action'' under Executive Order 12866;
2. Is not a ''significant rule'' under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979);
3. Will not affect intrastate aviation in Alaska; and
4. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this AD and placed it in the AD docket.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov/#!docketDetail;D=FAA-2013-0096;* or in person at the Docket Operations office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this AD, the MCAI, the regulatory evaluation, any comments received, and other information. The street address for the Docket Operations office (telephone (800) 647–5527) is in the **ADDRESSES** section.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new AD:

2013–17–02 Airbus: Amendment 39–17566. Docket No. FAA–2013–0096; Directorate Identifier 2012–NM–143–AD.

(a) Effective Date

This airworthiness directive (AD) becomes effective January 6, 2014.

(b) Affected ADs

None.

(c) Applicability

This AD applies to Airbus Model A318–112, A319–111, A319–112, A319–115, A319–132, and A319–133 airplanes; certificated in any category; manufacturer serial numbers 3983, 3985, 3998, 4000, 4004, 4007, 4018, 4020, 4029, 4036, 4038 through 4040 inclusive, 4048, 4052, 4056, 4069, 4071, 4076, 4080, 4087, 4089, 4121, 4125, 4127, 4129, 4132, 4141, 4151, 4163, 4164, 4166, 4169, 4171, 4182, 4192, 4200, 4204, 4211, 4215, 4222, 4227, 4228, 4254, 4256, 4258, 4259, 4262, 4268, 4275, 4282, 4285, 4287, 4301, 4313, 4319, 4327, 4332, and 4336.

(d) Subject

Air Transport Association (ATA) of America Code 53, Fuselage.

(e) Reason

This AD was prompted by a report that a fastener, which connects the cargo door keel beam foot to the circumferential butt-strap and the section 13–14 lower shell panel, was not installed on airplanes during production. We are issuing this AD to detect and correct the missing fastener, which could result in reduced structural integrity of the airplane.

(f) Compliance

You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

(g) Inspections

At the applicable time specified in paragraph (g)(1), (g)(2), or (g)(3) of this AD: Do a detailed inspection at forward fuselage frame 24, stringer 39, right hand, to determine if the fastener is missing, in accordance with the Accomplishment Instructions of Airbus Service Bulletin A320–53–1242, dated May 22, 2012.

(1) For Model A319 airplanes, except manufacturer serial numbers 4151, 4228, and 4319; and Model A318 airplanes, pre-modification 39195, and on which the actions specified in Airbus Service Bulletin A320–00–1219 have not been embodied in service: Inspect before the accumulation of 5,000 total flight cycles since first flight of the airplane, or within 4,300 flight cycles after the effective date of this AD, whichever occurs later.

(2) For Model A318 airplanes, post-modification 39195; and Model A318 airplanes on which the actions specified in Airbus Service Bulletin A320–00–1219 have been embodied in service: Inspect before the

accumulation of 3,000 total flight cycles since first flight of the airplane, or within 90 days after the effective date of this AD, whichever occurs later.

(3) For Model A319 airplanes, manufacturer serial numbers 4151, 4228, and 4319 (post-modification 28238, 28162, and 28342): Inspect before the accumulation of 2,500 total flight cycles since first flight of the airplane, or within 90 days after the effective date of this AD, whichever occurs later.

(h) Measurements and Corrective Actions

If, during any inspection required by paragraph (g) of this AD, the fastener is determined to be missing, within the applicable compliance time specified in paragraph (g)(1), (g)(2), or (g)(3) of this AD: Measure the hole dimensions of the five holes surrounding the missing fastener, and do all applicable related investigative and corrective actions, in accordance with the Accomplishment Instructions of Airbus Service Bulletin A320–53–1242, dated May 22, 2012; except where the service bulletin specifies to contact Airbus, before further flight, repair using a method approved by either the Manager, International Branch, ANM–116, Transport Airplane Directorate, FAA; or the European Aviation Safety Agency (EASA) (or its delegated agent). Do all applicable related investigative and corrective actions before further flight.

(i) Other FAA AD Provisions

The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, International Branch, ANM–116, Transport Airplane Directorate, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the International Branch, send it to ATTN: Sanjay Ralhan, Aerospace Engineer, International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue SW., Renton, Washington 98057–3356; telephone (425) 227–1405; fax (425) 227–1149. Information may be emailed to: *9-ANM-116-AMOC-REQUESTS@faa.gov.* Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office. The AMOC approval letter must specifically reference this AD.

(2) *Airworthy Product:* For any requirement in this AD to obtain corrective actions from a manufacturer or other source, use these actions if they are FAA-approved. Corrective actions are considered FAA-approved if they are approved by the State of Design Authority (or their delegated agent). You are required to assure the product is airworthy before it is returned to service.

(j) Related Information

Refer to Mandatory Continuing Airworthiness Information EASA Airworthiness Directive 2012–0132, dated July 19, 2012, for related information, which can be found in the AD docket on the Internet at *http://www.regulations.gov/#!documentDetail;D=FAA-2013-0096-0002.*

(k) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference (IBR) of the service information listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this service information as applicable to do the actions required by this AD, unless this AD specifies otherwise.

(i) Airbus Service Bulletin A320–53–1242, dated May 22, 2012.

(ii) Reserved.

(3) For service information identified in this AD, contact Airbus, Airworthiness Office—EIAS, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France; telephone +33 5 61 93 36 96; fax +33 5 61 93 44 51; email *account.airworth-eas@airbus.com;* Internet *http://www.airbus.com.*

(4) You may view this service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221.

(5) You may view this service information that is incorporated by reference at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal-register/cfr/ibr-locations.html.*

Issued in Renton, Washington, on August 9, 2013.

Jeffrey E. Duven,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2013–28170 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2013–0700; Directorate Identifier 2013–NM–102–AD; Amendment 39–17676; AD 2013–24–02]

RIN 2120–AA64

Airworthiness Directives; Bombardier, Inc. Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Final rule.

SUMMARY: We are adopting a new airworthiness directive (AD) for certain Bombardier, Inc. Model CL–600–2B19 (Regional Jet Series 100 & 440) airplanes. This AD was prompted by reports of fractured rudder pedal tubes installed on the pilot-side rudder bar assembly. This AD requires repetitive inspections for cracking and damage of both pilot-side rudder pedal tubes, and replacement of affected pilot-side rudder bar assemblies if necessary. We are issuing this AD to detect and correct cracking of both pilot-side rudder pedal tubes, which could result in loss of pilot rudder pedal input causing reduced yaw controllability or a runway excursion.

DATES: This AD becomes effective January 6, 2014.

The Director of the Federal Register approved the incorporation by reference of a certain publication listed in this AD as of January 6, 2014.

ADDRESSES: You may examine the AD on the Internet at *http://www.regulations.gov/#!docketDetail;D=FAA-2013-0700* or in person at the U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC.

For service information identified in this AD, contact Bombardier, Inc., 400 Côte-Vertu Road West, Dorval, Québec H4S 1Y9, Canada; telephone 514–855–5000; fax 514–855–7401; email *thd.crj@aero.bombardier.com;* Internet *http://www.bombardier.com.* You may view this referenced service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221.

FOR FURTHER INFORMATION CONTACT: Ricardo Garcia, Aerospace Engineer, Airframe and Propulsion Branch, ANE–171, FAA, New York Aircraft Certification Office, 1600 Stewart Avenue, Suite 410, Westbury, New York 11590; telephone (516) 228–7331; fax (516) 794–5531.

SUPPLEMENTARY INFORMATION:

Discussion

We issued a notice of proposed rulemaking (NPRM) to amend 14 CFR part 39 to include an AD that would apply to the specified products. The NPRM was published in the **Federal Register** on August 26, 2013 (78 FR 52712). The NPRM proposed to correct an unsafe condition for the specified products. Transport Canada Civil Aviation (TCCA), which is the aviation authority for Canada, has issued Canadian Airworthiness Directive CF–2013–12, dated May 14, 2013 (referred to after this as the Mandatory Continuing Airworthiness Information, or ''the MCAI''), to correct an unsafe condition for the specified products. The MCAI states:

There have been two in-service reports of fracture of rudder pedal tubes installed on the pilot-side rudder bar assembly.

Laboratory examination of the fractured rudder pedal tubes found that in both cases, the fatigue cracks initiated at the aft taper pin holes where the connecting rod fitting is attached. Fatigue testing of the rudder pedal tubes confirmed that the fatigue cracking is due to loads induced during parking brake application. Therefore, only the rudder pedal tubes on the pilot's side are vulnerable to fatigue cracking as the parking brake is primarily applied by the pilot.

Loss of pilot rudder pedal input during flight would result in reduced yaw controllability of the aeroplane. Loss of pilot rudder pedal input during takeoff or landing may lead to a runway excursion.

This [Canadian] AD mandates initial and repetitive [detailed or eddy current] inspections [for cracking and damage and replacement if necessary] of the pilot-side rudder * * * [bar assembly], until the terminating action is accomplished.

Required actions also include repairing damage. The terminating action is replacement of both pilot-side rudder bar assemblies. You may obtain further information by examining the MCAI in the AD docket on the Internet at *http://www.regulations.gov/#!documentDetail;D=FAA-2013-0700-0002.*

Comments

We gave the public the opportunity to participate in developing this AD.

We received no comments on the NPRM (78 FR 52712, August 26, 2013) or on the determination of the cost to the public.

Conclusion

We reviewed the available data and determined that air safety and the public interest require adopting this AD as proposed except for minor editorial changes. We have determined that these minor changes:

- Are consistent with the intent that was proposed in the NPRM (78 FR 52712, August 26, 2013) for correcting the unsafe condition; and
- Do not add any additional burden upon the public than was already proposed in the NPRM (78 FR 52712, August 26, 2013).

Costs of Compliance

We estimate that this AD affects 529 airplanes of U.S. registry. We estimate the following costs to comply with this AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Inspection	3 work-hours × $85 per hour = $255 per inspection cycle.	$0	$255 per inspection cycle.	$134,895 per inspection cycle.

We estimate the following costs to do any necessary replacement that would be required based on the results of the inspection. We have no way of determining the number of aircraft that might need this repair:

ON-CONDITION COSTS

Action	Labor cost	Parts cost	Cost per product
Replacement	6 work-hours × $85 per hour = $510	$2,850	$3,360

We have received no definitive data that would enable us to provide a cost estimate for the repair specified in this AD.

According to the manufacturer, some of the costs of this AD may be covered under warranty, thereby reducing the cost impact on affected individuals. We do not control warranty coverage for affected individuals. As a result, we have included all costs in our cost estimate.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. ''Subtitle VII: Aviation Programs,'' describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in ''Subtitle VII, Part A, Subpart III, Section 44701: General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

1. Is not a ''significant regulatory action'' under Executive Order 12866;

2. Is not a ''significant rule'' under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979);

3. Will not affect intrastate aviation in Alaska; and

4. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov/#!docketDetail;D=FAA-2013-0700;* or in person at the Docket Operations office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this AD the regulatory evaluation, any comments received, and other information. The street address for the Docket Operations office (telephone (800) 647–5527) is in the **ADDRESSES** section.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new AD:

2013–24–02 Bombardier, Inc.: Amendment 39–17676. Docket No. FAA–2013–0700; Directorate Identifier 2013–NM–102–AD.

(a) Effective Date

This airworthiness directive (AD) becomes effective January 6, 2014.

(b) Affected ADs

None.

(c) Applicability

This AD applies to Bombardier, Inc. Model CL–600–2B19 (Regional Jet Series 100 & 440) airplanes, certificated in any category, serial numbers 7003 and subsequent.

(d) Subject

Air Transport Association (ATA) of America Code 27, Flight controls.

(e) Reason

This AD was prompted by reports of fractured rudder pedal tubes installed on the pilot-side rudder bar assembly. We are issuing this AD to detect and correct cracking of both pilot-side rudder pedal tubes, which could result in loss of pilot rudder pedal input causing reduced yaw controllability or a runway excursion.

(f) Compliance

You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

(g) Initial Inspections

At the applicable time specified in paragraphs (g)(1) through (g)(6) of this AD, do a detailed or eddy current inspection for cracking and damage (i.e., corrosion or cracking) of both pilot-side rudder pedal tubes having part number (P/N) 600–90204–3, in accordance with the Accomplishment Instructions of Bombardier Service Bulletin 601R–27–162, including Appendix A, dated April 5, 2013.

(1) For airplanes that have accumulated less than 20,000 total flight cycles as of the effective date of this AD: Do the inspection before the accumulation of 23,000 total flight cycles.

(2) For airplanes that have accumulated 20,000 total flight cycles or more, but less than 25,000 total flight cycles as of the effective date of this AD: Do the inspection within 3,000 flight cycles after the effective date of this AD, but not to exceed 26,300 total flight cycles.

(3) For airplanes that have accumulated 25,000 total flight cycles or more, but less than 30,000 total flight cycles as of the effective date of this AD: Do the inspection within 1,300 flight cycles after the effective date of this AD, but not to exceed 30,800 total flight cycles.

(4) For airplanes that have accumulated 30,000 total flight cycles or more, but less than 33,000 total flight cycles as of the effective date of this AD: Do the inspection within 800 flight cycles after the effective date of this AD, but not to exceed 33,500 total flight cycles.

(5) For airplanes that have accumulated 33,000 total flight cycles or more, but less than 37,000 total flight cycles as of the effective date of this AD: Do the inspection within 500 flight cycles after the effective of this AD, but not to exceed 37,300 total flight cycles.

(6) For airplanes that have accumulated 37,000 total flight cycles or more as of the effective date of this AD: Do the inspection within 300 flight cycles after the effective date of this AD.

(h) Inspection Definition

For the purposes of this AD, a detailed inspection is an intensive examination of a specific item, installation, or assembly to detect damage, failure, or irregularity. Available lighting is normally supplemented with a direct source of good lighting at an intensity deemed appropriate. Inspection aids such as a mirror, magnifying lenses, etc., may be necessary. Surface cleaning and elaborate procedures may be required.

(i) Repetitive Inspections

For any tube on which no cracking and no damage is found during any inspection required by paragraph (g) of this AD: At the applicable time specified in paragraph (i)(1) or (i)(2) of this AD, repeat the detailed or eddy current inspection for cracking of the pilot-side rudder pedal tubes, specified in paragraph (g) of this AD, until the terminating action specified in paragraph (k) of this AD has been accomplished.

(1) If the most recent inspection was a detailed inspection: Repeat the inspection within 600 flight cycles thereafter.

(2) If the most recent inspection was an eddy current inspection: Repeat the inspection within 1,000 flight cycles thereafter.

(j) Corrective Actions

(1) If any cracking is found around the aft tapered holes during any inspection required by paragraph (g) or (i) of this AD, before further flight, replace the affected rudder bar assemblies, in accordance with the Accomplishment Instructions of Bombardier Service Bulletin 601R–27–162, including Appendix A, dated April 5, 2013.

(2) If any other damage (i.e., corrosion or cracking), other than that specified in paragraph (j)(1) of this AD, is found during any inspection required by paragraph (g) or (i) of this AD, before further flight, repair using a method approved by either the Manager, New York Aircraft Certification Office (ACO), ANE–170, FAA; or Transport Canada Civil Aviation (TCCA) (or its delegated agent).

(k) Optional Terminating Action

Replacement of both pilot-side rudder bar assemblies, in accordance with the Accomplishment Instructions of Bombardier Service Bulletin 601R–27–162, including Appendix A, dated April 5, 2013, terminates the inspections required by paragraphs (g) and (i) of this AD.

(l) Other FAA AD Provisions

The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, New York Aircraft Certification Office (ACO), ANE–170, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the ACO, send it to ATTN: Program Manager, Continuing Operational Safety, FAA, New York ACO, 1600 Stewart Avenue, Suite 410, Westbury, NY 11590; telephone 516–228–7300; fax 516–794–5531. Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office. The AMOC approval letter must specifically reference this AD.

(2) *Airworthy Product:* For any requirement in this AD to obtain corrective actions from a manufacturer or other source, use these actions if they are FAA-approved. Corrective actions are considered FAA-approved if they are approved by the State of Design Authority (or their delegated agent). You are required to assure the product is airworthy before it is returned to service.

(m) Related Information

Refer to Mandatory Continuing Airworthiness Information (MCAI) Canadian Airworthiness Directive CF–2013–12, dated May 14, 2013, for related information, which can be found in the AD docket on the internet at *http://www.regulations.gov/#!documentDetail;D=FAA-2013-0700-0002*.

(n) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference (IBR) of the service information listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this service information as applicable to do the actions required by this AD, unless the AD specifies otherwise.

(i) Bombardier Service Bulletin 601R–27–162, including Appendix A, dated April 5, 2013.

(ii) Reserved.

(3) For service information identified in this AD, contact Bombardier, Inc., 400 Côte-Vertu Road West, Dorval, Québec H4S 1Y9, Canada; telephone 514–855–5000; fax 514–855–7401; email *thd.crj@aero.bombardier.com*; Internet *http://www.bombardier.com*.

(4) You may view this service information at the FAA, Transport Airplane Directorate,

1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221.

(5) You may view this service information that is incorporated by reference at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal-register/cfr/ibr-locations.html.*

Issued in Renton, Washington, on November 15, 2013.

John Piccola,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2013–28104 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0449; Airspace Docket No. 13–AEA–8]

Amendment of Class D and E Airspace, and Establishment of Class E Airspace; Salisbury, MD

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action amends Class D and Class E airspace, and establishes Class E airspace at Salisbury-Ocean City Wicomico Regional Airport, Salisbury, MD, due to the decommissioning of the Salisbury VHF Omnidirectional Radio Range Tactical Air Navigation Aid (VORTAC) and cancellation of the VOR approach. This enhances the safety and management of aircraft operations at the airport. This action also updates the geographic coordinates of the airport, and changes the Class D city designator.

DATES: Effective 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under title 1, Code of Federal Regulations, part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: John Fornito, Operations Support Group, Eastern Service Center, Federal Aviation Administration, P.O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–6364.

SUPPLEMENTARY INFORMATION:

History

On August 22, 2013, the FAA published in the **Federal Register** a notice of proposed rulemaking (NPRM) to amend Class D and Class E surface area, and establish Class E airspace designated as an extension to a Class D surface area at Salisbury-Ocean City Wicomico Regional Airport, Salisbury, MD. (78 FR, 52109). Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. No comments were received.

Class D and Class E airspace designations are published in paragraphs 5000, 6002, 6004, and 6005, respectively, of FAA Order 7400.9X dated August 7, 2013, and effective September 15, 2013, which is incorporated by reference in 14 CFR 71.1. The Class D and E airspace designations listed in this document will be published subsequently in the Order.

The Rule

This amendment to Title 14, Code of Federal Regulations (14 CFR) part 71 amends Class D airspace and Class E surface airspace to within a 4.3-mile radius of the airport. Class E airspace extending upward from 700 feet above the surface is amended to within a 7-mile radius of the airport. Class E airspace designated as an extension to a Class D surface area airspace is established within a 4.3-mile radius of the airport, with segments extending 7 miles southeast, northeast, and southwest of the airport. The geographic coordinates of the airport are adjusted to coincide with the FAA's aeronautical database. The Class D city designation is changed from Salisbury-Ocean City Wicomico Regional Airport, MD, to Salisbury, MD.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current, is non-controversial and unlikely to result in adverse or negative comments. It, therefore, (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it amends controlled airspace at Salisbury-Ocean City Wicomico Regional Airport, Salisbury, MD.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1E, ''Environmental Impacts: Policies and Procedures,'' paragraph 311a. This airspace action is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment.

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9X Airspace Designations and Reporting Points, dated August 7, 2013, effective September 15, 2013, is amended as follows:

Paragraph 5000 Class D Airspace

* * * * *

AEA MD D Salisbury, MD [Amended]

Salisbury-Ocean City Wicomico Regional Airport, MD
(Lat. 38°20′25″ N., long. 75°30′34″ W.)

That airspace extending upward from the surface to and including 2,500 feet MSL

within a 4.3-mile radius of Salisbury-Ocean City Wicomico Regional Airport. This Class D airspace area is effective during specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

Paragraph 6002 Class E Airspace Areas Extending Upward from the Surface.

* * * * *

AEA MD E2 Salisbury, MD [Amended]

Salisbury-Ocean City Wicomico Regional Airport, MD
(Lat. 38°20′25″ N., long. 75°30′34″ W.)

That airspace extending upward from the surface within a 4.3-mile radius of Salisbury-Ocean City Wicomico Regional Airport. This Class E airspace area is effective during specific dates and times established in advance by a Notice to Airmen.

Paragraph 6004 Class E Airspace Designated as an Extension to a Class D Surface Area.

* * * * *

AEA MD E4 Salisbury, MD [New]

Salisbury-Ocean City Wicomico Regional Airport, MD
(Lat. 38°20′25″ N., long. 75°30′34″ W.)

That airspace extending upward from the surface within 2.5 miles each side of a 133° bearing from Salisbury-Ocean City Wicomico Regional Airport extending from the 4.3-mile radius of the airport to 7 miles southeast of the airport, and 2.5 miles each side of a 51° bearing from the airport, extending from the 4.3-mile radius of the airport to 7 miles northeast of the airport, and 2.5 miles each side of a 209° bearing from the airport, extending from the 4.3-mile radius of the airport to 7 miles southwest of the airport.

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 feet or More Above the Surface of the Earth.

* * * * *

AEA MD E5 Salisbury, MD [Amended]

Salisbury-Ocean City Wicomico Regional Airport, MD
(Lat. 38°20′25″ N., long. 75°30′34″ W.)

That airspace extending upward from 700 feet above the surface within a 7-mile radius of Salisbury-Ocean City Wicomico Regional Airport.

Issued in College Park, Georgia, on November 19, 2013.

Kip B. Johns,

Manager, Operations Support Group, Eastern Service Center, Air Traffic Organization.

[FR Doc. 2013–28674 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0469; Airspace Docket No. 13–AEA–9]

Amendment of Class E Airspace; Danville, VA

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action amends Class E Airspace at Danville Regional Airport, Danville, VA, to accommodate new landing and departure procedures, and by removing the operating hours established by a Notice to Airmen (NOTAM). This enhances the safety and management of aircraft operations at the airport. This action also updates the geographic coordinates of the airport.

DATES: Effective 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under title 1, Code of Federal Regulations, part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: John Fornito, Operations Support Group, Eastern Service Center, Federal Aviation Administration, P.O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–6364.

SUPPLEMENTARY INFORMATION:

History

On August 7, 2013, the FAA published in the **Federal Register** a notice of proposed rulemaking (NPRM) to amend Class E surface area airspace at Danville Regional Airport, Danville, VA. (78 FR, 48079). Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. No comments were received.

Class E airspace designations are published in paragraph 6002 of FAA Order 7400.9X dated August 7, 2013, and effective September 15, 2013, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designations listed in this document will be published subsequently in the Order.

The Rule

This amendment to Title 14, Code of Federal Regulations (14 CFR) part 71 amends Class E surface area airspace at Danville Regional Airport, Danville, VA, within a 5-mile radius of the airport, with segments extending from the 5-mile radius to 7 miles southwest and 7 miles northeast of the airport. Due to increased air traffic, controlled airspace is continuous 24 hours, and no longer effective during the specific dates and times established in advanced by NOTAM. The geographic coordinates of the airport also are adjusted to be in concert with FAAs aeronautical database.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current, is non-controversial and unlikely to result in adverse or negative comments. It, therefore, (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it amends controlled airspace at Danville Regional Airport, Danville, VA.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1E, ''Environmental Impacts: Policies and Procedures,'' paragraph 311a. This airspace action is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, effective September 15, 2013, is amended as follows:

Paragraph 6002 Class E Airspace Designated as Surface Areas.

* * * * *

AEA VA E2 Danville, VA [Amended]

Danville Regional Airport
(Lat. 36°34′22″ N., long. 79°20′10″ W.)

That airspace extending upward from the surface within a 5-mile radius of Danville Regional Airport and within 2.4-mile each side of a 208° bearing from the airport, extending from the 5-mile radius to 7 miles southwest of the airport, and within 2.4-mile each side of a 016° bearing from the airport, extending from the 5-mile radius to 7 miles northeast of the airport.

Issued in College Park, Georgia, on November 19, 2013.

Kip B. Johns,

Manager, Operations Support Group, Eastern Service Center, Air Traffic Organization.

[FR Doc. 2013–28665 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0681; Airspace Docket No. 13–AEA–15]

Amendment of Class E Airspace; Olean, NY

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action amends Class E Airspace at Olean, NY, as the Olean Non-Directional Beacon (NDB) has been decommissioned, requiring airspace redesign at Cattaraugus County-Olean Airport. This enhances the safety and management of aircraft operations at the airport. This action also updates the geographic coordinates of the airport.

DATES: Effective 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under title 1, Code of Federal Regulations, part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: John Fornito, Operations Support Group, Eastern Service Center, Federal Aviation Administration, P.O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–6364.

SUPPLEMENTARY INFORMATION:

History

On August 22, 2013, the FAA published in the **Federal Register** a notice of proposed rulemaking (NPRM) to amend Class E airspace at Cattaraugus County-Olean Airport, Olean, NY. (78 FR 52115). Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. No comments were received.

Class E airspace designations are published in paragraph 6005 of FAA Order 7400.9X dated August 7, 2013, and effective September 15, 2013, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designations listed in this document will be published subsequently in the Order.

The Rule

This amendment to Title 14, Code of Federal Regulations (14 CFR) part 71 amends Class E airspace extending upward from 700 feet above the surface within a 10-mile radius of Cattaraugus County-Olean Airport, Olean, NY. Airspace reconfiguration is necessary due to the decommissioning of the Olean NDB and cancellation of the NDB approach, and for continued safety and management of IFR operations at the airport. The geographic coordinates of the airport are adjusted to coincide with the FAAs aeronautical database.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current, is non-controversial and unlikely to result in adverse or negative comments. It, therefore, (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it amends controlled airspace at Cattaraugus County-Olean Airport, Olean, NY.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1E, ''Environmental Impacts: Policies and Procedures,'' paragraph 311a. This airspace action is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment.

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, effective September 15, 2013, is amended as follows:

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 feet or More Above the Surface of the Earth.

* * * * *

AEA NY E5 Olean, NY [Amended]

Cattaraugus County-Olean Airport, NY
(Lat. 42°14′28″ N., long. 78°22′17″ W.)

That airspace extending upward from 700 feet above the surface within a 10-mile radius of Cattaraugus County-Olean Airport.

Issued in College Park, Georgia, on November 19, 2013.

Kip B. Johns,

Manager, Operations Support Group, Eastern Service Center, Air Traffic Organization.

[FR Doc. 2013–28676 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0513; Airspace Docket No. 13–ASO–13]

Amendment of Class E Airspace; Tazewell, TN

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action amends Class E Airspace at Tazewell, TN, as new Standard Instrument Approach Procedures have been developed at New Tazewell Municipal Airport. This enhances the safety and management of aircraft operations at the airport.

DATES: Effective 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under title 1, Code of Federal Regulations, part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: John Fornito, Operations Support Group, Eastern Service Center, Federal Aviation Administration, P.O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–6364.

SUPPLEMENTARY INFORMATION:

History

On August 7, 2013, the FAA published in the **Federal Register** a notice of proposed rulemaking (NPRM) to amend Class E airspace at New Tazewell Municipal Airport, Tazewell, TN. (78 FR 48078). Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. No comments were received.

Class E airspace designations are published in paragraph 6005 of FAA Order 7400.9X dated August 7, 2013, and effective September 15, 2013, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designations listed in this document will be published subsequently in the Order.

The Rule

This amendment to Title 14, Code of Federal Regulations (14 CFR) part 71 amends Class E airspace extending upward from 700 feet above the surface within a 13.4-mile radius of New Tazewell Municipal Airport, Tazewell, TN. Airspace reconfiguration is necessary due to the development of the RNAV (GPS) RWY 7 approach and for continued safety and management of IFR operations at the airport.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current, is non-controversial and unlikely to result in adverse or negative comments. It, therefore, (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it amends controlled airspace at New Tazewell Municipal Airport, Tazewell, TN.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1E, ''Environmental Impacts: Policies and Procedures,'' paragraph 311a. This airspace action is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, effective September 15, 2013, is amended as follows:

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 feet or More Above the Surface of the Earth.

* * * * *

ASO TN E5 Tazewell, TN [Amended]

New Tazewell Municipal Airport, TN
(Lat. 36°24′32″ N., long. 83°33′26″ W.)

That airspace extending upward from 700 feet above the surface within a 13.4 mile radius of New Tazewell Municipal Airport.

Issued in College Park, Georgia, on November 20, 2013.

Kip B. Johns,

Manager, Operations Support Group, Eastern Service Center, Air Traffic Organization.

[FR Doc. 2013–28681 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

Docket No. FAA–2013–0989; Airspace Docket No. 13–AEA–17

RIN 2120–AA66

Amendment of VOR Federal Airway V–374, Northeastern United States

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule; technical amendment.

SUMMARY: This action makes an editorial change to the legal description of VHF Omnidirectional Range (VOR) Federal airway V–374 to reverse the order points listed in the route description. This action is simply to comply with the standard format for describing routes and does not alter the alignment of the airway.

DATES: *Effective Date:* 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under 1 CFR part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: Paul Gallant, Airspace Policy and ATC Procedures Group, Office of Airspace Services, Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591; telephone: (202) 267–8783.

SUPPLEMENTARY INFORMATION:

Background

Airway and route legal descriptions are published in FAA Order 7400.9X, Airspace Designations and Reporting Points. Current format guidelines for these legal descriptions require that the order of points in a description be listed from ''west-to-east'' or from ''south-to-north,'' as applicable. The description for V–374 lists the points from ''east-to-west.'' This rule simply reverses the order of the points listed in Order 7400.9X to a ''west-to-east'' format for standardization.

The Rule

This action amends Title 14 Code of Federal Regulations (14 CFR) part 71 by reversing the order of points listed in the legal description of Domestic VOR Federal Airway V–374 to comply with the standard route description format. The change does not alter the current alignment of V–374 and the airway track is correct on aeronautical charts.

Since this action merely involves an editorial change in the legal description of VOR Federal airway V–374 to standardize the format, and does not involve a change in the dimensions or operating requirements of the affected route, I find that notice and public procedure under 5 U.S.C. 553(b) are unnecessary.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this regulation: (1) Is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority.

This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of the airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it is merely an editorial change of the legal description of V–374 to comply with existing administrative format procedures.

Domestic VOR Federal Airways are published in paragraph 6010(a) of FAA Order 7400.9X, dated August 7, 2013, and effective September 15, 2013, which is incorporated by reference in 14 CFR 71.1. The VOR Federal Airway listed in this document will be published subsequently in the Order.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1E, Environmental Impacts: Policies and Procedures, paragraph 311a. This airspace action consists of editorial changes only and is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, and effective September 15, 2013, is amended as follows:

Paragraph 6010(a) Domestic VOR Federal Airways

* * * * *

V–374 [Amended]

From Binghamton, NY; INT Binghamton 119° and Deer Park, NY, 308° radials; INT Deer Park 308° and Carmel, NY, 254° radials; Carmel; INT Carmel 099° and Calverton, NY, 044° radials; INT Calverton 044° and Groton, CT, 276° radials; Groton; to Martha's Vineyard, MA.

Issued in Washington, DC, on November 25, 2013.

Donna Warren,

Acting Manager, Airspace Policy and ATC Procedures Group.

[FR Doc. 2013–28753 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0991; Airspace Docket No. 13–ASO–4]

RIN 2120–AA66

Amendment of VOR Federal Airway V–45, North Carolina

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule; technical amendment.

SUMMARY: This action amends the legal description of VHF Omnidirectional Range (VOR) Federal airway V–45 to update the name of a navigation aid used in the route description. This action is simply to comply with standard formatting for describing routes and does not alter the alignment of the airway.

DATES: *Effective Date:* 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under 1 CFR part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: Paul Gallant, Airspace Policy and ATC Procedures Group, Office of Airspace Services, Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591; telephone: (202) 267–8783.

SUPPLEMENTARY INFORMATION:

The Rule

This action amends Title 14 Code of Federal Regulations (14 CFR) part 71 to update the legal description of a portion of VOR Federal Airway V–45 by replacing the words ''Hickory, NC, 049°'' with ''Pulaski, VA, 147°.'' The ''Hickory VOR/DME'' was renamed the ''Barretts Mountain VOR/DME,'' but the V–45 description was never updated. This action, instead, replaces the Hickory 049° radial with the Pulaski, VA, VORTAC 147° radial. The intersection of the Greensboro 334° and the Pulaski 147° radials form the exact same point as was previously defined by the Hickory 049° radial. This editorial change does not alter the current alignment of V–45 and the airway track remains correct on aeronautical charts.

Since this action merely involves an editorial change to update the legal description of VOR Federal airway V–45, and does not involve any change in the alignment or operating requirements of the affected route, I find that notice and public procedure under 5 U.S.C. 553(b) are unnecessary.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this regulation: (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority.

This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of the airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it updates the legal description of an airway in the southeastern United States.

Domestic VOR Federal Airways are published in paragraph 6010(a) of FAA Order 7400.9X, dated August 7, 2013, and effective September 15, 2013, which is incorporated by reference in 14 CFR 71.1. The VOR Federal Airway listed in this document will be published subsequently in the Order.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1E, Environmental Impacts: Policies and Procedures, paragraph 311a. This airspace action consists of an editorial change only and is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, and effective September 15, 2013, is amended as follows:

Paragraph 6010(a) Domestic VOR Federal Airways

* * * * *

V–45 [Amended]

From New Bern, NC; Kinston, NC; Raleigh-Durham, NC; INT Raleigh-Durham 275° and Greensboro, NC, 105° radials; Greensboro; INT Greensboro 334° and Pulaski, VA, 147° radials; Pulaski; Bluefield, WV; Charleston, WV; Henderson, WV; Appleton, OH; Waterville, OH; INT Waterville 306° and Jackson, MI, 166° radials; Jackson; Lansing, MI; Saginaw, MI; Alpena, MI; Sault Ste Marie, MI. The airspace within R–5502A and R–5502B is excluded.

* * * * *

Issued in Washington, DC, on November 25, 2013.

Donna Warren,

Acting Manager, Airspace Policy and ATC Procedures Group.

[FR Doc. 2013–28757 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0659; Airspace Docket No. 13–AWP–12]

Establishment of Class D Airspace and Class E Airspace; Laguna AAF, AZ

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action establishes Class D airspace and Class E airspace at Laguna Army Air Field (AAF), (Yuma Proving Ground), Yuma, AZ. The establishment of an air traffic control tower has made this action necessary for the safety and management of Instrument Flight Rules (IFR) operations at the airport.

DATES: Effective date, 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under 1 CFR Part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: Eldon Taylor, Federal Aviation Administration, Operations Support Group, Western Service Center, 1601 Lind Avenue SW., Renton, WA 98057; telephone (425) 203–4537.

SUPPLEMENTARY INFORMATION:

History

On September 19, 2013, the FAA published in the **Federal Register** a notice of proposed rulemaking (NPRM) to establish controlled airspace at Laguna AAF, AZ (78 FR 57545). Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. No comments were received.

Class D airspace and Class E airspace designations are published in paragraphs 5000 and 6005, respectively, of FAA Order 7400.9X dated August 7, 2013, and effective September 15, 2013, which is incorporated by reference in 14 CFR 71.1. The Class D and Class E airspace designations listed in this document will be published subsequently in that Order.

The Rule

This action amends Title 14 Code of Federal Regulations (14 CFR) Part 71 by establishing Class D airspace extending upward from the surface to and including 1,700 feet mean sea level (MSL) within a 3.5-mile radius of Laguna AAF (Yuma Proving Ground), Yuma, AZ; and Class E airspace extending upward from 700 feet above the surface within a 8.8-mile radius of the airfield, with a segment extending from the 8.8-mile radius to 13.5 miles northwest of the airfield. The establishment of an air traffic control tower has made this action necessary and provides the required controlled airspace for the safety and management of IFR operations at the airfield.

The FAA has determined this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this regulation: (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the U.S. Code. Subtitle 1, Section 106 discusses the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it establishes controlled airspace at Laguna AAF, (Yuma Proving Ground), Yuma, AZ.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1E, ''Environmental Impacts: Policies and Procedures,'' paragraph 311a. This airspace action is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air)

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for 14 CFR Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E. O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, and effective September 15, 2013 is amended as follows:

Paragraph 5000 Class D airspace.

* * * * *

AWP AZ D Laguna AAF, AZ [New]

Laguna AAF (Yuma Proving Ground), Yuma, AZ
(Lat. 32°51′53″ N., long. 114°23′35″ W.)

That airspace extending upward from the surface to and including 1,700 feet MSL within a 3.5-mile radius of Laguna AAF; excluding that airspace in Restricted Area R–2306E and R–2307 when they are in effect. This Class D airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface of the earth.

* * * * *

AWP AZ E5 Laguna AAF, AZ [New]

Laguna AAF (Yuma Proving Ground), Yuma, AZ
(Lat. 32°51′53″ N., long. 114°23′35″ W.)

That airspace extending upward from 700 feet above the surface within 8.8-mile radius of the Laguna AAF and within 2 miles each side of the Laguna AAF 348° bearing extending from the 8.8-mile radius to 13.5 miles northwest of the airport.

Issued in Seattle, Washington, on November 15, 2013 .

Clark Desing,

Manager, Operations Support Group, Western Service Center.

[FR Doc. 2013–28482 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0558; Airspace Docket No. 13–AEA–10]

Establishment of Class E Airspace; McConnellsburg, PA

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action establishes Class E Airspace at McConnellsburg, PA, to accommodate a new Area Navigation (RNAV) Global Positioning System (GPS) special Standard Instrument Approach Procedure (SIAP) serving Fulton County Medical Center Heliport. This action enhances the safety and airspace management of Instrument Flight Rules (IFR) operations within the National Airspace System.

DATES: Effective 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under title 1, Code of Federal Regulations, part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: John Fornito, Operations Support Group,

Eastern Service Center, Federal Aviation Administration, P. O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–6364.

SUPPLEMENTARY INFORMATION:

History

On August 7, 2013, the FAA published in the **Federal Register** a notice of proposed rulemaking (NPRM) to establish Class E airspace at McConnellsburg, PA, (78 FR 48081) Docket No. FAA–2013–0558. Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. No comments were received. Class E airspace designations are published in paragraph 6005 of FAA Order 7400.9X dated August 7, 2013, and effective September 15, 2013, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designations listed in this document will be published subsequently in the Order.

The Rule

This amendment to Title 14, Code of Federal Regulations (14 CFR) part 71 establishes Class E airspace extending upward from 700 feet above the surface within a 6 mile radius of the point in space coordinates for Fulton County Medical Center Heliport, providing the controlled airspace required to accommodate the new RNAV (GPS) Standard Instrument Approach Procedures developed for the heliport. This action enhances the safety and management of IFR operations within the National Airspace System.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current, is non-controversial and unlikely to result in adverse or negative comments. It, therefore, (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it establishes controlled airspace at Fulton County Medical Center Heliport, McConnellsburg, PA.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1E, ''Environmental Impacts: Policies and Procedures,'' paragraph 311a. This airspace action is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment.

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, effective September 15, 2013, is amended as follows:

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 feet or More Above the Surface of the Earth.

* * * * *

AEA PA E5 McConnellsburg, PA [New]

Fulton County Medical Center Heliport, PA
(Lat. 39°56′17″ N., long. 78°00′27″ W.)
Point in Space Coordinates
(Lat. 39°55′25″ N., long. 78°00′26″ W.)

That airspace extending upward from 700 feet above the surface within a 6-mile radius of the Point in Space Coordinates (lat. 39°55′25″ N., long.78°00′26″ W.) serving Fulton County Medical Center Heliport.

Issued in College Park, Georgia, on November, 19, 2013.

Kip B. Johns,

Manager, Operations Support Group, Eastern Service Center, Air Traffic Organization.

[FR Doc. 2013–28672 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0431; Airspace Docket No. 13–ASO–7]

Establishment of Class E Airspace; Aliceville, AL

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action establishes Class E Airspace at Aliceville, AL, to accommodate a new Area Navigation (RNAV) Global Positioning System (GPS) Standard Instrument Approach Procedure (SIAP) serving George Downer Airport. This action enhances the safety and management of Instrument Flight Rules (IFR) operations at the airport.

DATES: Effective 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under title 1, Code of Federal Regulations, part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: John Fornito, Operations Support Group, Eastern Service Center, Federal Aviation Administration, P. O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–6364.

SUPPLEMENTARY INFORMATION:

History

On August 22, 2013, the FAA published in the **Federal Register** a notice of proposed rulemaking to establish Class E airspace at Aliceville, AL(78 FR 52111) Docket No. FAA–2013–0431. Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. No comments were received. Class E airspace designations are published in paragraph 6005 of FAA Order 7400.9X dated August 7, 2013, and effective September 15, 2013, which is

incorporated by reference in 14 CFR 71.1. The Class E airspace designations listed in this document will be published subsequently in the Order.

The Rule

This amendment to Title 14, Code of Federal Regulations (14 CFR) part 71 establishes the Class E airspace extending upward from the surface within a 7-mile radius at George Downer Airport, providing the controlled airspace required to accommodate the new RNAV (GPS) Standard Instrument Approach Procedures developed at the airport. This action provides for the safety and management of IFR operations at the airport.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current, is non-controversial and unlikely to result in adverse or negative comments. It, therefore, (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it establishes controlled airspace at George Downer Airport, Aliceville, AL.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1E, ''Environmental Impacts: Policies and Procedures,'' paragraph 311a. This airspace action is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment.

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, effective September 15, 2013, is amended as follows:

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 Feet or More Above the Surface of the Earth.

* * * * *

ASO AL E5 Aliceville, AL [New]

George Downer Airport, AL
(Lat. 33°06′23″ N., long. 88°11′52″ W.)

That airspace extending upward from 700 feet above the surface within a 7- mile radius of George Downer Airport.

Issued in College Park, Georgia, on November 20, 2013.

Kip B. Johns,

Manager, Operations Support Group, Eastern Service Center, Air Traffic Organization.

[FR Doc. 2013–28677 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0440; Airspace Docket No. 13–ASO–10]

Establishment of Class E Airspace; Star, NC

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action establishes Class E Airspace at Star, NC, to accommodate a new Area Navigation (RNAV) Global Positioning System (GPS) Standard Instrument Approach Procedure (SIAP) serving Montgomery County Airport. This action enhances the safety and management of Instrument Flight Rules (IFR) operations at the airport.

DATES: Effective 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under title 1, Code of Federal Regulations, part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: John Fornito, Operations Support Group, Eastern Service Center, Federal Aviation Administration, P.O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–6364.

SUPPLEMENTARY INFORMATION:

History

On September 4, 2013, the FAA published in the **Federal Register** a notice of proposed rulemaking to establish Class E airspace at Star, NC (78 FR 54413) Docket No. FAA–2013–0440. Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. No comments were received. Class E airspace designations are published in paragraph 6005 of FAA Order 7400.9X dated August 7, 2013, and effective September 15, 2013, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designations listed in this document will be published subsequently in the Order.

The Rule

This amendment to Title 14, Code of Federal Regulations (14 CFR) part 71 establishes the Class E airspace extending upward from 700 feet above the surface within a 6.8-mile radius at Montgomery County Airport, Star, NC, providing the controlled airspace required to accommodate the new RNAV (GPS) Standard Instrument Approach Procedures developed at the airport. This action provides for the safety and management of IFR operations at the airport.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current, is non-controversial and unlikely to result in adverse or negative comments. It, therefore, (1) is not a ''significant regulatory action'' under

Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it establishes controlled airspace at Montgomery County Airport, Star, NC.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1E, ''Environmental Impacts: Policies and Procedures,'' paragraph 311a. This airspace action is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment.

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, effective September 15, 2013, is amended as follows:

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 Feet or More Above the Surface of the Earth.

* * * * *

ASO NC E5 Star, NC [New]

Montgomery County Airport, NC
(Lat. 35°23′05″N., long. 79°47′25″W.)

That airspace extending upward from 700 feet above the surface within a 6.8- mile radius of Montgomery County Airport.

Issued in College Park, Georgia, on November 20, 2013.

Kip B. Johns,

Manager, Operations Support Group, Eastern Service Center, Air Traffic Organization.

[FR Doc. 2013–28678 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0430; Airspace Docket No. 13–ASO–8]

Establishment of Class E Airspace; Magee, MS

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action establishes Class E Airspace at Magee, MS, to accommodate a new Area Navigation (RNAV) Global Positioning System (GPS) special Standard Instrument Approach Procedure (SIAP) serving Magee Municipal Airport. This action enhances the safety and airspace management of Instrument Flight Rules (IFR) operations within the National Airspace System. This action also updates the geographic coordinates of the airport.

DATES: Effective 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under title 1, Code of Federal Regulations, part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: John Fornito, Operations Support Group, Eastern Service Center, Federal Aviation Administration, P. O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–6364.

SUPPLEMENTARY INFORMATION:

History

On August 7, 2013, the FAA published in the **Federal Register** a notice of proposed rulemaking (NPRM) to establish Class E airspace at Magee, MS, (78 FR 48080) Docket No. FAA–2013–0430. Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. No comments were received. Subsequent to publication, the FAA found an error in the geographic coordinates of Magee Municipal Airport. This action corrects that error. Except for editorial changes, and the change noted above, this rule is the same as published in the NPRM.

Class E airspace designations are published in paragraph 6005 of FAA Order 7400.9X dated August 7, 2013, and effective September 15, 2013, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designations listed in this document will be published subsequently in the Order.

The Rule

This amendment to Title 14, Code of Federal Regulations (14 CFR) part 71 establishes Class E airspace extending upward from 700 feet above the surface within a 6.3 mile radius at Magee Municipal Airport, Magee, MS, providing the controlled airspace required to accommodate the new RNAV (GPS) Standard Instrument Approach Procedures developed at the airport. This action is necessary for the safety and management of IFR operations at the heliport. Also, the geographic coordinates of the airport are adjusted to be in concert with the FAAs aeronautical database.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current, is non-controversial and unlikely to result in adverse or negative comments. It, therefore, (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial

number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it establishes controlled airspace at Magee Municipal Airport, Magee, MS.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1E, ''Environmental Impacts: Policies and Procedures,'' paragraph 311a. This airspace action is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment.

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, effective September 15, 2013, is amended as follows:

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 feet or More Above the Surface of the Earth.

* * * * *

ASO MS E5 Magee, MS [New]

Magee Municipal Airport, MS
(Lat. 31°51′46″ N., long. 89°48′02″ W.)

That airspace extending upward from 700 feet above the surface within a 6.3- mile radius of Magee Municipal Airport.

Issued in College Park, Georgia, on November 20, 2013.

Kip B. Johns,

Manager, Operations Support Group, Eastern Service Center, Air Traffic Organization.

[FR Doc. 2013–28679 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0002; Airspace Docket No. 12–ASO–46]

Establishment of Class E Airspace; Umatilla, FL

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule: correction.

SUMMARY: This action corrects the geographic coordinates in the airspace description of a final rule, published in the **Federal Register** on August 23, 2013, establishing controlled airspace at Umatilla Municipal Airport, Umatilla, FL.

DATES: Effective 0901 UTC, December 12, 2013. The Director of the Federal Register approves this incorporation by reference action under title 1, Code of Federal Regulations, part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: John Fornito, Operations Support Group, Eastern Service Center, Federal Aviation Administration, P.O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–6364.

SUPPLEMENTARY INFORMATION:

History

On August 23, 2013, the FAA published a final rule in the **Federal Register** establishing Class E airspace at Umatilla Municipal Airport, Umatilla, FL (78 FR 52425). After publication, the FAA found that the geographic coordinates of the airport were incorrect. The longitude coordinate is corrected from ''long. 82°39′07″ W.'' to ''long. 81°39′07″ W.''

Correction to Final Rule

Accordingly, pursuant to the authority delegated to me, amendatory instruction 2 and the geographic coordinates listed in the airspace designation of the Class E airspace for Umatilla Municipal Airport, Umatilla, FL, as published in the **Federal Register** of August 23, 2013, (78 FR 52425), FR Doc. 2013–20512, are corrected as follows:

PART 71 [AMENDED]

■ 1. On page 52425, column 3, revise amendatory instruction 2 to read: The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, and effective September 15, 2013, is amended as follows:

ASO FL E5 Umatilla, FL [Corrected]

■ 2. On page 52425, column 3, line 59, remove, ''lat. 28°55′27″ N., long. 82°39′07″ W'', and insert ''lat. 28°55′27″ N., long. 81°39′07″ W''.

Issued in College Park, Georgia, on November 20, 2013.

Kip B. Johns,

Manager, Operations Support Group, Eastern Service Center, Air Traffic Organization.

[FR Doc. 2013–28758 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 460

Interpretation Concerning Involvement of NASA Astronauts During a Licensed Launch or Reentry

AGENCY: Federal Aviation Administration, DOT.

ACTION: Interpretation.

SUMMARY: This interpretation responds to a request from the National Aeronautics and Space Administration (NASA) regarding whether the space transportation regulations of the Federal Aviation Administration (FAA) would restrict NASA astronauts from performing operational functions during a commercial space launch or reentry under license from the FAA.

DATES: Effective December 2, 2013.

FOR FURTHER INFORMATION CONTACT: For technical questions, contact Pam Underwood, Deputy Manager, Operations Integration Division; *pam.underwood@faa.gov.* For legal questions, contact Alex Zektser, Office of the Chief Counsel, International Law, Legislation, and Regulations Division, Federal Aviation Administration; email *alex.zektser@faa.gov.*

SUPPLEMENTARY INFORMATION:

Background

On July 3, 2013, NASA asked the FAA whether the FAA would restrict NASA astronauts, who are U.S. Government employees, from engaging in operational functions during an FAA-licensed launch or reentry. NASA noted that all NASA astronauts undergo extensive training and must meet rigorous medical and training requirements. NASA will also ensure astronauts complete training specific to each launch and reentry operator's vehicle and operations.

Specifically, NASA asked whether, under the FAA's statute and regulations, a NASA astronaut flying as a space flight participant could engage in ''all nominal and off-nominal operational functions,'' including ''the conduct of aborts, emergency response, and monitoring and operating environmental controls and life support systems.'' NASA also asked the FAA whether NASA's astronauts could ''perform operational activities up to and including flight.'' In response to NASA's question, the FAA examined the launch and reentry scenarios currently envisioned, and concludes that NASA astronauts may perform these functions in FAA-licensed launches and reentries.

Scenarios

The FAA understands that the following scenarios are likely, but not definite. It is the FAA's understanding that a NASA astronaut's interaction with the controls of a launch or reentry vehicle may vary depending on a launch or reentry operator's designs and operational procedures, which are currently under development. During a nominal launch, a launch operator under an FAA license would most likely conduct the ascent using a flight computer as the primary means of controlling the flight path of the vehicle. Any persons on board would not likely affect the flight path of the launch vehicle. If an emergency situation arose, a NASA astronaut could override the launch operator's flight computer to initiate an abort from the launch vehicle and take manual control of the spacecraft atop the launch vehicle. NASA astronaut emergency operations could include manually initiating an abort, using thrusters to orient a capsule to support chute deployment, and subsequent deployment of any parachutes. Emergency operations could also include the NASA astronaut manually piloting a vehicle to a water or runway landing.

For a reentry, a licensed operator's flight computer could serve as the primary means of controlling the flight path of the vehicle during a nominal reentry. A NASA astronaut might manually initiate the reentry burn, and the flight computer could conduct the reentry of the vehicle during nominal operations. The NASA astronaut could also have the capability to take manual control over the reentry vehicle in an off-nominal or emergency situation. During an off-nominal or emergency situation, the NASA astronaut would, much of the time, be using procedures or training prepared by the reentry operator.

Discussion

A. Space Flight Participants Who are NASA Astronauts

Based on the above scenarios, we conclude that, under 51 U.S.C. ch. 509 (Chapter 509), the FAA's space regulations at 14 CFR ch. III, and consistent with the FAA's discussion of its human space flight requirements,[1] a NASA astronaut may engage in operational functions, up to and including piloting the vehicle, the conduct of aborts, emergency response, and monitoring and operating environmental controls and life support systems, and the launch or reentry would remain under FAA jurisdiction.

Chapter 509 addresses crew and space flight participants, and, according to Chapter 509's definition, NASA astronauts are space flight participants. Chapter 509 defines ''crew'' as ''any employee of a licensee or transferee, or of a contractor or subcontractor of a licensee or transferee, who performs activities in the course of that employment directly relating to the launch, reentry, or other operation of or in a launch vehicle or reentry vehicle that carries human beings.'' 51 U.S.C. 50902(2). Conversely, a ''space flight participant'' is ''an individual, who is not crew, carried within a launch vehicle or reentry vehicle.'' *Id.* § 50902(17). Because a NASA astronaut is not an employee of a licensee or transferee, or of a contractor or subcontractor of a licensee or transferee, a NASA astronaut is not crew. Consequently, a NASA astronaut who is being carried within a launch or reentry vehicle is a space flight participant.

B. Limitations

Chapter 509 does not specify any limitations on a space flight participant's conduct or operations during a launch or reentry. Similarly, FAA regulations implementing Chapter 509 for space flight participants, codified at 14 CFR part 460, also do not specify any limitations on a space flight participant's conduct or operations during a launch or reentry. *See* 14 CFR 460.41, *et. seq.*[2] The only place where the FAA limits space-flight-participant conduct or operations is in the preamble to the Human Space Flight rule that created part 460. There the FAA states that:

> For public safety reasons, the FAA will not allow space flight participants to pilot launch or reentry vehicles at this time. A space flight participant who wants to pilot a launch or reentry vehicle would have to become an employee or independent contractor of the operator to acquire vehicle and mission-specific training. The operator will be in a better position to evaluate the skills of an employee or independent contractor than of a space flight participant, particularly as those skills relate to the requirements of the operator's particular vehicle. The FAA acknowledges that this restriction may create a dilemma for someone who wishes to acquire training in order to become employed, but, while the technology is so new, it is important for public safety that pilots be highly skilled at the outset.[3]

As can be seen, the FAA's concern with space flight participants interacting with a launch or reentry vehicle was based on the possibility that space flight participants would not have the proper vehicle and mission-specific training. However, as NASA notes, NASA astronauts must meet rigorous medical and training requirements, which include training specific to each mission, launch vehicle, and reentry vehicle. Because NASA astronauts are not the untrained space-flight participants originally contemplated by the FAA, the considerations underlying the policy have, at best, a limited applicability to NASA astronauts. Thus, for the scenarios currently envisioned, NASA astronauts may engage in operational activities during a licensed launch or reentry to ensure safety and mission success

C. Jurisdiction

We note that Chapter 509 does not apply to launches or reentries the U.S. Government carries out for itself. 51 U.S.C. 50919(g). Accordingly, NASA is not carrying out the launches or reentries that are subject to Chapter 509. In the event, not contemplated in this interpretation, that a NASA astronaut

[1] *Human Space Flight Requirements for Crew and Space Flight Participants, Final Rule,* 71 FR 75616 (Dec. 15, 2006) (''Human Space Flight Rule'').

[2] The pertinent FAA regulations simply require that space flight participants: (1) be informed of risk; (2) execute a waiver of claims against the U.S. Government; (3) receive training on how to respond to emergency situations; and (4) not carry any weapons onboard. *See* 14 CFR §§ 460.45–460.53.

[3] *Human Space Flight Requirements Final Rule,* 71 FR at 75618.

exercised sufficient operational control to carry out the launch or reentry, § 50919(g) would serve as a bar to FAA licensing the activity.

In the scenarios described above, as currently under development by launch and reentry operators, the NASA astronaut would likely not affect the flight path of the vehicle during a nominal launch. During a launch, the astronaut would likely only manipulate the flight path of the vehicle if an emergency arose. Accordingly, section 50919(g) would not limit a NASA astronaut's ability to engage in operational functions during launch. Most of the conduct or operations would simply constitute the execution of emergency training required of space flight participants by § 460.51.

The analysis for a reentry is similar to that of a launch, with some additional consideration for the possible manual operation of the reentry vehicle by a NASA astronaut. Specifically, a NASA astronaut could initiate reentry manually, but because the scenarios have the reentry operator's flight computer directing the reentry, the NASA astronaut's interaction would not be sufficient to constitute NASA carrying out the reentry. Additionally, the NASA astronaut's exercise of manual control over the vehicle in an off-nominal situation would also not rise to NASA carrying out the reentry because, as discussed above, in an off-nominal situation, the astronaut would largely be implementing procedures created by a commercial launch or reentry operator for purposes of safety or mission success.

In conclusion, Chapter 509 and the FAA's regulations impose no operational constraints on NASA astronauts for the scenarios envisioned here.

Issued in Washington, DC, on November 21, 2013.

Mark W. Bury,

Assistant Chief Counsel for International Law, Legislation and Regulations.

[FR Doc. 2013–28405 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

21 CFR Part 1308

[Docket No. DEA–374]

Schedules of Controlled Substances: Placement of Perampanel into Schedule III

AGENCY: Drug Enforcement Administration, Department of Justice.

ACTION: Final rule.

SUMMARY: With the issuance of this final rule, the Deputy Administrator of the Drug Enforcement Administration (DEA) places the substance perampanel [2-(2-oxo-1-phenyl-5-pyridin-2-yl-1,2-dihydropyridin-3-yl) benzonitrile], including its salts, isomers, and salts of isomers, into schedule III of the Controlled Substances Act (CSA). This scheduling action is pursuant to the CSA which requires that such actions be made on the record after opportunity for a hearing through formal rulemaking. This action imposes the regulatory controls and administrative, civil, and criminal sanctions applicable to schedule III controlled substances on persons who handle (manufacture, distribute, dispense, import, export, engage in research, conduct instructional activities with, or possess) or propose to handle perampanel.

DATES: *Effective Date:* January 2, 2014.

FOR FURTHER INFORMATION CONTACT: Ruth A. Carter, Chief, Policy Evaluation and Analysis Section, Office of Diversion Control, Drug Enforcement Administration; Mailing Address: 8701 Morrissette Drive, Springfield, Virginia 22152; Telephone: (202) 598–6812.

SUPPLEMENTARY INFORMATION:

Legal Authority

The DEA implements and enforces titles II and III of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended. Titles II and III are referred to as the ''Controlled Substances Act'' and the ''Controlled Substances Import and Export Act,'' respectively, but they are collectively referred to as the ''Controlled Substances Act'' or the ''CSA'' for the purposes of this action. 21 U.S.C. 801–971. The DEA publishes the implementing regulations for these statutes in title 21 of the Code of Federal Regulations (CFR) parts 1300 to 1321. The CSA and its implementing regulations are designed to prevent, detect, and eliminate the diversion of controlled substances and listed chemicals into the illicit market while providing for the legitimate medical, scientific, research, and industrial needs of the United States. Controlled substances have the potential for abuse and dependence and are controlled to protect the public health and safety.

Under the CSA, controlled substances are classified in one of five schedules based upon their potential for abuse, their currently accepted medical use, and the degree of dependence the substance may cause. 21 U.S.C. 812. The initial schedules of controlled substances established by Congress are found at 21 U.S.C. 812(c) and the current list of scheduled substances is published at 21 CFR part 1308.

Pursuant to 21 U.S.C. 811(a)(1), the Attorney General may, by rule, ''add to such a schedule or transfer between such schedules any drug or other substance if he (A) finds that such drug or other substance has a potential for abuse, and (B) makes with respect to such drug or other substance the findings prescribed by [21 U.S.C. 812(b)] for the schedule in which such drug is to be placed. . . .'' Pursuant to 28 CFR 0.100(b), the Attorney General has delegated this scheduling authority to the Administrator of the DEA, who has further delegated this authority to the Deputy Administrator of the DEA. 28 CFR 0.104.

The CSA provides that scheduling of any drug or other substance may be initiated by the Attorney General (1) on his own motion; (2) at the request of the Secretary of the Department of Health and Human Services (HHS),[1] or (3) on the petition of any interested party. 21 U.S.C. 811(a). This action is based on a recommendation from the Assistant Secretary of the HHS and on an evaluation of all other relevant data by the DEA. This action imposes the regulatory controls and administrative, civil, and criminal sanctions applicable to schedule III controlled substances on persons who handle or propose to handle perampanel.

Background

Perampanel [2-(2-oxo-1-phenyl-5-pyridin-2-yl-1,2-dihydropyridin-3-yl) benzonitrile] is a new chemical entity with central nervous system (CNS)

[1] As set forth in a memorandum of understanding entered into by the HHS, the Food and Drug Administration (FDA), and the National Institute on Drug Abuse (NIDA), the FDA acts as the lead agency within the HHS in carrying out the Secretary's scheduling responsibilities under the CSA, with the concurrence of NIDA. 50 FR 9518, Mar. 8, 1995. In addition, because the Secretary of the HHS has delegated to the Assistant Secretary for Health of the HHS the authority to make domestic drug scheduling recommendations, for purposes of this document, all subsequent references to ''Secretary'' have been replaced with ''Assistant Secretary.''

depressant and hallucinogenic properties. On October 22, 2012, the Food and Drug Administration (FDA) approved a new drug application for perampanel as an adjunctive therapy for the treatment of partial-onset seizures with or without secondarily generalized seizures in patients with epilepsy aged 12 years and older. Perampanel will be marketed in the United States under the trade name FYCOMPA®. Perampanel is a non-competitive AMPA (α-amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid)-type glutamate receptor antagonist. Perampanel was approved in Europe in May 2012 and has been marketed there since July 2012.

HHS and DEA Eight-Factor Analyses

On January 22, 2013, the Assistant Secretary of the HHS provided to the DEA a scientific and medical evaluation and scheduling recommendation entitled ''Basis for the Recommendation for Control of Perampanel and its Salts in Schedule III of the Controlled Substances Act.'' Following consideration of the eight factors and findings related to the substance's abuse potential, legitimate medical use, and dependence liability, the Assistant Secretary of the HHS recommended that perampanel be controlled in schedule III of the CSA under 21 U.S.C. 812(b). In response, the DEA conducted its own eight-factor analysis of perampanel pursuant to 21 U.S.C. 811(c). Electronic copies of these documents are available at *www.regulations.gov* for easy reference.

Determination to Schedule Perampanel

After a review of the available data, including the scientific and medical evaluation and the scheduling recommendation from the HHS, the Deputy Administrator of the DEA published in the **Federal Register** a notice of proposed rulemaking (NPRM) entitled ''Schedules of Controlled Substances: Placement of Perampanel into Schedule III'' on October 22, 2013 (78 FR 62500), which proposed placement of perampanel in schedule III of the CSA. The NPRM provided an opportunity for interested persons to file a request for hearing in accordance with DEA regulations on or before November 21, 2013. No requests for such a hearing were received by the DEA. The NPRM also provided an opportunity for interested persons to submit written comments on the proposed rule on or before November 21, 2013.

Comments Received

The DEA received two comments on the proposed rule to schedule perampanel. One commenter was in favor of controlling perampanel as a schedule III controlled substance. Another commenter requested that the DEA make the rule effective on the same date as the publication of the final rule.

Support for the Proposed Rule: One commenter supported controlling perampanel as a schedule III controlled substance, as opposed to a schedule II controlled substance, but expressed concern about the unknown effects and abuse potential of this new drug at higher doses. However, the commenter indicated that the controls applicable to schedule III controlled substances are appropriate until there is more available data on perampanel's effects.

DEA Response: The DEA appreciates the comment in support of this rulemaking.

Request to Change Effective Date: One commenter requested that the DEA make this rule effective on the same date as publication to enable physicians and their patients to have access to perampanel as soon as possible and pointed out that the DEA has included an earlier effective date in the final rule for other drugs including zopiclone, pregablin, and ezogabine.

DEA Response: The DEA appreciates the commenter's request, but does not believe an earlier effective date is warranted. As provided in 21 CFR 1308.45, final orders shall not have an effective date of ''less than 30 days from the date of publication in the **Federal Register** unless the Administrator finds that the conditions of public health or safety necessitate an earlier effective date . . . .'' The Administrator finds that the conditions of public health or safety do not necessitate such an earlier effective date in this instance. There are other anti-seizure medications currently available, specifically lacosamide, an anti-epileptic medication that has a similar clinical indication to perampanel. Though the mechanisms of actions of perampanel and lacosamide are different, the indications are very similar. Like perampanel, lacosamide is indicated as an adjunctive therapy for the treatment of partial-onset seizures, and did not have its 30-day implementation period waived. Furthermore, the DEA believes that providing 30 days for this Final Rule to become effective is expeditious and sufficient to allow handlers to obtain the appropriate registration with the DEA and to comply with regulatory requirements for handling schedule III controlled substances.

Scheduling Conclusion

Based on consideration of all comments, the scientific and medical evaluation and accompanying recommendation of the HHS, and based on the DEA's consideration of its own eight-factor analysis, the DEA finds that these facts and all relevant data constitute substantial evidence of potential for abuse of perampanel. As such, the DEA is scheduling perampanel as a controlled substance under the CSA.

Determination of Appropriate Schedule

The CSA establishes five schedules of controlled substances known as schedules I, II, III, IV, and V. The statute outlines the findings required for placing a drug or other substance in any particular schedule. 21 U.S.C. 812(b). After consideration of the analysis and recommendation of the Assistant Secretary for Health of the HHS and review of all available data, the Deputy Administrator of the DEA, pursuant to 21 U.S.C. 812(b)(3), finds that:

1. Perampanel has a potential for abuse less than the drugs or other substances in schedules I and II;

2. Perampanel has a currently accepted medical use in treatment in the United States. Perampanel was approved for marketing by the FDA as an adjunctive treatment of partial-onset seizures with or without secondarily generalized seizures in patients with epilepsy aged 12 years and older; and

3. Abuse of perampanel may lead to moderate or low physical dependence or high psychological dependence.

Based on these findings, the Deputy Administrator of the DEA concludes that perampanel, including its salts, isomers, and salts of isomers, warrants control in schedule III of the CSA. 21 U.S.C. 812(b)(3).

Requirements for Handling Perampanel

Upon the effective date of this final rule, any person who handles perampanel is subject to the CSA's schedule III regulatory controls and administrative, civil, and criminal sanctions applicable to the manufacture, distribution, dispensing, importing, exporting, engagement of research, and conduct of instructional activities, of schedule III controlled substances including the following:

Registration. Any person who handles (manufactures, distributes, dispenses, imports, exports, engages in research, or conducts instructional activities with) perampanel, or who desires to handle perampanel, must be registered with the DEA to conduct such activities, pursuant to 21 U.S.C. 822, 823, 957, and 958, and in accordance with 21 CFR parts 1301 and 1312 as of January 2, 2014. Any person who is currently engaged in any of the above activities and is not registered with the DEA must

submit an application for registration and may not continue their activities as of January 2, 2014 unless the DEA has approved that application, pursuant to 21 U.S.C. 822, 823, 957, and 958, and in accordance with 21 CFR parts 1301 and 1312.

Security. Perampanel is subject to schedule III–V security requirements and must be handled and stored in accordance with 21 CFR 1301.71–1301.93, pursuant to 21 U.S.C. 823, 821, 871(b) as of January 2, 2014.

Labeling and Packaging. All labels and labeling for commercial containers of perampanel must be in accordance with 21 CFR 1302.03–1302.07, pursuant to 21 U.S.C. 825, 958(e) as of January 2, 2014.

Inventory. Every DEA registrant who possesses any quantity of perampanel on the effective date of this final rule is required to take an inventory of all stocks of perampanel on hand as of January 2, 2014, pursuant to 21 U.S.C. 827, 958(e), and in accordance with 21 CFR 1304.03, 1304.04, and 1304.11(a) and (d). Any person who becomes registered with the DEA after January 2, 2014 is required to take an initial inventory of all controlled substances (including perampanel) on hand at the time of registration, pursuant to 21 U.S.C. 827, 958(e) and in accordance with 21 CFR 1304.03, 1304.04, and 1304.11(a) and (b). After the initial inventory, every DEA registrant is required to take a biennial inventory of all controlled substances (including perampanel), on hand pursuant to 21 U.S.C. 827, 958(e) and in accordance with 21 CFR 1304.03, 1304.04 and 1304.11.

Records. All DEA registrants must keep records with respect to perampanel pursuant to 21 U.S.C. 827, 958(e) and in accordance with 21 CFR parts 1304, 1307, and 1312, as of January 2, 2014.

Prescriptions. All prescriptions for perampanel or prescriptions for products containing perampanel must comply with 21 U.S.C. 829 and must be issued in accordance with 21 CFR part 1306 as of January 2, 2014.

Importation and Exportation. All importation and exportation of perampanel must be done in accordance with 21 CFR part 1312, pursuant to 21 U.S.C. 952, 953, 957, and 958 as of January 2, 2014.

Criminal Liability. Any activity involving perampanel not authorized by, or in violation of, the CSA, occurring as of January 2, 2014 is unlawful, and may subject the person to administrative, civil, and/or criminal sanctions.

Regulatory Analyses

Executive Orders 12866 and 13563

In accordance with 21 U.S.C. 811(a), this scheduling action is subject to formal rulemaking procedures performed ''on the record after opportunity for a hearing,'' which are conducted pursuant to the provisions of 5 U.S.C. 556 and 557. The CSA sets forth the procedures and criteria for scheduling a drug or other substance. Such actions are exempt from review by the Office of Management and Budget (OMB) pursuant to section 3(d)(1) of Executive Order 12866 and the principles reaffirmed in Executive Order 13563.

Executive Order 12988

This regulation meets the applicable standards set forth in sections 3(a) and 3(b)(2) of Executive Order 12988 Civil Justice Reform to eliminate drafting errors and ambiguity, minimize litigation, provide a clear legal standard for affected conduct, and promote simplification and burden reduction.

Executive Order 13132

This rulemaking does not have federalism implications warranting the application of Executive Order 13132. The rule does not have substantial direct effects on the States, on the relationship between the national government and the States, or the distribution of power and responsibilities among the various levels of government.

Executive Order 13175

This rule does not have tribal implications warranting the application of Executive Order 13175. It does not have substantial direct effects on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

Regulatory Flexibility Act

The Deputy Administrator, in accordance with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601–612), has reviewed this rule and by approving it certifies that it will not have a significant economic impact on a substantial number of small entities. The purpose of this rule is to place perampanel, including its salts, isomers, and salts of isomers, into schedule III of the CSA. No less restrictive measures (i.e., non-control or control in a lower schedule) enable the DEA to meet its statutory obligations under the CSA. In preparing this certification, the DEA has assessed economic impact by size category and has considered costs with respect to the various DEA registrant business activity classes.

Perampanel is a new molecular entity, approved by the FDA on October 22, 2012. It was approved in Europe in May 2012, and has been marketed in Europe since July 2012. According to publically available information reviewed by the DEA, perampanel is currently anticipated to enjoy patent protection for at least a decade before generic equivalents may be manufactured and marketed. Accordingly, the number of currently identifiable manufacturers, importers, and distributors for perampanel is extremely small. The publically available materials also specify the readily identifiable persons subject to direct regulation by this final rule. Based on guidelines utilized by the Small Business Administration (SBA), the perampanel manufacturer/distributor/importer was determined not to be a small entity. Once generic equivalents are developed and approved for manufacturing and marketing, there may be additional manufacturers, importers, and distributors of perampanel, but whether they may qualify as small entities cannot be determined at this time.

There are approximately 1.5 million controlled substance registrants, who represent approximately 381,000 entities. The DEA estimates that 371,000 (97 percent) of these businesses are considered ''small entities'' in accordance with the RFA and SBA standards. 5 U.S.C. 601(6) and 15 U.S.C. 632. Due to the wide variety of unidentifiable and unquantifiable variables that could potentially influence the dispensing rates of new chemical entities, the DEA is unable to determine the number of small entities that might dispense (including administer and prescribe) perampanel (e.g., pharmacies and prescribers).

Despite the fact that the number of small businesses potentially impacted by this final rule could not be determined at this time, the DEA concludes that they would not experience a significant economic impact as a result of this rule. The DEA estimates all anticipated perampanel handlers to be DEA registrants and currently 98 percent of DEA registrants (most of which are small businesses) are authorized to handle schedule III controlled substances. Even if we assume that all of the DEA registrants were to dispense perampanel, (e.g., practitioners prescribe, administer, or dispense the substance, and pharmacies dispense the prescriptions), the costs that they would incur as a result of perampanel scheduling would be

minimal. Registrants that dispense (but not prescribe) would incur nominal additional security, inventory, recordkeeping, and labeling costs, as they have already established and implemented the required systems and processes to handle schedule III controlled substances. For example, pharmacies and institutional practitioners may disperse schedule II–V controlled substances throughout their stock of non-controlled substances in such a manner as to obstruct theft or diversion of the controlled substances. The inclusion of one additional substance to this system would result in little or no additional burden to such practitioners. In addition, because DEA-registered dispensers must label all schedule II–V controlled substances dispensed, the requirement to label all controlled substances containing perampanel would not impose a significant economic burden upon DEA-registered dispensers (as the infrastructure and materials for doing so would already be in place). Accordingly, compliance would not require significant manpower, capital investments, or recordkeeping burdens.

Registrants who only prescribe perampanel by oral or written prescription would not incur any additional security, inventory, recordkeeping, or labeling costs as a result of this rule, as they would not physically handle perampanel.

Because of these facts, this rule will not result in significant economic impact on a substantial number of small entities.

Unfunded Mandates Reform Act of 1995

In accordance with the Unfunded Mandates Reform Act (UMRA) of 1995 (2 U.S.C. 1501 *et seq.*), on the basis of information contained in the ''Regulatory Flexibility Act'' section above, the DEA has determined and certifies pursuant to UMRA that this action would not result in any Federal mandate that may result ''in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more (adjusted for inflation) in any one year . . . .'' Therefore, neither a Small Government Agency Plan nor any other action is required under provisions of UMRA of 1995.

Paperwork Reduction Act of 1995

This action does not impose a new collection of information requirement under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521). This action would not impose recordkeeping or reporting requirements on State or local governments, individuals, businesses, or organizations. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Congressional Review Act

This rule is not a major rule as defined by section 804 of the Small Business Regulatory Enforcement Fairness Act of 1996 (Congressional Review Act (CRA)). This rule will not result in: an annual effect on the economy of $100,000,000 or more; a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based companies to compete with foreign based companies in domestic and export markets. However, pursuant to the CRA, the DEA has submitted a copy of this final rule to both Houses of Congress and to the Comptroller General.

List of Subjects in 21 CFR Part 1308

Administrative practice and procedure, Drug traffic control, Reporting and recordkeeping requirements.

For the reasons set out above, 21 CFR part 1308 is amended as follows:

PART 1308—SCHEDULES OF CONTROLLED SUBSTANCES

■ 1. The authority citation for 21 CFR part 1308 continues to read as follows:

Authority: 21 U.S.C. 811, 812, 871(b), unless otherwise noted.

■ 2. Amend § 1308.13 by redesignating paragraphs (c)(11) through (c)(14) as paragraphs (c)(12) through (c)(15) and adding new paragraph (c)(11) to read as follows:

§ 1308.13 Schedule III.

* * * * *

(c) * * *

(11) Perampanel, and its salts, isomers, and salts of isomers 2261

* * * * *

Dated: November 25, 2013.

Thomas M. Harrigan,

Deputy Administrator.

[FR Doc. 2013–28778 Filed 11–29–13; 8:45 am]

BILLING CODE 4410–09–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 300

[TD 9647]

RIN 1545–BL37

User Fees for Processing Installment Agreements and Offers in Compromise

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations that provide user fees charged for processing installment agreements and offers in compromise. The final regulations affect taxpayers who wish to pay their federal tax liabilities through installment agreements and offers in compromise.

DATES: *Effective date:* These regulations are effective on December 2, 2013.

Applicability Date: These regulations apply to installment agreements entered into, restructured, or reinstated and offers in compromise processed on or after January 1, 2014.

FOR FURTHER INFORMATION CONTACT: Concerning cost methodology, Eva Williams, at (202) 803–9728; concerning the regulations, Girish Prasad, at (202) 317–5429 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background and Explanation of Provisions

This document contains amendments to 26 CFR part 300. On August 30, 2013, a notice of proposed rulemaking (REG–144990–12) relating to the user fees charged for processing installment agreements and offers in compromise was published in the **Federal Register** (78 FR 53702). The charging of user fees for services provided by agencies is authorized by the Independent Offices Appropriations Act (IOAA), which is codified at 31 U.S.C. 9701. Under the IOAA and OMB Circular A–25, 58 FR 38142 (July 15, 1993) (the OMB Circular), the charges must be fair and must be based on the costs to the government, the value of the service to the recipient, the public policy or interest served, and other relevant facts. In general, the amount of a user fee should recover the cost of providing the service, unless the Office of Management and Budget (OMB) grants an exception under the OMB Circular.

The notice of proposed rulemaking proposed to increase the fee under § 300.1 for entering into an installment agreement from $105 to $120 and to increase the fee under § 300.2 for

restructuring or reinstating an installment agreement from $45 to $50. Under the notice of proposed rulemaking, the fee for a direct debit installment agreement remained $52, and low-income taxpayers, as defined in § 300.1(b)(2), would continue to pay $43 for any new installment agreement, including a direct debit installment agreement. The notice of proposed rulemaking also proposed to increase the fee under § 300.3 for processing an offer in compromise from $150 to $186. Offers based on doubt as to liability and offers from low-income taxpayers continue to be excepted from a user fee. The new fee rates for both installment agreements and offers in compromise will be effective January 1, 2014. As explained in the notice of proposed rulemaking, the fees proposed (even after the increase) were substantially less than the full costs to the Government of providing the services and OMB has granted a waiver of the full-cost requirement.

No public hearing on the notice of proposed rulemaking was held because no one requested to speak. One comment was received. After consideration of the comment, this Treasury decision adopts the proposed regulations without change.

Summary of Comment

Under the proposed regulations, the reduced fee of $43 for low-income taxpayers that request a new installment agreement would remain unchanged. This fee is substantially less than the full cost to the IRS of processing a request ($282) and the fee charged to other taxpayers ($120). The commenter commended the IRS for not increasing the user fee for low-income taxpayers, but maintained that *any* user fee discourages low-income taxpayers from entering into installment agreements. The commenter recommended that the fee be reduced to zero. The commenter stated that many low-income taxpayers do not have the means to pay the user fee, even at the reduced rate. The commenter stated that low-income taxpayers often enter into installment agreements to pay as little as $20–30 per month based on their available net income, and believed that an upfront $43 fee makes it difficult for such taxpayers to enter into the agreement.

The effect of the fee on low-income taxpayers was considered in 2006 when the installment agreement fee was last updated. The IRS determined that the fee should remain $43 for low-income taxpayers because requiring the full rate would be burdensome and many low-income taxpayers do not have bank accounts and cannot take advantage of the reduced fee for direct-debit installment agreements.

The user fee is only charged if the taxpayer enters into the agreement and the fee is collected directly from the amounts paid under the terms of the installment agreement. When the IRS grants an installment agreement, the IRS asks that the taxpayer's first payment be at least the amount of the fee for the agreement. In cases where the installment payments are more than the amount of the fee, a portion of the first payment satisfies the fee and the balance of the first payment is applied toward the liability. In cases where the installment payments are less than the amount of the fee, the full amount of the fee is sought and, in the case of direct-debit installment agreements, automatically deducted from the taxpayer's bank account. The IRS, however, does not default an agreement or otherwise penalize a taxpayer whose first payment is less than the fee but otherwise in the amount of the agreed installments. Rather, the IRS applies the first payment and successive installments against the fee until the fee is paid, and thereafter credits the balance of the payments against the liability. In all cases, the taxpayer does not have to pay both the fee and the installment agreement amount in the first month and the taxpayer does not have to pay the fee in full before the IRS respects the installment agreement. The reduced fee is, therefore, not a barrier to an installment agreement. Nevertheless, the IRS will be reviewing its procedures in light of the comment and will consider clarifying its communications with taxpayers in accordance with that review.

The commenter also questioned why the fee was waived entirely for low-income taxpayers making offers in compromise but only reduced for low-income taxpayers entering into installment agreements. The Treasury Department and the IRS believe it is appropriate to charge a reduced fee for a low-income taxpayer to enter into an installment agreement but not to charge a fee to low-income taxpayers for the consideration of an offer in compromise for two reasons. First, unlike the fee for an installment agreement, which is charged only when the taxpayer enters into an installment agreement, the fee for an offer in compromise is charged for the mere consideration of the offer and is not refunded if the offer is not accepted. Therefore, the fee for an offer in compromise could dissuade a low-income taxpayer from making an offer because the taxpayer cannot be assured of reaching an agreement.

Second, a low-income taxpayer making an offer in compromise ostensibly does not have the ability to pay the tax liability in full. Section 7122(d)(3)(A) specifically provides that the IRS should not reject an offer from a low-income taxpayer based solely on the amount of the offer, and requiring a fee from low-income taxpayers could result in a similar hardship in cases where the taxpayer does not have the ability to pay the fee. In contrast, the vast majority of installment agreements contemplate full payment of the tax liability because the taxpayer has the ability to do so over time. While there are partial-payment installment agreements—those that do not provide for full payment of the liability—they are rarely used.

The commenter also expressed concern that, in order to avoid the fee associated with an installment agreement, a low-income taxpayer might request to be put into currently-not-collectible (CNC) status rather than enter into an installment agreement. The commenter was concerned, moreover, that without an installment agreement the taxpayer would not pay the tax and would instead incur substantial penalties and interest. Generally, a taxpayer who has the ability to pay his tax liability over time (and thus is eligible for an installment agreement) will not qualify for CNC status. The IRS places a taxpayer in CNC status on the basis of hardship when it determines that the taxpayer cannot pay the tax debts after paying reasonable living expenses. Even a taxpayer in CNC status may, without an installment agreement, pay the tax over time to help limit the accrual of penalties and interest. To the extent a low-income taxpayer has the ability to pay his tax liability over time, entering into an installment agreement would be in his interest because it will most likely reduce the overall amount required to be paid on his tax liability. Under section 6651(h), the penalty rate on the balance owed is reduced while an installment agreement is in effect. Additionally, interest and penalties accruing on an account will be minimized if regular payments are being applied to reduce the tax liability against which penalties and interest are calculated.

Finally, the commenter voiced concern that the reduced fee of $43 may prove to be too large in proportion to relatively smaller balances owed. The purpose of a fee, however, is to recover the cost to the Government for a particular service to the recipient, and the cost to the Government does not vary based on the amount of the balance due. The reduced fee for low-income

taxpayers is therefore appropriate, regardless of the amount of taxes owed.

The commenter made two additional recommendations. The commenter recommended that the IRS implement procedures to require IRS employees to investigate whether a taxpayer making an installment agreement is eligible for the reduced fee for low-income taxpayers. The commenter also recommended that the IRS enhance internal training and establish procedures to better promote viable payment plans and avoid unrealistic installment agreements for low-income taxpayers. These comments do not affect the content of these final regulations, but the IRS will, nevertheless, consider them when updating the procedures for entering into installment agreements. The IRS notes, however, that as of January of 2008, taxpayers meeting the low-income criteria are identified systemically based on the taxpayer's last return and the account is identified as being eligible for the reduced user fee.

Special Analyses

It has been determined that these final regulations are not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It is hereby certified that these regulations will not have a significant economic impact on a substantial number of small entities. Accordingly, a regulatory flexibility analysis is not required. This certification is based on the information that follows. The economic impact of these regulations on any small entity would result from the entity being required to pay a fee prescribed by these regulations to obtain a particular service. The dollar amount of the fee is not, however, substantial enough to have a significant economic impact on any entity subject to the fee. Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding this regulation was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business and no comments were received.

Drafting Information

The principal author of these regulations is Girish Prasad of the Office of Associate Chief Counsel (Procedure and Administration).

List of Subjects in 26 CFR Part 300

Estate taxes, Excise taxes, Gift taxes, Income taxes, Reporting and recordkeeping requirements, User fees.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 300 is amended as follows:

PART 300—USER FEES

■ **Paragraph 1.** The authority citation for part 300 continues to read as follows:

Authority: 31 U.S.C. 9701.

■ **Par. 2.** In § 300.1, paragraphs (b) introductory text and (d) are revised to read as follows:

§ 300.1 Installment agreement fee.

* * * * *

(b) *Fee.* The fee for entering into an installment agreement before January 1, 2014, is $105. The fee for entering into an installment agreement on or after January 1, 2014, is $120. A reduced fee applies in the following situations:

* * * * *

(d) *Effective/applicability date.* This section is applicable beginning January 1, 2014.

■ **Par. 3.** In § 300.2, paragraphs (b) and (d) are revised to read as follows:

§ 300.2 Restructuring or reinstatement of installment agreement fee.

* * * * *

(b) *Fee.* The fee for restructuring or reinstating an installment agreement before January 1, 2014, is $45. The fee for restructuring or reinstating an installment agreement on or after January 1, 2014, is $50.

* * * * *

(d) *Effective/applicability date.* This section is applicable beginning January 1, 2014.

■ **Par. 4.** In § 300.3, paragraphs (b)(1) introductory text and (d) are revised to read as follows:

§ 300.3 Offer to compromise fee.

* * * * *

(b) *Fee.* (1) The fee for processing an offer to compromise before January 1, 2014, is $150. The fee for processing an offer to compromise on or after January 1, 2014, is $186. No fee will be charged if an offer is—

* * * * *

(d) *Effective/applicability date.* This section is applicable beginning January 1, 2014.

Approved: November 22, 2013.

John Dalrymple,

Deputy Commissioner for Services and Enforcement.

Mark J. Mazur,

Assistant Secretary of the Treasury (Tax Policy).

[FR Doc. 2013–28863 Filed 11–29–13; 8:45 am]

BILLING CODE 4830–01–P

PENSION BENEFIT GUARANTY CORPORATION

29 CFR Part 4044

Allocation of Assets in Single-Employer Plans; Valuation of Benefits and Assets; Expected Retirement Age

AGENCY: Pension Benefit Guaranty Corporation.

ACTION: Final rule.

SUMMARY: This rule amends the Pension Benefit Guaranty Corporation's regulation on Allocation of Assets in Single-Employer Plans by substituting a new table for determining expected retirement ages for participants in pension plans undergoing distress or involuntary termination with valuation dates falling in 2014. This table is needed in order to compute the value of early retirement benefits and, thus, the total value of benefits under a plan.

DATES: *Effective Date:* January 1, 2014.

FOR FURTHER INFORMATION CONTACT: Catherine B. Klion, Assistant General Counsel for Regulatory Affairs, Pension Benefit Guaranty Corporation, 1200 K Street NW., Washington, DC 20005, 202–326–4024. (TTY/TDD users may call the Federal relay service toll-free at 1–800–877–8339 and ask to be connected to 202–326–4024.)

SUPPLEMENTARY INFORMATION: The Pension Benefit Guaranty Corporation (PBGC) administers the pension plan termination insurance program under Title IV of the Employee Retirement Income Security Act of 1974 (ERISA). PBGC's regulation on Allocation of Assets in Single-Employer Plans (29 CFR part 4044) sets forth (in subpart B) the methods for valuing plan benefits of terminating single-employer plans covered under Title IV. Guaranteed benefits and benefit liabilities under a plan that is undergoing a distress termination must be valued in accordance with subpart B of part 4044. In addition, when PBGC terminates an underfunded plan involuntarily pursuant to ERISA section 4042(a), it uses the subpart B valuation rules to determine the amount of the plan's underfunding.

Under § 4044.51(b) of the asset allocation regulation, early retirement benefits are valued based on the annuity starting date, if a retirement date has been selected, or the expected retirement age, if the annuity starting date is not known on the valuation date. Sections 4044.55 through 4044.57 set forth rules for determining the expected retirement ages for plan participants entitled to early retirement benefits. Appendix D of part 4044 contains tables

to be used in determining the expected early retirement ages.

Table I in appendix D (Selection of Retirement Rate Category) is used to determine whether a participant has a low, medium, or high probability of retiring early. The determination is based on the year a participant would reach ''unreduced retirement age'' (*i.e.,* the earlier of the normal retirement age or the age at which an unreduced benefit is first payable) and the participant's monthly benefit at unreduced retirement age. The table applies only to plans with valuation dates in the current year and is updated annually by the PBGC to reflect changes in the cost of living, etc.

Tables II–A, II–B, and II–C (Expected Retirement Ages for Individuals in the Low, Medium, and High Categories respectively) are used to determine the expected retirement age after the probability of early retirement has been determined using Table I. These tables establish, by probability category, the expected retirement age based on both the earliest age a participant could retire under the plan and the unreduced retirement age. This expected retirement age is used to compute the value of the early retirement benefit and, thus, the total value of benefits under the plan.

This document amends appendix D to replace Table I–13 with Table I–14 in order to provide an updated correlation, appropriate for calendar year 2014, between the amount of a participant's benefit and the probability that the participant will elect early retirement. Table I–14 will be used to value benefits in plans with valuation dates during calendar year 2014.

PBGC has determined that notice of, and public comment on, this rule are impracticable and contrary to the public interest. Plan administrators need to be able to estimate accurately the value of plan benefits as early as possible before initiating the termination process. For that purpose, if a plan has a valuation date in 2014, the plan administrator needs the updated table being promulgated in this rule. Accordingly, the public interest is best served by issuing this table expeditiously, without an opportunity for notice and comment, to allow as much time as possible to estimate the value of plan benefits with the proper table for plans with valuation dates in early 2014.

PBGC has determined that this action is not a ''significant regulatory action'' under the criteria set forth in Executive Order 12866.

Because no general notice of proposed rulemaking is required for this regulation, the Regulatory Flexibility Act of 1980 does not apply (5 U.S.C. 601(2)).

List of Subjects in 29 CFR Part 4044

Pension insurance, Pensions.

In consideration of the foregoing, 29 CFR part 4044 is amended as follows:

PART 4044

■ 1. The authority citation for part 4044 continues to read as follows:

Authority: 29 U.S.C. 1301(a), 1302(b)(3), 1341, 1344, 1362.

■ 2. Appendix D to part 4044 is amended by removing Table I–13 and adding in its place Table I–14 To read as follows:

Appendix D to Part 4044 —Tables Used To Determine Expected Retirement Age

TABLE I–14—SELECTION OF RETIREMENT RATE CATEGORY

[For Plans with valuation dates after December 31, 2013, and before January 1, 2015]

If participant reaches URA in year—	Participant's Retirement Rate Category is—			
	Low [1] if monthly benefit at URA is less than—	Medium [2] if monthly benefit at URA is—		High [3] if monthly benefit at URA is greater than—
		From—	To—	
2015	614	614	2,594	2,594
2016	627	627	2,651	2,651
2017	641	641	2,710	2,710
2018	655	655	2,769	2,769
2019	670	670	2,830	2,830
2020	685	685	2,893	2,893
2021	700	700	2,956	2,956
2022	715	715	3,021	3,021
2023	731	731	3,088	3,088
2024 or later	747	747	3,156	3,156

[1] Table II–A.
[2] Table II–B.
[3] Table II–C.

* * * * *

Issued in Washington, DC, this 19th day of November, 2013.

Judith Starr,

General Counsel, Pension Benefit Guaranty Corporation.

[FR Doc. 2013–28682 Filed 11–29–13; 8:45 am]

BILLING CODE 7709–02–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 100

[Docket No. USCG–2013–0937]

Special Local Regulation; Southern California Annual Marine Events for the San Diego Captain of the Port Zone

AGENCY: Coast Guard, DHS.

ACTION: Notice of enforcement of regulation.

SUMMARY: The Coast Guard will enforce the Mission Bay Parade of Lights special local regulations during this year's parade held on December 14, 2013. This event occurs on Mission Bay in San Diego, CA. These special local regulations are necessary to provide for the safety of the participants, crew, spectators, sponsor vessels of the parade, and general users of the waterway. During the enforcement period, persons and vessels are

prohibited from entering into, transiting through, or anchoring within this regulated area unless authorized by the Captain of the Port, or his designated representative.

DATES: This rule is effective from 6 p.m. to 9 p.m. on December 14, 2013.

FOR FURTHER INFORMATION CONTACT: If you have questions on this notice, call or email Petty Officer Bryan Gollogly, Waterways Management, U.S. Coast Guard Sector San Diego, CA; telephone (619) 278–7656, email *D11–PF-MarineEventsSanDiego@uscg.mil.*

SUPPLEMENTARY INFORMATION: The Coast Guard will enforce the special local regulations in 33 CFR 100.1101 in support of the Mission Bay Parade of Lights (Item 6 on Table 1 of 33 CFR 100.1101). The Coast Guard will enforce the special local regulations on the navigable waters of Mission Bay to include Quivira Basin and Sail Bay on December 14, 2013 from 6 p.m. to 9 p.m.

Under the provisions of 33 CFR 100.1101, persons and vessels are prohibited from entering into, transiting through, or anchoring within this regulated area unless authorized by the Captain of the Port, or his designated representative. The Coast Guard may be assisted by other Federal, State, or local law enforcement agencies in enforcing this regulation.

This notice is issued under authority of 5 U.S.C. 552 (a) and 33 CFR 100.1101. In addition to this notice in the **Federal Register,** the Coast Guard will provide the maritime community with advance notification of this enforcement period via the Local Notice to Mariners and local advertising by the event sponsor.

If the Captain of the Port Sector San Diego or his designated representative determines that the regulated area need not be enforced for the full duration stated on this notice, he or she may use a Broadcast Notice to Mariners or other communications coordinated by the event sponsor to grant general permission to enter the regulated area.

Dated: November 14, 2013.

S. M. Mahoney,

Captain, U. S. Coast Guard, Captain of the Port San Diego.

[FR Doc. 2013–28697 Filed 11–29–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2013–0638]

RIN 1625–AA09

Drawbridge Operation Regulation; Passaic River, Kearney and Newark, NJ

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is temporarily modifying the operating schedule that governs the operation of the Route 1 & 9 (Lincoln Highway) Bridge across the Passaic River, mile 1.8, between Kearny and Newark, New Jersey. The bridge owner, New Jersey Department of Transportation, submitted a request to restrict bridge openings during the morning and afternoon rush hour periods to alleviate traffic congestion resulting from area roadway closures. It is expected that this change to the regulations would provide relief to vehicular traffic while continuing to meet the reasonable needs of navigation.

DATES: This temporary final rule is effective from March 1, 2014 through March 1, 2016.

ADDRESSES: Documents mentioned in this preamble are part of docket USCG–2013–0638. To view documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov,* type in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this rulemaking. You may also visit the Docket Management Facility in room W12–140 on Ground Floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary final rule, call or email Mr. Joe Arca, Project Officer, First Coast Guard District Bridge Branch, 212–668–7165, *joe.m.arca@uscg.mil.* If you have questions on viewing the docket, call Barbara Hairston, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION:

Table of Acronyms

CFR Code of Federal Regulations
DHS Department of Homeland Security
FR Federal Register
NPRM Notice of Proposed Rulemaking
§ Section Symbol
U.S.C. United States Code

A. Regulatory History and Information

On August 28, 2013, we published a notice of proposed rulemaking (NPRM) entitled Drawbridge Operation Regulations Passaic River in the **Federal Register** (78 FR 53107). We received no comments on the proposed rule. No public meeting was requested, and none was held.

B. Basis and Purpose

The Route 1 & 9 (Lincoln Highway) Bridge at mile 1.8, across the Passaic River between Kearny and Newark, New Jersey, has a vertical clearance of 40 feet at mean high water and 45 feet at mean low water. The drawbridge operation regulations are listed at 33 CFR 117.739(b).

The waterway users are predominantly recreational vessels and commercial vessels.

The owner of the bridge, New Jersey Department of Transportation, submitted a request to the Coast Guard to temporarily change the drawbridge operating regulations.

The purpose of this temporary final rule is to help provide relief to help reduce vehicular traffic congestion during the morning and afternoon vehicular rush hour periods due to local construction detours. Additional vehicular traffic will be detoured across the Route 1 & 9 (Lincoln Highway) Bridges for two years from the adjacent Pulaski Skyway Bridge which will be under construction to replace its deck commencing on March 1, 2014 and continuing through March 1, 2016.

The existing regulations presently require the bridge to open on signal at all times provided a four hour advance notice is given.

Under this temporary final rule the draw shall open on signal provided a four hour advance notice is given; except that, the draw need not open for the passage of vessel traffic between 6 a.m. and 10 a.m. and 2 p.m. and 6 p.m., Monday through Friday, except holidays.

Tide dependent deep draft vessels may request bridge openings during the two rush hour closed periods provided at least a twelve hour advance notice is given.

C. Discussion of Comments, Changes and the Final Rule

The Coast Guard received no comments in response to the notice of proposed rulemaking. As a result, no changes have been made to this final rule.

D. Regulatory Analyses

We developed this rule after considering numerous statutes and executive orders related to rulemaking. Below we summarize our analyses based on these statutes or executive orders.

1. Regulatory Planning and Review

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order. We believe that this rule is not a significant regulatory action because the bridge provides adequate clearance for recreational vessels in the closed position and the commercial vessels will be able to get openings at any time provided the advance notice is given by calling the number posted at the bridge.

2. Impact on Small Entities

The Regulatory Flexibility Act of 1980 (RFA), 5 U.S.C. 601–612, as amended, requires federal agencies to consider the potential impact of regulations on small entities during rulemaking. The Coast Guard received no comments from the Small Business Administration on this rule. The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

This rule should not have a significant effect on small entities since the bridges provide 40 feet of vertical clearance at mean high water which should accommodate most recreational vessels that transit this waterway. Deep draft commercial vessels can transit during the two rush hour closure periods provided they give the twelve hour advance notice for openings.

There is no permanent restriction or regulation being imposed by this rule; therefore, the Coast Guard certifies under 5 U.S.C. 605(b) that this temporary final rule will not have a significant economic impact on a substantial number of small entities.

3. Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this temporary final rule, if the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT**, above.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

4. Collection of Information

This rule calls for no new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

5. Federalism

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on State or local governments and would either preempt State law or impose a substantial direct cost of compliance on them. We have analyzed this rule under that Order and have determined that it does not have implications for federalism.

6. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

7. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

8. Taking of Private Property

This rule will not cause a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

9. Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

10. Protection of Children

We have analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and would not create an environmental risk to health or risk to safety that might disproportionately affect children.

11. Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

12. Energy Effects

This action is not a ''significant energy action'' under Executive order 13211, Actions Concerns Regulations That Significantly Affect Energy Supply, Distribution, or Use.

13. Technical Standards

The National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note) directs agencies to use voluntary consensus standards in their regulatory activities unless the agency provides Congress, through the Office of Management and Budget, with an explanation of why using these standards would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (e.g., specifications of materials, performance, design, or operation; test methods; sampling procedures; and related management systems practices) that are developed or adopted by voluntary consensus standards bodies.

This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

14. Environment

We have analyzed this rule under Department of Homeland Security Management Directive 023–01 and Commandant Instruction M16475.lD,

which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA)(42 U.S.C. 4321–4370f), and have concluded that this action is one of a category of actions which do not individually or cumulatively have a significant effect on the human environment. This rule involves operating the bridge from a remote location. This rule is categorically excluded, under figure 2–1, paragraph (32)(e), of the Instruction.

Under figure 2–1, paragraph (32)(e), of the Instruction, an environmental analysis checklist and a categorical exclusion determination are not required for this rule.

List of Subjects in 33 CFR Part 117

Bridges.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 117 as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

■ 1. The authority citation for part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 33 CFR 1.05–1; Department of Homeland Security Delegation No. 0170.1.

■ 2. Amend § 117.739 by suspending paragraph (b) and adding paragraph (p) to read as follows:

§ 117.739 Passaic River.

* * * * *

(p) The draw of the Route 1 & 9 (Lincoln Highway) Bridge, mile 1.8, between Kearny and Newark, shall open on signal if at least a four hour advance notice is given; except that, the draw need not open for the passage of vessel traffic between 6 a.m. and 10 a.m. and between 2 p.m. and 6 p.m., Monday through Friday, except holidays. Tide dependant deep draft vessels may request bridge openings between 6 a.m. and 10 a.m. and between 2 p.m. and 6 p.m., provided at least a twelve hour advance notice is given by calling the number posted at the bridge.

Dated: Novenber 5, 2013.

D.B. Abel,

Rear Admiral, U.S. Coast Guard, Commander, First Coast Guard District.

[FR Doc. 2013–28033 Filed 11–29–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2013–0964]

Drawbridge Operation Regulation; Upper Mississippi River, Dubuque, IA

AGENCY: Coast Guard, DHS.

ACTION: Notice of deviation from drawbridge regulation.

SUMMARY: The Coast Guard has issued a temporary deviation from the operating schedule that governs the Illinois Central Railroad Drawbridge across the Upper Mississippi River, mile 579.9, at Dubuque, Iowa. The deviation is necessary to allow the bridge owner time to perform preventive maintenance that is essential to the continued safe operation of the drawbridge. Maintenance is scheduled in the winter and when there is less impact on navigation; instead of scheduling work in the summer, when river traffic increases. This deviation allows the bridge to open on signal if at least 24 hours advance notice is given.

DATES: This deviation is effective from 12:01 a.m., December 18, 2013 to 7 a.m. March 3, 2014.

ADDRESSES: The docket for this deviation, [USCG–2013–0964] is available at *http://www.regulations.gov.* Type the docket number in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this deviation. You may also visit the Docket Management Facility in Room W12–140 on the ground floor of the Department of Transportation, West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary deviation, call or email Eric A. Washburn, Bridge Administrator, Western Rivers, Coast Guard; telephone 314–269–2378, email *Eric.Washburn@uscg.mil.* If you have questions on viewing the docket, call Barbara Hairston, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION: The Chicago, Central & Pacific Railroad requested a temporary deviation for the Illinois Central Railroad Drawbridge, across the Upper Mississippi River, mile 579.9, at Dubuque, Iowa to open on signal if at least 24 hours advance notice is given for 76 days from 12:01 a.m., December 18, 2013 to 7 a.m., March 3, 2014 to allow the bridge owner time for preventive maintenance. The Illinois Central Railroad Drawbridge currently operates in accordance with 33 CFR 117.5, which states the general requirement that drawbridges shall open promptly and fully for the passage of vessels when a request to open is given in accordance with the subpart.

There are no alternate routes for vessels transiting this section of the Upper Mississippi River.

Winter conditions on the Upper Mississippi River coupled with the closure of Army Corps of Engineer's Lock No 18 (Mile 410.5 UMR) and Lock No. 22 (Mile 301.2 UMR) until 11:00 a.m., March 4, 2014 will preclude any significant navigation demands for the drawspan opening.

The Illinois Central Railroad Drawbridge, in the closed-to-navigation position, provides a vertical clearance of 19.9 feet above normal pool. Navigation on the waterway consists primarily of commercial tows and recreational watercraft. The drawbridge will open if at least 24-hours advance notice is given. This temporary deviation has been coordinated with waterway users. No objections were received.

In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the effective period time of this temporary deviation. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: November 18, 2013.

Eric A. Washburn,

Bridge Administrator, Western Rivers.

[FR Doc. 2013–28692 Filed 11–29–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2013–0961]

Drawbridge Operation Regulation; Atlantic Intracoastal Waterway, Wrightsville Beach, NC

AGENCY: Coast Guard, DHS.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Coast Guard has issued a temporary deviation from the operating schedule that governs the S.R. 74 Bridge, across the Atlantic Intracoastal Waterway (AICW), mile 283.1, at Wrightsville Beach, NC. This deviation

is necessary to accommodate the 2014 Quintiles Wrightsville Beach Full and Half Marathon. This deviation allows the bridge to remain in the closed position during the race.

DATES: This deviation is effective from 5 a.m. through 10 a.m., Sunday, March 16, 2014.

ADDRESSES: The docket for this deviation, [USCG–2013–0961] is available at *http://www.regulations.gov*. Type the docket number in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this deviation. You may also visit the Docket Management Facility in Room W12–140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary deviation, call or email Kashanda Booker, Bridge Administration Branch, Fifth Coast Guard District; telephone 757–398–6227, email *Kashanda.l.booker@uscg.mil*. If you have questions on viewing the docket, call Barbara Hairston, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION: The Quintiles Wrightsville Beach Full and Half Marathon committee on behalf of the North Carolina Department of Transportation (NCDOT) has requested a temporary deviation from the current operating schedule for the S.R. 74 Bascule Drawbridge across the AICW mile 283.1, at Wrightsville Beach, NC. The requested deviation will accommodate the 2014 Quintiles Wrightsville Beach Full and Half Marathon scheduled for Sunday, March 16, 2014. To facilitate this event, the draw of the bridge will be maintained in the closed-to-navigation position from 5 a.m. until 10 a.m. to allow race participants to cross during the scheduled event.

The current operating schedule for the bridge is set out in 33 CFR 117.821(a)(4). The regulation requires the bridge to open on signal for vessels at all times except that from 7 a.m. until 7 p.m. the bridge shall open on the hour; every third and fourth Saturday in September the bridge shall remain closed from 7 a.m. until 11 a.m.; and the last Saturday of October or the first or second Saturday of November the bridge shall remain closed from 7 a.m. until 10:30 a.m. The bascule drawbridge has a vertical clearance of 20 feet above mean high water in the closed position. Vessels that can pass through the bridge in the closed position may do so at any time.

Since the race is an annual event, local waterway users should be familiar with the closure. To ensure that waterway users are aware of the closure, the Coast Guard will issue a Local and Broadcast Notice to Mariners to allow mariners to schedule their transits accordingly. There are no alternate routes available to vessels. Most waterway traffic consists of recreational boats with a few barges and tugs during the daytime. The bridge is able to open for emergencies.

In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the designated time period. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: November 15, 2013.

Waverly W. Gregory, Jr.,

Bridge Program Manager, Fifth Coast Guard District.

[FR Doc. 2013–28694 Filed 11–29–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2013–0921]

RIN 1625–AA09

Drawbridge Operation Regulation; Genessee River, Rochester, NY

AGENCY: Coast Guard, DHS.

ACTION: Final rule.

SUMMARY: The Coast Guard is removing the existing drawbridge operation regulation for the CSX Transportation Bridge across Genessee River, mile 0.9, at Rochester, NY. The drawbridge was removed in 2013 and the operating regulation is no longer applicable or necessary.

DATES: This rule is effective December 2, 2013.

ADDRESSES: The docket for this final rule, [USCG–2013–0921] is available at *http://www.regulations.gov*. Type the docket number in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this final rule. You may also visit the Docket Management Facility in Room W12–140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Mr. Lee Soule, Bridge Management Specialist, Ninth Coast Guard District, Coast Guard; telephone 216–902–6087, email *Lee.D.Soule@uscg.mil*. If you have questions on viewing the docket, call Barbara Hairston, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION:

A. Regulatory History and Information

The Coast Guard is issuing this final rule without prior notice and opportunity to comment pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and opportunity to comment when the agency for good cause finds that those procedures are ''impracticable, unnecessary, or contrary to the public interest.'' Under 5 U.S.C. 553(b), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because the CSX Transportation Bridge that once required draw operations in 33 CFR 117.785 was removed from the waterway in 2013. Therefore, the regulation is no longer applicable and shall be removed from publication. It is unnecessary to publish an NPRM because this regulatory action does not purport to place any restrictions on mariners but rather removes a restriction that has no further use or value.

Under 5 U.S.C. 553(d)(1), a rule that relieves a restriction is not required to provide the 30 day notice period before its effective date. This rule removes the CSX Transportation Bridge draw operation requirements under 33 CFR 117.785, thus removing a regulatory restriction on the public. Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective in less than 30 days after publication in the **Federal Register**. The bridge was removed from the waterway in 2013 and this rule merely requires an administrative change to the **Federal Register**, in order to omit a regulatory requirement that is no longer applicable or necessary.

B. Basis and Purpose

The CSX Transportation Bridge across Genessee River, mile 0.9, was removed in 2013. It has come to the attention of the Coast Guard that the governing regulation for this drawbridge was never

removed subsequent to the removal of the drawbridge. The elimination of this drawbridge necessitates the removal of the drawbridge operation regulation found in 33 CFR 117.785, that pertains to the former drawbridge.

The purpose of this rule is to remove the section of 33 CFR 117.785 that refers to the CSX Transportation Bridge at mile 0.9 from the Code of Federal Regulations since it governs a bridge that has been removed from the waterway.

C. Discussion of Rule

The Coast Guard is revising the regulation in 33 CFR 117.785 by removing restrictions and the regulatory burden related to the draw operations for this bridge that is no longer in existence. The change removes the section of the regulation governing the CSX Transportation Bridge since the bridge has been removed from the waterway. This Final Rule seeks to update the Code of Federal Regulations by removing language that governs the operation of the CSX Transportation Bridge, which in fact no longer exists. This change does not affect waterway or land traffic. This change does not affect nor does it alter the operating schedules in 33 CFR 117.785 that govern the remaining active drawbridge on the Genessee River.

D. Regulatory Analyses

We developed this rule after considering numerous statutes and executive orders related to rulemaking. Below we summarize our analyses based on these statutes or executive orders.

1. Regulatory Planning and Review

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866, Regulatory Planning and Review, as supplemented by Executive Order 13563, Improving Regulation and Regulatory Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of Order 12866 or under section 1 of Executive Order 13563. The Office of Management and Budget has not reviewed it under those Orders.

The Coast Guard does not consider this rule to be ''significant'' under that order because it is an administrative change and does not affect the way vessels operate on the waterway.

2. Impact on Small Entities

The Regulatory Flexibility Act of 1980 (RFA), 5 U.S.C. 601–612, as amended, requires federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

This rule will have no effect on small entities since this drawbridge has been removed and the regulation governing draw operations for this bridge is no longer applicable. There is no new restriction or regulation being imposed by this rule; therefore, the Coast Guard certifies under 5 U.S.C. 605(b) that this final rule will not have a significant economic impact on a substantial number of small entities.

3. Collection of Information

This rule calls for no new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

4. Federalism

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. We have analyzed this rule under that Order and have determined that it does not have implications for federalism.

5. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the ''For Further Information Contact'' section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

6. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

7. Taking of Private Property

This rule will not cause a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

8. Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

9. Protection of Children

We have analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and does not create an environmental risk to health or risk to safety that might disproportionately affect children.

10. Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

11. Energy Effects

This action is not a ''significant energy action'' under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use.

12. Technical Standards

This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

13. Environment

We have analyzed this rule under Department of Homeland Security Management Directive 023–01 and Commandant Instruction M16475.lD, which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have concluded that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves an administrative change to remove an existing drawbridge regulation for a drawbridge that has been removed from the waterway. This rule is categorically

excluded, under figure 2–1, paragraph (32)(e), of the Instruction.

Under figure 2–1, paragraph (32)(e), of the Instruction, an environmental analysis checklist and a categorical exclusion determination are not required for this rule.

List of Subjects in 33 CFR Part 117

Bridges.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 117 as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

■ 1. The authority citation for part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 33 CFR 1.05–1; Department of Homeland Security Delegation No. 0170.1.

■ 2. Revise § 117.785 to read as follows:

§ 117.785 Genessee River.

The draw of the Colonel Patrick Henry O'Rorke Memorial Bridge, mile 1.2 at Rochester, shall open on signal from April 1 through December 15; however, from 7 a.m. to 9 a.m. and from 4 p.m. to 6 p.m., Monday through Friday, except Federal holidays, the draw need be opened only for the passage of commercial vessels. From 9 a.m. to 4 p.m. and 6 p.m. to 11 p.m., Monday through Friday, except Federal holidays, and from 7 a.m. to 11 p.m. on Saturdays, Sundays, and Federal holidays, the draw need be opened only on the hour and half-hour, except that commercial vessels shall be passed at any time. From December 16 through March 31, the draw shall open on signal if at least 12 hours notice is given. The owners of the bridge shall maintain clearance gauges in accordance with 33 CFR 118.160.

Dated: November 16, 2013.

F. M. Midgette,

Rear Admiral, U.S. Coast Guard Commander, Ninth Coast Guard District.

[FR Doc. 2013–28695 Filed 11–29–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG–2013–0580]

RIN 1625–AA87

Security Zones; Naval Base Point Loma; Naval Mine Anti Submarine Warfare Command; San Diego Bay, San Diego, CA

AGENCY: Coast Guard, DHS.

ACTION: Final rule.

SUMMARY: The Coast Guard is increasing a portion of an existing San Diego Bay security zone at Naval Base Point Loma to support the construction of a new Naval fuel pier. Concurrent with the construction of the new pier, the Coast Guard is also establishing a new security zone at the Naval Mine and Anti-Submarine Warfare Command to protect the relocated marine mammal program throughout the temporary construction process. The security zone modifications are intended to restrict vessels from portions of the San Diego Bay in order to ensure the safety and security of Naval assets. Both security zones will safeguard Naval assets, such as vessels, property and waterfront facilities from destruction, loss or injury from sabotage or other subversive acts. No persons or vessel may enter or remain in the security zones without permission of the Captain of the Port, the Commander of Naval Base Point Loma, the Commander of the Naval Mine Anti Submarine Warfare Command, and the Commander of Naval Region Southwest, or a designated representative of those individuals.

DATES: This rule is effective January 2, 2014.

ADDRESSES: Documents mentioned in this preamble are part of docket [USCG–2013–0580]. To view documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov,* type the docket number in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this rulemaking. You may also visit the Docket Management Facility in Room W12–140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Lieutenant John Bannon, U.S. Coast Guard Sector San Diego; telephone (619) 278–7261 or by email at *John.E.Bannon@uscg.mil.* If you have questions on viewing or submitting material to the docket, call Barbara Hairston, Program Manager, Docket Operations, telephone (202) 366–9826.

SUPPLEMENTARY INFORMATION:

Table of Acronyms

DHS Department of Homeland Security
FR Federal Register
NPRM Notice of Proposed Rulemaking

A. Regulatory History and Information

The Coast Guard is issuing this final rule after publishing a Notice of Proposed Rulemaking (NPRM) on August 28, 2013 (78 FR 53109).

The Coast Guard received no comments on that NPRM and as such, no changes have been made to these proposed security zones. The Coast Guard also received no requests for public meeting.

B. Basis and Purpose

The legal basis for the rule is the Coast Guard's authority to establish regulated navigation areas and limited access areas: 33 U.S.C. 1231; 46 U.S.C. Chapter 701, 3306, 3703; 50 U.S.C. 191, 195; 33 CFR 1.05–1, 6.04–6, 160.5; Public Law 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

The U.S. Navy is requesting an extension of the existing security zone for the Naval Base Point Loma Fuel Pier construction and the establishment of a temporary security zone at the Naval Mine and Anti-Submarine Warfare Command to temporarily house the Navy's marine mammal program during the multi-year construction phase of the new fuel pier.

The extended security zone at Naval Base Point Loma will add an additional 500 feet east to provide standoff from the new replacement fuel pier which will place the end of the pier closer to the federal channel in deeper water. The marine mammal pen security zone will also be established at the Naval Mine and Anti-Submarine Warfare Command to provide a 100 foot standoff for marine mammal pens. The marine mammal pens need to be moved due to the construction activity and noise near their current pens.

Both security zones will safeguard Naval assets, such as vessels and waterfront facilities from destruction, loss or injury from sabotage, or other subversive acts, accidents or other causes of a similar nature and still allow for safe navigation around the security zones. No persons or vessel may enter

or remain in the security zones without permission of the Captain of the Port, the Commander of Naval Base Point Loma, The Commander of the Naval Mine Anti Submarine Warfare Command, the Commander of Naval Region Southwest, or a designated representative of those individuals.

C. Discussion of Comments, Changes and the Final Rule

The Coast Guard received 0 comments on the NPRM for this rule and as such, no changes have been made to the final rule.

The Coast Guard at the request of the U.S. Navy is extending the existing security zone for the Naval Base Point Loma Fuel Pier and establishing a temporary security zone at the Naval Mine and Anti-Submarine Warfare Command to temporarily house the Navy's marine mammal program during the construction phase of the new fuel pier.

The extended security zone at Naval Base Point Loma will add an additional 500 feet east to provide standoff from the new replacement fuel pier which will exist closer to the federal channel in deeper water. The marine mammal pen security zone will also be established at the Naval Mine and Anti-Submarine Warfare Command to provide a 100 foot standoff for marine mammal pens. The marine mammal pens need to be moved due to the construction near their current pens. This project has been well advertised in the local community.

Both security zones will safeguard Naval assets, such as vessels and waterfront facilities from destruction, loss or injury from sabotage, or other subversive acts, accidents or other causes of a similar nature and still allow for safe navigation around the security zones. No persons or vessel may enter or remain in the security zones without permission of the Captain of the Port, the Commander of Naval Base Point Loma, The Commander of the Naval Mine Anti Submarine Warfare Command, the Commander of Naval Region Southwest, or a designated representative of those individuals.

The existing Naval Base Point Loma Fuel Pier security zone listed in 33 CFR 165.1102, is being amended to reflect the additional 500 feet of standoff distance adjacent to the fuel pier. The limits of the revised Naval Base Point Loma Fuel Pier security zone are bound by the following coordinates:

32°42′28.8″ N, 117°14′13.2″ W
32°42′28.8″ N, 117°14′12.6″ W
32°42′10.2″ N, 117°14′03.0″ W
32°42′06.2″ N, 117°14′01.5″ W
32°41′49.5″ N, 117°14′07.0″ W
32°41′47.4″ N, 117°14′11.4″ W
32°41′43.8″ N, 117°14′12.6″ W
32°41′31.8″ N, 117°14′13.8″ W
32°41′33.0″ N, 117°14′01.2″ W
32°41′10.2″ N, 117°13′57.0″ W
32°41′10.2″ N, 117°13′58.2″ W

The security zone at the Naval Mine and Anti-Submarine Warfare Command will provide for 100 feet of standoff distance. The limits of the new Naval Mine and Anti-Submarine Warfare Command security zone are bound by the following coordinates:

32°43′40.9″ N, 117°12′54.9″ W
32°43′40.6″ N, 117°12′52.3″ W
32°43′22.5″ N, 117°12′57.8″ W
32°43′23.4″ N, 117°13′01.3″ W

Both security zones safeguard Naval assets, such as vessels and waterfront facilities from destruction, loss or injury from sabotage, other subversive acts, accidents or other causes of a similar nature and still allow for safe navigation around the security zones.

No persons or vessel may enter or remain in the security zones without permission of the Captain of the Port, the Commander of Naval Base Point Loma, the Commander of the Naval Mine Anti Submarine Warfare Command, the Commander of Naval Region Southwest, or a designated representative of those individuals.

Before the rule becomes effective, the Coast Guard will publish a Coast Guard District Eleven Local Notice to Mariners information on the established and modified Naval security zones.

D. Regulatory Analyses

We developed this rule after considering numerous statutes and executive orders related to rulemaking. Below we summarize our analyses based on a number of these statutes and executive orders.

1. Regulatory Planning and Review

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866, Regulatory Planning and Review, as supplemented by Executive Order 13563, Improving Regulation and Regulatory Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of Executive Order 12866 or under section 1 of Executive Order 13563. The Office of Management and Budget has not reviewed it under those Orders.

This determination is based on the size, and location of the security zones. Vessels that may operate for recreational or commercial purposes within the area encompassed by the security zone expansion and establishment will not be impacted by the proposed regulation. Sufficient navigable water exists adjacent to the security zones and the Federal channel. Additionally, before the effective period, the Coast Guard will publish a Local Notice to Mariners.

2. Impact on Small Entities

The Regulatory Flexibility Act of 1980 (RFA), 5 U.S.C. 601–612, as amended, requires federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard received 0 comments from the Small Business Administration on this rule. The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

(1) This rule will affect the following entities, some of which may be small entities: the owners or operators of vessels intending to transit or anchor in specified portions of San Diego Bay.

(2) These security zones will not have a significant economic impact on a substantial number of small entities for the following reasons: The security zones will only apply to areas of the bay where vessel traffic is already aware of Naval vessel traffic and security concerns and sufficient navigable water exists adjacent to the security zones. Vessel traffic can transit safely around the security zones. Information on the security zones will be published in the Coast Guard's Local Notice to Mariners as well as updated on applicable nautical charts.

3. Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule. If the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT**, above.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's

responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

4. Collection of Information

This rule will not call for a new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

5. Federalism

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. We have analyzed this rule under that Order and determined that this rule does not have implications for federalism.

6. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the **FOR FURTHER INTFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

7. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

8. Taking of Private Property

This rule will not cause a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

9. Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

10. Protection of Children

We have analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and does not create an environmental risk to health or risk to safety that may disproportionately affect children.

11. Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

12. Energy Effects

This action is not a ''significant energy action'' under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use.

13. Technical Standards

This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

14. Environment

We have analyzed this rule under Department of Homeland Security Management Directive 023–01 and Commandant Instruction M16475.lD, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA)(42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves the establishment of security zones. This rule is categorically excluded from further review under paragraph 34(g) of Figure 2–1 of the Commandant Instruction. An environmental analysis checklist supporting this determination and a Categorical Exclusion Determination are available in the docket where indicated under **ADDRESSES.** We seek any comments or information that may lead to the discovery of a significant environmental impact from this rule.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR Part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1231; 46 U.S.C. Chapter 701, 3306, 3703; 50 U.S.C. 191, 195; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. Revise § 165.1102 to read as follows:

§ 165.1102 Security Zone; Naval Base Point Loma; San Diego Bay, CA.

(a) *Location.* The following area is a security zone: The water adjacent to the Naval Base Point Loma, San Diego, CA, enclosed by the following coordinates:

32°42′28.8″ N, 117°14′13.2″ W (Point A)
32°42′28.8″ N, 117°14′12.6″ W (Point B)
32°42′10.2″ N, 117°14′03.0″ W (Point C)
32°42′06.2″ N, 117°14′01.5″ W (Point D)
32°41′49.5″ N, 117°14′07.0″ W (Point E)
32°41′47.4″ N, 117°14′11.4″ W (Point F)
32°41′43.8″ N, 117°14′12.6″ W (Point G)
32°41′31.8″ N, 117°14′13.8″ W (Point H)
32°41′33.0″ N, 117°14′01.2″ W (Point I)
32°41′10.2″ N, 117°13′57.0″ W (Point J)
32°41′10.2″ N, 117°13′58.2″ W (Point K)

Thence running generally north along the shoreline to Point A.

(b) *Regulations.* (1) The general regulations governing security zones found in 33 CFR 165.33 apply to the security zone described in paragraph (a) of this section.

(2) Entry into, or remaining in, the areas of either zone is prohibited unless authorized by the Captain of the Port San Diego; Commanding Officer, Naval Base Point Loma; or Commander, Naval Region Southwest.

(3) Persons desiring to transit the area of the security zone may request permission from the Captain of the Port San Diego at telephone number (619) 278–7033 or on VHF channel 16 (156.8 MHz) or from either the Commanding Officer, Naval Base Point Loma or the Commanding Officer Navy Region Southwest by calling the Navy Port Operation Dispatch at telephone number (619) 556–1433 or on VHF–FM channels 16 or 12. If permission is granted, all persons and vessels must comply with the instructions of the Captain of the Port San Diego or his or her designated representative.

(c) *Definitions.* For purposes of this section: Captain of the Port San Diego, means the Commanding Officer of the Coast Guard Sector San Diego; Commander, Navy Region Southwest,

means Navy Region Commander responsible for the Southwest Region; Commanding Officer, Naval Base Point Loma, means the Installation Commander of the naval base located on Point Loma, San Diego, California; Designated Representative, means any U.S. Coast Guard commissioned, warrant, or petty officer who has been designated by the Captain of the Port San Diego to assist in the enforcement of the security zone described in paragraph (a) of this section.

(d) *Enforcement.* The U.S. Coast Guard may be assisted in the patrol and enforcement of the security zone described in paragraph (a) of this section by the U.S. Navy and local law enforcement agencies.

■ 3. Add § 165.1103 to read as follows:

§ 165.1103 Security Zone; Naval Mine Anti Submarine Warfare Command; San Diego Bay, San Diego, CA.

(a) *Location.* (1) The following area is a security zone: The water adjacent to the Naval Mine Anti Submarine Warfare Command, bound by the following coordinates:

32°43′40.9″ N, 117°12′54.9″ W (A)
32°43′40.6″ N, 117°12′52.3″ W (B)
32°43′22.5″ N, 117°12′57.8″ W (C)
32°43′23.4″ N, 117°13′01.3″ W (D)

Thence running generally northwest along the shoreline to Point A.

(2) The proposed security zone at the Naval Mine Anti Submarine Warfare Command would be established to provide for the 100 feet of standoff distance.

(b) Regulations. (1) The general regulations governing security zones found in 33 CFR 165.33 apply to the security zone described in paragraph (a) of this section.

(2) Entry into, or remaining in, the areas of either zone is prohibited unless authorized by the Captain of the Port San Diego; Commanding Officer, Naval Mine Anti Submarine Warfare Command; or Commander, Naval Region Southwest.

(3) Persons desiring to transit the area of the security zone may request permission from the Captain of the Port San Diego at telephone number (619) 278–7033 or on VHF channel 16 (156.8 MHz) or from either the Commanding Officer, Naval Mine Anti Submarine Warfare Command or the Commander, Navy Region Southwest by calling the Navy Port Operation Dispatch at telephone number (619) 556–1433 or on VHF–FM channels 16 or 12. If permission is granted, all persons and vessels must comply with the instructions of the Captain of the Port San Diego or his or her designated representative.

(c) *Definitions.* For purposes of this section: Captain of the Port San Diego, means the Commanding Officer of the Coast Guard Sector San Diego; Commander, Navy Region Southwest, means Navy Region Commander responsible for the Southwest Region; Commanding Officer, Naval Mine Anti Submarine Warfare Command, means the Installation Commander of the naval base located on Point Loma, San Diego, California; Designated Representative, means any U.S. Coast Guard commissioned, warrant, or petty officer who has been designated by the Captain of the Port San Diego to assist in the enforcement of the security zone described in paragraph (a) of this section.

(d) *Enforcement.* The U.S. Coast Guard may be assisted in the patrol and enforcement of the security zone described in paragraph (a) of this section by the U.S. Navy and local law enforcement agencies.

Dated: October 30, 2013.

S. M. Mahoney,

Captain, U.S. Coast Guard, Captain of the Port San Diego.

[FR Doc. 2013–28035 Filed 11–29–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF THE INTERIOR

National Park Service

36 CFR Part 7

[NPS–CURE–13810; 122PPIMCURES1,PPMPSPD1Z.YM0000]

RIN 1024–AD76

Special Regulations, Areas of the National Park System, Curecanti National Recreation Area, Snowmobiles and Off-Road Motor Vehicles

AGENCY: National Park Service, Interior.

ACTION: Final rule.

SUMMARY: The National Park Service amends the special regulations for Curecanti National Recreation Area, Colorado, to designate routes, water surfaces, and areas where snowmobiles or motor vehicles may be used off park roads.

DATES: This rule is effective January 2, 2014.

FOR FURTHER INFORMATION CONTACT: Ken Stahlnecker, Chief of Resource Stewardship and Science, Curecanti National Recreation Area, 102 Elk Creek, Gunnison, CO 81230. Phone: (970) 641–2337x225. Email: *ken_stahlnecker@nps.gov.*

SUPPLEMENTARY INFORMATION:

Background

History of Curecanti National Recreation Area

The Blue Mesa Dam and Reservoir, Morrow Point Dam and Reservoir, and Crystal Dam and Reservoir make up the Curecanti Unit, one of the four main units authorized by the Colorado River Storage Project Act of April 11, 1956 (Pub. L. 84–485) (CRSPA). The Curecanti Unit is also known as the Wayne N. Aspinall Storage Unit.

Section 8 of CRSPA directed the Secretary of the Interior (Secretary) ''to investigate, plan, construct, operate, and maintain (1) public recreational facilities on lands withdrawn or acquired for the development of [the Colorado River Storage Project] to conserve the scenery, the natural, historic, and archeological objects, and the wildlife on said lands, and to provide for public use and enjoyment of the same and of the water areas created by these projects by such means as are consistent with the primary purposes of said projects. . . .''

Pursuant to that provision, the National Park Service (NPS) began managing natural and cultural resources and recreational uses within the Aspinall Storage Unit and established the Curecanti National Recreation Area (CURE or recreation area) in 1965 under a Memorandum of Agreement (MOA) with the Bureau of Reclamation. In 1978, Bureau of Reclamation lands in the East Portal area were added to CURE and placed under the management authority of the NPS pursuant to the MOA.

NPS Authority and Jurisdiction

The NPS manages CURE under the NPS Organic Act of 1916 (Organic Act) (16 U.S.C. 1 *et seq.*), which gives the NPS broad authority to regulate the use of the park areas under its jurisdiction. The Organic Act authorizes the Secretary to ''make and publish such rules and regulations as he may deem necessary or proper for the use and management of the parks.''

The purpose of the recreation area, as provided for in the MOA, is to conserve its scenery, natural and cultural resources, and wildlife, and to manage its lands, waters, fish, wildlife, and recreational activities consistent with section 8 of CRSPA and the Federal Water Project Recreation Act (16 U.S.C. 460l–12; Pub. L. 89–72, July 9, 1965, as amended).

Description and Significance of CURE

CURE is located in Gunnison and Montrose Counties in southwestern

Colorado. The reservoirs and the surrounding lands provide recreational opportunities amidst a variety of natural, cultural, and scenic resources, including recently discovered dinosaur fossils, a 5,000-acre archeological district, and traces of 6,000 year-old dwellings. Approximately one million people visit CURE annually to take advantage of numerous recreational opportunities. Most visitors come during the summer months when temperatures are warmer and water-based activities are more popular.

The recreation area contains water resources, including three reservoirs that provide a variety of recreational opportunities in a spectacular geological setting. Blue Mesa Reservoir is one of the largest high-altitude bodies of water in the United States. It provides exciting and diverse water recreation opportunities for windsurfers, sail boaters, and water skiers.

Motor Vehicle and Snowmobile Use at CURE

Visitors to CURE use motor vehicles to access campsites, fishing spots, marinas, trailheads, and other destinations throughout the recreation area, both on and off roads. Motor vehicle access is also an important means for disabled or mobility impaired visitors to experience the recreation area.

Motor vehicles have traditionally been used to access certain sites within the recreation area, including areas below the high-water mark of Blue Mesa Reservoir. The high-water mark is defined as the point at which the reservoir is at maximum capacity (full pool), an elevation of 7,519 feet. NPS policy at the recreation area has been to allow the operation of motor vehicles between the high-water mark and the water surface of Blue Mesa Reservoir for the purpose of fishing access and boat launching. In addition, the NPS has established several access roads that service power lines as roads open for motor vehicle access. Access to areas below the high-water mark is primarily from maintained roads. However, unmaintained routes off established roads also provide access for travel below the high-water mark in a few areas. The most common motor vehicles that access these areas are cars and trucks. During the winter months, snowmobiles are used to reach popular fishing locations on the frozen surface of Blue Mesa Reservoir. Snowmobiles access the frozen surface from designated access points.

Off-Road Motor Vehicle and Snowmobile Regulation

Executive Order 11644, Use of Off-Road Vehicles on the Public Lands, issued in 1972 and amended by Executive Order 11989 in 1977, required federal agencies to issue regulations designating specific areas and routes on public lands where the use of off-road vehicles may be used. The NPS has implemented these Executive Orders in 36 CFR 2.18 and 4.10.

Under 36 CFR 4.10, the use of motor vehicles off established roads is prohibited unless routes and areas are designated for off-road motor vehicle use by a special regulation. Under 36 CFR 4.10(b), such routes and areas ''may be designated only in national recreation areas, national seashores, national lakeshores and national preserves.'' Similarly, under 36 CFR 2.18, the use of snowmobiles is prohibited except on routes and water surfaces used by motor vehicles or motorboats during other seasons. Under 36 CFR 2.18(b), routes and water surfaces must be designated for snowmobile use by special regulation.

The NPS is issuing this rule to designate routes, water surfaces, and areas where motor vehicles and snowmobiles may be used off park roads, in compliance with 36 CFR 2.18 and 4.10 and Executive Orders 11644 and 11989.

Motorized Vehicle Access Plan/ Environmental Assessment

This rule implements the preferred alternative (Alternative C) for CURE described in the October 2010 Motor Vehicle Access Plan/Environmental Assessment (EA). The EA was open for public review and comment from November 17, 2010 until January 15, 2011. CURE completed a Finding of No Significant Impact (FONSI) on July 10, 2012, which selected for implementation the preferred alternative (Alternative C). The EA and FONSI are available for review at *http://parkplanning.nps.gov/cure* by clicking the link entitled ''Motorized Access Plan/Environmental Assessment'' and then clicking the link entitled ''Document List.'' An analysis of potential costs and benefits of this rule is available for review in the report entitled ''Summary of Economic Analyses'' found at *http://parkplanning.nps.gov/cure* then clicking the link entitled ''Motorized Access Plan/Environmental Assessment'' and then clicking the link entitled ''Document List.''

Proposed Rule and Public Comment Period

The NPS published the proposed rule on May 9, 2013, (78 FR 27132) with request for public comment through the Federal eRulemaking portal at *regulations.gov,* or by mail or hand delivery. The 60-day comment period ended on July 8, 2013. No comments were received. There are no changes from the proposed rule in the final rule other than a few minor, non-substantive edits. The final rule revises the section heading for § 7.51 from ''Curecanti Recreation Area'' to ''Curecanti National Recreation Area,'' which is the actual name of the recreation area.

Final Rule

This rule amends the special regulations for CURE at 36 CFR 7.51 to implement the selected action in the FONSI. The rule designates frozen water surfaces where snowmobiles may be used, designates new access points, and designates routes from the access points to the frozen surface of the Blue Mesa Reservoir. The rule also designates routes and areas where motor vehicles may be used off park roads within the recreation area, and access routes at various locations throughout the recreation area.

Snowmobiles

This rule amends section 7.51(c) to modify the designated access routes and frozen water surface where snowmobiles may be used. Snowmobiles may continue to operate on designated routes and areas within the boundaries of CURE provided their use conforms to the regulations governing the use of snowmobiles in 36 CFR 2.18 and applicable State laws. The rule retains the frozen surface of Blue Mesa Reservoir as a designated area for snowmobile use and designates specific access points and access routes to the reservoir. Routes are designated for travel by snowmobiles from the access points to the frozen surface of Blue Mesa Reservoir. These access routes are limited to the most direct route from the access points to the frozen surface. Traveling parallel to the reservoir, before accessing the frozen surface, is prohibited. Routes may be marked where possible, but changing weather conditions and terrain often make posting routes difficult. The rule also creates three new snowmobile access points: one at the Lake Fork Visitor Center boat ramp; one on the southeast shore of Iola Basin near Willow Creek; and one near McIntyre Gulch. The new access points will reduce environmental impacts by shortening the distance some

visitors travel over the frozen surface by snowmobile to fish. A map of the water surfaces and routes open to snowmobile use and designated access points will be available in the office of the Superintendent, at the Elk Creek Visitor Center, at the Lake Fork Visitor Center, at the Cimarron Visitor Center, and on the recreation area's Web site.

Snowmobile gross weight continues to be limited to a maximum of 1,200 pounds (including cargo but excluding the weight of the driver and any passenger). The snowmobile speed limit remains 45 mph (36 CFR 2.18(d)(4)).

Off Road Vehicles

The final rule adds paragraph 7.51(e) to designate three groups of routes and areas where motor vehicles may be used off park roads in the recreation area. First, the frozen surface of Blue Mesa Reservoir is designated for use by motor vehicles, in addition to snowmobiles. Second, the exposed lake bottom of Blue Mesa Reservoir is a designated area for motor vehicle use. This designated area between the high water mark and the actual water level of the reservoir is limited to a maximum area of approximately 958 acres. Third, approximately 24 miles of off-road routes are designated open to public motor vehicle use. These designated routes provide access to Blue Mesa Reservoir, other CURE lands, and to adjacent public lands. A map of routes and areas open to off-road motor vehicle use will be available in the office of the Superintendent, at the Elk Creek Visitor Center, at the Lake Fork Visitor Center, at the Cimarron Visitor Center, and on the recreation area's Web site. Under 36 CFR 1.4, the term ''motor vehicle'' does not include snowmobiles. As a result, paragraph 7.51(e) does not apply to snowmobiles.

The provisions of 36 CFR Part 4, including state law adopted by 36 CFR 4.1, apply within the recreation area. Unless posted otherwise, the speed limit is 15 mph for motor vehicles on all designated off-road routes and areas. Speed limits are implemented for visitor safety and to prohibit driving that may damage resources. The 45 mph speed limit for snowmobiles is higher than the 15 mph speed limit for motor vehicles, even though both will be allowed to travel on the frozen surface of Blue Mesa Reservoir, because snowmobiles are more easily controlled on snow and ice due to vehicle design and a lower center of gravity. As a result, there are less safety and resource concerns with driving snowmobiles in excess of 15 mph. Motor vehicle gross weight is limited to a maximum of 1,800 pounds (including cargo but excluding the driver and any passenger) on the frozen surface of Blue Mesa Reservoir. This vehicle restriction is intended to allow only lightweight all-terrain vehicles (ATV) or utility task vehicles (UTV or sometimes referred to as a side-by-side) onto the frozen surface.

To prevent impacts to areas outside of existing routes, wheelbase width for motor vehicles on all designated routes may not exceed 8 feet, 6 inches. The NPS may also recommend, but will not require, four-wheel drive and/or high-clearance vehicles on particular routes, based on visitor safety and route conditions.

Superintendent's Authority

Routes, water surface, areas, or access points designated for snowmobile, personal watercraft, or off-road motor vehicle use will be subject to year-round, seasonal, or temporary site-specific closures, conditions, or restrictions with public notice provided under 36 CFR 1.7. The Superintendent's authority in § 7.51(d)(5), related to personal watercraft use, is removed because it is redundant with the Superintendent's authority in paragraph (e) of this rule.

Compliance With Other Laws, Executive Orders and Department Policy

Use of Off-Road Vehicles on the Public Lands (Executive Orders 11644 and 11989)

Section 3(a)(4) of Executive Order 11644 provides that off-road vehicle (ORV) ''[a]reas and trails shall be located in areas of the National Park system, Natural Areas, or National Wildlife Refuges and Game Ranges only if the respective agency head determines that off-road vehicle use in such locations will not adversely affect their natural, aesthetic, or scenic values.'' Since the Executive Order clearly was not intended to prohibit all ORV use everywhere in these units, the term ''adversely affect'' does not have the same meaning as the somewhat similar terms ''adverse impact'' and ''adverse effect'' used in NEPA. In analyses under NEPA, a procedural statute that provides for the study of environmental impacts, the term ''adverse effect'' includes minor or negligible effects. Section 3(a)(4) of the Executive Order, by contrast, concerns substantive management decisions and must be read in the context of the authorities applicable to such decisions. CURE is an area of the National Park System. Therefore, the NPS interprets the Executive Order term ''adversely affect'' consistent with NPS Management Policies (2006). Those policies require that the NPS only allow ''appropriate use'' of parks and avoid ''unacceptable impacts.''

This rule is consistent with those requirements. It will not impede attainment of CURE's desired future conditions for natural and cultural resources as identified in the EA. The NPS has determined that this rule will not unreasonably interfere with the atmosphere of peace and tranquility or the natural soundscape maintained in natural locations within CURE. Therefore, within the context of the resources and values of CURE, motor vehicle use on the routes and areas designated by this rule (which are also subject to resource closures and other species management measures that would be implemented under the preferred alternative in the EA) will not cause an unacceptable impact to the natural, aesthetic, or scenic values of CURE.

Section 8(a) of the Executive Order requires agency heads to monitor the effects of ORV use on lands under their jurisdictions. On the basis of information gathered, agency heads shall from time to time amend or rescind designations of areas or other actions as necessary to further the policy of the Executive Order. The preferred alternative (Alternative C) for the EA identifies monitoring and resource protection procedures and periodic review to provide for the ongoing and future evaluation of impacts of motor vehicle use on protected resources. The Superintendent has the existing authority under both this final rule and 36 CFR 1.5 to close portions of CURE as needed to protect recreational area resources.

Regulatory Planning and Review (Executive Orders 12866 and 13563)

Executive Order 12866 provides that the Office of Information and Regulatory Affairs (OIRA) in the Office of Management and Budget will review all significant rules. OIRA has determined that this rule is not significant.

Executive Order 13563 reaffirms the principles of Executive Order 12866 while calling for improvements in the nation's regulatory system to promote predictability, to reduce uncertainty, and to use the best, most innovative, and least burdensome tools for achieving regulatory ends. The Executive Order directs agencies to consider regulatory approaches that reduce burdens and maintain flexibility and freedom of choice for the public where these approaches are relevant, feasible, and consistent with regulatory

objectives. Executive Order 13563 emphasizes further that regulations must be based on the best available science and that the rulemaking process must allow for public participation and an open exchange of ideas. We have developed this rule in a manner consistent with these requirements.

Regulatory Flexibility Act (RFA)

This rule will not have a significant economic effect on a substantial number of small entities under the RFA (5 U.S.C. 601 *et seq.*). This certification is based on the regulatory flexibility analysis found in the report entitled ''Summary of Economic Analyses'' that may be reviewed on the recreation area's planning Web site at *http://parkplanning.nps.gov/cure,* then clicking the link entitled ''Motorized Access Plan/Environmental Assessment'' and then clicking the link entitled ''Document List.''

Small Business Regulatory Enforcement Fairness Act (SBREFA)

This rule is not a major rule under 5 U.S.C. 804(2), the SBREFA. This rule:

(a) Does not have an annual effect on the economy of $100 million or more.

(b) Will not cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions.

(c) Does not have significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of U.S.-based enterprises to compete with foreign-based enterprises.

Unfunded Mandates Reform Act (UMRA)

This rule does not impose an unfunded mandate on State, local, or tribal governments or the private sector of more than $100 million per year. The rule does not have a significant or unique effect on State, local or tribal governments or the private sector. A statement containing the information required by the UMRA (2 U.S.C. 1531 *et seq.*) is not required.

Takings (Executive Order 12630)

This rule does not affect a taking of private property or otherwise have takings implications under Executive Order 12630. A takings implication assessment is not required.

Federalism (Executive Order 13132)

Under the criteria in section 1 of Executive Order 13132, this rule does not have sufficient federalism implications to warrant the preparation of a Federalism summary impact statement. This rule only affects use of NPS administered lands and waters. A Federalism summary impact statement is not required.

Civil Justice Reform (Executive Order 12988)

This rule complies with the requirements of Executive Order 12988. Specifically, this rule:

(a) Meets the criteria of section 3(a) requiring that all regulations be reviewed to eliminate errors and ambiguity and be written to minimize litigation; and

(b) Meets the criteria of section 3(b)(2) requiring that all regulations be written in clear language and contain clear legal standards.

Consultation With Indian Tribes (Executive Order 13175 and Department Policy)

The Department of the Interior strives to strengthen its government-to-government relationship with Indian Tribes through a commitment to consultation with Indian Tribes and recognition of their right to self-governance and tribal sovereignty. We have evaluated this rule under the Department's consultation policy and under the criteria in Executive Order 13175 and have determined that it has no substantial direct effects on federally recognized Indian tribes and that consultation under the Department's tribal consultation policy is not required.

Recreation area staff consulted with representatives from the Southern Ute Indian tribe, Uintah and Ouray Tribal Business Committee, Ute tribe of the Uintah and Ouray Reservation, and the Ute Mountain Ute tribe. The tribes have not commented or identified any concerns to date.

Paperwork Reduction Act (PRA)(44 U.S.C. 3501 *et seq.*)

This rule does not contain information collection requirements, and a submission to the Office of Management and Budget under the PRA is not required. We may not conduct or sponsor and you are not required to respond to a collection of information unless it displays a currently valid OMB control number.

National Environmental Policy Act (NEPA)

This rule does not constitute a major Federal action significantly affecting the quality of the human environment. A detailed statement under NEPA is not required because we reached the FONSI. The EA and FONSI are available for review at *http://parkplanning.nps.gov/cure* then clicking the link entitled ''Motorized Access Plan/Environmental Assessment'' and then clicking on the link entitled ''Document List.''

Effects on the Energy Supply (Executive Order 13211)

This rule is not a significant energy action under the definition in Executive Order 13211. A Statement of Energy Effects is not required.

List of Subjects in 36 CFR Part 7

National parks, Reporting and recordkeeping requirements.

In consideration of the foregoing, the National Park Service amends 36 CFR part 7 as follows:

PART 7—SPECIAL REGULATIONS, AREAS OF THE NATIONAL PARK SYSTEM

■ 1. The authority citation for part 7 continues to read as follows:

Authority: 16 U.S.C. 1, 3, 9a, 462(k); Sec. 7.96 also issued under 36 U.S.C. 501–511, DC Code 10–137 (2001) and DC Code 50–2201.07 (2001).

■ 2. Amend § 7.51 by revising the section heading and the introductory text of paragraph (c), revising paragraphs (c)(2) and (c)(3), adding paragraph (c)(4), removing paragraph (d)(5), and adding paragraphs (e) and (f). The revisions and additions read as follows:

§ 7.51 Curecanti National Recreation Area.

* * * * *

(c) *Snowmobiles.* Operating a snowmobile is allowed within the boundaries of Curecanti National Recreation Area under the following conditions:

* * * * *

(2) *Designated water surface and routes.* Snowmobile use is confined to the following water surface and routes:

(i) The frozen surface of Blue Mesa Reservoir; and

(ii) Lake Fork Visitor Center access point, McIntyre Gulch access point, Sapinero Beach access point, Dillon Pinnacles access point, Windsurf Beach access point, Elk Creek Marina, Dry Creek access point, North Willow access point, Old Stevens access point, Iola access point, Willow Creek access point, and the most direct route from each of these access points to the frozen surface of Blue Mesa Reservoir.

(3) *Identification of designated water surface and routes.* The designated water surface and routes are identified on maps available at the office of the Superintendent, Elk Creek Visitor Center, Lake Fork Visitor Center, Cimarron Visitor Center, and on the recreation area Web site.

(4) *Snowmobile requirements.* Snowmobiles are limited to a maximum of 1200 pounds gross vehicle weight (GVW), including cargo but excluding the weight of the driver and any passenger.

* * * * *

(e) *Off-road motor vehicle use.* Operating a motor vehicle is allowed within the boundaries of Curecanti National Recreation Area off park roads under the following conditions:

(1) *Designated routes and areas.* Motor vehicle use off park roads is confined to the following routes and areas:

(i) Via the access points and routes listed in paragraph (c)(2)(ii) of this section, directly to the frozen surface of Blue Mesa Reservoir;

(ii) A maximum area of approximately 958 acres of the exposed lake bottom of Blue Mesa Reservoir between the high-water mark and the water of the reservoir; and

(iii) Posted designated access routes through the recreation area described and selected in the Curecanti Motor Vehicle Access Plan/Finding of No Significant Impact dated July 10, 2012.

(2) *Identification of designated routes and areas.* These routes and areas are identified on Maps 6a and 6b, dated January 1, 2011, which are available at the office of the Superintendent, Elk Creek Visitor Center, Lake Fork Visitor Center, Cimarron Visitor Center, and on the recreation area Web site.

(3) *Vehicle requirements.* Motor vehicles operating off park roads must meet the following requirements:

(i) Wheelbase width must not exceed 8 feet, 6 inches.

(ii) Maximum gross vehicle weight for motor vehicle use on the frozen surface of Blue Mesa Reservoir is 1800 pounds GVW, including cargo but excluding the weight of the driver and any passenger. This restricts vehicle use on the frozen surface to all-terrain and utility task type vehicles.

(4) *Speed limits.* Unless otherwise posted, motor vehicles may not exceed 15 miles per hour on designated off-road routes and areas.

(f) *Superintendent's authority.* The Superintendent may open or close designated routes, water surfaces, access points, or areas open to snowmobile, PWC, or off-road motor vehicle use, or portions thereof, or impose conditions or restrictions for snowmobile, PWC, or off-road motor vehicle use after taking into consideration public health and safety, natural and cultural resource protection, and other management activities and objectives.

(1) The Superintendent will provide public notice of all such actions through one or more of the methods listed in § 1.7 of this chapter.

(2) Violating a closure, condition or restriction is prohibited.

Dated: November 20, 2013.

Rachel Jacobson,

Principal Deputy Assistant Secretary for Fish and Wildlife and Parks.

[FR Doc. 2013–28788 Filed 11–29–13; 8:45 am]

BILLING CODE 4312–EJ–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[Docket No. EPA–R02–OAR–2013–0618; FRL–9903–24-Region 2]

Approval and Promulgation of Air Quality Implementation Plans; New York; Determination of Clean Data for the 1987 PM_{10} Standard for the New York County Area

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The Environmental Protection Agency (EPA) is determining that the New York County nonattainment area in New York is attaining the National Ambient Air Quality Standard (NAAQS) for particulate matter with an aerodynamic diameter of less than or equal to a nominal ten micrometers (PM_{10}) based on certified, quality-assured ambient air monitoring data for the years 2010 through 2012. EPA is also determining that New York's obligation to make submissions to meet certain Clean Air Act requirements related to attainment of the NAAQS is not applicable for as long as the New York County nonattainment area continues to attain the NAAQS.

DATES: This rule is effective on January 2, 2014.

ADDRESSES: EPA has established a docket for this action under Docket ID Number EPA–R02–OAR–2013–0618. All documents in the docket are listed in the *http://www.regulations.gov* Web site. Although listed in the electronic docket, some information is not publicly available, i.e., confidential business information (CBI) or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically through *http://www.regulations.gov* or in hard copy for public inspection during normal business hours at the Air Programs Branch, Environmental Protection Agency, Region II, 290 Broadway, New York, New York 10007.

FOR FURTHER INFORMATION CONTACT: If you have questions concerning today's final action, please contact Henry Feingersh, Air Programs Branch, Environmental Protection Agency, 290 Broadway, 25th Floor, New York, New York 10007–1866, telephone number (212) 637–3382, fax number (212) 637–3901, email *feingersh.henry@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. What action is EPA taking?

EPA is determining that the New York County nonattainment area in New York is attaining the National Ambient Air Quality Standard (NAAQS) for particulate matter with an aerodynamic diameter of less than or equal to a nominal ten micrometers (PM_{10}). This determination is based upon certified, quality-assured ambient air monitoring data that show the area has monitored attainment of the PM_{10} NAAQS for the years 2010 through 2012. Actually, New York County has been attaining the PM_{10} standard since 1992. Specific details regarding the determination and the rationale for EPA's action are explained in the proposed rulemaking published in the **Federal Register** (FR) on September 13, 2013 (78 FR 56633). EPA's determination is being made in accordance with its longstanding interpretation under the Clean Data Policy, and with previously issued rules and determinations of attainment. A description of the Clean Data Policy with respect to the PM_{10} standard can be seen in 78 FR 56633.

II. What comments did EPA receive on its proposal and what is EPA's response?

EPA did not receive any comments on the proposal.

III. What is EPA's final action?

This final action, in accordance with the Clean Data Policy, which is reflected in 40 CFR 51.1004(c), suspends the requirements for the State of New York, to submit an attainment demonstration, associated reasonably available control measures, reasonable further progress plans, and contingency measures for the New York County PM_{10} nonattainment area for so long as the area continues to attain the PM_{10} NAAQS.

This action does not constitute a redesignation to attainment under section 107(d)(3) of the CAA, because the area does not have an approved maintenance plan as required under section 175A of the CAA. Nor is it a determination that the area has met the other requirements for redesignation.

The designation status of the area remains nonattainment for the PM_{10} NAAQS until such time as EPA determines that the area, and/or a State portion thereof, meets the CAA requirements for redesignation to attainment.

EPA is determining that the New York County PM_{10} nonattainment area has attained both the 24-hour PM_{10} NAAQS and the revoked annual PM_{10} NAAQS. This determination is based upon certified, quality-assured ambient air monitoring data that show that the area has monitored attainment of the PM_{10} NAAQS for the 2010–2012 monitoring period. Preliminary air monitoring data available for 2013 are consistent with the determination that the New York County area PM_{10} nonattainment area is continuing to meet the PM_{10} NAAQS. This final action, in accordance with the Clean Data Policy, suspends the requirements for the State of New York to submit, for the New York County PM_{10} nonattainment area, an attainment demonstration, associated reasonably available control measures, reasonable further progress plans, and contingency measures in the area for so long as the area continues to attain the PM_{10} NAAQS. If EPA subsequently determines, after notice-and-comment rulemaking in the **Federal Register**, that the New York County PM_{10} nonattainment area has violated the PM_{10} NAAQS, the basis for the suspension of the specific requirements would no longer exist for the area, and New York would thereafter have to address the applicable requirements for the PM_{10} NAAQS.

IV. Statutory and Executive Order Reviews

This action makes an attainment determination based on air quality and results in the suspension of certain Federal requirements, and it does not impose additional requirements beyond those imposed by state law. For these reasons, this action:

- Is not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and
- does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in the state, and EPA notes that it will not impose substantial direct costs on tribal governments or preempt tribal law.

The Congressional Review Act, 5 U.S.C. 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this action and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by January 31, 2014. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this action for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2).)

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Particulate matter.

Dated: November 8, 2013.

Judith A. Enck,

Regional Administrator, Region 2.

Part 52, chapter I, title 40 of the Code of Federal Regulations is amended as follows:

PART 52—APPROVAL AND PROMULGATION OF IMPLEMENTATION PLANS

■ 1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart HH—New York

■ 2. Section 52.1678 is amended by adding paragraph (g) to read as follows:

§ 52.1678 Control strategy and regulations: Particulate matter.

* * * * *

(g) *Determination of Attainment.* EPA has determined, as of December 2 2013, that the New York County fine particle (PM_{10}) nonattainment area has attained the PM_{10} National Ambient Air Quality Standard. This determination suspends the requirements for this area to submit an attainment demonstration, associated reasonably available control measures, reasonable further progress plans, and contingency measures for as long as the area continues to attain the PM_{10} NAAQS.

[FR Doc. 2013–28655 Filed 11–29–13; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R04–OAR–2012–0385; FRL–9903–23-Region 4]

Approval and Promulgation of Implementation Plans; Florida: General Requirements and Gasoline Vapor Control; Correcting Amendment

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule; correcting amendments.

SUMMARY: On June 1, 2009, EPA published a final rule in the **Federal Register** approving a Florida State Implementation Plan (SIP) revision, submitted through the Florida

Department of Environmental Protection (FDEP), related to the State's gasoline vapor recovery program. This correcting amendment corrects errors in the regulatory language in paragraph (c) of EPA's June 1, 2009, final rule.

DATES: Effective on December 2, 2013.

FOR FURTHER INFORMATION CONTACT: Kelly Sheckler, Air Quality Modeling and Transportation Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. The telephone number is (404) 562–9222. Ms. Sheckler can be reached via electronic mail at *sheckler.kelly@epa.gov.*

SUPPLEMENTARY INFORMATION: This action corrects inadvertent errors in a rulemaking related to Florida's gasoline vapor recovery program SIP provision. In summary, this action corrects the effective date for the Florida rules included in the regulatory text section of EPA's June 1, 2009, final rulemaking (74 FR 26103). Specifically, EPA is correcting the June 1, 2009, final rule to provide the correct effective date for Florida Code Annotated Sections 62–210.300, 62–210.310, 62–210.920, 62–252.200, 62–252.300, 62–252.400, 62–252.500 and 62–296.418 related to the State's gasoline vapor recovery program. In its May 31, 2007, SIP revision, FDEP erroneously listed September 4, 2006, as the effective date for the gasoline vapor recovery program rules. The correct effective date of Florida's rules related to the gasoline vapor recovery program, as provided by FDEP in a November 29, 2012, letter, is May 9, 2007. This action corrects the regulatory text section of EPA's June 1, 2009 final rule approving the Florida ''Gasoline Vapor Recovery'' SIP revision to reflect a State effective date of May 9, 2007. *See* 74 FR 26103. Today's action also serves to update the State effective dates of the relevant rules in the Table of EPA-Approved Florida Regulations at 40 CFR 52.520.

EPA has determined that today's actions fall under the ''good cause'' exemption in section 553(b)(3)(B) of the Administrative Procedure Act (APA) which, upon finding ''good cause,'' authorizes agencies to dispense with public participation where public notice and comment procedures are impracticable, unnecessary, or contrary to the public interest. Public notice and comment for this action is unnecessary because today's action to correct inadvertent regulatory text errors included in EPA's June 1, 2009, final rule is consistent with the substantive revision to the Florida SIP described therein related to the gasoline vapor recovery program for the Florida SIP. In addition, EPA can identify no particular reason why the public would be interested in having the opportunity to comment on the correction prior to this action being finalized, since this correction action does not change EPA's analysis or overall action related to the approval of the State's gasoline vapor recovery program into the Florida SIP.

EPA also finds that there is good cause under APA section 553(d)(3) for this correction to become effective on the date of publication of this action. Section 553(d)(3) of the APA allows an effective date less than 30 days after publication ''as otherwise provided by the agency for good cause found and published with the rule.'' 5 U.S.C. 553(d)(3). The purpose of the 30-day waiting period prescribed in APA section 553(d)(3) is to give affected parties a reasonable time to adjust their behavior and prepare before the final rule takes effect. Today's rule, however, does not create any new regulatory requirements such that affected parties would need time to prepare before the rule takes effect. Rather, today's action merely corrects inadvertent errors for the regulatory text of EPA's prior rulemaking for the Florida SIP. For these reasons, EPA finds good cause under APA section 553(d)(3) for this correction to become effective on the date of publication of this action.

Statutory and Executive Order Reviews

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a ''significant regulatory action'' and therefore is not subject to review by the Office of Management and Budget. For this reason, this action is also not subject to Executive Order 13211, ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001). This action merely corrects an inadvertent error in the regulatory text of EPA's June 1, 2009, final rule addressing the gasoline vapor recovery program in the Florida SIP, and imposes no additional requirements beyond those imposed by state law. Accordingly, the Administrator certifies that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this rule merely corrects an inadvertent error for the regulatory text of EPA's June 1, 2009, final rule addressing the gasoline vapor recovery program in the Florida SIP, and does not impose any additional enforceable duty beyond that required by state law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

This rule also does not have tribal implications because it will not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000). This rule also does not have Federalism implications because it does not have substantial direct effects on the states, on the relationship between the national government and the states, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132 (64 FR 43255, August 10, 1999). This rule merely corrects inadvertent errors in the regulatory text of EPA's June 1, 2009, final rule addressing the gasoline vapor recovery program in the Florida SIP, and does not alter the relationship or the distribution of power and responsibilities established in the CAA. This rule also is not subject to Executive Order 13045 ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997), because it is not economically significant. In addition, this rule does not involve technical standards, thus the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. This rule also does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

The Congressional Review Act, 5 U.S.C. section 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Reporting and recordkeeping requirements, Volatile organic compounds.

Dated: November 12, 2013.

Beverly H. Banister,

Acting Regional Administrator, Region 4.

40 CFR part 52 is amended as follows:

PART 52–APPROVAL AND PROMULGATION OF IMPLEMENTATION PLANS

■ 1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart K—Florida

■ 2. Section 52.520(c) is amended:

■ a. Under Chapter 62–210, by revising the entries for ''62–210.300,'' ''62–210.310,'' and ''62–210.920;''

■ b. Under Chapter 62–252, by revising the entries for ''62–252.200,'' ''62–252.300,'' ''62–252.400,'' and ''62–252.500;'' and

■ c. Under Chapter 62–296, by revising the entry for ''62–296.418'' to read as follows:

§ 52.520 Identification of plan.

* * * * *

(c) * * *

EPA-APPROVED FLORIDA REGULATIONS

State citation	Title/subject	State effective date	EPA approval date	Explanation
* *	*	*	* *	*
Chapter 62–210 Stationary Sources-General Requirements				
* *	*	*	* *	*
62–210.300	Permits Required	5/9/2007	6/1/2009 63 FR 26103	
62–210.310	Air General Permits	5/9/2007	6/1/2009 63 FR 26103	
* *	*	*	* *	*
62–210.920	Air General Permit Forms	5/9/2007	6/1/2009 63 FR 26103	
* *	*	*	* *	*
Chapter 62–252 Gasoline Vapor Control				
* *	*	*	* *	*
62–252.200	Definitions	5/9/2007	6/1/2009 63 FR 26103	
62–252.300	Gasoline Dispensing Facilities-Stage I Vapor Recovery.	5/9/2007	6/1/2009 63 FR 26103	
62–252.400	Gasoline Dispensing Facilities Stage II Vapor Recovery.	5/9/2007	6/1/2009 63 FR 26103	
62–252.500	Gasoline Tanker Trucks	5/9/2007	6/1/2009 63 FR 26103	
* *	*	*	* *	*
Chapter 62–296 Stationary Sources-Emission Standards				
* *	*	*	* *	*
62–296.418	Bulk Gasoline Plants	5/9/2007	6/1/2009 63 FR 26103	
* *	*	*	* *	*

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[FR Doc. 2013–28654 Filed 11–29–13; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 52 and 81

[EPA–R04–OAR–2013–0129; FRL–9903–37–Region–4]

Approval and Promulgation of Implementation Plans and Designation of Areas for Air Quality Planning Purposes; North Carolina; Redesignation of the Charlotte; 1997 8-Hour Ozone Moderate Nonattainment Area to Attainment

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is taking final action to redesignate the portion of North Carolina that is within the bi-state Charlotte-Gastonia-Rock Hill, North Carolina-South Carolina 8-hour ozone nonattainment area (hereafter referred to as the ''Area,'' ''North Carolina portion of the bi-state Charlotte Area,'' ''North Carolina portion of the Area,'' or ''Metrolina nonattainment area'') to attainment for the 1997 8-hour ozone national ambient air quality standards (NAAQS), and to approve the maintenance plan for the Area. The State of North Carolina, through the North Carolina Department of Environment and Natural Resources, Department of Air Quality (NC DAQ), submitted the redesignation request and maintenance plan on November 2, 2011. The State supplemented the redesignation request and maintenance plan on March 28, 2013, extending the maintenance plan to the year 2025 and updating the sub-area motor vehicle emission budgets (MVEBs) for nitrogen oxides (NO_X) and volatile organic compounds (VOC) for the years 2013 and 2025 for the North Carolina portion of the Area. EPA's approval of NC DAQ's redesignation request is based on the determination that North Carolina has met the criteria for redesignation to attainment set forth in the Clean Air Act (CAA or Act). EPA finalized action to redesignate the South Carolina portion of the Area, including approval of South Carolina's maintenance plan for the 1997 8-hour ozone NAAQS, in a separate action.

DATES: This rule will be effective on January 2, 2014.

ADDRESSES: EPA has established a docket for this action under Docket Identification No. EPA–R04–OAR–2013–0129. All documents in the docket are listed on the *www.regulations.gov* Web site. Although listed in the index, some information is not publicly available, i.e., Confidential Business Information or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically through *www.regulations.gov* or in hard copy at the Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street SW., Atlanta, Georgia 30303–8960. EPA requests that if at all possible, you contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to schedule your inspection. The Regional Office's official hours of business are Monday through Friday, 8:30 to 4:30, excluding Federal holidays.

FOR FURTHER INFORMATION CONTACT: Jane Spann or Sara Waterson of the Regulatory Development Section, in the Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street SW., Atlanta, Georgia 30303–8960. Ms. Spann may be reached by phone at (404) 562–9029, or via electronic mail at *spann.jane@epa.gov.* Ms. Waterson may be reached by phone at (404) 562–9061, or via electronic mail at *waterson.sara@epa.gov.*

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II. What are the actions EPA is taking?
III. Why is EPA taking these actions?
IV. What are the effects of these actions?
V. Final Action
VI. Statutory and Executive Order Reviews

I. What is the background for the actions?

On November 2, 2011, North Carolina requested redesignation of the North Carolina portion of the bi-state Charlotte Area to attainment for the 1997 8-hour ozone NAAQS. The bi-state Charlotte Area consists of Cabarrus, Gaston, Lincoln, Mecklenburg, Rowan, Union, and a portion of Iredell County (Davidson and Coddle Creek Townships), North Carolina; and a portion of York County, South Carolina. The redesignation request included three years of complete, quality-assured ambient air quality data for the 1997 8-hour ozone NAAQS for 2008–2010, indicating that the 1997 8-hour ozone NAAQS had been achieved for the Area. Under the CAA, nonattainment areas may be redesignated to attainment if sufficient, complete, quality-assured data is available for the Administrator to determine that the area has attained the standard and the area meets the other CAA redesignation requirements in section 107(d)(3)(E).

Subsequently, on November 15, 2011 (76 FR 70656), EPA determined that the bi-state Charlotte Area attained the 1997 8-hour ozone NAAQS. The determination of attaining data was based upon complete, quality-assured and certified ambient air monitoring data for the 2008–2010 period, showing that the Area had monitored attainment of the 1997 8-hour ozone NAAQS.

On March 28, 2013, North Carolina submitted a supplemental SIP revision to the redesignation request and maintenance plan that extends the final year of the maintenance plan to 2025. Specifically, this revision updates emissions data, emissions projections, MVEBs, and safety margins to 2025. Additionally, it provides updated ozone design values for the bi-state Charlotte Area.

EPA reviewed quality-assured ozone monitoring data from ambient ozone monitoring stations in the Charlotte Area, as recorded in Air Quality System (AQS), and summarized the 3-year average of the annual fourth highest daily maximum 8-hour average (i.e., design value) for each monitor for 2008–2010, 2009–2011, and 2010–2012 in Tables 1, 2, and 3 below. The 2008–2010 design values demonstrate that the Area attained by its attainment date, and the 2009–2011 and 2010–2012 design values demonstrate that the bi-state Charlotte Area continues to meet the 1997 8-hour ozone NAAQS. Preliminary data indicate that the Area continues to attain with 2011–2013 data.

TABLE 1—2008–2010 DESIGN VALUE CONCENTRATION FOR THE CHARLOTTE AREA* FOR THE 1997 8-HOUR OZONE NAAQS

[Parts per million (ppm)]

Location	County	Monitor ID	4th highest 8-hour ozone value			3-Year design values
			2008	2009	2010	2008–2010
Lincoln County Replacing Iron Station.	Lincoln	37–109–0004	0.079	0.065	0.072	0.072
Garinger High School	Mecklenburg	37–119–0041	0.085	0.069	0.082	0.078
Westinghouse Blvd	Mecklenburg	37–119–1005	0.073	0.068	0.078	0.073
29 N at Mecklenburg Cab Co.	Mecklenburg	37–119–1009	0.093	0.071	0.082	0.082
Rockwell	Rowan	37–159–0021	0.084	0.071	0.077	0.077
Enochville School	Rowan	37–159–0022	0.082	0.073	0.078	0.077
Monroe Middle School	Union	37–179–0003	0.080	0.067	0.071	0.072

*An ozone monitor is located in York County, SC; however, it is outside of the nonattainment area. This monitor is monitoring attainment of the 1997 8-hour ozone NAAQS.

TABLE 2—2009–2011 DESIGN VALUE CONCENTRATION FOR THE CHARLOTTE AREA* FOR THE 1997 8-HOUR OZONE NAAQS

[ppm]

Location	County	Monitor ID	4th highest 8-hour ozone value			3-Year design values
			2009	2010	2011	2009–2011
Lincoln County Replacing Iron Station.	Lincoln	37–109–0004	0.065	0.072	0.077	0.071
Garinger High School	Mecklenburg	37–119–0041	0.069	0.082	0.088	0.079
Westinghouse Blvd	Mecklenburg	37–119–1005	0.068	0.078	0.082	0.076
29 N at Mecklenburg Cab Co.	Mecklenburg	37–119–1009	0.071	0.082	0.083	0.078
Rockwell	Rowan	37–159–0021	0.071	0.077	0.077	0.075
Enochville School	Rowan	37–159–0022	0.073	0.078	0.078	0.076
Monroe Middle School	Union	37–179–0003	0.067	0.071	0.073	0.070

*An ozone monitor is located in York County, SC; however, it is outside of the nonattainment area. This monitor is monitoring attainment of the 1997 8-hour ozone NAAQS.

TABLE 3—2010–2012 DESIGN VALUE CONCENTRATION FOR THE CHARLOTTE AREA* FOR THE 1997 8-HOUR OZONE NAAQS

[ppm]

Location	County	Monitor ID	4th highest 8-hour ozone value			3-Year design values
			2010	2011	2012	2010—2012
Lincoln County Replacing Iron Station.	Lincoln	37–109–0004	0.072	0.077	0.076	0.075
Garinger High School	Mecklenburg	37–119–0041	0.082	0.088	0.080	0.083
Westinghouse Blvd	Mecklenburg	37–119–1005	0.078	0.082	0.073	0.077
29 N at Mecklenburg Cab Co.	Mecklenburg	37–119–1009	0.082	0.083	0.085	0.083
Rockwell	Rowan	37–159–0021	0.077	0.077	0.080	0.078
Enochville School	Rowan	37–159–0022	0.078	0.078	0.077	0.077
Monroe Middle School	Union	37–179–0003	0.071	0.073	0.075	0.073

*An ozone monitor is located in York County, SC; however, it is outside of the nonattainment area. This monitor is monitoring attainment of the 1997 8-hour ozone NAAQS.

This rulemaking does not address requirements for the bi-state Charlotte Area that was designated nonattainment for the 2008 8-hour ozone NAAQS. Requirements for the bi-state Charlotte 2008 8-hour ozone nonattainment area will be addressed in the future.

NC DAQ chose to establish sub-area MVEBs based on geographical areas that correspond to the Metropolitan Planning Organization (MPO) and/or Rural Planning Organization (RPO) boundaries. Accordingly, NC DAQ established MVEBs for the CRMPO (Cabarrus and Rowan Counties), for the Gaston Urban Area MPO and Lake Norman RPO (Gaston, Iredell, and Lincoln Counties), and for the MUMPO and Rocky River RPO (Mecklenburg and Union Counties) geographical areas.

II. What are the actions EPA is taking?

In today's rulemaking, EPA is approving: (1) North Carolina's 1997 8-hour ozone maintenance plan as amended by the State's March 28, 2013 supplemental SIP submittal (such approval being one of the CAA criteria for redesignation to attainment) for the North Carolina portion of the Area, including the sub-area MVEBs; and (2)

North Carolina's redesignation request to change the legal designation of the North Carolina portion of the Area from nonattainment to attainment for the 1997 8-hour ozone NAAQS. The maintenance plan meets the requirements of section 175A and is designed to demonstrate that the North Carolina portion of the Area (as part of the bi-state Charlotte Area) will continue to attain the 1997 8-hour ozone NAAQS through 2025. EPA's approval of the redesignation request is based on EPA's determination that North Carolina meets the criteria for the North Carolina portion of the Area for redesignation set forth in CAA section 107(d)(3)(E), including EPA's determination that the North Carolina portion of the Area has attained the 1997 8-hour ozone NAAQS. EPA's analyses of North Carolina's redesignation request and maintenance plan are described in detail in the July 26, 2013, proposed rule. *See* 78 FR 45152. EPA did not receive any comments, adverse or otherwise, on the July 26, 2013, proposed rule to redesignate the North Carolina portion of the bi-state Charlotte Area to attainment for the 1997 8-hour ozone NAAQS. EPA finalized the adequacy determination for the MVEBs on August 13, 2013. *See* 78 FR 49265. EPA finalized approval of South Carolina's request to redesignate the South Carolina portion of the Area, including approval of South Carolina's maintenance plan for the 1997 8-hour ozone NAAQS, in a separate action. *See* 77 FR 75862.

Consistent with the CAA, the maintenance plan that EPA is approving also includes 2013 and 2025 sub-area MVEBs for NO_X and VOC for the North Carolina portion of the Area. EPA informed the public that the 2013 and 2025 sub-area MVEBs are adequate for transportation conformity on August 13, 2013. *See* 78 FR 49265. Tables 4 through 6 below provide the NO_X and VOC sub-area MVEBs in kilograms per day (kg/day),[1] for 2013 and 2025.

TABLE 4—CABARRUS-ROWAN MPO MVEBS

(kg/day)

	2013	2025
NO_X Emissions		
On-Road Mobile Emissions	19,838	9,961
Safety Margin Allocated to MVEBs	1,984	1,992
NO_X Conformity MVEBs	21,822	11,953
VOC Emissions		
On-Road Mobile Emissions	9,863	5,425
Safety Margin Allocated to MVEBs	986	1,085
VOC Conformity MVEBs	10,849	6,510

TABLE 5—GASTON URBAN AREA MPO/LAKE NORMAN RPO MVEBS

(kg/day)

	2013	2025
NO_X Emissions		
On-Road Mobile Emissions	19,957	10,360
Safety Margin Allocated to MVEBs	2,211	2,181
NO_X Conformity MVEBs	22,168	12,541
VOC Emissions		
On-Road Mobile Emissions	10,442	5,815
Safety Margin Allocated to MVEBs	1,168	1,232
VOC Conformity MVEBs	11,610	7,047

TABLE 6—MECKLENBURG-UNION MPO/ROCKY RIVER RPO MVEBS

(kg/day)

	2013	2025
NO_X Emissions		
On-Road Mobile Emissions	57,198	30,391
Safety Margin Allocated to MVEBs	4,303	5,337
NO_X Conformity MVEBs	61,501	35,728
VOC Emissions		
On-Road Mobile Emissions	26,250	14,769
Safety Margin Allocated to MVEBs	2,002	2,609
VOC Conformity MVEBs	28,252	17,378

North Carolina has chosen to allocate a portion of the available safety margin to the NO_X and VOC MVEBs for 2013 and 2025 (45.20 tpd and 107.38 tpd of the NO_X 2013 and 2025 safety margins remain, respectively, and 19.96 tpd and 27.95 tpd of the VOC 2013 and 2025 safety margins remain, respectively).

In this action, EPA is also approving these NO_X and VOC sub-area MVEBs for the purposes of transportation conformity. For required regional emissions analysis years involving 2013 and prior to 2025, the applicable budgets will be the new 2013 sub-area MVEBs. For required regional emissions analysis years that involve 2025 or beyond, the applicable budgets will be the new 2025 sub-area MVEBs.

III. Why is EPA taking these actions?

EPA has determined that the North Carolina portion of the Area has attained the 1997 8-hour ozone NAAQS and has also determined that all other criteria for the redesignation of the North Carolina portion of the Area from nonattainment to attainment of the 1997 8-hour ozone NAAQS have been met. *See* CAA section 107(d)(3)(E). One of those requirements is that the North Carolina portion of the Area has an approved plan demonstrating maintenance of the 1997 8-hour ozone NAAQS. EPA is taking final action to approve the maintenance plan for the North Carolina portion of the Area as meeting the requirements of sections 175A and 107(d)(3)(E) of the CAA. EPA is also approving the new NO_X and VOC sub-area MVEBs for the years 2013 and 2025 as contained in North Carolina's maintenance plan for the North Carolina portion of the Area because these sub-area MVEBs are consistent with maintenance of the 1997 8-hour ozone NAAQS in the Area. The detailed rationale for EPA's findings and actions are set forth in the July 26, 2013, proposed rulemaking and in other discussion in this final rulemaking.

IV. What are the effects of these actions?

Approval of the redesignation request changes the legal designation of the North Carolina portion of the Area from nonattainment to attainment for the 1997 8-hour ozone NAAQS. EPA is modifying the regulatory table in 40 CFR 81.334 to reflect a designation of attainment for the affected counties. EPA is also approving, as a revision to the North Carolina SIP, the State's plan for maintaining the 1997 8-hour ozone NAAQS in the North Carolina portion of the Area through 2025. The maintenance plan includes contingency measures to remedy possible future violations of the 1997 8-hour ozone NAAQS, and establishes NO_X and VOC subarea MVEBs for the years 2013 and 2025 for the North Carolina portion of the Area.

V. Final Action

EPA is taking final action to approve the redesignation and change the legal designation of the North Carolina portion of the Area from nonattainment

[1] The conversion to kilograms used the actual emissions reported in the MOVES model. The conversion was done utilizing the ''CONVERT'' function in an EXCEL spreadsheet.

to attainment for the 1997 8-hour ozone NAAQS. Through this action, EPA is also approving into the North Carolina SIP the 1997 8-hour ozone maintenance plan for the North Carolina portion of the Area, which includes the new NO_X and VOC sub-area MVEBs for 2013 and 2025 for the North Carolina portion of the Area.

VI. Statutory and Executive Order Reviews

Under the CAA, redesignation of an area to attainment and the accompanying approval of the maintenance plan under CAA section 107(d)(3)(E) are actions that affect the status of geographical area and do not impose any additional regulatory requirements on sources beyond those required by state law. A redesignation to attainment does not in and of itself impose any new requirements, but rather results in the application of requirements contained in the CAA for areas that have been redesignated to attainment. Moreover, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the CAA. Accordingly, these actions merely approve state law as meeting Federal requirements and do not impose additional requirements beyond those imposed by state or federal law. For these reasons, these actions:

- Are not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- do not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- are certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- do not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Public Law 104–4);
- do not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- are not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- are not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- are not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and,
- do not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in the State, and EPA notes that it will not impose substantial direct costs on tribal governments or preempt tribal law.

The Congressional Review Act, 5 U.S.C. 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this action and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

Under section 307(b)(1) of the CAA, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by January 31, 2014. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this action for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. *See* section 307(b)(2).

List of Subjects

40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Nitrogen dioxide, Ozone, Reporting and recordkeeping requirements, Volatile organic compounds.

40 CFR Part 81

Environmental protection, Air pollution control.

Dated: November 14, 2013.

A. Stanley Meiburg,

Acting Regional Administrator, Region 4.

40 CFR parts 52 and 81 are amended as follows:

PART 52—[APPROVAL AND PROMULGATION OF IMPLEMENTATION PLANS]

■ 1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart II—North Carolina

■ 2. Section 52.1770(e) is amended by adding an entry ''1997 8-hour ozone Maintenance Plan for the North Carolina portion of the bi-state Charlotte Area'' at the end of the table to read as follows:

§ 52.1770 Identification of plan.

* * * * *

(e) * * *

EPA-APPROVED NORTH CAROLINA NON-REGULATORY PROVISIONS

Provision	State submittal date/ effective date	EPA approval date	**Federal Register** citation	Explanation
* * *	*	*	*	*
1997 8-hour ozone Maintenance Plan for the North Carolina portion of the bi-state Charlotte Area.	November 2, 2011, and supplemented on March 28, 2013.	12/2/13	[Insert citation of publication].	

PART 81—[DESIGNATION OF AREAS FOR AIR QUALITY PLANNING PURPOSES]

■ 3. The authority citation for part 81 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

■ 4. In § 81.334, the table entitled ''North Carolina-1997 8-Hour Ozone NAAQS (Primary and Secondary)'' is by revising the entries for ''Charlotte-Gastonia-Rock Hill, NC–SC,'' ''Cabarrus County,'' ''Gaston County,'' ''Iredell County (part) Davidson Township, Coddle Creek Township,'' ''Lincoln County,'' ''Mecklenburg County,'' ''Rowan County,'' and ''Union County'' to read as follows:

§ 81.334 North Carolina.

* * * * *

NORTH CAROLINA-1997 8-HOUR OZONE NAAQS

[Primary and secondary]

Designated area	Designated [a]		Category/classification	
	Date [1]	Type	Date [1]	Type
Charlotte-Gastonia-Rock Hill, NC–SC	This action is effective 12/2/13	Attainment.		
Cabarrus County	This action is effective 12/2/13	Attainment.		
Gaston County	This action is effective 12/2/13	Attainment.		
Iredell County (part) Davidson Township, Coddle Creek Township.	This action is effective 12/2/13	Attainment.		
Lincoln County	This action is effective 12/2/13	Attainment.		
Mecklenburg County	This action is effective 12/2/13	Attainment.		
Rowan County	This action is effective 12/2/13	Attainment.		
Union County	This action is effective 12/2/13	Attainment.		
*	*	*	*	*

[a] Includes Indian Country located in each county or area, except as otherwise specified.
[1] This date is June 15, 2004, unless otherwise noted.
[2] Effective April 15, 2008.
[3] November 22, 2004.
[4] Attainment date extended to June 15, 2011.

* * * * *

[FR Doc. 2013–28099 Filed 11–29–13; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 52 and 81

[EPA–R04–OAR–2012–0986; FRL–9903–32–Region 4]

Approval and Promulgation of Implementation Plans and Designation of Areas for Air Quality Planning Purposes; Georgia; Redesignation of the Atlanta 1997 8-Hour Ozone Moderate Nonattainment Area to Attainment

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is taking final action to approve a request submitted on April 4, 2012, from the State of Georgia, through the Georgia Environmental Protection Division (GA EPD), to redesignate the Atlanta, Georgia, ozone nonattainment area (hereafter referred to as the ''Atlanta Area,'' or ''Area'') to attainment for the 1997 8-hour ozone National Ambient Air Quality Standards (NAAQS). The Atlanta Area consists of Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Rockdale, Spalding and Walton Counties in their entireties. EPA's approval of the redesignation request is based on the determination that Georgia has met the criteria for redesignation to attainment set forth in the Clean Air Act (CAA or Act). Additionally, EPA is approving, as a revision to the Georgia State Implementation Plan (SIP) a maintenance plan for the 1997 8-hour ozone standard for the Atlanta Area, including new 2024 motor vehicle emission budgets (MVEBs) for nitrogen oxides (NO_X) and volatile organic compounds (VOC). In this final notice, EPA also responds to comments received on EPA's February 4, 2013, proposed rulemaking.

DATES: This rule will be effective on January 2, 2014.

ADDRESSES: EPA has established a docket for this action under Docket Identification No. EPA–R04–OAR–2012–0986. All documents in the docket are listed on the *www.regulations.gov* Web site. Although listed in the index, some information is not publicly available, i.e., Confidential Business Information or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically through *www.regulations.gov* or in hard copy at the Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street SW., Atlanta, Georgia 30303–8960. EPA requests that if at all possible, you contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to schedule your inspection. The Regional Office's official hours of business are Monday through Friday, 8:30 to 4:30, excluding Federal holidays.

FOR FURTHER INFORMATION CONTACT: Jane Spann or Sara Waterson of the Regulatory Development Section, in the Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street SW., Atlanta, Georgia 30303–8960. Ms. Spann may be reached by phone at (404) 562–9029, or via electronic mail at *spann.jane@epa.gov.* Ms. Waterson may be reached by phone at (404) 562–9061, or via electronic mail at *waterson.sara@epa.gov.*

SUPPLEMENTARY INFORMATION:

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I. What is the background for these final actions?

On April 4, 2012, Georgia submitted to EPA a request to redesignate the Atlanta Area to attainment for the 1997 8-hour ozone NAAQS and to approve Georgia's SIP revision containing a maintenance plan for the Atlanta Area. In an action published on February 4, 2013 (78 FR 7705), EPA proposed approval of Georgia's maintenance plan for the 1997 8-hour ozone NAAQS, including the NO_X and VOC MVEBs contained therein. At that time, EPA also proposed to approve the redesignation of the Atlanta Area to attainment. Additional background for today's action is set forth in EPA's February 4, 2013, proposal. *See* 78 FR 7705.

As stated in the February 4, 2013, proposal, this redesignation addresses the Atlanta Area's status solely with respect to the 1997 8-hour ozone NAAQS, for which designations were finalized on April 30, 2004.[1] *See* 69 FR 23857. On March 7, 2012, at 77 FR 13491, EPA determined that the Atlanta Area attained the 1997 8-hour ozone NAAQS by its June 15, 2011, applicable attainment date,[2] and that the Area was continuing to attain the ozone NAAQS based on quality-assured monitoring data that was currently available.

EPA reviewed quality-assured ozone monitoring data from ambient ozone monitoring stations in the Atlanta Area from 2008–2011, as recorded in Air Quality System (AQS), and summarized the 3-year average of the annual fourth highest daily maximum 8-hour average (i.e., design value) for 2008–2010 and 2009–2011 in Tables 1 and 2. The data for 2012 were certified on May 1, 2013, and the design value for 2010–2012 is in Table 3. The 2008–2010 design value establishes that the Area attained by its attainment date and the 2009–2011, and the 2010–2012 design values establish that the Atlanta Area continues to meet the 1997 8-hour ozone NAAQS. Preliminary data provided by GA EPD for 2013 indicate that the Atlanta Area continues to attain the 1997 8-hour ozone NAAQS and further indicate that in 2013 no monitors in the Area recorded a fourth-high ozone value above the 1997 8-hour ozone NAAQS. See Response 1 below for more detail on the 2013 preliminary data.

TABLE 1—2008–2010 DESIGN VALUE CONCENTRATION FOR THE ATLANTA AREA FOR THE 1997 8-HOUR OZONE NAAQS (PPM)

Location	County	Monitor ID	4th highest 8-hour ozone value			3-Year design values
			2008	2009	2010	2008–2010
GA National Guard McCollum Pkwy	Cobb	13–067–0003	0.075	0.076	0.079	0.076
University of West Georgia at Newnan.	Coweta	13–077–0002	0.075	0.065	0.065	0.068
2390–B Wildcat Road Decatur	Dekalb	13–089–0002	0.087	0.077	0.075	0.079
Douglasville W. Strickland St.	Douglas	13–097–0004	0.080	0.072	0.074	0.075
Gwinnett Tech 1250 Atkinson Rd	Gwinnett	13–135–0002	0.079	0.073	0.072	0.074
Henry County Extension Office	Henry	13–151–0002	0.086	0.074	0.078	0.079
Yorkville	Paulding	13–223–0003	0.072	0.067	0.071	0.070
Conyers Monastery	Rockdale	13–247–0001	0.089	0.070	0.076	0.078
Confederate Ave	Fulton	13–121–0055	0.084	0.077	0.080	0.080
Fayetteville-GDOT	Fayette	13–113–0001	0.086	*	*	*

* The Fayetteville-GDOT monitor was temporarily discontinued on October 31, 2008.

TABLE 2—2009–2011 DESIGN VALUE CONCENTRATION FOR THE ATLANTA AREA FOR THE 1997 8-HOUR OZONE NAAQS (PPM)

Location	County	Monitor ID	4th highest 8-hour ozone value			3-Year design values
			2009	2010	2011	2009–2011
GA National Guard McCollum Pkwy.	Cobb	13–067–0003	0.076	0.079	0.079	0.078
University of West Georgia at Newnan.	Coweta	13–077–0002	0.065	0.065	0.072	0.067
2390–B Wildcat Road Decatur.	Dekalb	13–089–0002	0.077	0.075	0.080	0.077
Douglasville W. Strickland St..	Douglas	13–097–0004	0.072	0.074	0.078	0.074
Gwinnett Tech 1250 Atkinson Rd.	Gwinnett	13–135–0002	0.073	0.072	0.082	0.075
Henry County Extension Office.	Henry	13–151–0002	0.074	0.078	0.082	0.078
Yorkville	Paulding	13–223–0003	0.067	0.071	0.075	0.071
Conyers Monastery	Rockdale	13–247–0001	0.070	0.076	0.081	0.075
Confederate Ave	Fulton	13–121–0055	0.077	0.080	0.084	0.080

[1] On March 6, 2008, the Atlanta Area was reclassified to moderate nonattainment for the 1997 8-hour ozone NAAQS. *See* 73 FR 12013.

[2] On November 30, 2010, EPA published a final rule extending the attainment date for the Atlanta Area until June 15, 2011. *See* 75 FR 73969.

TABLE 3—2010–2012 DESIGN VALUE CONCENTRATION FOR THE ATLANTA AREA FOR THE 1997 8-HOUR OZONE NAAQS (PPM)

Location	County	Monitor ID	4th highest 8-hour ozone value			3-Year design values
			2010	2011	2012	2010–2012
GA National Guard McCollum Pkwy	Cobb	13–067–0003	0.079	0.079	0.075	0.077
University of West Georgia at Newnan.	Coweta	13–077–0002	0.065	0.072	0.062	0.066
2390–B Wildcat Road Decatur	Dekalb	13–089–0002	0.075	0.080	0.085	0.080
Douglasville W. Strickland St.	Douglas	13–097–0004	0.074	0.078	0.073	0.075
Gwinnett Tech 1250 Atkinson Rd	Gwinnett	13–135–0002	0.072	0.082	0.080	0.078
Henry County Extension Office	Henry	13–151–0002	0.078	0.082	0.088	0.082
Yorkville	Paulding	13–223–0003	0.071	0.075	0.072	0.072
Conyers Monastery	Rockdale	13–247–0001	0.076	0.081	0.081	0.079
Confederate Ave	Fulton	13–121–0055	0.080	0.084	0.087	0.083

Effective July 20, 2012, EPA designated a portion of the Atlanta Area for the 1997 8-hour ozone NAAQS as nonattainment for the 2008 8-hour ozone NAAQS. This rulemaking does not address requirements for the 2008 8-hour ozone NAAQS. Requirements for the Area for the 2008 8-hour ozone NAAQS will be addressed in the future.

II. What are the actions EPA is taking?

In today's rulemaking, EPA is approving: (1) Georgia's 1997 8-hour ozone maintenance plan for the Atlanta Area, including the MVEBs contained therein (such approval being one of the CAA criteria for redesignation to attainment status); and (2) Georgia's redesignation request to change the legal designation of the Atlanta Area from nonattainment to attainment for the 1997 8-hour ozone NAAQS. The maintenance plan is designed to demonstrate that the Atlanta Area will continue to attain the 1997 8-hour ozone NAAQS through 2024. EPA's approval of the redesignation request is based on EPA's determination that Georgia has shown that the Atlanta Area meets the criteria for redesignation set forth in CAA, sections 107(d)(3)(E) and 175A, including the determination that the Atlanta Area has attained the 1997 8-hour ozone NAAQS. EPA's analyses of Georgia's redesignation request and maintenance plan are described in detail in the February 4, 2013, proposed rule (see 78 FR 7705), and in responses to comments in this final rulemaking. As stated above, since the publication of EPA's proposed rule, preliminary data available for 2013 show the Area continues to attain the 1997 8-hour ozone NAAQS.

Consistent with the CAA, the maintenance plan that EPA is approving includes the 2024 MVEBs for NO_X and VOC for the Atlanta Area. In this action, EPA is approving these NO_X and VOC MVEBs for the purposes of transportation conformity. For required regional emissions analysis for 2024 and beyond, the applicable budgets will be the new 2024 MVEBs.

Georgia has chosen to allocate a portion of the available safety margin to the NO_X and VOC MVEBs for 2024 for the Atlanta Area. This allocation is 26.9 tons per day (tpd) and 29.4 tpd for NO_X and VOC, respectively. The remaining safety margins for 2024 are 276.69 tpd and 28.87 tpd NO_X and VOC, respectively.[3]

The MVEBs, specified in tpd, included in the maintenance plan are as follows:

TABLE 4—2024 ATLANTA AREA NO_X AND VOC MVEBS (TPD)

NO_X Emissions	
Base Emissions	99.43
Safety Margin Allocated to MVEB[4]	26.9
NO_X Conformity MVEB	126
VOC Emissions	
Base Emissions	62.56
Safety Margin Allocated to MVEB	29.4
VOC Conformity MVEB	92

In its February 4, 2013, proposed action, EPA noted that the public comment period on the adequacy of the Atlanta Area MVEBs for the year 2024 (as contained in Georgia's submittal) began on February 29, 2012, and closed on March 30, 2012. No comments were received during the public comment period.

[3] The remaining safety margins for NO_X and VOC were inadvertently listed in reverse order in the February 4, 2013, proposal. *See* 78 FR 7716. The remaining safety margins for NO_X are 276.69 tpd and 28.87 tpd for VOC as correctly stated in section vi of the proposed rulemaking notice.

III. What are EPA's responses to comments?

EPA received one set of comments on the February 4, 2013, proposed actions associated with the redesignation of the Atlanta Area for the 1997 8-hour ozone NAAQS. These comments were submitted by GreenLaw on behalf of Mothers & Others for Clean Air, Sierra Club, and its members. A summary of the comments and EPA's responses to them are provided below.

Comment 1: The Commenter contends that EPA cannot redesignate the Atlanta Area because the Agency relied on ambient air quality data from 2008–2011 to determine that the area has attained the NAAQS and did not consider data from 2012. The Commenter states that the fourth-highest ozone value at two monitors in the Atlanta Area exceeded 0.084 ppm in 2012. The Commenter claims that this shows that the Area ''has not solved its ozone problem,'' and that EPA should require GA EPD to certify the 2012 data before approving the final redesignation to attainment.

Response 1: EPA disagrees with the Commenter's claim that the monitored air quality in the Atlanta Area precludes EPA from approving Georgia's request to redesignate the area to attainment. The quality-assured monitoring data show that the Area continues to qualify for redesignation. First, EPA has considered complete, quality-assured and certified data for all monitors through 2012. These data have been certified and show that the Area continues to attain the standard. In accordance with 40 CFR Part 50, Appendix I, the determination as to whether the Area meets the NAAQS is based on the three-year average of the annual fourth-highest readings at a monitor, and not a monitor's fourth-highest ozone value in a single year. No monitored value in a single year can itself be a violation. A violation of the 1997 8-hour ozone

NAAQS occurs when the three-year average of the annual fourth-highest daily maximum 8-hour average ozone concentrations measured at a monitor in an area exceeds 0.084 ppm (i.e., a violation occurs when the three-year average exceeds 0.084 ppm at any one monitor in the area). This three-year average is called the monitor's ''design value.'' Even if the fourth-highest daily maximum at one monitor in one year exceeds 0.084 ppm, this does not constitute a violation. Only a three-year average of monitor readings can establish that a violation has occurred. Data must be quality-assured according to the data handling and reporting convention described in 40 CFR Part 50, Appendix I before it can be used to determine whether a violation has occurred. An ambient air monitor reading that exceeds 0.084 ppm in any one year is not determinative of a violation.

The certified data in Tables 1, 2, and 3 show that the Atlanta Area is attaining the 1997 8-hour ozone standard. The 2012 data are now certified, and the Area remains in attainment of the 1997 8-hour ozone NAAQS because the 3-year design value is below 0.084 ppm. The Commenter's reference to the East Confederate Avenue Site (AQS ID 131210055) and the Henry County Extension Office Site (AQS ID 131510002) do not call into question the Area's attainment status, because the three-year 2010–2012 design values for these two monitors remain below the 1997 8-hour ozone NAAQS. Moreover, GA EPD provided preliminary data through October 2013 indicating that the Atlanta Area continues to attain the 1997 8-hour ozone NAAQS and further indicate that in 2013 no monitors in the Area recorded a fourth-high ozone value above the 1997 8-hour ozone NAAQS.[5]

Comment 2: The Commenter contends that Georgia's redesignation submittal is flawed because it ''fails to demonstrate that past reductions in levels of harmful ozone were not due to temporary factors such as the Great Recession and weather'' and that EPA cannot approve the redesignation request without a weather adjusted analysis. The Commenter specifically contends that it would be arbitrary for EPA to rely on ambient monitoring data from 2008–2011 to satisfy the section 107(d)(3)(E)(i) requirement that the Area attain the NAAQS because the emissions and air quality from these years were influenced by temporary economic conditions (the ''Great Recession'') and that EPA has failed to provide any analysis to the contrary. According to the Commenter, ''[c]ertain monitors in the Atlanta nonattainment area have higher values in 2012 than in 2008–2011—the years referenced by EPA in its Proposed Rule—and the readings have been increasing as the economy rebounds.'' The Commenter also contends that it is inappropriate to use data from 2008–2010 to determine if the improvement in air quality is due to permanent and enforceable reductions under section 107(d)(3)(E)(iii) because the data ''does not take into account economic conditions and other considerations'' such as weather.

Response 2: As noted above, EPA, pursuant to established regulations, uses a three-year cycle to determine attainment of the 1997 8-hour ozone NAAQS. The averaging of values over three years serves to account for variations in meteorology and the economy from year to year. *See* 40 CFR 50.10 and Appendix I to CFR part 50. Although EPA's proposal referred to 2008–2010 data, EPA has shown that additional monitoring data establish that the Atlanta Area has continued to attain the 1997 8-hour ozone NAAQS beyond the attainment period of 2008–2010. EPA's review of all data currently available, including certified 2009–2011 data and now-certified 2010–2012 data, establishes that the Area continued to attain the standard with 2009–2011 and now-certified 2010–2012 data. This is the case despite the fact that conditions in the 2012 ozone season were more conducive to ozone formation than in many other previous years. EPA disagrees with the Commenter's assertion that that two individual monitor readings in 2012 cast doubt on the Atlanta Area's attainment status. Nor does the Commenter provide information to support its contention that the improvement in air quality during this period was due to the economy and favorable meteorological conditions rather than to measures the State and EPA have undertaken to reduce emissions of ozone precursors. To the contrary, the certified data show that the Area remained continuously in attainment throughout three sets of three-year period, during varying meteorological and economic conditions.

Regarding the Commenter's contention that economic conditions influenced the 2008–2010 ambient ozone concentrations, annual NO_X emissions data for Georgia electric generating units (EGUs) in 2008, emissions in the first year of the ''Great Recession,'' were in fact similar to emissions from these units for 2003–2007. *See* Table 5 below.

TABLE 5—GEORGIA EGU SUMMER SEASON NO_X EMISSION DATA *

Power plant	2003	2004	2005	2006	2007	2008
Bowen	5068.67	4689.08	5510.13	5671.34	4531.89	4824.60
Hammond	2377.06	2039.56	2756.03	2560.85	2327.03	2439.41
Harllee Branch	7603.69	7708.01	10369.23	11298.11	10456.83	10274.67
Jack McDonough	1982.57	2100.07	2241.88	2108.11	2204.02	1760.46
Kraft	2156.75	1783.23	1914.35	2024.73	2292.75	1685.40
McIntosh	1438.09	1404.47	1246.55	1635.37	1260.17	1184.90
Mitchell	1117.94	904.84	1472.60	1037.79	1028.78	1145.54
Scherer	9695.31	9763.72	9289.08	8854.13	9311.99	9627.62
Wansley	2523.59	2709.45	3411.88	3063.36	3303.27	3052.20
Yates	4935.43	4961.97	5706.27	5917.75	5894.25	5984.46
Total	38899.10	38064.41	43917.99	44171.54	42610.97	41979.24

* From EPA Clean Air Markets Division Web site.

[5] These preliminary data are included in the docket and are provided for the purpose of indicating continued attainment of the 1997 8-hour ozone NAAQS. The data have not yet been quality-assured or certified, and therefore may be subject to change.

Furthermore, NOx emission data for the 10 state VISTAS region from 2002–2009 demonstrate that mobile and non-road NOx emissions have decreased substantially in Georgia and region-wide and to a much greater extent than can be attributed to economic fluctuations during this period. These reductions are attributable to permanent and enforceable reductions from the numerous Federal and state mobile and non-road measures implemented during this period. *See* Tables 6 and 7.

TABLE 6—2002 VISTAS BASE INVENTORY FOR NO_X

[Tons]

State	Point	Non-road	Area	Mobile	Total
AL	244,348	65,366	34,900	158,212	502,826
FL	302,833	180,627	48,664	465,640	997,764
GA	196,731	97,961	49,987	307,732	652,411
KY	237,209	104,571	40,966	156,417	539,163
MS	104,661	88,787	7,528	111,914	312,890
NC	196,731	84,284	41,517	327,329	649,861
SC	130,394	50,249	24,602	140,489	345,734
TN	221,638	96,827	20,063	238,577	577,105
VA	147,301	63,219	52,396	222,374	485,290
WV	277,589	33,239	13,631	58,999	383,458
Total	2,059,435	865,130	334,254	2,187,683	5,446,502

* From GA Regional Haze Plan Appendix C.3 Table 4 (page 15).

TABLE 7—2009 VISTAS BASE INVENTORY FOR NO_X

[Tons]

State	Point	Non-road	Area	Mobile	Total
AL	151,714	56,862	35,831	101,831	346,238
FL	132,185	163,794	47,979	315,840	659,798
GA	148,809	85,733	51,925	209,349	495,816
KY	129,779	94,752	43,548	101,182	369,261
MS	92,409	80,567	8,048	70,743	251,767
NC	101,236	70,997	45,382	201,609	419,224
SC	86,934	43,235	25,259	92,499	247,927
TN	124,274	86,641	20,717	151,912	383,544
VA	288,213	54,993	53,596	134,232	531,034
WV	124,359	30,133	14,384	35,635	204,511
Total	1,379,912	767,707	346,669	1,414,832	3,909,120

* From GA Regional Haze Plan Appendix C.3 Table 5 (page 15).

Regarding the Commenter's contention that weather influenced the 2008–2010 ambient ozone concentrations, EPA agrees that weather conditions have an effect on ozone concentrations, both in terms of increasing ozone and decreasing ozone. However, weather effects are not controllable, and EPA determines compliance with the ozone NAAQS using a three-year average to account for changes in meteorology. In the case of Atlanta, the Area has continuously attained for three three-year averaging periods, thereby reinforcing the conclusion that attainment is due to permanent and enforceable reductions rather than variable economic conditions or favorable meteorology.

Ozone season temperatures and precipitation are two readily available parameters that can be used to evaluate the potential weather impacts on ozone concentrations. Ozone is more readily formed on warm, sunny days when the air is stagnant. Conversely, ozone production is generally more limited when it is cloudy, cool, rainy, or windy.[6] Table 8 provides temperature and precipitation data for Georgia for the ozone seasons (March-October) from 2008–2012 obtained from the National Oceanic and Atmospheric Administration's National Climatic Data Center (NOAA NCDC). The data in Table 8 show that both average temperature and precipitation varied significantly from 2008–2012.

TABLE 8—GEORGIA TEMPERATURE AND PRECIPITATION OZONE SEASON (MARCH–OCTOBER) DATA [7]

Year	Average March–October temperature [degrees F] (anomaly [degrees F])	Rank [since 1895, scale of 1–118]	Precipitation [inches] (anomaly, inches)	Rank [since 1895, scale of 1–118]
2008	70.2 (−0.7)	30	30.22 (−4.07)	29
2009	70.5 (−0.4)	41	43.91 (+9.62)	112

[6] *http://www.epa.gov/airtrends/weather.html.*

[7] Data obtained from the National Climatic Data Center (NCDC) Web site: *http://gis.ncdc.noaa.gov/map/cag/#app=cdo.*

TABLE 8—GEORGIA TEMPERATURE AND PRECIPITATION OZONE SEASON (MARCH–OCTOBER) DATA [7]—Continued

Year	Average March–October temperature [degrees F] (anomaly [degrees F])	Rank [since 1895, scale of 1–118]	Precipitation [inches] (anomaly, inches)	Rank [since 1895, scale of 1–118]
2010	72.0 (+1.1)	101	29.40 (−4.89)	24
2011	71.9 (+1.0)	98	26.25 (−4.0)	9
2012	72.2 (+1.3)	108	29.04 (−5.25)	22

Table 8 provides the following data: Average ozone season (March–October) temperature and precipitation; deviation from the 118 year average ozone season temperature and precipitation (termed the ''anomaly''); and the rank of the given year on the 118 year (1895–2012) recorded history list. A rank of 118 is given to the hottest or wettest year. The rank and anomaly data in Table 8 show that average ozone season temperatures were below normal in 2008 and 2009 with precipitation below normal in 2008 and much above normal in 2009. Temperatures were much above normal and precipitation was much below normal for the years 2010, 2011, and 2012. If weather was the controlling factor for ozone concentrations, the levels of 2008–2010 ozone design values would be expected to be lower than the 2009–2011 design values. However, for six out of the nine monitoring sites listed in Tables 1 and 2 above, the 2008–2010 design values are higher than the 2009–2011 design values. Therefore, factors other than weather appear to be controlling the ozone concentrations. Further, there was nothing about the weather during the 2008–2010 three-year period that would indicate that EPA cannot go forward with the proposed approval of the Atlanta redesignation.

Additionally, 2012 was one of the hottest and driest years in the recent past. See Table 8, above. In fact, a record-setting heat wave occurred in late June through early July 2012, which resulted in high ozone levels measured across the southeast, and yet (as indicated in the Response to Comment 1 above), data for the 2010–2012 ozone season show that the Atlanta Area continues to be in attainment of the 1997 ozone standard. This fact further supports EPA's position that weather is not the controlling factor in the Area's attainment.

The analysis of meteorological conditions and emissions trends discussed above, along with the analysis of permanent and enforceable emissions reduction measures described in the proposed rulemaking and in the Responses to Comment 3, below, demonstrate that the improvement in air quality in the Atlanta Area is independent of weather or economic factors.

Comment 3(a): The Commenter states that EPA relied on a number of state-only Georgia rules as permanent and enforceable measures and specifically refers to the Georgia Multipollutant Rule and the Smoke Management Plan. The Commenter further states that ''[u]nless Georgia submits these rules, and EPA adopts them into the enforceable implementation plan, they cannot be relied upon for redesignation as they are not enforceable by EPA or the public and they are not permanent.''

Response 3(a): EPA did not rely on any state-only Georgia rules as permanent and enforceable measures under section 107(d)(3)(E)(iii). The Commenter correctly states that Georgia's Smoke Management Plan and Georgia Rule (sss)—Multipollutant Rule are not incorporated into the Georgia SIP and thus, EPA is not relying on emissions associated with those rules as part of this redesignation. As noted in the proposed rule, ''Georgia's smoke management plan is a state-only requirement and is therefore not federally enforceable. This measure is not necessary for the continued maintenance of the Atlanta nonattainment area.'' The proposed rule also states that ''Georgia Rule (sss) has not been submitted to EPA for approval into the SIP and is therefore not federally enforceable.'' *See* 78 FR 7705.

While Georgia Rule (sss) may contribute to future NO_X reductions, which may help continue to assure maintenance, it did not contribute to NO_X reductions that resulted in the Atlanta Area becoming attainment for the 1997 8-hour ozone NAAQS. This is demonstrated by the fact that EGUs contributed 63.62 tpd of the 606.78 tpd NO_X emissions for 2008, or only about 10.5 percent of the NO_X emissions, based on the Atlanta attainment year inventory.

Comment 3(b): The Commenter contends that reductions associated with the NO_X SIP Call are not permanent and enforceable because the NO_X SIP Call ''has been replaced and therefore effectively no longer exists.'' The Commenter further states that the NO_X SIP Call ''is a cap and trade program, which means that there are no actual reductions required from the emission sources in the Metro-Atlanta nonattainment area. Rather, to the extent that any reductions were once required, they could have happened only in areas downwind that have little to no impact on the Metro-Atlanta area nonattainment.'' The Commenter cites to the United States Court of Appeals for the District of Columbia Circuit (D.C. Circuit) decision in *NRDC* v. *EPA,* 571 F.3d 1245 (D.C. Cir. 2009) to support its position that ''EPA cannot use cap-and-trade programs to satisfy an area-specific statutory mandate.''

Response 3(b): EPA disagrees that the emission reductions resulting from the NO_X SIP Call are not permanent and enforceable under section 107(d)(3)(E)(iii). The Commenter's contention that reductions associated with the NO_X SIP Call cannot be considered permanent and enforceable because the rule ''has been replaced and therefore effectively no longer exists'' is erroneous. As noted in the proposal, even though EPA discontinued the NO_X Budget Trading Program when it promulgated CAIR, ''all states regardless of the current status of their regulations that previously required participation in the NO_X Budget Trading Program will remain subject to all of the requirements in the NO_X SIP Call even if the existing CAIR ozone season trading program is withdrawn or altered.'' *See* 78 FR 7712. Participation in the CAIR ozone season trading program is one acceptable way for states to meet their NO_X SIP Call obligations, but obligations under the NO_X SIP Call exist independent of CAIR and are independently permanent and enforceable. EPA further explained in the proposal that the anti-backsliding provisions of 40 CFR 51.905(f) specifically provide that the provisions of the NO_X SIP Call, including the statewide NO_X emission budgets, continue to apply after revocation of the 1-hour NAAQS. EPA therefore does not agree with the Commenter that reductions associated with the NO_X SIP Call are not permanent and enforceable because of the status of the rule.

Although Georgia was not subject to the NO_X SIP Call, reductions from the NO_X SIP Call in upwind states helped the Atlanta Area achieve attainment.

EPA also disagrees that the Atlanta Area cannot be redesignated for the 1997 8-hour ozone NAAQS solely because the NO_X SIP Call is a cap-and-trade program. The Commenter's reliance on *NRDC* v. *EPA,* 571 F.3d 1245 (D.C. Cir. 2009) is inapposite. The D.C. Circuit's decision in that case does not support the Commenter's argument and is entirely consistent with EPA's position here. That case addressed a specific aspect of the cap-and-trade program, solely within the very different context of EPA's determination that the NO_X SIP Call trading program presumptively satisfied the nonattainment Reasonably Available Control Technology (RACT) requirement. The Court's decision centered on whether the RACT requirement could be satisfied by reductions outside the nonattainment area. The Court simply held that because EPA had not shown the trading program would result in sufficient reductions *in a nonattainment area,* its determination that the program satisfied the nonattainment RACT requirement was not supported.[8] *Id.* at 1256– 58. The Court did not hold, or address the issue, as Commenter suggests, of how emissions trading programs that require emissions reductions—either inside or outside a nonattainment area—and which result in air quality improvement, should be considered in evaluating redesignation requests. Trading programs require total mass emission reductions by establishing mandatory caps on total emissions to permanently reduce the total mass emissions allowed by sources subject to the programs, validated through rigorous continuous emission monitoring and reporting regimes. The emission caps and associated controls are enforced through associated SIP rules or Federal implementation plans (FIPs). Any purchase of allowances and increase in emissions by one source necessitates a corresponding sale of allowances and either reduction in emissions or use of allowances by another source. Given the regional nature of ozone, the corresponding NO_X emission and/or allowance reduction in one affected area will have an air quality benefit that will compensate, at least in part, for the impact of any emission increase in another affected area. In this case, as shown in Tables 6 and 7 of this notice, the NO_X SIP Call and other Federal mobile and non-road control regulations achieved measurable reductions in NO_X emissions in the states upwind from and affecting the Atlanta Area. For the reasons explained above, reductions associated with the NO_X SIP Call are permanent and enforceable because states remain subject to the requirements of that rule. EPA has therefore determined that with regard to the reductions associated with the NO_X SIP Call, in accordance with section 107(d)(3)(E)(iii), ''the improvement in air quality is due to permanent and enforceable reductions in emissions resulting from implementation of . . . applicable Federal air pollutant control regulations.'' Thus, EPA disagrees that the Commenter has identified a basis on which EPA should disapprove Georgia's redesignation request.

Comment 3(c): The Commenter does not believe that EPA can rely on CAIR or CSAPR to provide permanent and enforceable emissions reductions under section 107(d)(3)(E)(iii). According to the Commenter, EPA cannot rely on CAIR because it has been remanded, and cites to two prior **Federal Register** notices in support of its position that EPA's proposed reliance on CAIR as a permanent and enforceable measure for redesignation is contrary to other EPA Region 4 actions. The Commenter reiterates its position that emissions reductions associated with CAIR cannot be considered permanent and enforceable because CAIR is a cap-and-trade program (citing again to *NRDC* v. *EPA* for the proposition that ''cap and trade programs cannot be used to satisfy area-specific mandates''). Specifically, the Commenter contends that, under CAIR, ''[a]ny emissions reductions impacting the Metro-Atlanta nonattainment area achieved through CAIR could be lost through the purchase of emissions credits or trading of credits'' and that ''[a]ny source could decide at any time in the future to purchase emissions credits, increasing its emissions and thus impacts to the Atlanta Area.'' The Commenter contends that ''CAIR did not impose any reductions'' and that the use of modeling in developing CAIR is unreliable because it used assumptions about the economy, the weather, and international commodity prices like the price of coal and natural gas. Instead, the Commenter believes that EPA could impose unit specific emission limits for units in and impacting the Atlanta Area, and argues that such limits would not be redundant of reductions required by CAIR ''because CAIR did not impose any reductions on these units.'' The Commenter also states that ''to the extent'' that EPA relies on reductions from CSAPR, that rule has been vacated and EPA may not rely on reductions associated with CSAPR for the purposes of this redesignation.

Response 3(c): EPA does not agree that emission reductions associated with CAIR cannot be considered permanent and enforceable for purposes of meeting the requirements of section 107(d)(3)(E)(iii). Section 107(d)(3)(E) of the CAA sets out the requirements for redesignation, and states in relevant part that the Administrator must ''determine[] that the improvement in air quality is due to permanent and enforceable reductions in emissions resulting from implementation of the applicable implementation plan and applicable Federal air pollutant control regulations and other permanent and enforceable reductions.'' 42 U.S.C. 7407(d)(3)(E)(iii).

EPA recognizes that the D.C. Circuit's remand of CAIR necessarily means that CAIR will at some point cease to be in effect. However, EPA disagrees that the Court's remand forecloses the Agency and states from relying on CAIR for purposes such as redesignating an area from nonattainment to attainment. Subsection (iii) of section 107(d)(3)(E) is a backwards looking requirement; it requires that the attainment air quality in the area is ''due to'' permanent and enforceable emission reductions. The purpose of this requirement is to ensure that in redesignating areas from nonattainment to attainment, EPA does not rely on ephemeral, temporarily improved air quality that results from circumstances such as temporary shutdowns of plants or reduced emission rates because of slowed production. *See* Procedures for Processing Requests to Redesignate Areas to Attainment,'' Memorandum from John Calcagni, Director, Air Quality Management Division, September 4, 1992 (Calcagni Memorandum) at page 4. The structure of section 107(d)(3)(E)(iii) indicates that the Act generally considers reductions resulting from SIPs and Federal regulations as permanent and enforceable. It references ''other'' reductions that are comparable to measures adopted into SIPs or federally adopted regulations and can therefore *also* qualify as permanent and enforceable reductions, indicating that, in general, SIP reductions and

[8] The Court specifically elected not to vacate the RACT provision and left open the possibility that EPA may be able to reinstate the provision for particular nonattainment areas if, upon conducting a technical analysis, it finds the NO_X SIP Call results in greater emissions reductions in a nonattainment area than would be achieved if RACT-level controls were installed in that area. *Id.* at 1258.

reductions from Federal regulations are the types of reductions that the Act views in the first instance as having the requisite permanence and enforceability for purposes of redesignation.

Georgia's CAIR provisions can be found in Georgia Rule 391–3–1–.02(12)—Clean Air Interstate Rule NO_X Annual Trading Program. On October 9, 2007, at 72 FR 57202, EPA approved Georgia's CAIR provisions, including CAIR NO_X allocations. These SIP provisions are in place and are federally enforceable. And, because CAIR has been in force since 2005, the monitoring data used to demonstrate the Area's attainment of the 1997 8-hour ozone NAAQS by the June 2011 attainment deadline were impacted by CAIR. CAIR reductions began as early as 2005, with full program requirements beginning in 2009. CAIR was thus in place and federally enforceable at the time the Atlanta Area began monitoring attainment, and it continues to remain in place under the instruction of the Court in *EME Homer City Generation, L.P.* v. *EPA,* 696 F.3d. 7 (D.C. Cir., 2012), which vacated CSAPR and explicitly left CAIR in place until EPA implements a replacement rule.

With regard to the **Federal Register** notices cited by Commenter, those notices pre-date the D.C. Circuit's decision in *EME Homer City.* Thus, statements regarding CAIR in those notices would not be appropriately applied to the Atlanta action because of the significantly changed circumstances surrounding CAIR. It is not unreasonable for the Agency to reassess its position about whether the reductions of CAIR can be considered sufficiently permanent and enforceable for purposes of redesignation, in light of the D.C. Circuit's vacatur of CSAPR and its order that the Agency continue to implement CAIR in *EME Homer City.* That decision significantly altered the status of CAIR, particularly in the context of redesignations.

As noted in the proposed rule (78 FR 7712), EPA believes that relying on CAIR emission reductions in order to redesignate the Atlanta Area, which has been attaining the NAAQS for many years and continues to maintain the standard, is precisely the type of ''reliance interest'' that the D.C. Circuit was concerned about in ordering the Agency to continue administering CAIR. *EME Homer City,* 696 F.3d at 38. In addition, in its substantive holdings, the D.C. Circuit in *EME Homer City* held that ''a SIP logically cannot be deemed to lack a 'required submission' before EPA quantifies the good neighbor obligation.'' *Id.* at 32. Under this holding, states have no obligation to submit ''good neighbor'' SIPs until EPA has quantified their ''good neighbor'' obligations and EPA may not promulgate a FIP to address such obligations until the Agency first quantifies the state's obligations, and provides the state an opportunity to submit a plan consistent with that defined obligation. 696 F.3d at 28–37. The *EME Homer* City decision thus significantly lengthens the time it will take to get in place regulations to replace the remanded CAIR. Under the *EME Homer City* decision, SIP provisions to replace CAIR could not go into effect until EPA has undertaken analysis and rulemaking to define states' obligations in accordance with the other statutory requirements identified by the *EME Homer City* Court, provided states adequate time to develop implementation plans consistent with the defined obligations, and EPA has reviewed and approved the SIP submissions in notice-and-comment rulemakings. Similarly, no FIP to replace CAIR could go into effect unless EPA found a state failed to submit a SIP within the time given to develop such implementation plans or disapproved such a SIP submittal. It is not unreasonable for EPA to determine that in light of these circumstances, CAIR will be in place for a significant amount of time. EPA therefore disagrees with the Commenter that its prior statements regarding the status of CAIR before the *EME Homer City* decision dictate how the Agency must view CAIR after that decision.

In addition, the modeling EPA conducted for the CSAPR rulemaking demonstrates that the Atlanta Area would have attained and will continue to maintain the standard even without CAIR. The air quality modeling analysis, which analyzed a base-case and future-year modeling scenario in which neither CAIR nor CSAPR was in place demonstrated that the Atlanta Area would have been able to attain and will be able to maintain the 1997 8-hour ozone NAAQS in the absence of any transport rule. *See* ''Air Quality Modeling Final Rule Technical Support Document,'' Appendix B, B–8 to B–9. This modeling is available in the docket for this redesignation action. Nothing in the *EME Homer City* decision undermines that conclusion or suggests that the air quality modeling conducted during the rulemaking was flawed.

EPA also disagrees with the Commenter that emission reductions occurring within the relevant nonattainment area cannot be relied upon for the purpose of redesignations simply because they are associated with the emissions trading programs established in CAIR. As discussed in Response to Comment 3(b), EPA does not agree that *NRDC* v. *EPA* supports the Commenter's position. Although framed in terms of the requirements of section 107(d)(3)(E)(iii), that is, the Act's requirement that an area's current attainment is a *result* of permanent and enforceable measures, the Commenter's concerns appear more focused on potential future problems in the Atlanta Area. For instance, the Commenter notes that reductions that were achieved through CAIR that impacted the Atlanta Area ''could be lost'' because of future emissions trading, and that sources could decide ''in the future'' to purchase emissions credit and therefore have a negative impact on the Atlanta Area. The Commenter's focus on future reductions under CAIR suggests concern not with EPA's approval under section 107(d)(3)(E)(iii), but rather the requirements for a fully approved maintenance plan in section 107(d)(3)(E)(iv) and section 175A that require the state to show that the area will maintain the standard for ten years following redesignation. In the proposal, EPA provided projected emissions of NO_X and VOC, the precursors to ozone pollution, for the Atlanta Area for the relevant maintenance period. *See* 78 FR 7714, tbls. 2–4. Under its existing suite of control measures, including CAIR, Atlanta is attaining the 1997 8-hour ozone NAAQS. Over the maintenance period, emissions for each precursor are expected to further decrease in the Atlanta Area. If violations of the standard after redesignation nevertheless occur, EPA has approved the contingency measures in the maintenance plan to account for such events.

Further, evaluations have been made to see whether trading has created emissions ''hot spots.'' For example, since the beginning of the Acid Rain Program, there have been no emissions hot spots identified or created as a result of the program (see ''The Acid Rain Program Experience: Should We Be Concerned About SO_2 Emissions Hotspots?'' at *http://epa.gov/airmarkets/resource/acidrain-resource.html*).

Additionally, states and localities may impose stricter limits on sources to address specific local air quality concerns. For example, Georgia has adopted a multipollutant rule for Electricity Generating Units that control emissions of sulfur dioxide (SO_2) and NO_X, and North Carolina has adopted its Clean Smokestacks Act. Florida recently revised its Regional Haze Plan which imposed additional restrictions on a number of facilities in the State.

These limits must be met regardless of a source's accumulated allowances.

The Commenter's statement that ''CAIR did not impose any reductions'' is simply incorrect, and indicates a lack of understanding of cap-and-trade programs. In general, cap-and-trade programs provide economic incentives for early reductions in emissions and encourage sources to install controls earlier than required for compliance with future caps on emissions. The flexibility under a cap and trade system is not about *whether* to reduce emissions; rather, it is about how to reduce them at the lowest possible cost. As explained above in Response to Comment 3(b), trading programs require total mass emission reductions by establishing mandatory caps on total emissions to permanently reduce the total mass emissions allowed by sources subject to the programs, validated through rigorous continuous emission monitoring and reporting regimens. The emission caps and associated controls are enforced through the associated SIP rules or FIPs. Any purchase of allowances and increase in emissions by one source necessitates a corresponding sale of allowances and either reduction in emissions or use of banked allowances by another covered source. Given the regional nature of ozone, the corresponding NO_X emission and/or allowance reduction in one affected area will have an air quality benefit that will compensate, at least in part, for the impact of any emission increase in another affected area. EPA disagrees with the Commenter's suggestion that only specific emission limits on units can be considered ''reductions.''

In fact, the actual data that EPA has evaluated in order to conclude that the Atlanta Area has met the criteria for redesignation shows that power plant emissions in both Atlanta and the surrounding region have substantially decreased as a result of cap-and-trade programs, including CAIR. The facts contradict the theoretical concerns raised by the Commenter, and show that the emission trading programs, combined with other controls, in fact worked to improve air quality in the Area. Moreover, the NO_X SIP Call and CAIR have successfully reduced transported emissions contributing to ozone nonattainment in areas across the country. Data collected from long-term national air quality monitoring networks demonstrate that these regional cap-and-trade programs have resulted in substantial achievements in air quality caused by emission reductions from power sector sources.[9] In 2004, EPA designated 91 areas in the Eastern half of the United States as nonattainment for the 8-hour ozone standard adopted in 1997, using data from 2001–2003. Based on data gathered from 2009—2011, 90 of these original Eastern nonattainment areas show concentrations below the 1997 ozone standard. *Id.* at 12. Many states have sought and continue to seek redesignation of their nonattainment areas, relying in part on the reductions attributable to these cap-and-trade programs. *See, e.g.,* 76 FR at 59607 (proposing to redesignate a portion of the Chicago area for the 1997 8-hour ozone NAAQS), finalized at 76 FR 76302, and 74 FR 63995 (redesignation of Great Smoky Mountain National Park for the 1997 8-hour ozone NAAQS). The Commenter's contention that EPA and Georgia may not rely on the substantial emission reductions that have already occurred from these rules based on a faulty and rigid interpretation of the CAA would impose a major obstacle for nonattainment areas across the country that have achieved attainment air quality because of the reductions required by the rules. This would unnecessarily undermine a reasonable, proven, and cost-effective approach to combating regional pollution problems.

Of the federally-enforceable rules relied upon by Georgia in its redesignation request, the Commenter singles out cap-and-trade programs as insufficiently permanent and enforceable to meet the requirements for redesignation. Measures that have been approved into Georgia's SIP that have helped contribute to the Area's attainment of the 1997 8-hour ozone standard include: Georgia Rule (yy)—Emissions of Nitrogen Oxides, Georgia Rule (lll)—NO_X from Fuel Burning Equipment, Georgia Rule (rrr)—NO_X from Small Fuel Burning Equipment, and Georgia Rule (jjj)—NO_X from EGUs. Federal rules relied upon by Georgia in its redesignation request include Tier 2 vehicle standards, Large Non-road Diesel Engines Rule, and nonroad spark-ignition engines and recreational engines standards. *See* 78 FR 7705. There is inherent flexibility in nearly all of these requirements relied upon in Georgia's redesignation request, including Federal transportation control measures and SIP emission rate limits, also known as ''command-and-control'' regulations. For example, the rules do not and cannot account for when and where people drive their cars, nor do they dictate that consumers in a certain area invest in newer, lower-emitting cars. Similarly, emission rate limits limit the rate of emissions per unit of fuel consumed, or parts per million of emissions in the exhaust but do not regulate throughput or hours of operation of the regulated sources. It would be unworkable for EPA to disqualify a requirement as ''permanent and enforceable'' for the purposes of redesignation simply because the requirement did not require the exact same pollutant emission reduction every hour of every day of every year. The Atlanta Area relied on a suite of requirements that, while inherently allowing for some flexibility, has collectively served to bring the Area into, and to maintain, attainment of the NAAQS.

Moreover, the Commenter's concerns about modeling with regard to the CAIR rulemaking are not germane to this redesignation; it is the Atlanta Area's monitored attainment and continued monitored attainment that EPA is relying on in finalizing redesignation for this area, as opposed to modeling that EPA conducted for the CAIR rulemaking and any assumptions about commodity prices and the economy that necessarily went into that rulemaking.

Finally, EPA is not relying on CSAPR for continued maintenance of the Area and in approving this redesignation of Atlanta. As such, there is no basis to conclude that it would be improper to redesignate the Area even in the absence of CSAPR.

Comment 4(a): The Commenter states that EPA cannot approve the emissions inventory under CAA section 182(a)(1) because ''portions of the emissions inventory were estimated, as opposed to being based on actual emissions.''

Response 4(a): In a prior, separate rulemaking, EPA has already taken final action to approve the emissions inventory for the Atlanta Area under section 182(a)(1). *See* 77 FR 24399. It is settled law that, in evaluating redesignations, EPA is not required to review already-approved SIP revisions. EPA may rely on prior SIP approvals in approving a redesignation request (*Southwestern Pennsylvania Growth Alliance* v. *Browner,* 144 F.3d 984, 989–90 (6th Cir. 1998), *Wall* v. *EPA,* 265 F.3d 426 (6th Cir. 2001)), plus any additional measures it may approve in conjunction with a redesignation action (*see* Calcagni Memorandum at page 3; 68 FR 25426 (May 12, 2003) and citations therein). In EPA's prior rulemaking action on Atlanta's emissions inventory,

[9] 2011 Environmental and Health Results Report, CAIR, Acid Rain Program, and former NO_X Budget Trading Program Progress Report 2011 (March 2013), *http://www.epa.gov/airmarkets/progress/ARPCAIR11_downloads/ARPCAIR11_environmental_health.pdf* (''2011 Environmental and Health Results Report'').

EPA provided an opportunity for public notice and comment; and no comments were submitted. EPA approved the emissions inventory as consistent with the requirements of section 182(a)(1), the CAA implementing regulations, and EPA guidance for emission inventories. Thus, any comments regarding EPA's approval of the emissions inventory are untimely and unfounded. EPA notes that the maintenance demonstration accompanying the redesignation request includes an attainment year inventory that serves as the base year for projecting emissions over the maintenance period. The State has shown, and EPA agrees, that this inventory is accurate and comprehensive. Since EPA has already approved the inventory under section 182(b)(1), no additional approval is necessary.

Comment 4(b): The Commenter further disputes the approvability of the emissions inventory because ''[t]here is no indication that EPA accounted for the increase in NO_X and VOC emissions that will result from use of E15 when it approved GA EPD's estimate of on-road emissions as satisfying the section 182(a)(1) comprehensive emissions inventory requirement.''

Response 4(b): EPA does not believe that the Commenter's concerns regarding E15 use in the Atlanta Area and increases in VOC and NOx emissions are supported. The Commenter's concerns appear to derive not from the emissions inventories that EPA approved, but rather from the possibility that the future increases in NO_X and VOC that the Commenter believes might result from the use of E15. Therefore, this appears to be a concern regarding future maintenance of the standard rather than a concern about the approvability of the prior emissions inventories. In any event, EPA believes that the Commenter's concerns regarding E15 use in that Atlanta Area and potential resulting increases in VOC and NO_X emissions are unfounded. Georgia has a state fuel rule that covers 45 counties that is inclusive of the 20-county Atlanta Area that was designated nonattainment for the 1997 8-hour ozone NAAQS. Regardless of the allowance for increased ethanol in conventional fuel (i.e., E15), Georgia must comply with the requirements of its state fuel rule which was put in place specifically to reduce fuel-related VOC and NO_X emissions for the Atlanta Area. EPA approved Georgia's fuel rule into the Georgia SIP for the purposes of meeting 1-hour ozone NAAQS (see 67 FR 8200 (February 20, 2002)), and this rule remains in Georgia's federally-enforceable SIP. GA EPD modeled the Georgia fuel rule requirements in developing the emissions inventory for the maintenance plan.

In 2010 and 2011, EPA granted partial waivers for use of E15 in model year (MY) 2001 and newer light-duty motor vehicles (75 FR 68094 and 76 FR 4662). As discussed in the partial waiver decisions, there may be some small emission impacts from the use of E15. E15 is expected to cause a small immediate emissions increase in NO_X emissions. However, due to its lower volatility than the E10 currently in-use, its use is also expected to result in lower evaporative emissions. Other possible emissions impacts may be from the misfueling of E15 in vehicles or engines for which its use is not approved, i.e. MY2000 and older motor vehicles, heavy-duty engines and vehicles, motorcycles and all nonroad engines, vehicles and equipment. EPA promulgated a separate rule dealing specifically with the mitigation of misfueling to reduce the potential emissions impacts from misfueling (76 FR 44406).

However, the E15 partial waivers do not require that E15 be made or sold and it is unclear if and to what extent E15 may even be used in Georgia. Even if E15 is introduced into commerce in Georgia, considering the likely small and offsetting direction of the emission impacts, the limited set of motor vehicles approved for its use, and the measures required to mitigate misfueling, EPA believes that any potential emission impacts of E15 will be less than the maintenance plan safety margin by which Georgia shows maintenance of the 1997 8-hour ozone NAAQS. As shown in Tables 9 and 10, total VOC and NO_X emissions decrease significantly from 2008 through 2024, the last year of the maintenance plan. During this period, total NO_X emissions decrease 50 percent (by 303 tpd) and VOC emissions decrease 12 percent (by 58 tpd). It should be noted that EPA recently proposed the Tier 3 vehicle emissions and fuel standards program. The proposal calls for more stringent limits on emissions of NO_X and VOCs from new motor vehicles beginning with the 2017 model year resulting in emissions reductions as these vehicles enter the fleet. The proposal also calls for reducing the annual average sulfur content of gasoline from 30 ppm to 10 ppm beginning on January 1, 2017. Reductions in the sulfur content of gasoline would enable automobile manufacturers to comply with the proposed vehicle emissions standards, and would also achieve significant immediate benefits by reducing emissions from existing vehicles. The maintenance plan does not include emissions reductions from these proposed regulatory changes. If the Tier 3 vehicle emissions and fuel standards program is finalized as proposed, it would result in additional reductions in on-road emissions of NO_X and VOC that go beyond those which are consistent with maintenance of the 1997 ozone NAAQS in the Atlanta Area.

TABLE 9—ACTUAL AND PROJECTED ANNUAL NO_X EMISSIONS (TPD) FOR THE ATLANTA AREA

Sector	2008	2014	2017	2020	2024
Point	75.99	60.69	53.05	54.43	56.27
Area *	49.30	54.92	57.73	60.62	64.48
Nonroad	117.47	99.18	90.04	87.03	83.01
On-road	364.02	264.80	215.19	165.58	99.43
Total **	606.78	479.59	416.01	367.66	303.19

* For nonpoint emissions, excluding fire.
** Numbers may be slightly different than the April 4, 2012, submittal based on rounding conventions.

TABLE 10—ACTUAL AND PROJECTED ANNUAL VOC EMISSIONS (TPD) FOR THE ATLANTA AREA

Sector	2008	2014	2017	2020	2024
Point	13.79	15.80	16.81	17.80	19.13
Area*	216.46	243.28	256.69	270.61	289.16

TABLE 10—ACTUAL AND PROJECTED ANNUAL VOC EMISSIONS (TPD) FOR THE ATLANTA AREA—Continued

Sector	2008	2014	2017	2020	2024
Nonroad	96.03	74.75	64.11	63.50	62.69
On-road	165.53	126.92	107.61	88.30	62.56
Total **	491.82	460.75	445.22	440.21	433.55

* For nonpoint emissions, excluding fire.
** Numbers may be slightly different than the April 4, 2012, submittal based on rounding conventions.

Georgia used EPA's approved motor vehicle emissions factor model, MOVES2010, to prepare the on-road inventory. Additionally, EPA has concluded that GA EPD used the appropriate parameters for modeling the Georgia fuel rule and that the emissions inventories are approvable.

Comment 5(a): The Commenter claims that EPA cannot approve the maintenance plan because it ''would need to show, at a minimum, [that] the 2014, 2017, 2020, and 2024 emissions will be significantly below the 2012 emissions'' given that ''2012 emission levels result in ambient concentrations over the NAAQS.''

Response 5(a): The Commenter's contention that maintenance can be shown only by emissions that are ''significantly below the 2012'' emissions is based solely on the same misguided premise as its argument in Comment 1: that two monitor readings in 2012 showed concentrations above the level of the 1997 8-hour ozone NAAQS. As EPA explained in Reponses to Comments 1 and 2 above, these readings did not establish violations or alter the Area's attainment status, and the Area continued to attain the 1997 8-hour ozone NAAQS in 2012. These readings also in no way undermine the validity of the attainment year emissions inventory, which remains the benchmark for showing the levels of emissions that are needed to maintain the NAAQS. Consequently, the Area need not, as the Commenter claims, show that emissions levels in the future will be significantly lower in order to demonstrate continued attainment. Therefore, the State met the criteria for demonstrating maintenance by establishing its attainment inventories at the time of the development of the maintenance plan and showing that future projected emissions remain at or below the attainment emissions levels. *See Wall* v. *EPA,* supra.

For its maintenance demonstration, Georgia used the 2008 National Emissions Inventory (NEI) as base year emissions inventory reflecting one of the years in a three-year period (2008 –2011) when attainment was reached. Georgia's maintenance plan projected that total emissions during the 10-year maintenance period after redesignation will stay below attainment year levels. The 2008 inventory, one of the years in the three-year period in which the Area attained the 1997 8-hour ozone NAAQS, is an appropriate inventory to be used to demonstrate maintenance of the NAAQS.[10]

The Commenter asserts that ''2012 emissions levels result in ambient concentrations above the NAAQS.'' Again, as set forth in Response 1 above, a violation of the 1997 8-hour ozone NAAQS is based on a three-year average, and does not, as the Commenter claims, result from a one-year fourth high value. The 2010–2012 ozone season data established that the Area continues to attain the 1997 8-hour ozone NAAQS. Preliminary data for 2013 indicate continued attainment. Moreover, the maintenance plan also provides a mechanism for anticipating and preventing violations. For example, the maintenance plan's Tier I contingency measures are triggered when ''the periodic emission inventory updates reveal excessive or unanticipated growth greater than 10 percent in emissions of either ozone precursor over the attainment or intermediate emissions inventories for the Atlanta maintenance area (as determined by the triennial emission reporting required by AERR).'' *See* 78 FR 7705.

Comment 5(b): The Commenter states its view that the maintenance plan is not approvable because it is missing contingency provisions that provide for the prompt correction of violations. According to the Commenter, neither the Tier I nor the Tier II response ''occurs on a prompt schedule, and several of the potential contingency measures listed are inappropriate, inadequate, or vague.'' The Commenter goes on to state that the Tier I response to prepare a comprehensive study to develop corrective measures ''is not a corrective measure at all.'' The Commenter states its belief that a period of 18 to 24 months, or more, to adopt and implement corrective measures does not satisfy the statutory requirement for prompt correction of violations under either the Tier I or Tier II response, that the contingency measures listed in the maintenance plan are ''too vague,'' and that the procedure for selecting contingency measures has not been provided.

Response 5(b): EPA, consistent with its views set forth in many other redesignation rulemakings, believes that the contingency measures in the maintenance plan are adequate under section 175A(d). EPA therefore disagrees with the Commenter's contention that the contingency measures are vague and do not provide for prompt correction of a NAAQS violation. Section 175A(d) of the CAA requires that a maintenance plan include such contingency provisions, ''as the Administrator deems necessary,'' to assure that the state will promptly correct a violation of the NAAQS that occurs after redesignation of the area. *See* 42 U.S.C. 7505A(d). Unlike section 172(c)(9), which governs contingency measures for nonattainment areas, section 175A does not require the adoption of specific contingency measures that must take effect without further action by the State or EPA. Instead, Congress provided EPA with the discretion to determine the form and timing of the contingency that are required. Section 175A(d) provides leeway for EPA to take into account the need of a state to assess, adopt, and implement contingency measures if and when a violation occurs after an area's redesignation to attainment. Therefore, in accordance with the discretion accorded it by statute, EPA may allow reasonable time for states to analyze data and address the causes and appropriate means of remedying a violation. In assessing what ''promptly'' means in this context, EPA also may take into account time for adopting and implementation of the appropriate measure. In the case of the Atlanta Area, EPA reasonably concluded that 18–24 months constitutes a timeline consistent

[10] As explained in the Calcagni Memorandum, ''[w]here a state has made an adequate demonstration that air quality has improved as a result of the SIP, the attainment inventory will generally be the actual inventory at the time the area attained the standard.''

with prompt correction of a potential monitored violation. This timeframe also conforms with EPA's many prior rulemakings on acceptable schedules for implementing section 175A contingency measures. EPA has long exercised this discretion in its rulemakings on section 175A contingency measures in redesignation maintenance plans, allowing as contingency measures commitments to adopt and implement in lieu of fully adopted contingency measures, and finding that implementation within 18 to 24 months of a violation complies with the requirements of section 175A. See recent redesignations such as Indianapolis Area 1997 Annual $PM_{2.5}$ standard (76 FR 59512, 59522 (Sept. 27, 2011)); Baton Rouge Area 1997 8-hour ozone standard (76 FR 74000 (Nov. 30, 2011) (final); 76 FR 53853, 53869 (Aug. 30, 2011) (proposed)); Crittenden County, Arkansas portion of the Memphis Area 1997 8-hour ozone standard (75 FR 14077 (Mar. 24, 2010) (final); 75 FR 2091, 2100 (Jan. 14, 2010) (proposal)); 76 FR 79579, 79590 (Dec. 22, 2011) (proposed)); Hickory-Morganton-Lenoir Area 1997 Annual $PM_{2.5}$ standard, 76 FR 71452 (Nov. 18, 2011) (final); 76 FR 58210, 58222 (Sept. 20, 2011) (proposed)). Section 175A does not establish any deadlines for implementation of contingency measures after redesignation to attainment. It also provides far more latitude than does section 172(c)(9), which applies to a different set of contingency measures applicable to nonattainment areas. Section 172(c)(9) contingency measures must ''take effect . . . without further action by the State or [EPA].''

EPA has consistently applied this interpretation of section 175A since its announcement in a September 4, 1992, Calcagni Memorandum (noting that a State is *not* required under 175A ''to have fully adopted contingency measures that will take effect without further action by the State in order for the maintenance plan to be approved''), and two U.S. Circuit Courts of Appeal have agreed with the Agency. In *Greenbaum* v. *EPA,* the U.S. Court of Appeals for the Sixth Circuit endorsed the Calcagni Memorandum's statements regarding contingency measures for 175A maintenance plans and noted that EPA ''has been granted broad discretion by Congress in determining what is 'necessary to assure' prompt correction'' under this section. 370 F.3d 527, 540 (6th Cir. 2004). The Court also stated that ''no pre-determined schedule for adoption of the measures is necessary in each specific case.'' Id. In *Sierra Club* v. *EPA,* the U.S. Court of Appeals for the Seventh Circuit agreed with *Greenbaum* on these issues and identified the rationale behind the discretion afforded to EPA and the states in the timing and development of contingency measures, noting that ''[i]ntelligent decisions may depend on the nature of future developments.'' 375 F.3d 537, 540 (7th Cir. 2004) (also noting that the ''statute does not call for any particular degree of precision in the period after attainment . . . so again, the EPA (and the affected states) had choices to make, choices that may be gainsaid only if obviously misguided.''). The CAA does not specify the requisite nature, scope, specificity, or number of contingency measures to be included in a maintenance plan under section 175A. It is for EPA to determine whether the state has given adequate assurance that it can promptly correct a violation. The State has committed to remedy a future violation,[11] and included measures to address future violations and a timeline for promptly completing adoption and implementation. For example, Georgia included a consideration of expansion of RACT for point sources of VOC and NOx, specifically the adoption of new and revised RACT rules based on Groups II, III and IV control technique guidelines (CTGs) as a possible contingency measure to implement. This identification of measures is sufficiently specific while allowing for latitude in potential scope. This will enable the State to address a range of potential sources and differing degrees and types of violations. EPA believes that the contingency measures set forth in the submittal, combined with the State's commitment to an expeditious timeline and process for implementation, provide assurance that the State will promptly correct a future violation. Given the uncertainty as to timing, degree, and nature of any future violation, EPA believes that the contingency measures set forth adequately balance the need for flexibility in the scope and type of measure to be implemented with the need for expeditious state action.

Given the discretion provided to EPA and the states under section 175A(d), the need for flexibility in developing appropriate contingency measures in light of potential future developments, and the need for an appropriate amount of time to develop and adopt these measures, EPA has determined that Georgia's maintenance plan satisfies all applicable requirements.

[11] In the context of this rulemaking, a future violation indicates that the Tier II trigger is activated.

The maintenance plan for the Atlanta Area contains two different types of contingency measures. The ''Tier I'' response, is not required under section 175A, and therefore not subject to its criteria. The Tier I response is triggered before any violation has occurred. It is designed not to correct a violation, but to anticipate and evaluate circumstances that may prefigure a violation.[12]

Georgia's Tier II contingency measures, by contrast, are triggered by a violation of the NAAQS. It compels the State to first conduct a comprehensive study to determine what contingency measures are required for the maintenance of the ozone NAAQS. Georgia must submit this study to EPA for review as expeditiously as practicable but no later than nine months after the trigger date. The State must adopt and implement measures within 18 to 24 months after the trigger occurs. In addition to setting these specific timing requirements, the maintenance plan (see page 37 of the narrative) also lists a number of measures (e.g., expansion of RACT for point sources of VOC and NOx, specifically the adoption of new and revised RACT rules based on Groups II, III and IV CTGs) that Georgia may select as a contingency measure (see the proposed rule for this action at 78 FR 7716 for a complete list). In a September 20, 2013 letter to EPA that has been placed in the docket for this action, GA EPD confirms that it commits to address and correct any violation of the 1997 8-hour ozone NAAQS as expeditiously as practicable, and no later than 24 months from trigger activation. For additional details pertaining to the State's commitments regarding contingency measures, see the September 20, 2013 letter from GA EPD, included in the rulemaking docket. For all of the reasons set forth above, EPA finds that, pursuant to CAA section 175A(d), the contingency measures included in the maintenance plan and the schedule for the development and adoption of measures are adequate to assure that the State will promptly correct any future violation of the NAAQS that may occur after redesignation.

Comment 6: The Commenter contends that EPA cannot approve the redesignation request or maintenance plan without considering the impacts

[12] Specifically, the ''Tier I'' response in the Atlanta maintenance plan is triggered: (1) when any quality-assured 8-hour ozone monitoring reading exceeds 0.084 ppm at an ambient air monitoring station in the Atlanta maintenance area; or (2) if the periodic emission inventory updates reveal excessive or unanticipated growth greater than 10 percent in ozone precursors emissions in the Atlanta maintenance area.

that climate change will have on ozone formation during the maintenance period. The Commenter states that ''climate change will make our ozone problems worse'' and cites to an April 2009 EPA document for support.

Response 6: EPA agrees that climate change is a serious environmental issue; however, EPA does not agree that the redesignation and maintenance plan at issue in today's notice are flawed because they do not specifically consider the impacts of climate change on future ozone concentrations. Given the potential wide-ranging impacts of climate change on air quality planning, EPA is developing climate adaptation implementation plans to assess the key vulnerabilities to our programs (including how climate change might affect attainment of national ambient air quality standards) and to identify priority actions to minimize these vulnerabilities. With respect to climate impacts on future ozone levels, EPA's Office of Air and Radiation has identified as a priority action the need to adjust air quality modeling tools and guidance as necessary to account for climate-driven changes in meteorological conditions and meteorologically-dependent emissions. However, the broad range of potential future climate outcomes and variability of projected response to these outcomes limits EPA's ability, at this time, to translate a general expectation that average ozone levels will increase with rising temperatures to specific ''actionable'' SIP policies at any specific location. Additionally, EPA believes that the natural variability in meteorological patterns will have a larger influence on ozone concentrations than climate influences over the relatively short-term SIP maintenance period. Thus, EPA believes it is appropriate to rely upon the existing air quality modeling tools and guidance and applicable CAA provisions to ensure that ozone maintenance areas do not violate the NAAQS (as a result of climate change or any other cause). In addition, in spite of the uncertainty associated with short-term climate change impacts on ozone concentrations, the projected emissions reductions of 50 percent for NOx and 12 percent for VOC in the Atlanta Area over the next 10 years are so large that they would overwhelm any potential climate change impacts on ozone. EPA therefore believes that climate change will not impact the ability of the Atlanta Area to maintain the 1997 8-hour ozone NAAQS.

Comment 7: The Commenter asserts that EPA cannot redesignate the Atlanta Area or approve the maintenance plan because the Area ''does not have SIP approved contingency measures for VOCs and NOx, an attainment demonstration and reasonable further progress for VOC and NOx.'' According to the Commenter, ''the contingency measures should have already been triggered or at most may be triggered this year if Metro-Atlanta's design value exceeds 0.084 ppm'' which distinguishes the Atlanta Area from prior actions where ''EPA has claimed that these provisions do not matter because if any area is attaining, these requirements would not apply anyway.'' The Commenter believes that ''all provisions that were in the nonattainment SIP would need to become applicable again'' if the Area violates the NAAQS in the future, and that ''under EPA's interpretation, there are no provisions that were in the SIP before redesignation that will become effective again if the area falls out of compliance with the NAAQS.''

Response 7: On June 23, 2011 (76 FR 36873), EPA determined that the Atlanta Area had attained the 1997 8-hour ozone NAAQS based on 2008–2010 monitoring data. Under 40 CFR 51.918, upon a finding that the area is attaining the standard, requirements for SIP submissions linked to attainment demonstrations, RFP, and attainment plan contingency measures are suspended for so long as the area is attaining the standard.[13]

In addition, in the context of redesignations, EPA has long interpreted requirements related to attainment planning (e.g., attainment demonstrations, RFP, and attainment plan contingency measures) as not applicable for purposes of redesignation. In the General Preamble EPA stated that: [t]he section 172(c)(9) requirements are directed at ensuring reasonable further progress (RFP) and attainment by the applicable date. These requirements no longer apply when an area has attained the standard and is eligible for redesignation. Furthermore, section 175A for maintenance plans provides specific requirements for contingency measures that effectively supersede the requirements of section 172(c)(9) for these areas. ''General Preamble for the Interpretation of Title I of the Clean Air Act Amendments of 1990,'' (General Preamble) 57 FR 13498, 13564 (April 16, 1992). *See* also Calcagni Memorandum (dated 9/4/1992) at page 6. (''The requirements for reasonable further progress and other measures needed for attainment will not apply for redesignations because they only have meaning for areas not attaining the standard.'').

In any event, EPA has previously determined that the Atlanta Area attained by its attainment date (77 FR 13491), and therefore, no contingency measures under the requirements of section 172(c)(9) can be triggered, since those ''contingency measures are directed at ensuring RFP and attainment by the applicable date.'' Id. at 13564.

The State must continue to operate an appropriate monitoring network, in accordance with 40 CFR part 58, to verify the attainment status of the Area. The air quality data relied upon to determine that the Area is attaining the ozone standard must be consistent with 40 CFR part 58 requirements and other relevant EPA guidance and recorded in EPA's AQS.

As stated in Response 1, the Area remains in attainment of the 1997 8-hour ozone NAAQS, and the 2010—2012 quality-assured three-year design value remains below 0.084 ppm. Preliminary data for 2013 show continued attainment; therefore, no additional measures have been triggered. Even if approved section 172(c)(9) contingency measures were contained in the SIP, these measures are undertaken solely to address a failure to attain by the Area's attainment date. For an area like the Atlanta Area that has attained by its attainment date, no 172(c)(9) contingency measures would be triggered by a violation that occurred subsequently. After attainment, section 172(c)(9) contingency measures are no longer deployed. Because the Area qualifies for redesignation, the 175A maintenance plan approved today ensures that GA EPD will adopt and implement any required measures in accordance with the schedule and procedure for adoption and implementation of contingency measures.'' *See* 78 FR 7705.

Comment 8: The Commenter states that ''EPA has failed to conduct an adequate analysis with respect to the

[13] EPA described its interpretation in a May 10, 1995 memorandum from John S. Seitz, Director, Office of Air Quality Planning and Standards, entitled ''Reasonable Further Progress, Attainment Demonstration, and Related Requirements for Ozone Nonattainment Areas Meeting the Ozone Ambient Air Quality Standard'' (hereafter referred to as the ''Seitz Memorandum''). *See also* the discussion and rulemakings cited in EPA's Final Rule to Implement the 8-Hour Ozone NAAQS—Phase 2, 70 FR 71612, 71644–71646 (November 29, 2005). The Tenth, Seventh and Ninth Circuits have upheld EPA rulemakings applying the Clean Data Policy. *See Sierra Club* v. *EPA,* 99 F. 3d 1551 (10th Cir. 1996); *Sierra Club* v. *EPA,* 375 F.3d 537 (7th Cir. 2004); and *Our Children's Earth Foundation* v. *EPA,* No. 04–73032 (9th Cir. June 28, 2005) (memorandum opinion). As explained in the Seitz Memorandum, EPA believes it is appropriate to interpret the more specific attainment demonstration and related provisions of subpart 2 in the same manner. *See Sierra Club* v. *EPA,* 99 F.3d. 1551 (10th Cir. 1996).

1997 annual $PM_{2.5}$ NAAQS, the 2006 24-hour $PM_{2.5}$ NAAQS, the 1-hour NO_X NAAQS, the 1-hour SO_2 NAAQS, and the 2008 8-hour ozone NAAQS'' and that without such an analysis, ''EPA cannot ensure that redesignation will not interfere with attainment of these NAAQS and thus cannot approve the redesignation.'' The Commenter continues by stating ''EPA's redesignation of Metro-Atlanta will delay attainment of the 2008 ozone NAAQS because the 2012 ambient data proved that the current emission limits are not adequate to maintain the 1997 NAAQS much less the 2008 NAAQS. Thus, if EPA does not approve the redesignation request, Georgia EPD will have to provide for additional emission reductions of ozone precursors. These emission reductions will assist in attaining the 2008 ozone NAAQS as quickly as possible.''

Response 8: First, as set forth earlier in other responses to comments, the 2012 data do not ''prove that the current emissions limits are not adequate to maintain the 1997 NAAQS . . . .'' The data for 2012 establish, and preliminary data for 2013 also indicate, that current emissions levels are consistent with continued attainment of the 1997 8-hour ozone NAAQS. EPA does not agree that additional emissions reductions are required in order for the Area to qualify for redesignation. EPA has also evaluated the redesignation in relation to the requirements of section 110(l) and believes that redesignation is consistent with the provisions of that section. Section 110(l) provides in part: ''[t]he Administrator shall not approve a revision of a plan if the revision would interfere with any applicable requirement concerning attainment and reasonable further progress . . ., or any other applicable requirement of this chapter.'' 42 U.S.C. 7410(l). EPA does not believe it is necessary to conduct an analysis with respect to the impact of the redesignation on the 1997 annual $PM_{2.5}$ NAAQS, the 2006 24-hour $PM_{2.5}$ NAAQS, the 1-hour NO_X NAAQS, the 1-hour SO_2 NAAQS, and the 2008 8-hour ozone NAAQS. Although EPA does not interpret section 110(l) as requiring a full attainment demonstration for every SIP revision, the Agency does consider section 110(l) requirements when acting on each SIP revision. *See,* e.g., 70 FR 53, 57 (January 3, 2005); 70 FR 17029, 17033 (April 4, 2005); 70 FR 28429, 28431 (May 18, 2005); and 70 FR 58119, 58134 (October 5, 2005). In this instance, the redesignation does not relax any existing control requirements, nor does it alter any existing control requirements, and therefore, EPA concludes that this redesignation will not interfere with attainment or maintenance of any of these air quality standards. The Commenter did not provide any information that would cause EPA to conclude that approval of Georgia's redesignation will have any impact on the Area's ability to comply with the 1997 annual $PM_{2.5}$ NAAQS, the 2006 24-hour $PM_{2.5}$ NAAQS, the 1-hour NO_X NAAQS, the 1-hour SO_2 NAAQS, and the 2008 8-hour ozone NAAQS.

As set forth above, Georgia's April 4, 2012, redesignation request and maintenance plan for the 1997 8-hour ozone NAAQS do not revise or remove any existing emissions limit for any NAAQS or remove any other existing substantive SIP provisions. In fact, the maintenance plan provided with the State's submission demonstrates a decline in the ozone precursors (e.g., NO_X and VOC) emissions over the timeframe of the initial maintenance period.[14] Furthermore, EPA designated 15 of the 20 counties in the 1997 8-hour ozone area as nonattainment for the 2008 8-hour ozone NAAQS. With this nonattainment designation, EPA notes that, even after the redesignation of the Atlanta Area for the 1997 8-hour ozone NAAQS, 15 of these counties will continue to have to comply with nonattainment new source review requirements for ozone. For all of these reasons, EPA disagrees that the Commenter has identified a rationale on which EPA could disapprove of the SIP revision at issue.

IV. Why is EPA taking these actions?

EPA has determined that the Atlanta Area has attained the 1997 8-hour ozone NAAQS and has also determined that all other criteria for the redesignation of the Atlanta Area from nonattainment to attainment of the 1997 8-hour ozone NAAQS have been met. *See* CAA section 107(d)(3)(E). One of those requirements is that the Atlanta Area has an approved plan demonstrating maintenance of the 1997 8-hour ozone NAAQS. EPA is also taking final action to approve the maintenance plan for the Atlanta Area as meeting the requirements of sections 175A and 107(d)(3)(E) of the CAA. EPA is also approving the new NO_X and VOC MVEBs for the year 2024 as contained in Georgia's maintenance plan for the Atlanta Area because these MVEBs are consistent with maintenance of the 1997 8-hour ozone NAAQS in the Area. The detailed rationale for EPA's findings and actions is set forth in the February 4, 2013, proposed rulemaking and in the Reponses to Comments and other discussion in this final rulemaking.

V. What are the effects of these actions?

Approval of the redesignation request changes the legal designation of the Atlanta Area from nonattainment to attainment for the 1997 8-hour ozone NAAQS. EPA is modifying the regulatory table in 40 CFR 81.341 to reflect a designation of attainment for the counties. EPA is also approving, as a revision to the Georgia SIP, the State's plan for maintaining the 1997 8-hour ozone NAAQS in the Atlanta Area through 2024. The maintenance plan includes contingency measures to remedy possible future violations of the 1997 8-hour ozone NAAQS, and establishes NO_X and VOC MVEBs for the year 2024 for the Atlanta Area.

VI. Final Action

EPA is taking final action to approve the State of Georgia's request for redesignation and change the legal designation the Atlanta Area from nonattainment to attainment for the 1997 8-hour ozone NAAQS. Through this action, EPA is also approving into the Georgia SIP the 1997 8-hour ozone maintenance plan for the Atlanta Area, which includes for this Area the new NO_X and VOC MVEB for 2024 for the Atlanta Area of 126 tpd and 92 tpd, respectively.

VII. Statutory and Executive Order Reviews

Under the CAA, redesignation of an area to attainment and the accompanying approval of the maintenance plan under CAA section 107(d)(3)(E) are actions that affect the status of geographical area and do not impose any additional regulatory requirements on sources beyond those required by state law. A redesignation to attainment does not in and of itself impose any new requirements, but rather results in the application of requirements contained in the CAA for areas that have been redesignated to attainment. Moreover, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the CAA. Accordingly, these actions merely approve state law as meeting Federal requirements and do not impose additional requirements beyond those

[14] EPA notes that the Atlanta Area does not have violating monitors for the 1997 annual $PM_{2.5}$ NAAQS, the 2006 24-hour $PM_{2.5}$ NAAQS, the 1-hour NO_X NAAQS, the 1-hour SO_2 NAAQS, and that this Area has never been designated nonattainment for 2006 24-hour $PM_{2.5}$ NAAQS, the 1-hour NO_X NAAQS, or the 1-hour SO_2 NAAQS.

imposed by state or federal law. For these reasons, these actions:

- Are not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- do not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- are certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- do not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- do not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- are not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- are not significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- are not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and,
- do not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in the State, and EPA notes that it will not impose substantial direct costs on tribal governments or preempt tribal law.

The Congressional Review Act, 5 U.S.C. 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this action and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

Under section 307(b)(1) of the CAA, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by January 31, 2014. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this action for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. *See* section 307(b)(2).

List of Subjects

40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Nitrogen dioxide, Ozone, Reporting and recordkeeping requirements, Volatile organic compounds.

40 CFR Part 81

Environmental protection, Air pollution control.

Dated: November 14, 2013.

A. Stanley Meiburg,

Acting Regional Administrator, Region 4.

40 CFR parts 52 and 81 are amended as follows:

PART 52—APPROVAL AND PROMULGATION OF IMPLEMENTATION PLANS

■ 1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart L—Georgia

■ 2. Section 52.570(e) is amended by adding an entry for ''1997 8-hour ozone *Maintenance Plan for the Atlanta Area''* at the end of the table to read as follows:

§ 52.570 Identification of plan.

* * * * *

(e) * * *

EPA-APPROVED GEORGIA NON-REGULATORY PROVISIONS

Name of nonregulatory SIP provision	Applicable geographic or nonattainment area	State submittal date/ effective date	EPA approval date	Explanation
*	*	*	*	*
1997 8-hour ozone *Maintenance Plan for the Atlanta Area.*	Atlanta 1997 8-Hour Ozone Nonattainment Area.	4/4/2012	12/2/2013	

* * * * *

PART 81–DESIGNATION OF AREAS FOR AIR QUALITY PLANNING PURPOSES

■ 3. The authority citation for part 81 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

■ 4. In § 81.311, the table entitled ''Georgia-1997 8-Hour Ozone NAAQS (Primary and Secondary)'' is amended under ''Atlanta, GA'' by revising the entries for ''Barrow County,'' ''Bartow County,'' ''Carroll County,'' ''Cherokee County,'' ''Clayton County,'' ''Cobb County,'' ''Coweta County,'' ''DeKalb County,'' ''Douglas County,'' ''Fayette County,'' ''Forsyth County,'' ''Fulton County,'' ''Gwinnett County,'' ''Hall County,'' ''Henry County,'' ''Newton County,'' ''Paulding County,'' ''Rockdale County,'' ''Spalding County'' and ''Walton County'' to read as follows:

§ 81.311 Georgia.

* * * * *

GEORGIA-1997 8-HOUR OZONE NAAQS

[Primary and secondary]

Designated area	Designation [a]		Category/classification	
	Date [1]	Type	Date [1]	Type
Atlanta, GA:				
Barrow County	This action is effective 12/2/13	Attainment.		
Bartow County	This action is effective 12/2/13	Attainment.		
Carroll County	This action is effective 12/2/13	Attainment.		
Cherokee County	This action is effective 12/2/13	Attainment.		
Clayton County	This action is effective 12/2/13	Attainment.		
Cobb County	This action is effective 12/2/13	Attainment.		
Coweta County	This action is effective 12/2/13	Attainment.		
DeKalb County	This action is effective 12/2/13	Attainment.		
Douglas County	This action is effective 12/2/13	Attainment.		
Fayette County	This action is effective 12/2/13	Attainment.		
Forsyth County	This action is effective 12/2/13	Attainment.		
Fulton County	This action is effective 12/2/13	Attainment.		
Gwinnett County	This action is effective 12/2/13	Attainment.		
Hall County	This action is effective 12/2/13	Attainment.		
Henry County	This action is effective 12/2/13	Attainment.		
Newton County	This action is effective 12/2/13	Attainment.		
Paulding County	This action is effective 12/2/13	Attainment.		
Rockdale County	This action is effective 12/2/13	Attainment.		
Spalding County	This action is effective 12/2/13	Attainment.		
Walton County	This action is effective 12/2/13	Attainment.		
* * *	* *	*	*	*

[a] Includes Indian Country located in each county or area, except as otherwise specified.
[1] This date is June 15, 2004, unless otherwise noted.
[2] Effective April 15, 2008.
[3] The boundary change is effective October 13, 2006.

* * * * *

[FR Doc. 2013–28105 Filed 11–29–13; 8:45 am]

BILLING CODE 6560–50–P

Proposed Rules

Federal Register
Vol. 78, No. 231
Monday, December 2, 2013

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0757; Airspace Docket No. 13–ASO–19]

Proposed Amendment of Class D and Class E Airspace; Christiansted, St. Croix, VI

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This action proposes to amend Class D and Class E Airspace at Christiansted, St. Croix, VI, to adjust the geographic coordinates of Henry E Rohlsen Airport. The airport name also would be changed from Alexander Hamilton Airport. This action would bring current the effected charting and enhance airspace management within the National Airspace System.

DATES: Comments must be received on or before January 16, 2014.

ADDRESSES: Send comments on this rule to: U. S. Department of Transportation, Docket Operations, West Building Ground Floor, Room W12–140, 1200 New Jersey SE., Washington, DC 20590–0001; Telephone: 1–800–647–5527; Fax: 202–493–2251. You must identify the Docket Number FAA–2013–0757; Airspace Docket No. 13–ASO–19, at the beginning of your comments. You may also submit and review received comments through the Internet at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: John Fornito, Operations Support Group, Eastern Service Center, Federal Aviation Administration, P.O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–6364.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to comment on this rulemaking by submitting such written data, views, or arguments, as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal.

Communications should identify both docket numbers (FAA Docket No. FAA–2013–0757; Airspace Docket No. 13–ASO–19) and be submitted in triplicate to the Docket Management System (see **ADDRESSES** section for address and phone number). You may also submit comments through the Internet at *http://www.regulations.gov.*

Persons wishing the FAA to acknowledge receipt of their comments on this action must submit with those comments a self-addressed stamped postcard on which the following statement is made: ''Comments to Docket No. FAA–2013–0757; Airspace Docket No. 13–ASO–19.'' The postcard will be date/time stamped and returned to the commenter. All communications received before the specified closing date for comments will be considered before taking action on the proposed rule. The proposal contained in this notice may be changed in light of the comments received. A report summarizing each substantive public contact with FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRMs

An electronic copy of this document may be downloaded from and comments submitted through *http://www.regulations.gov.* Recently published rulemaking documents can also be accessed through the FAA's Web page at *http://www.faa.gov/airports_airtraffic/air_traffic/publications/airspace_amendments/.*

You may review the public docket containing the proposal, any comments received, and any final disposition in person in the Dockets Office (see the **ADDRESSES** section for address and phone number) between 9:00 a.m. and 5:00 p.m., Monday through Friday, except Federal Holidays. An informal docket may also be examined between 8:30 a.m. and 5;00 p.m., Monday through Friday, except Federal Holidays at the office of the Eastern Service Center, Federal Aviation Administration, room 350, 1701 Columbia Avenue, College Park, Georgia 30337.

Persons interested in being placed on a mailing list for future NPRM's should contact the FAA's Office of Rulemaking, (202) 267–9677, to request a copy of Advisory circular No. 11–2A, Notice of Proposed Rulemaking distribution System, which describes the application procedure.

The Proposal

The FAA is considering an amendment to Title 14, Code of Federal Regulations (14 CFR) part 71 by modifying Class D airspace and Class E airspace extending upward from 700 feet above the surface by amending the geographic coordinates of Henry E. Rohlsen Airport, Christiansted, St. Croix, VI, to bring it in concert with the FAAs aeronautical database. The coordinates would change from (lat.17°42′07″ N., long. 64°47′55″ W.) to (lat. 17°42′06″ N., long. 64°48′06″ W.) Also, the airport formerly called Alexander Hamilton Airport would be changed to Henry E Rohlsen Airport.

Class D and Class E airspace designations are published in Paragraphs 5000 and 6005, respectively, of FAA Order 7400.9X, dated August 7, 2013, and effective September 15, 2013, which is incorporated by reference in 14 CFR 71.1. The Class D and Class E airspace designation listed in this document will be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore, (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this proposed rule, when promulgated, would not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in

Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This proposed rulemaking is promulgated under the authority described in Subtitle VII, Part, A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This proposed regulation is within the scope of that authority as it would amend Class D and Class E airspace at Henry E Rohlsen Airport, Christiansted, St. Croix, VI.

This proposal would be subject to an environmental analysis in accordance with FAA Order 1050.1E, ''Environmental Impacts: Policies and Procedures'' prior to any FAA final regulatory action.

Lists of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR Part 71 as follows:

PART 71 —DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, effective September 15, 2013, is amended as follows:

Paragraph 5000 Class D Airspace

* * * * *

ASO VI D Christiansted St. Croix, VI [Amended]

Henry E Rohlsen Airport, VI
(Lat. 17°42′06″ N., long. 64°48′06″ W.)

That airspace extending upward from the surface to and including 2,500 feet MSL within a 5.7-mile radius of Henry E Rohlsen Airport. This Class D airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 feet or More Above the Surface of the Earth.

* * * * *

ASO VI E5 Christiansted St. Croix, VI [Amended]

Henry E Rohlsen Airport, VI
(Lat. 17°42′06″ N., long. 64°48′06″ W.)
St Croix VOR/DME
(Lat. 17°44′04″ N., long. 64°42′03″ W.)
PESTE NDB
(Lat. 17°41′31″ N., long. 64°53′05″ W.)

That airspace extending upward from 700 feet above the surface within a 7.4-mile radius of Henry E Rohlsen Airport, and within 3 miles each side of St. Croix VOR/DME 069° radial, extending from the 7.4-mile radius to 7 miles east of the VOR/DME; and that airspace extending upward from 1,200 feet above the surface within a 13-mile radius of Henry E Rohlsen Airport, and within 8 miles north and 4 miles south of the St. Croix VOR/DME 069° radial, extending from the 13-mile radius to 16 miles east of the VOR/DME, and within 8 miles south and 4 miles north of the ILS localizer west course, extending from the 13-mile radius to 16 miles west of the PESTE NDB.

Issued in College Park, Georgia, on November 20, 2013.

Kip B. Johns,

Manager, Operations Support Group, Eastern Service Center, Air Traffic Organization.

[FR Doc. 2013–28706 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

FEDERAL TRADE COMMISSION

16 CFR Part 300

Rules and Regulations Under the Wool Products Labeling Act

AGENCY: Federal Trade Commission (''FTC'' or ''Commission'').

ACTION: Extension of the deadline for filing public comments.

SUMMARY: The Commission grants an eight (8) day extension until December 3, 2013 for filing public comments in response to the Commission's Notice of Proposed Rulemaking published on September 20, 2013 (''NPRM'').

DATES: Comments for the NPRM published on September 20, 2013 (78 FR 57808) must be submitted by December 3, 2013.

ADDRESSES: Interested parties may file a comment online or on paper, by following the instructions in the NPRM.[1] Write ''Wool Rules, 16 CFR Part 300, Project No. P124201'' on your comment, and file your comment online at *https://ftcpublic.commentworks.com/ftc/woolrulesnprm* by following the instructions on the web-based form. If you prefer to file your comment on paper, mail or deliver your comment to the following address: Federal Trade Commission, Office of the Secretary, Room H–113 (Annex Q), 600 Pennsylvania Avenue NW., Washington, DC 20580.

FOR FURTHER INFORMATION CONTACT: Robert M. Frisby, Attorney, (202) 326–2098, Division of Enforcement, Bureau of Consumer Protection, Federal Trade Commission, 600 Pennsylvania Avenue NW., Washington, DC 20580.

SUPPLEMENTARY INFORMATION: On September 20, 2013, the Commission published its NPRM seeking comment on the Commission's proposed amendments to the Rules and Regulations under the Wool Products Labeling Act of 1939 (''Wool Rules'').[2] The NPRM designated November 25, 2013, as the deadline for filing public comments.

On November 20, 2013, the Embassy of Australia contacted the Commission on behalf of the Federation of Australian Wool Organisations (''FAWO'') to seek an eight (8) day extension of the comment deadline until December 3, 2013. It explained that the FAWO will be participating in a meeting of the International Wool Textile Organisation (''IWTO'') in Guangzhou, China, on November 25–26, 2013, to discuss the proposed amendments. FAWO contends that the record will benefit from comments informed by the meeting deliberations given the role of the IWTO in representing wool industry stakeholders at an international level.

FAWO's input would likely assist the Commission in evaluating the proposed amendments to the Wool Rules. Moreover, the requested short extension of the comment period will not substantially delay the rulemaking process. The Commission recognizes that its NPRM addresses complex issues and believes that extending the comment period to facilitate a more complete record outweighs any harm that might result from an eight (8) day delay. Accordingly, the Commission is extending the comment period for eight (8) days until December 3, 2013.

By direction of the Commission.

Janice Podoll Frankle,

Acting Secretary.

[FR Doc. 2013–28662 Filed 11–29–13; 8:45 am]

BILLING CODE 6750–01–P

[1] 78 FR 57808 (Sept. 20, 2013).

[2] The Commission issued the Wool Rules to implement the Wool Products Labeling Act of 1939, 15 U.S.C. 68–68j.

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

[Docket No. FWS–R5–ES–2011–0024]; [4500030113]

RIN 1018–AY98

Endangered and Threatened Wildlife and Plants; Listing the Northern Long-Eared Bat as an Endangered Species

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed rule; extension of comment period.

SUMMARY: On October 2, 2013, we, the U.S. Fish and Wildlife Service (Service), announced a 12-month finding on a petition to list the eastern small-footed bat (*Myotis leibii*) and the northern long-eared bat (*Myotis septentrionalis*) as endangered or threatened under the Endangered Species Act of 1973, as amended (Act) and to designate critical habitat. After review of the best available scientific and commercial information, we found that listing the eastern small-footed bat is not warranted but listing the northern long-eared bat is warranted. Accordingly, we proposed to list the northern long-eared bat as an endangered species throughout its range under the Act. In the October 2, 2013, proposed rule, we also determined that critical habitat for the northern long-eared bat is not determinable at this time.

We announce the extension of the comment period for our October 2, 2013, proposed rule to ensure the public has sufficient time to comment on the proposal for this wide-ranging species that involves many stakeholders. The Service seeks data and comments from the public on the October 2, 2013, proposed listing rule for the northern long-eared bat.

DATES: The comment period for the proposed rule published October 2, 2013 (78 FR 61046), is extended. We request that comments on this proposal be submitted by the close of business on January 2, 2014.

ADDRESSES: *Document availability:* You may obtain copies of the proposed rule on the Internet at *http://www.regulations.gov* at Docket No. FWS–R5–ES–2011–0024, or by mail from U.S. Fish and Wildlife Service, Green Bay, Wisconsin Field Office (see **FOR FURTHER INFORMATION CONTACT**).

Written comments: You may submit comments by one of the following methods:

(1) *Electronically:* Go to the Federal eRulemaking Portal: *http://www.regulations.gov.* In the Search box, enter Docket No. FWS–R5–ES–2011–0024, which is the docket number for this rulemaking. Then, in the Search panel on the left side of the screen, under the Document Type heading, click on the Proposed Rules link to locate this document. You may submit a comment by clicking on ''Comment Now!'' If your comments will fit in the provided comment box, please use this feature of *http://www.regulations.gov,* as it is most compatible with our comment review procedures. If you attach your comments as a separate document, our preferred file format is Microsoft Word. If you attach multiple comments (such as form letters), our preferred format is a spreadsheet in Microsoft Excel.

(2) *By hard copy:* Submit by U.S. mail or hand-delivery to: Public Comments Processing, Attn: FWS–R5–ES–2011–0024; Division of Policy and Directives Management; U.S. Fish and Wildlife Service; 4401 N. Fairfax Drive, MS 2042–PDM; Arlington, VA 22203.

We request that you send comments only by the methods described above. We will post all information received on *http://www.regulations.gov.* This generally means that we will post any personal information you provide us (see the Information Requested section below for more details).

FOR FURTHER INFORMATION CONTACT: Peter Fasbender, Field Supervisor, U.S. Fish and Wildlife Service, Green Bay Ecological Services Office, 2661 Scott Tower Dr., New Franken, Wisconsin 54229; by telephone (920) 866–3650 or by facsimile (920) 866–1710. If you use a telecommunications device for the deaf (TDD), please call the Federal Information Relay Service (FIRS) at 800–877–8339.

SUPPLEMENTARY INFORMATION:

Background

On October 2, 2013, we published a 12-month finding on a petition to list the eastern small-footed bat (*Myotis leibii*) and the northern long-eared bat (*Myotis septentrionalis*) as endangered or threatened under the Endangered Species Act of 1973, as amended (Act) and to designate critical habitat (78 FR 61046). After review of the best available scientific and commercial information, we find that listing the eastern small-footed bat is not warranted but listing the northern long-eared bat is warranted. Accordingly, we proposed to list the northern long-eared bat as an endangered species throughout its range under the Act and also determined that critical habitat for the northern long-eared bat is not determinable at this time (78 FR 61046).

We received several requests to extend the public comment period on the proposed endangered species status of the northern long-eared bat beyond the December 2, 2013, due date. The northern long-eared bat has an extensive range; in the United States, it occurs in 39 states, and thus there are many involved stakeholders. Thus, in order to ensure that the public has an adequate opportunity to review and comment on our proposed rule, we are extending the comment period for an additional 30 days.

Information Requested

We intend that any final action resulting from this proposed rule will be based on the best scientific and commercial data available and be as accurate and as effective as possible. Therefore, we request comments or information from other concerned Federal and State agencies, the scientific community, or any other interested party concerning this proposed rule. We particularly seek comments regarding the northern long-eared bat concerning:

(1) The species' biology, range, and population trends, including:

(a) Habitat requirements for feeding, breeding, and sheltering;

(b) Genetics and taxonomy;

(c) Historical and current range, including distribution patterns;

(d) Historical and current population levels, and current and projected trends; and

(e) Past and ongoing conservation measures for the species, its habitat, or both.

(2) Any information on the biological or ecological requirements of the species, and ongoing conservation measures for the species and its habitat.

(3) Biological, commercial trade, or other relevant data concerning any threats (or lack thereof) to this species and regulations that may be addressing those threats.

(4) Current or planned activities in the areas occupied by the species and possible impacts of these activities on this species.

(5) Additional information regarding the threats to the species under the five listing factors, which are:

(a) The present or threatened destruction, modification, or curtailment of its habitat or range;

(b) Overutilization for commercial, recreational, scientific, or educational purposes;

(c) Disease or predation;

(d) The inadequacy of existing regulatory mechanisms; and

(e) Other natural or manmade factors affecting its continued existence.

(6) The reasons why areas should or should not be designated as critical

habitat as provided by section 4 of the Act (16 U.S.C. 1531 *et seq.*), including the possible risks or benefits of designating critical habitat, including risks associated with publication of maps designating any area on which this species may be located, now or in the future, as critical habitat.

(7) The following specific information on:

(a) The amount and distribution of habitat for the northern long-eared bat;

(b) What areas, that are currently occupied and that contain the physical and biological features essential to the conservation of this species, should be included in a critical habitat designation and why;

(c) Special management considerations or protection that may be needed for the essential features in potential critical habitat areas, including managing for the potential effects of climate change;

(d) What areas not occupied at the time of listing are essential for the conservation of this species and why;

(e) The amount of forest removal occurring within known summer habitat for this species;

(f) Information on summer roost habitat requirements that are essential for the conservation of the species and why; and

(g) Information on species winter habitat (hibernacula) features and requirements for the species.

(8) Information on the projected and reasonably likely impacts of changing environmental conditions resulting from climate change on the species and its habitat.

For more background on our proposed rule, see the October 2, 2013, **Federal Register**. The proposed rule is available at the Federal eRulemaking Portal at *http://www.regulations.gov* (see **ADDRESSES** section above).

If you previously submitted comments or information on the proposed rule, please do not resubmit them. We have incorporated them into the public record, and we will fully consider them in our final rulemaking. Our final determination concerning this proposed rulemaking will take into consideration all written comments and any additional information we receive.

Please note that submissions merely stating support for or opposition to the action under consideration without providing supporting information, although noted, will not be considered in making a determination, as section 4(b)(1)(A) of the Act directs that determinations as to whether any species is an endangered or threatened species must be made ''solely on the basis of the best scientific and commercial data available.''

You may submit your comments and materials concerning this proposed rule by one of the methods listed in **ADDRESSES**. We request that you send comments only by the methods described in the **ADDRESSES** section. If you submit information via *http://www.regulations.gov,* your entire submission—including any personal identifying information—will be posted on the Web site. If your submission is made via a hardcopy that includes personal identifying information, you may request at the top of your document that we withhold this information from public review. However, we cannot guarantee that we will be able to do so. We will post all hardcopy submissions on *http://www.regulations.gov.* Please include sufficient information with your comments to allow us to verify any scientific or commercial information you include.

Comments and materials we receive, as well as supporting documentation we used in preparing this proposed rule, will be available for public inspection on *http://www.regulations.gov,* or by appointment, during normal business hours, at the U.S. Fish and Wildlife Service, Green Bay, Wisconsin Field Office (see **FOR FURTHER INFORMATION CONTACT**). You may obtain copies of the proposed rule on the Internet at *http://www.regulations.gov* at Docket No. FWS–R5–ES–2011–0024, or by mail from U.S. Fish and Wildlife Service, Green Bay, Wisconsin Field Office (see **FOR FURTHER INFORMATION CONTACT**).

Authors

The primary authors of this notice are the staff members of the Green Bay, Wisconsin, Field Office.

Authority

The authority for this action is the Endangered Species Act of 1973, as amended (16 U.S.C. 1531 *et seq.*).

Dated: November 21, 2013.

Stephen Guertin,

Acting Director, U.S. Fish and Wildlife Service.

[FR Doc. 2013–28705 Filed 11–29–13; 8:45 am]

BILLING CODE 4310–55–P

Notices

Federal Register

Vol. 78, No. 231

Monday, December 2, 2013

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Forest Service

Chimney Rock National Monument Management Plan; San Juan National Forest; Colorado

AGENCY: Forest Service, USDA.

ACTION: Notice of intent to prepare an environmental impact statement.

SUMMARY: The Forest Service intends to prepare an environmental impact statement (EIS) to establish management direction for the land and resources within Chimney Rock National Monument, designated by Presidential Proclamation on September 21, 2012. The Forest Service, as the responsible agency, proposes to amend the 2013 San Juan National Forest Land and Resource Management Plan to provide for the protection of the objects of interest identified in the Proclamation. These objects include significant archaeology, archaeoastronomy, visual and landscape characteristics, and geological and biological features.

DATES: Comments concerning the scope of the analysis must be received by January 16, 2014.

ADDRESSES: Send written comments to Kevin Khung, Pagosa District Ranger, PO Box 310, Pagosa Springs, CO 81147]. Comments may also be sent via email to [*comments-rocky-mountain-san-juan-pagosa@fs.fed.us*], or via facsimile to [970–264–1538].

FOR FURTHER INFORMATION CONTACT: Sara Brinton, Interdisciplinary Team Leader at 970–264–1532, or sbrinton@fs.fed.us.

Individuals who use telecommunication devices for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339 between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday.

SUPPLEMENTARY INFORMATION:

Estimated Dates

The draft environmental impact statement is expected in April, 2014 and the final environmental impact statement is expected in September, 2014.

Purpose and Need for Action

The Presidential Proclamation establishing Chimney Rock National Monument (the Monument) requires preparation of a management plan. The purpose and need of developing the management plan is to ensure that the lands and resources within the Monument are managed in accordance with the intent of the Presidential Proclamation that established the Monument. As stated in the proclamation, the plan will provide for protection and interpretation of the scientific and historic objects identified, including nationally significant archaeology, archaeoastronomy, visual and landscape characteristics, and geological and biological features, as well as objects of deep cultural and educational value. The plan will also provide for continued public access to those objects consistent with their protection, and protect and preserve access by tribal members for traditional cultural, spiritual, and food- and medicine-gathering purposes, consistent with the purposes of the monument, to the maximum extent permitted by law in order to protect the objects of interest. The management plan will amend the 2013 San Juan National Forest Land and Resource Management Plan.

The management plan will be prepared pursuant to the requirements of the National Forest Management Act of 1976 (NFMA) and the 1982 U.S. Forest Service (USFS) planning regulations (36 CFR part 219) as allowed by the transition provision of the 2012 forest planning regulations. The 1982 planning regulations are available at *http://www.fs.fed.us/emc/nfma/includes/nfmareg.html.*

Proposed Action

The San Juan National Forest proposes to develop a management plan that will: (1) Identify the goals (desired conditions) for the Monument; (2) identify suitable uses for areas within the Monument; (3) establish the Strategies, Objectives, and Standards and Guidelines for management of the Monument; (4) Evaluate and recommend Special Area designations; (5) Identify the Monitoring and Evaluation requirements for the Monument; and (6) Establish a transportation plan for the Monument.

Responsible Official

San Juan Forest Supervisor.

Scoping Process

This notice of intent initiates the scoping process, which guides the development of the environmental impact statement. Information regarding this project is available at the Pagosa Ranger District office in Pagosa Springs, Colorado, and on the San Juan National Forest Web site at *www.fs.usda.gov/sanjuan.* Public open houses may be scheduled at a later date to provide further information as needed. The dates of any public open houses will be announced by press releases in local papers, direct mailings, emails, and will be posted on the San Juan National Forest Web site.

It is important that reviewers provide their comments at such times and in such manner that they are useful to the agency's preparation of the environmental impact statement. Therefore, comments should be provided prior to the close of the comment period and should clearly articulate the reviewer's concerns.

Comments received in response to this solicitation, including names and addresses of those who comment, will be part of the public record for this proposed action. Comments submitted anonymously will be accepted and considered; however, anonymous comments will not provide the Agency with the ability to provide the respondent with subsequent environmental documents.

Dated: November 20, 2013.

Mark W. Stiles,

Forest Supervisor.

[FR Doc. 2013–28774 Filed 11–29–13; 8:45 am]

BILLING CODE 3410–11–P

COMMISSION ON CIVIL RIGHTS

Agenda and Notice of Public Meeting of the District of Columbia Advisory Committee

Notice is hereby given, pursuant to the provisions of the rules and regulations of the U.S. Commission on

Civil Rights (Commission), and the Federal Advisory Committee Act (FACA), that a meeting of the District of Columbia Advisory Committee to the Commission will convene at 12:00 p.m. (ET) on Tuesday, December 17, 2013, at 1331 Pennsylvania Avenue NW., Suite 1150, Washington, DC 20425. The purpose of the meeting is for the Advisory Committee to review documents related to its human trafficking project and plan the next steps for preparing a report after its September briefing.

Members of the public are entitled to submit written comments. The comments must be received in the regional office by Friday, January 17, 2013. Comments may be mailed to the Eastern Regional Office, U.S. Commission on Civil Rights, 1331 Pennsylvania Avenue, Suite 1150, Washington, DC 20425, faxed to (202) 376–7548, or emailed to *ero@usccr.gov.* Persons who desire additional information may contact the Eastern Regional Office at 202–376–7533.

Persons needing accessibility services should contact the Eastern Regional Office at least 10 working days before the scheduled date of the meeting.

Records generated from this meeting may be inspected and reproduced at the Eastern Regional Office, as they become available, both before and after the meeting. Persons interested in the work of this advisory committee are advised to go to the Commission's Web site, *www.usccr.gov,* or to contact the Eastern Regional Office at the above phone number, email or street address.

The meetings will be conducted pursuant to the provisions of the rules and regulations of the Commission and FACA.

Dated on November 26, 2013.

David Mussatt,

Acting Chief, Regional Programs Coordination Unit.

[FR Doc. 2013–28762 Filed 11–29–13; 8:45 am]

BILLING CODE 6335–01–P

DEPARTMENT OF COMMERCE

Economic Development Administration

Notice of Petitions by Firms for Determination of Eligibility To Apply for Trade Adjustment Assistance

AGENCY: Economic Development Administration, Department of Commerce.

ACTION: Notice and Opportunity for Public Comment.

Pursuant to Section 251 of the Trade Act 1974, as amended (19 U.S.C. 2341 *et seq.*), the Economic Development Administration (EDA) has received petitions for certification of eligibility to apply for Trade Adjustment Assistance from the firms listed below. Accordingly, EDA has initiated investigations to determine whether increased imports into the United States of articles like or directly competitive with those produced by each of these firms contributed importantly to the total or partial separation of the firm's workers, or threat thereof, and to a decrease in sales or production of each petitioning firm.

LIST OF PETITIONS RECEIVED BY EDA FOR CERTIFICATION ELIGIBILITY TO APPLY FOR TRADE ADJUSTMENT ASSISTANCE

[11/21/2013 through 11/25/2013]

Firm name	Firm address	Date accepted for investigation	Product(s)
Advanced Microsensors Corporation	333 South Street, Bldg. 2, Shrewsbury, MA 01545.	11/22/2013	The firm manufactures magnetic compass sensors and micro switches.
Senior Aerospace Connecticut	4 Peerless Way, Enfield, CT 99991	11/22/2013	The firm manufactures machined and assembled aerospace components.
Western Electronics, LLC	1550 S Tech Lane, Meridian, ID 83642.	11/22/2013	The firm manufactures electronic wire harnesses and printed circuit boards.
Twinlab Corporation	600 Quality Drive, American Fork, UT 84003.	11/22/2013	The firm manufacturers vitamins, minerals, sport nutrition formulas, herbs and tea products.
Esco Lighting, Inc	3254 N. Kilbourn Ave., Chicago, IL 60641.	11/22/2013	The firm manufacturers lighting fixtures utilizing HID, induction, LED and fluorescent light sources.

Any party having a substantial interest in these proceedings may request a public hearing on the matter. A written request for a hearing must be submitted to the Trade Adjustment Assistance for Firms Division, Room 71030, Economic Development Administration, U.S. Department of Commerce, Washington, DC 20230, no later than ten (10) calendar days following publication of this notice.

Please follow the requirements set forth in EDA's regulations at 13 CFR 315.9 for procedures to request a public hearing. The Catalog of Federal Domestic Assistance official number and title for the program under which these petitions are submitted is 11.313, Trade Adjustment Assistance for Firms.

Dated: November 25, 2013.

Michael DeVillo,

Eligibility Examiner.

[FR Doc. 2013–28744 Filed 11–29–13; 8:45 am]

BILLING CODE 3510–WH–P

DEPARTMENT OF COMMERCE

International Trade Administration

Initiation of Five-Year (''Sunset'') Review

AGENCY: Enforcement and Compliance, formerly Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: In accordance with section 751(c) of the Tariff Act of 1930, as amended (''the Act''), the Department of Commerce (''the Department'') is automatically initiating five-year reviews (''Sunset Reviews'') of the antidumping and countervailing duty (''AD/CVD'') orders listed below. The International Trade Commission (''the Commission'') is publishing concurrently with this notice its notice of *Institution of Five-Year Review* which covers the same orders.

DATES: *Effective Date:* December 1, 2013.

FOR FURTHER INFORMATION CONTACT: The Department official identified in the

Initiation of Review section below at AD/CVD Operations, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue NW., Washington, DC 20230. For information from the Commission contact Mary Messer, Office of Investigations, U.S. International Trade Commission at (202) 205–3193.

SUPPLEMENTARY INFORMATION:

Background

The Department's procedures for the conduct of Sunset Reviews are set forth in its *Procedures for Conducting Five-Year (''Sunset'') Reviews of Antidumping and Countervailing Duty Orders,* 63 FR 13516 (March 20, 1998) and 70 FR 62061 (October 28, 2005). Guidance on methodological or analytical issues relevant to the Department's conduct of Sunset Reviews is set forth in *Antidumping Proceedings: Calculation of the Weighted-Average Dumping Margin and Assessment Rate in Certain Antidumping Duty Proceedings; Final Modification,* 77 FR 8101 (February 14, 2012).

Initiation of Review

In accordance with 19 CFR 351.218(c), we are initiating Sunset Reviews of the following antidumping duty orders:

DOC Case No.	ITC Case No.	Country	Product	Department contact
A–570–935	731–TA–1149	China	Circular Welded Carbon Quality Steel Line Pipe (1st Review).	Charles Riggle (202) 482–0650.
C–570–936	701–TA–455	China	Circular Welded Carbon Quality Steel Line Pipe (1st Review).	David Goldberger (202) 482–4136.
A–570–900	731–TA–1092	China	Diamond Sawblades (1st Review)	David Goldberger (202) 482–4136.

Filing Information

As a courtesy, we are making information related to sunset proceedings, including copies of the pertinent statute and Department's regulations, the Department's schedule for Sunset Reviews, a listing of past revocations and continuations, and current service lists, available to the public on the Department's Web site at the following address: ''*http://enforcement.trade.gov/sunset/*.'' All submissions in these Sunset Reviews must be filed in accordance with the Department's regulations regarding format, translation, and service of documents. These rules, including electronic filing requirements via Import Administration's Antidumping and Countervailing Duty Centralized Electronic Service System (''IA ACCESS''), can be found at 19 CFR 351.303. *See also Antidumping and Countervailing Duty Proceedings: Electronic Filing Procedures; Administrative Protective Order Procedures,* 76 FR 39263 (July 6, 2011).

This notice serves as a reminder that any party submitting factual information in an AD/CVD proceeding must certify to the accuracy and completeness of that information. *See* section 782(b) of the Act. Parties are hereby reminded that revised certification requirements are in effect for company/government officials as well as their representatives in all AD/CVD investigations or proceedings initiated on or after August 16, 2013. *See Certification of Factual Information To Import Administration During Antidumping and Countervailing Duty Proceedings,* 78 FR 42678 (July 17, 2013) (''*Final Rule*'') (amending 19 CFR 351.303(g)). The formats for the revised certifications are provided at the end of the *Final Rule.* The Department intends to reject factual submissions if the submitting party does not comply with the revised certification requirements.

On April 10, 2013, the Department published *Definition of Factual Information and Time Limits for Submission of Factual Information: Final Rule,* 78 FR 21246 (April 10, 2013), which modified two regulations related to antidumping and countervailing duty proceedings: The definition of factual information (19 CFR 351.102(b)(21)), and the time limits for the submission of factual information (19 CFR 351.301). The final rule identifies five categories of factual information in 19 CFR 351.102(b)(21), which are summarized as follows: (i) Evidence submitted in response to questionnaires; (ii) evidence submitted in support of allegations; (iii) publicly available information to value factors under 19 CFR 351.408(c) or to measure the adequacy of remuneration under 19 CFR 351.511(a)(2); (iv) evidence placed on the record by the Department; and (v) evidence other than factual information described in (i)–(iv). The final rule requires any party, when submitting factual information, to specify under which subsection of 19 CFR 351.102(b)(21) the information is being submitted and, if the information is submitted to rebut, clarify, or correct factual information already on the record, to provide an explanation identifying the information already on the record that the factual information seeks to rebut, clarify, or correct. The final rule also modified 19 CFR 351.301 so that, rather than providing general time limits, there are specific time limits based on the type of factual information being submitted. These modifications are effective for all segments initiated on or after May 10, 2013. Please review the final rule, available at *http://enforcement.trade.gov/frn/2013/1304frn/2013-08227.txt*, prior to submitting factual information in this segment. To the extent that other regulations govern the submission of factual information in a segment (such as 19 CFR 351.218), these time limits will continue to be applied.

On September 20, 2013, the Department modified its regulation concerning the extension of time limits for submissions in antidumping and countervailing duty proceedings: *Extension of Time Limits,* 78 FR 57790 (September 20, 2013). The modification clarifies that parties may request an extension of time limits before a time limit established under Part 351 of the Department's regulations expires, or as otherwise specified by the Secretary. In general, an extension request will be considered untimely if it is filed after the time limit established under Part 351 expires. For submissions which are due from multiple parties simultaneously, an extension request will be considered untimely if it is filed after 10:00 a.m. on the due date. Under certain circumstances, the Department may elect to specify a different time limit by which extension requests will be considered untimely for submissions which are due from multiple parties simultaneously. In such a case, the Department will inform parties in the letter or memorandum setting forth the deadline (including a specified time) by which extension requests must be filed to be considered timely. This modification also requires that an extension request must be made in a

separate, stand-alone submission, and clarifies the circumstances under which the Department will grant untimely-filed requests for the extension of time limits. These modifications are effective for all segments initiated on or after October 21, 2013. Please review the final rule, available at *http://www.gpo.gov/fdsys/pkg/FR-2013-09–20/html/2013-22853 .htm*, prior to submitting factual information in these segments.

Pursuant to 19 CFR 351.103(d), the Department will maintain and make available a service list for these proceedings. To facilitate the timely preparation of the service list(s), it is requested that those seeking recognition as interested parties to a proceeding contact the Department in writing within 10 days of the publication of the Notice of Initiation.

Because deadlines in Sunset Reviews can be very short, we urge interested parties to apply for access to proprietary information under administrative protective order (''APO'') immediately following publication in the **Federal Register** of this notice of initiation by filing a notice of intent to participate. The Department's regulations on submission of proprietary information and eligibility to receive access to business proprietary information under APO can be found at 19 CFR 351.304–306.

Information Required from Interested Parties

Domestic interested parties, as defined in section 771(9)(C), (D), (E), (F), and (G) of the Act and 19 CFR 351.102(b), wishing to participate in a Sunset Review must respond not later than 15 days after the date of publication in the **Federal Register** of this notice of initiation by filing a notice of intent to participate. The required contents of the notice of intent to participate are set forth at 19 CFR 351.218(d)(1)(ii). In accordance with the Department's regulations, if we do not receive a notice of intent to participate from at least one domestic interested party by the 15-day deadline, the Department will automatically revoke the order without further review. *See* 19 CFR 351.218(d)(1)(iii).

If we receive an order-specific notice of intent to participate from a domestic interested party, the Department's regulations provide that *all parties* wishing to participate in a Sunset Review must file complete substantive responses not later than 30 days after the date of publication in the **Federal Register** of this notice of initiation. The required contents of a substantive response, on an order-specific basis, are set forth at 19 CFR 351.218(d)(3). Note that certain information requirements differ for respondent and domestic parties. Also, note that the Department's information requirements are distinct from the Commission's information requirements. Please consult the Department's regulations for information regarding the Department's conduct of Sunset Reviews. Please consult the Department's regulations at 19 CFR part 351 for definitions of terms and for other general information concerning antidumping and countervailing duty proceedings at the Department.

This notice of initiation is being published in accordance with section 751(c) of the Act and 19 CFR 351.218(c).

Dated: November 25, 2013.

Christian Marsh,

Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations.

[FR Doc. 2013–28807 Filed 11–29–13; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

National Institute of Standards and Technology

Open Meeting of the Information Security and Privacy Advisory Board

AGENCY: National Institute of Standards and Technology, Commerce.

ACTION: Notice.

SUMMARY: The Information Security and Privacy Advisory Board (ISPAB) will meet Thursday, December 19, 2013, from 8:00 a.m. until 5:00 p.m. Eastern Time, and Friday, December 20, 2013, from 8:00 a.m. until 5:00 p.m. Eastern Time. All sessions will be open to the public.

DATES: The meeting will be held on Thursday, December 19, 2013, from 8:00 a.m. until 5:00 p.m. Eastern Time, and Friday, December 20, 2013, from 8:00 a.m. until 5:00 p.m. Eastern Time.

ADDRESSES: The meeting will be held at Microsoft Innovation & Policy Center, 901 K Street NW., Suite 1100, Washington, DC 20001 (TEL. 202–263–5900). Please note admittance instructions under the **SUPPLEMENTARY INFORMATION** section of this notice.

FOR FURTHER INFORMATION CONTACT: Annie Sokol, Information Technology Laboratory, National Institute of Standards and Technology, 100 Bureau Drive, Mail Stop 8930, Gaithersburg, MD 20899–8930, telephone: (301) 975–2006, or by email at: *annie.sokol@nist.gov.*

SUPPLEMENTARY INFORMATION: Pursuant to the Federal Advisory Committee Act, as amended, 5 U.S.C. App., notice is hereby given that the Information Security and Privacy Advisory Board (ISPAB) will meet Thursday, December 19, 2013, from 8:00 a.m. until 5:00 p.m. Eastern Time, and Friday, December 20, 2013, from 8:00 a.m. until 5:00 p.m. Eastern Time. All sessions will be open to the public. The ISPAB is authorized by 15 U.S.C. 278g–4, as amended, and advises the Secretary of Commerce, the Director of the Office of Management and Budget, and the Director of NIST on information security and privacy issues pertaining to federal computer systems. Details regarding the ISPAB's activities are available at *http://csrc.nist.gov/groups/SMA/ispab/index.html.*

The agenda is expected to include the following items:

—Cybersecurity
- Executive Order 13636, Improving Critical Infrastructure Cybersecurity (78 FR 11737, February 19, 2013);
- Development of New Cybersecurity Framework;
- Request for Information (RFI)—Developing a Framework to Improve Critical Infrastructure Cybersecurity (78 FR 13024, February 26, 2013);
- Notice of Inquiry (NOI)—Incentives to Adopt Improved Cybersecurity Practices (78 FR 18954, March 28, 2013),

—Update on Legislative proposals relating to information security and privacy,
—Information Sharing Update: CNCI–5 ISA Brief—Information Security,
—National Infrastructure Protection Plan (NIPP) Updates,
—Regulatory updates of Embedded Software Security Updates,
—Discussion on cryptography,
—Update on Privacy and Civil Liberties Oversight Board (PCLOB), and
—Update on NIST Computer Security Division.

Note that agenda items may change without notice because of possible unexpected schedule conflicts of presenters. The final agenda will be posted on the Web site indicated above. Seating will be available for the public and media.

Public Participation: The ISPAB agenda will include a period of time, not to exceed thirty minutes, for oral comments from the public (Friday, December 20, 2013, between 9:00 a.m. and 9:30 a.m.). Speakers will be selected on a first-come, first-served basis. Each speaker will be limited to five minutes. Questions from the public will not be considered during this period. Members

of the public who are interested in speaking are requested to contact Annie Sokol at the contact information indicated in the **FOR FURTHER INFORMATION CONTACT** section of this notice.

Speakers who wish to expand upon their oral statements, those who had wished to speak but could not be accommodated on the agenda, and those who were unable to attend in person are invited to submit written statements. In addition, written statements are invited and may be submitted to the ISPAB at any time. All written statements should be directed to the ISPAB Secretariat, Information Technology Laboratory, 100 Bureau Drive, Stop 8930, National Institute of Standards and Technology, Gaithersburg, MD 20899–8930.

All visitors to this meeting are requested to pre-register to be admitted. Please submit your name, time of arrival, and email address to Annie Sokol, *annie.sokol@nist.gov,* by 5:00 p.m. Eastern Time, Friday, December 13, 2013.

Dated: November 22, 2013.

Willie E. May,

Associate Director for Laboratory Programs.

[FR Doc. 2013–28789 Filed 11–29–13; 8:45 am]

BILLING CODE 3510–13–P

DEPARTMENT OF COMMERCE

United States Patent and Trademark Office

[Docket No. PTO–C–2013–0039]

Request for Comments on Methods for Studying the Diversity of Patent Applicants

AGENCY: United States Patent and Trademark Office, Commerce.

ACTION: Request for Comments.

SUMMARY: The United States Patent and Trademark Office (''USPTO'' or ''the Office'') is interested in gathering information on approaches for studying the diversity of patent applicants in accordance with research methodology developed as required by the America Invents Act (AIA or Act). To assist in gathering this information, the USPTO invites the public to provide comments on collecting information on the diversity of patent applicants consistent with the AIA.

Written Comments: Written comments should be sent by email to *saurabh.vishnubhakat@uspto.gov.* Comments may also be submitted by postal mail addressed to Saurabh Vishnubhakat, Expert Advisor, Office of Chief Economist, United States Patent and Trademark Office, Mail Stop External Affairs, P.O. Box 1450, Alexandria, VA 22313–1450. Although comments may be submitted by postal mail, the USPTO prefers to receive comments via email. The deadline for receipt of written comments is January 31, 2014. Written comments should be identified in the subject line of the email or postal mailing as ''Diversity of Patent Applicants.''

Because written comments will be made available for public inspection, information that a respondent does not desire to be made public, such as a telephone number, should not be included in the written comments.

FOR FURTHER INFORMATION CONTACT: Saurabh Vishnubhakat, Expert Advisor, Office of Chief Economist, by telephone at (571) 272–6900, or by email at *saurabh.vishnubhakat@uspto.gov.*

SUPPLEMENTARY INFORMATION: Section 29 of the AIA charged the Director of the USPTO with ''establish[ing] methods for studying the diversity of patent applicants, including those applicants who are minorities, women, or veterans'' no later than six months after the enactment of the Act (i.e., by March 16, 2012). This section further provided that the Director shall not use the results of such study to provide any preferential treatment to patent applicants. The USPTO developed and timely published a methodology to study important issues related to applicant diversity. See ''Diversity of Applicant Methodology'' (March 16, 2012) on USPTO Web site for AIA Implementation (under ''Programs'').

This methodology respects the interests of individuals and organizations in protecting private information. It underscores the Office's sensitivity to this issue by taking an iterative, careful approach to potentially sensitive information from patent applicants, and includes input from the public. The methodology includes two initial steps: (1) Cooperate with the U.S. Census Bureau (''Census'') to analyze currently available public information data; and (2) seek public comment on whether or how to collect additional information. This Request for Comments constitutes the second stop in the methodology.

As to the first step in the methodology, the USPTO cooperated with Census to analyze currently available public information data. Consistent with the language and legislative history of Section 29 of the AIA, the analysis sought: (1) To describe the overall, cumulative (i.e., highly aggregated) demographic characteristics, such as race, gender, age, and geography, of inventors as a group; and (2) to describe the overall, cumulative (i.e., highly aggregated) business characteristics, such as revenues, number of employees, and geography, for companies as a group. Note that this analysis gathered and evaluated cumulative data on groups of individuals and companies; this analysis did not gather and evaluate data in a manner that would identify any particular individual or company.

The analysis sought to match certain public information in USPTO files with confidential census information in Census files. Consistent with AIA Section 29, USPTO's analysis aimed to identify group demographics like race, gender and age of inventors in patents granted in 2005–2006; USPTO did not seek or obtain such demographic information for any particular inventor.

By using existing data and cooperating with Census, the USPTO could avoid any additional burden on applicants while also protecting the identity of particular individuals and companies. This is because Census would only share with USPTO the highly aggregated group data (i.e., devoid of any personal identifying information). Because sensitive Census information concerning diversity characteristics is protected under Title 13, United States Code, once the USPTO information becomes comingled with Census data, that comingled data is confidential under Title 13 and cannot be released.

The data provided by USPTO for this analysis consisted only of certain public information provided on the face of patents granted between January 1, 2005, and December 31, 2006. This information was the name and address (generally only the town and state) of the inventor. As stated above, USPTO provided this public information to Census, and Census then confidentially attempted to match this data against its own data with the goal of identifying, on an overall basis, the cumulative demographic information of the inventors as a group.

The analysis was only partially successful, however, since Census was able to match only 64% of the inventors provided by USPTO. The basic information collected by the USPTO from inventors—i.e., name, town, and state—was not a particularly strong basis for matching with Census data. For example, usually it was not possible to match common names (such as ''John Smith'' or ''Mary Johnson'') in large cities (such as ''New York, NY'' or ''Chicago, IL''). In sum, the poor quality of data-matching, as well as some statistical bias, suggest that the limited

information currently collected by the USPTO about inventors (i.e., name, town, state) is not sufficient to allow Census to meaningfully describe the cumulative diversity characteristics of inventors as a group within the meaning of AIA Section 29.

In sum, the first step of USPTO's methodology under AIA Section 29 was to cooperate with Census to analyze currently available data. The aim was to identify demographic information about inventors of patents granted in 2005–2006, as a collective group. Since step one was only partially successful, the Agency now proceeds to step two, which is to seek public comments on whether or how to collect further information for completing the diversity study under AIA Section 29.

Issues For Comment: The USPTO seeks comments on how to study the diversity of patent applicants before the USPTO pursuant to AIA Section 29. The questions below are intended to aid the USPTO in assessing whether and how to collect further information and in considering potential next steps for a diversity study. The questions should not be taken as an indication that the USPTO has taken a position or is predisposed to any particular view. The public is invited to answer any or all of these questions. The public is also invited to submit comments on any related issues that they believe are relevant.

(1) How and by which methods should the USPTO effectively study patent applicant diversity in accordance with the expressed intent of Congress in Section 29 of the AIA?

(2) Should the USPTO conduct surveys of patent applicants to obtain demographic data such as race, gender, age, and geography, of inventors as a group?

(3) Aside from surveys, how can the USPTO effectively collect personal identifying information about U.S. and non-U.S. patent applicants in order to study applicant diversity through improved data matching, analytics, and studies?

(a) Should the USPTO collect certain personal identifying information about U.S. and non-U.S. patent applicants on a mandatory basis or on a voluntary basis? How would each of these approaches affect the accuracy of the information being provided?

(b) Can USPTO effectively collect personal identifying information from other institutions or organizations about U.S. and non-U.S. patent applicants?

(4) What particular personal identifying information should the USPTO seek (or not seek) in order to more effectively study applicant diversity? Why?

Dated: November 25, 2013.

Margaret A. Focarino,

Commissioner for Patents.

[FR Doc. 2013–28742 Filed 11–29–13; 8:45 am]

BILLING CODE 3510–16–P

DEPARTMENT OF DEFENSE

Office of the Secretary

[Docket ID: DoD–2013–OS–0222]

Proposed Collection; Comment Request

AGENCY: Department of Defense Education Activity, DoD.

ACTION: Notice.

SUMMARY: In compliance with Section 3506(c)(2)(A) of the *Paperwork Reduction Act of 1995,* the Department of Defense Education Activity announces a proposed public information collection and seeks public comment on the provisions thereof. Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed information collection; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology.

DATES: Consideration will be given to all comments received by January 31, 2014.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Federal Docket Management System Office, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350–3100.

Instructions: All submissions received must include the agency name, docket number and title for this **Federal Register** document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the Internet at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

Any associated form(s) for this collection may be located within this same electronic docket and downloaded for review/testing. Follow the instructions at *http://www.regulations.gov* for submitting comments. Please submit comments on any given form identified by docket number, form number, and title.

FOR FURTHER INFORMATION CONTACT: To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to the Department of Defense Education Activity, ATTN: Ms. Kathy Facon, 4800 Mark Center Dr., Alexandria, VA 22350–1400 or call (571) 372–5834.

SUPPLEMENTARY INFORMATION:

Title; Associated Form; and OMB Number: Application for DoD Impact Aid for Children with Severe Disabilities; SD Form 816 and SD Form 816c; OMB Number 0704–0425.

Needs and Uses: DoD funds are authorized for local educational agencies (LEAs) that educate military dependent students with severe disabilities and meet certain criteria. This application will be requested of military-impacted LEAs to determine if they meet the DoD criteria to receive compensation for the cost of educating military dependents with severe disabilities.

Affected Public: Local Education Agencies (LEAs).

Annual Burden Hours: 400.

Number of Respondents: 50.

Responses per Respondent: 1.

Average Burden per Response: 8 hours.

Frequency: Annually.

The data collection consists of an application and signature sheet that must be submitted by fax with the original signature clearly visible on the document. The application is identified as Secretary of Defense Form 816 (SD 816), with SD Form 816C to be used as a continuation page if necessary. In order for DoD to compute the maximum payment amount, the LEA will need to determine and provide the following information in its application. First, the LEA must provide the special education costs of individual military dependent children who have severe disabilities and meet the threshold for payments (at least two military dependents with severe disabilities and the cost per student must be at least five times the national average or three times the state average for students with disabilities, whichever is lower). These averages are provided to the LEAs by DoD in the application guidelines and

acknowledged by the LEA in the application. Second, LEAs are required to identify the number of eligible children who were residing on-base or off-base during the previous school year. If any of the eligible children were residing in base housing or in military housing undergoing renovation or rebuilding and deemed as eligible for on-base housing, LEAs will need to identify this number on the front page of the application. Third, the LEA must provide its banking information to receive payment. A sample ''Section II—Payment Determination'' is included as part of the form to provide an example for LEAs.

Dated: November 26, 2013.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2013–28780 Filed 11–29–13; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Office of the Secretary

[Docket ID: DoD–2013–OS–0223]

Proposed Collection; Comment Request

AGENCY: Office of the Under Secretary of Defense (Personnel and Readiness), DoD.

ACTION: Notice.

SUMMARY: In compliance with Section 3506(c)(2)(A) of the *Paperwork Reduction Act of 1995,* the Office of the Under Secretary of Defense (Personnel and Readiness) announces a proposed public information collection and seeks public comment on the provisions thereof. Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed information collection; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology.

DATES: Consideration will be given to all comments received by January 31, 2014.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Federal Docket Management Systems Office, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350–3100.

Instructions: All submissions received must include the agency name, docket number and title for this **Federal Register** document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the Internet at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

FOR FURTHER INFORMATION CONTACT: To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to the Department of Defense Education Activity (DoDEA), Office of the Director, ATTN: Martha Brown, Alexandria, VA 22350, or call DoDEA, Office of the Director, at 571–432–9069.

SUPPLEMENTARY INFORMATION:

Title; Associated Form; and OMB Control Number: Assessing Options for CONUS Domestic Dependents Elementary and Secondary Schools (DDESS); OMB Control Number 0704–TBD.

Needs and Uses: The objective of this project is to recommend options that most effectively balance cost and quality considerations for primary and secondary schooling of military dependents on each of the 15 continental United States (CONUS) installations where the Department of Defense currently operates Domestic Dependents Elementary and Secondary Schools (DDESS) or contracts with local educational agencies (LEAs) to operate schools on the installation. As part of the study, we will interview superintendents of LEAs that are in close proximity to installations that have DDESS schools (excluding those installations that only have special arrangement schools). The interviews will capture information on the approach the LEAs will adopt if they were given the responsibility to educate DDESS students, as well as identify factors that might facilitate or hinder LEAs taking the responsibility of educating DDESS students. This information is critical as it will identify whether transferring DDESS schools to LEAs is even a feasible option that could be plausibly considered for the governance of the current CONUS DDESS schools.

Affected Public: Individuals or households.

Annual Burden Hours: 56.

Number of Respondents: 28.

Responses per Respondent: 1.

Average Burden per Response: 120 minutes.

Frequency: Once.

Superintendents of local education agencies (LEAs) that are in the vicinity of the installations where the Department of Defense (DoD) currently operates Domestic Dependents Elementary and Secondary Schools (DDESS), as well as superintendents of LEAs that have contracts with DoD to operate schools at the installations will be interviewed. The interviews will address the type and quality of programs and services they provide to their students, their capacity to expand their student enrollment to include DDESS students, challenges they would face, and considerations they need to take into account. Participation in these interviews is completely voluntary. Information from the interviews will be used by policymakers at the Department of Defense to determine ways to best operate DDESS and contracted schools.

Dated: November 26, 2013.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2013–28787 Filed 11–29–13; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Office of the Secretary

[Transmittal Nos. 13–44]

36(b)(1) Arms Sales Notification

AGENCY: Department of Defense, Defense Security Cooperation Agency.

ACTION: Notice.

SUMMARY: The Department of Defense is publishing the unclassified text of a section 36(b)(1) arms sales notification. This is published to fulfill the requirements of section 155 of Public Law 104–164 dated July 21, 1996.

FOR FURTHER INFORMATION CONTACT: Ms. B. English, DSCA/DBO/CFM, (703) 601–3740.

The following is a copy of a letter to the Speaker of the House of Representatives, Transmittals 13–44 with attached transmittal, policy justification, and Sensitivity of Technology.

Dated:November 26, 2013.

Aaron Siegel

Alternate OSD Federal Register Liaison Officer, Department of Defense.

BILLING CODE 5001–06–P

DEFENSE SECURITY COOPERATION AGENCY
201 12TH STREET SOUTH, STE 203
ARLINGTON, VA 22202-5408

NOV 18 2013

The Honorable John A. Boehner
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

Pursuant to the reporting requirements of Section 36(b)(1) of the Arms Export Control Act, as amended, we are forwarding herewith Transmittal No. 13-44, concerning the Department of the Navy's proposed Letter(s) of Offer and Acceptance to the Kingdom of Saudi Arabia for defense articles and services estimated to cost $1.1 billion. After this letter is delivered to your office, we plan to issue a press statement to notify the public of this proposed sale.

Sincerely,

FOR J. W. Rixey
Vice Admiral, USN
Director

Enclosures:
1. Transmittal
2. Policy Justification

BILLING CODE 5001–06–C

Transmittal No. 13–44

Notice of Proposed Issuance of Letter of Offer Pursuant to Section 36(b)(1) of the Arms Export Control Act, as amended

(i) *Prospective Purchaser:* Kingdom of Saudi Arabia

(ii) *Total Estimated Value:*

Major Defense Equipment*	$.35 billion
Other	.75 billion
Total	1.10 billion

(iii) *Description and Quantity or Quantities of Articles or Services under Consideration for Purchase:* 109 Link—16 Multifunction Information Distribution System Low Volume Terminals (MIDS–LVT), Global Command and Control Systems—Joint (GCCS–J), Identification Friend or Foe (IFF), Commercial Satellite Communications (SATCOM), Combined Enterprise Regional Information

Exchange System (CENTRIXS) and follow-on systems, Commercial High Frequency (HF) Radios, Commercial Ultra High Frequency/Very High Frequency (UHF/VHF) Radios, HF Voice and Data, HF Sub-Net Relay (SNR), Commercial HF Internet Protocol (IP)/SNR, Global Positioning System (GPS), Air Defense System Interrogator (ADSI), communications support equipment, information technology upgrades, spare and repair parts, publications and technical documentation, personnel training and training equipment, U.S. Government and contractor engineering and technical support, and other elements of program support.

(iv) *Military Department:* Navy (SBQ).

(v) *Prior Related Cases, if any:* FMS Case BBG—$93M—29Apr02, FMS Case GBK—$101M—29Apr02, FMS Case GBL—$24M—29Apr02, FMS Case LCF—$15M—29Apr02, FMS Case GBM—$16M—31May11.

(vi) *Sales Commission, Fee, etc., Paid, Offered, or Agreed to be Paid:* None.

(vii) *Sensitivity of Technology Contained in the Defense Article or Defense Services Proposed to be Sold:* See Attached Annex.

(viii) *Date Report Delivered to Congress:* 18 Nov 13.

* as defined in Section 47(6) of the Arms Export Control Act.

POLICY JUSTIFICATION

Kingdom of Saudi Arabia—C4I System Upgrade and Maintenance

The Government of Saudi Arabia has requested a possible sale of C4I system upgrades and maintenance including: 109 Link-16 Multifunction Information Distribution System Low Volume Terminals (MIDS–LVT), Global Command and Control Systems—Joint (GCCS–J), Identification Friend or Foe (IFF), Commercial Satellite Communications (SATCOM), Combined Enterprise Regional Information Exchange System (CENTRIXS) and follow-on systems, Commercial High Frequency (HF) Radios, Commercial Ultra High Frequency/Very High Frequency (UHF/VHF) Radios, HF Voice and Data, HF Sub-Net Relay (SNR), Commercial HF Internet Protocol (IP)/SNR, Global Positioning System (GPS), Air Defense System Interrogator (ADSI), communications support equipment, information technology upgrades, spare and repair parts, publications and technical documentation, personnel training and training equipment, U.S. Government and contractor engineering and technical support, and other elements of program support. The estimated cost is $1.1 billion.

This proposed sale will contribute to the foreign policy and national security of the United States by helping to improve the security of a strategic regional partner which has been, and continues to be, an important force for political stability and economic progress in the Middle East.

The proposed sale will improve the Royal Saudi Naval Forces' capability to maintain and upgrade its current C4I system, increase the ability of RSNF vessels and manpower to effectively protect Saudi Arabia's coastal strategic assets, and keep pace with the rapid advances in C4I technology to remain a viable U.S. coalition partner in the region. The RSNF will use the upgraded C4I system to provide situational awareness of naval activity in the Persian Gulf and the Red Sea.

The proposed sale of this equipment and support will not alter the basic military balance in the region.

There will be no principal contractors involved with this proposed sale. The acquisition and integration of all systems will be managed by the U.S. Navy's Space and Naval Warfare Weapons Command (SPAWAR). There are no known offset agreements proposed in connection with this potential sale.

Implementation of this proposed sale will require the assignment of 14 U.S. Government and contractor representatives in the Kingdom of Saudi Arabia for ten years to support network design, acquisition, implementation, installation, and integration efforts.

There will be no adverse impact on U.S. defense readiness as a result of this proposed sale.

Transmittal No. 13–44

Notice of Proposed Issuance of Letter of Offer Pursuant to Section 36(b)(1) of the Arms Export Control Act

Annex

Item No. vii

(vii) *Sensitivity of Technology:*

1. The following technologies included in this sale are considered sensitive (there are no systems with embedded COMSEC identified in this notification with the exception of Link-16 Multifunction Information Distribution System Low Volume Terminals (MIDS–LVT) and IFF:

2. Link-16 Multifunction Information Distribution System Low Volume Terminals (MIDS–LVT) is a command, control, communications, and intelligence (C3I) system incorporating high-capacity, jam-resistant, digital communication links for exchange of near real-time tactical information including both data and voice, among air, ground and sea elements. Link-16 Multifunction Information Distribution System Low Volume Terminals (MIDS–LVT) is intended to support key theater functions such as surveillance, identification, air control, weapons engagement coordination, and direction for U.S. Services and those allied and partner nations for which there is a validated interoperability requirement. The system will provide jam-resistant, wide-area communications on a Link-16 Multifunction Information Distribution System Low Volume Terminals (MIDS–LVT) network among Link-16 Multifunction Information Distribution System Low Volume Terminals (MIDS–LVT) equipped platforms. Link-16 Multifunction Information Distribution System Low Volume Terminals (MIDS–LVT) will be used for both shore and shipboard use at the strategic and tactical levels as a real-time bridge between tactical data links and intelligence data sources Link-16 Multifunction Information Distribution System Low Volume Terminals (MIDS–LVT) receives, processes, correlates, and displays tracks from local radars, tactical data links, and intelligence sources with minimal operator interaction. Link-16 Multifunction Information Distribution System Low Volume Terminals (MIDS–LVT) provides a correlated, real-time picture of the battle space. These devices have embedded COMSEC which contains sensitive encryption algorithms and keying material.

3. Global Command and Control Systems—Joint (GCCS–J) provides the operational commander's warfighting capability with aids in the decision-making process by receiving, retrieving, and displaying information to allow warfighters to plan, coordinate, exercise, execute and evaluate naval and joint operations. GCCS–J is an open-ended architecture system consisting of servers, workstations, routers, hubs, and encryption devices, and integrates information from multiple C4I functional areas. (GCCS–J) operations contain sensitive operational data feeds, data formats, networking protocols and system architectures.

4. Combined Enterprise Regional Information Exchange System (CENTRIXS) is a collection of classified coalition networks that enable information sharing through the use of email and web services, instant messaging or chat, the Common Operational Picture service, and Voice over IP. CENTRIXS supports combatant commands throughout the world. CENTRIXS contains sensitive operational data feeds, data formats,

networking protocols and system architectures.

5. Air Defense System Interrogator (ADSI) provides an interface for military and commercial radars, tactical data links and intelligence reporting systems. ADSI also offers a general interface and translation capability for a variety of C4I data link formats and can interface tactical systems with simulations. ADSI contains sensitive operational data feeds, data formats, networking protocols and system architectures.

6. Sub-Net Relay is a masterless, ad-hoc, self-organizing data networking technology with inherent relay capabilities that employ tactical line-of-sight bearers to carry internet protocol data between groups of ships. HF Sub-Net Relay, which interfaces with Link-16 Multifunction Information Distribution System Low Volume Terminals (MIDS–LVT), contains sensitive operational data feeds, data formats, networking protocols and system architectures while the HF/IP Sub Net Relay is part of a commercial capability.

7. Radio Frequency (RF) and Internet Protocol (IP) Interfaces included in this case do not contain sensitive technology, however, they will connect to communications security devices which are not included in this case(s).

8. Identification Friend or Foe (IFF) is an identification system designed for command and control. It is a system that enables interrogation systems to distinguish friendly aircraft, vehicles, or forces, and to determine their bearing and range from the interrogator. IFF contains embedded security devices containing sensitive encryption algorithms and keying material. IFF contains sensitive operational data feeds, data formats, networking protocols and system architectures.

9. Commercial Global Positioning System (GPS)-provides a space-based global navigation satellite system (GNSS) that has reliable location and time information in all weather and at all times and anywhere on or near the Earth when and where there is an unobstructed line of sight to four or more GPS satellites. Emergent militarized GPS requirements will be addressed in future cases, if necessary.

10. Commercial HF Voice and Data Radios and Ultra High Frequency/Very High Frequency (UHF/VHF) Radios will be procured with this case. No sensitive encryption algorithms or keying material will be provided through this case.

11. If a technologically advanced adversary were to obtain knowledge of the specific hardware and software elements, the information could be used to develop countermeasures which might reduce weapon system effectiveness or be used in the development of a system with similar or advanced capabilities. Appropriate safeguards will be taken in regards to shared US Government information passed through the networks of our RSNF strategic partner.

[FR Doc. 2013–28766 Filed 11–29–13; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Department of the Army

[Docket ID USA–2013–0042]

Proposed Collection; Comment Request

AGENCY: Office of the Administrative Assistant to the Secretary of the Army (OAA–AAHS), DoD.

ACTION: Notice.

SUMMARY: In compliance with Section 3506(c)(2)(A) of the *Paperwork Reduction Act of 1995,* the Department of the Army announces a proposed public information collection and seeks public comment on the provisions thereof. Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed information collection; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology.

DATES: Consideration will be given to all comments received by January 31, 2014.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Federal Docket Management System Office, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350–3100.

Instructions: All submissions received must include the agency name, docket number and title for this **Federal Register** document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the Internet at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

Any associated form(s) for this collection may be located within this same electronic docket and downloaded for review/testing. Follow the instructions at *http://www.regulations.gov* for submitting comments. Please submit comments on any given form identified by docket number, form number, and title.

FOR FURTHER INFORMATION CONTACT: To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to the Military Surface Deployment and Distribution Command (AMSSD–PP), ATTN: John Becker, Scott AFB, Illinois, 62225–1604, or call the Department of the Army Reports Clearance Officer at (703) 428–6440.

SUPPLEMENTARY INFORMATION:

Title; Associated Form; and OMB Number: Uniform Tender of Rates and/or Changes for Domestic Transportation Services (DoD/USCG Sponsored Household Goods); OMB Control Number 0702–0018.

Needs and Uses: DoD approved household goods carrier file voluntary rates to engage in the movement of DoD and USCG Sponsored shipments within CONUS. SDDC evaluates the rates and awards the traffic to best value carriers whose rates are responsive and most service (value) to the government.

Affected Public: Business or other for-profit.

Annual Burden Hours: 279.

Number of Respondents: 836.

Responses per Respondent: 2.

Average Burden per Response: 10 minutes.

Frequency: Semi-annual.

The information collected on the Uniform Tender of Rates and/or Charges for Transportation Services and its iterations is provided by household good carriers to file rates in the Defense Personal Property System (DPPS). The electronic technology enhancement of the DPPS was fully implemented in November 2008. The form is currently available through the SDDC Web site.

Dated: November 26, 2013.

Aaron Siegel,

Alternate OSD Federal Register, Liaison Officer, Department of Defense.

[FR Doc. 2013–28751 Filed 11–29–13; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Department of the Army; Corps of Engineers

Inland Waterways Users Board

AGENCY: Department of the Army, U.S. Army Corps of Engineers, DoD.

ACTION: Notice of open meeting.

SUMMARY: In Accordance with 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), announcement is made of the forthcoming meeting.

Name of Committee: Inland Waterways Users Board (Board).

Date: January 14, 2014.

Location: Meeting at the Westin New Orleans Canal Place Hotel, 100 Rue Iberville, New Orleans, Louisiana 70130, at 504–566–7006, or *westinneworleanscanalplace.com.*

Time: Registration will begin at 8:30 a.m. and the meeting is scheduled to adjourn at approximately 1:00 p.m.

Agenda: The agenda will include the status of funding for inland navigation projects and studies, the status of the Inland Waterways Trust Fund, funding for Fiscal Year (FY) 2014, update of proposed water resources-related authorization bills, and the status of the Olmsted Locks and Dam Project.

FOR FURTHER INFORMATION CONTACT: Mr. Mark R. Pointon, Institute for Water Resources, U.S. Army Corps of Engineers, CEIWR–GM, 7701 Telegraph Road, Casey Building, Alexandria, VA 22315–3868; Ph: 703–428–6438 or Ms. Mindy M. Simmons, Headquarters, U.S. Army Corps of Engineers, CECW–IP, 441 G Street NW., Washington, DC 20314–1000; Ph: 202–761–1934.

SUPPLEMENTARY INFORMATION: The meeting is open to the public. Any interested person may attend, appear before, or file statements with the committee at the time and in the manner permitted by the committee.

Brenda S. Bowen,

Army Federal Register Liaison Officer.

[FR Doc. 2013–28785 Filed 11–29–13; 8:45 am]

BILLING CODE 3720–58–P

DEPARTMENT OF DEFENSE

Department of the Navy

Notice of Availability of Record of Decision for Atlantic Fleet Training and Testing

AGENCY: Department of the Navy, DoD.

ACTION: Notice.

SUMMARY: The United States Department of the Navy (DoN), after carefully weighing the strategic, operational and environmental consequences of the proposed action, announces its decision to support and conduct training and testing activities in the Atlantic Fleet study area as described in Alternative 2 for the proposed action. Under Alternative 2, the DoN analyzed areas where training and testing will continue as in the past, but were not considered in previous environmental analyzes; the establishment of new range capabilities, as well as modification of existing capabilities; adjustments to type and tempo of training and testing and the establishment of additional locations to conduct activities between the range complexes.

SUPPLEMENTARY INFORMATION: The complete text of the Record of Decision (ROD) is available on the project Web site at *http://aftteis.com,* along with the Final Environmental Impact Statement/ Overseas Environmental Impact Statement for Atlantic Fleet Training and Testing, dated August 2013 and supporting documents. Single copies of the ROD are available upon request by contacting: Naval Facilities Engineering Command Atlantic, Attn: Code EV22 (AFTT EIS/OEIS Project Manager), 6506 Hampton Boulevard, Norfolk, VA 23508–1278.

Dated: November 25, 2013.

N.A. Hagerty-Ford,

Commander, Office of the Judge Advocate General, U.S. Navy, Federal Register Liaison Officer.

[FR Doc. 2013–28771 Filed 11–29–13; 8:45 am]

BILLING CODE 3810–FF–P

DEPARTMENT OF EDUCATION

President's Advisory Commission on Educational Excellence for Hispanics

AGENCY: U.S. Department of Education, White House Initiative on Educational Excellence for Hispanics.

ACTION: Notice of an open meeting.

SUMMARY: This notice sets forth the schedule and agenda of the fourth meeting of the President's Advisory Commission on Educational Excellence for Hispanics. The notice also describes the functions of the Commission. Notice of the meeting is required by section 10(a)(2) of the Federal Advisory Committee Act and intended to notify the public of its opportunity to attend.

DATES: Wednesday, December 11, 2013.

Time: 10 a.m.–3 p.m. Eastern Standard Time.

ADDRESSES: Consumer Financial Protection Bureau Building Auditorium, 1700 G Street NW., Washington, DC 20552.

FOR FURTHER INFORMATION CONTACT: Emmanuel Caudillo, Special Advisor, White House Initiative on Educational Excellence for Hispanics, 400 Maryland Ave. SW., Room 4W110, Washington, DC 20202; telephone: 202–401–1411.

SUPPLEMENTARY INFORMATION: The President's Advisory Commission on Educational Excellence for Hispanics (the Commission) is established by Executive Order 13555 (Oct. 19, 2010; reestablished December 12, 2012). The Commission is governed by the provisions of the Federal Advisory Committee Act (FACA), (Pub. L. 92–463; as amended, 5 U.S.C.A., Appendix 2) which sets forth standards for the formation and use of advisory committees. The purpose of the Commission is to advise the President and the Secretary of Education on all matters pertaining to the education attainment of the Hispanic community.

The Commission shall advise the President and the Secretary in the following areas: (i) Developing, implementing, and coordinating educational programs and initiatives at the Department and other agencies to improve educational opportunities and outcomes for Hispanics of all ages; (ii) increasing the participation of the Hispanic community and Hispanic-Serving Institutions in the Department's programs and in education programs at other agencies; (iii) engaging the philanthropic, business, nonprofit, and education communities in a national dialogue regarding the mission and objectives of this order; (iv) establishing partnerships with public, private, philanthropic, and nonprofit stakeholders to meet the mission and policy objectives of this order.

Agenda

The Commission will review the 2013–2016 Commission strategic plan, including activities and engagement efforts for 2014 on key priorities, and hold breakout sessions with the established subcommittees.

Individuals who will need accommodations in order to attend the meeting (e.g., interpreting services, assistive listening devices, or material in alternative format) should notify Emmanuel Caudillo, Special Advisor, White House Initiative on Educational Excellence for Hispanics at 202–401–1411 or 202–401–0078, no later than Wednesday, December 4, 2013. We will attempt to meet requests for such accommodations after this date, but cannot guarantee their availability. The

meeting site is accessible to individuals with disabilities.

Individuals who wish to attend the Commission meeting must RSVP by 12 noon EST, Wednesday, December 4, 2013, to *WHIEEH@ed.gov.*

An opportunity for public comment will be available on Wednesday, December 11, 2013, from 10 a.m. to 3 p.m., EST. Individuals who wish to provide comments will be allowed three minutes to speak. Those members of the public interested in submitting written comments may do so by submitting them to the attention of Emmanuel Caudillo, White House Initiative on Educational Excellence for Hispanics, U.S. Department of Education, 400 Maryland Ave. SW., Room 4W108, Washington, DC 20202, by Wednesday, December 4, 2013 or via email at *WHIEEH@ed.gov.*

Records are kept of all Commission proceedings and are available for public inspection at the office of the White House Initiative on Educational Excellence for Hispanics, U.S. Department of Education, 400 Maryland Ave. SW., Room 4W108, Washington, DC, 20202, Monday through Friday (excluding Federal holidays) during the hours of 9 a.m. to 5 p.m.

Electronic Access to the Document: You may view this document, as well as all other documents of this Department published in the **Federal Register,** in text or Adobe Portable Document Format (PDF) on the Internet at: *www.ed.gov/fedregister/index.html.* To use PDF, you must have Adobe Acrobat Reader, which is available free at this site. For questions about using PDF, call the U.S. Government Printing Office (GPO), toll free at 1–866–512–1830; or in the Washington, DC, area at 202–512–0000.

Martha Kanter,

Under Secretary, U.S. Department of Education.

[FR Doc. 2013–28739 Filed 11–29–13; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Notice of Availability: Application Requirements for the American Assured Fuel Supply

AGENCY: U.S. Department of Energy.

ACTION: Notice of availability.

SUMMARY: Through this notice, the Department of Energy announces the availability of application requirements to access the American Assured Fuel Supply.

FOR FURTHER INFORMATION CONTACT: Rich Goorevich, Senior Policy Advisor, Office of Nonproliferation and International Security, National Nuclear Security Administration, U.S. Department of Energy, 1000 Independence Ave. SW., Washington DC 20585, Tel: 202–586–0589, Fax: 202–586–1348.

SUPPLEMENTARY INFORMATION:

I. Background

In August 2011, the Department of Energy (DOE) published a Notice of Availability announcing the Assured Fuel Supply (AFS), a backup supply of low-enriched uranium (LEU) available to domestic and foreign end-users in the event of a supply disruption in the nuclear fuel market. 76 FR 51357 (Aug. 18, 2011). The LEU that recipients will purchase from the AFS will be in the form of uranium hexafluoride at a specific assay (4.95% U–235). The U.S. Government will make no assurances about the material in the AFS beyond ensuring that Westinghouse, the private company storing the AFS LEU for DOE, can certify that the AFS LEU meets the ASTM International Standard Specification C996–04$_{E1}$.

As part of the AFS program implementation, DOE is publishing this notice to provide guidance on the information it will consider in evaluating the requests of potential applicants for access to the AFS.

II. Policy and Process for Accessing AFS Material

The DOE requests that persons or companies that seek to purchase low enriched uranium (LEU) from the U.S. Department of Energy's American Assured Fuel Supply (AFS) provide information sufficient to evaluate the request to the Office of Nonproliferation and International Security, National Nuclear Security Administration 1000 Independence Ave. SW., Washington, DC 20585, Tel: 202–586–0589, Fax: 202–586–1348.

DOE will require the following information from the requester to evaluate a request:

1. Provide name and contact information for end-user of desired LEU.

2. If end-user is not in the United States, provide country and name of end-user.

3. Is there any other logistical information that DOE should be made aware of?

4. Is the foreign recipient requesting LEU from the AFS experiencing a fuel supply disruption for which LEU cannot be obtained through normal market conditions? If yes, please provide facts that demonstrate that LEU is unavailable in the timeframe that it is needed.

5.a. For all U.S. end-users, is a Nuclear Regulatory Commission license authorizing possession and use in place?

5.b. If end-user is not in the United States, describe steps to be taken to obtain the necessary Nuclear Regulatory Commission export license.

5.c. If end-user is not in the United States, does the country have any outstanding issues with the International Atomic Energy Agency over their comprehensive safeguards agreement? If yes, please describe the nature of these issues.

6. What is the desired quantity of LEU and when is anticipated fueling into reactor? Please note that the LEU will be in the form of uranium hexafluoride at a specific assay (4.95% U–235). The U.S. Government does not assume responsibility or make any warranty, express or implied beyond assuring that Westinghouse, the company storing AFS LEU, can certify that the AFS LEU meets the ASTM International Standard Specification C996–04$_{E1}$.

7. When does requester want to take title of LEU from DOE?

8. Please provide evidence that requester can make all necessary and required arrangements to accept custody and take possession of the LEU from the place of storage, (Westinghouse's Columbia, South Carolina site) once title is transferred.

DOE reserves the right to request additional information or clarification of required information as deemed necessary to process the request.

III. Paperwork Reduction Act

A. OMB Control Number

OMB has reviewed and approved this collection and issued the OMB control number 1910–5173; the OMB control number expires on July 29, 2016.

An agency may not conduct or sponsor a collection of information unless the collection of information displays a currently valid OMB control number and the agency informs potential persons who are to respond to the collection of information that such persons are not required to respond to the collection of information unless it displays a currently valid OMB control number.

B. Burden Disclosure Statement

Public reporting burden for this collection of information is estimated to average 8 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data

needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Office of the Chief Information Officer, Records Management Division, IM–23, Paperwork Reduction Project (1910–5173), U.S. Department of Energy, 1000 Independence Ave. SW., Washington, DC 20585–1290; and to the Office of Management and Budget (OMB), Office of Information and Regulatory Affairs (OIRA), Paperwork Reduction Project (1910–5173), Washington, DC 20503.

Issued in Washington, DC, on November 22, 2013.

Anne Harrington,

Deputy Administrator for Defense Nuclear Nonproliferation.

[FR Doc. 2013–28770 Filed 11–29–13; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Proposed Subsequent Arrangement

AGENCY: Office of Nonproliferation and International Security, Department of Energy.

ACTION: Proposed subsequent arrangement.

SUMMARY: This notice is being issued under the authority of section 131a. of the Atomic Energy Act of 1954, as amended. The Department is providing notice of a proposed subsequent arrangement under Article X paragraph 3 of the Agreement for Cooperation Between the Government of the United States of America and the Government of the Republic of Korea Concerning Civil Uses of Atomic Energy and the Agreement for Cooperation in the Peaceful Uses of Nuclear Energy Between the United States of America and the European Atomic Energy Community.

DATES: This subsequent arrangement will take effect no sooner than December 17, 2013.

FOR FURTHER INFORMATION CONTACT: Mr. Sean Oehlbert, Office of Nonproliferation and International Security, National Nuclear Security Administration, Department of Energy. Telephone: 202–586–3806 or email: *Sean.Oehlbert@nnsa.doe.gov.*

SUPPLEMENTARY INFORMATION: This subsequent arrangement concerns the retransfer of 1,860 g of U.S.-origin atomized low-enriched uranium-7wt. % molybdenum powder, containing 365.638 g in the isotope uranium-235, 19.658 percent enrichment, from the Korea Atomic Energy Research Institute (KAERI) in Daejeon, South Korea, to the Belgian Nuclear Research Centre (SCK•CEN) in Mol, Belgium. The material, which is located at and was prepared by KAERI, will be used for the irradiation test of full-size fuel plates in the BR–2 research reactor by SCK•CEN in cooperation with the Global Threat Reduction Initiative program. KAERI originally obtained the material from the U.S. Department of Energy/National Nuclear Security Administration Y–12 National Security Complex pursuant to export license XSNM3613.

In accordance with section 131a. of the Atomic Energy Act of 1954, as amended, it has been determined that this subsequent arrangement concerning the retransfer of nuclear material of United States origin will not be inimical to the common defense and security of the United States.

Dated: November 12, 2013.

For the Department of Energy.

Anne M. Harrington,

Deputy Administrator, Defense Nuclear Nonproliferation.

[FR Doc. 2013–28769 Filed 11–29–13; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Office of Energy Efficiency and Renewable Energy

[Case No. CR–003]

Decision and Order Granting a Waiver to Hussmann From the Department of Energy Commercial Refrigerator, Freezer and Refrigerator-Freezer Test Procedure

AGENCY: Office of Energy Efficiency and Renewable Energy, Department of Energy.

ACTION: Decision and order.

SUMMARY: The U.S. Department of Energy (DOE) gives notice of the decision and order (Case No. CR–003) that grants to Hussmann Corporation (Hussmann) a waiver from the U.S. Department of Energy (DOE) test procedure for determining the energy consumption of its commercial freezers for the basic models set forth in its petition for waiver (petition). Hussmann claims in its petition that the specified basic models cannot be tested in accordance with the DOE test procedure for commercial refrigeration equipment because the equipment cannot operate at the specified integrated average product temperature of 0 °F ± 2 °F. Under today's decision and order, Hussmann shall be required to test and rate the commercial freezers specified in the petition at their lowest integrated average temperature of 8 ± 2 °F, which DOE confirmed is the lowest temperature at which those models can operate and which is consistent with the lowest application product temperature provision in the DOE test procedure.

DATES: This Decision and Order is effective December 2, 2013.

FOR FURTHER INFORMATION CONTACT: Mr. Bryan Berringer, U.S. Department of Energy, Building Technologies Program, Mail Stop EE–2J, Forrestal Building, 1000 Independence Avenue SW., Washington, DC 20585–0121. Telephone: (202) 586–0371. Email: *Bryan.Berringer@ee.doe.gov.*

Ms. Jennifer Tiedeman, U.S. Department of Energy, Office of the General Counsel, Mail Stop GC–71, Forrestal Building, 1000 Independence Avenue SW., Washington, DC 20585–0103. Telephone: (202) 287–6111. Email: *mailto:Jennifer.Tiedeman@hq.doe.gov.*

SUPPLEMENTARY INFORMATION: DOE issues notice of this Decision and Order in accordance with Title 10 of the Code of Federal Regulations (10 CFR) 431.401(f)(4). In this Decision and Order, DOE grants Hussmann a waiver for the commercial refrigerators specified in its petition submitted on January 12, 2012. Hussmann must test and rate this equipment at the lowest integrated average temperature at which the commercial refrigerators can operate, which is consistent with the lowest application product temperature provision in the DOE test procedure at 10 CFR 431.64(b)(3)(A).

Today's decision requires Hussmann to make representations concerning the energy efficiency of this equipment consistent with the provisions and restrictions of the alternate test procedure in the Decision and Order below, and the representations must fairly disclose the test results. (42 U.S.C. 6314(d)) The same standard applies to distributors, retailers, and private labelers when making representations of the energy efficiency of this equipment.

Issued in Washington, DC, on November 25, 2013.

Kathleen B. Hogan,

Deputy Assistant Secretary for Energy Efficiency, Energy Efficiency and Renewable Energy.

Decision and Order

In the Matter of: Hussmann Corporation (Hussmann) (Case No. CR–003).

I. Background and Authority

Title III, Part C of the Energy Policy and Conservation Act of 1975 (EPCA), Pub. L. 94–163 (42 U.S.C. 6311–6317), established the Energy Conservation Program for certain industrial equipment, which includes commercial refrigeration equipment, the focus of this notice.[1] Part C specifically includes definitions (42 U.S.C. 6311), energy conservation standards (42 U.S.C. 6313), test procedures (42 U.S.C. 6314), labeling provisions (42 U.S.C. 6315), and the authority to require information and reports from manufacturers. (42 U.S.C. 6316) With respect to test procedures, Part C authorizes the Secretary of Energy (the Secretary) to prescribe test procedures that are reasonably designed to produce results that measure energy efficiency, energy use, and estimated annual operating costs, and that are not unduly burdensome to conduct. (42 U.S.C. 6314(a)(2))

Section 343(a)(6)(C) of EPCA directs DOE to develop test procedures to establish the appropriate rating temperatures for products for which standards will be established under section 343(a)(6), including (1) Ice-cream freezers; (2) commercial refrigerators, freezers, and refrigerator-freezers with a self-contained condensing unit without doors; and (3) commercial refrigerators, freezers, and refrigerator-freezers with a remote condensing unit. Other provisions of section 343(a)(6) provide DOE with additional authority to establish and amend test procedures for commercial refrigeration equipment. (42 U.S.C. 6314(a)(6)(C)) On December 8, 2006, DOE published a final rule adopting test procedures for commercial refrigeration equipment. 71 FR 71340. Title 10 of the Code of Federal Regulations (10 CFR) 431.64 directs manufacturers of commercial refrigerators, freezers and refrigerator-freezers to use certain sections of Air-Conditioning and Refrigeration Institute (ARI) Standard 1200–2006, ''Performance Rating of Commercial Refrigerated Display Merchandisers and Storage Cabinets'' when measuring the energy consumption of this equipment. On January 9, 2009, DOE established energy conservation standards for certain classes of commercial refrigerators, effective January 1, 2012, and provided that the test procedures at 10 CFR 431.64 apply to that equipment. 74 FR 1092, 96. The basic models included in Hussmann's petition are subject to the applicable standards established in that rulemaking and are therefore required to be tested and rated according to the prescribed DOE test procedure as of January 1, 2012.

DOE's regulations for covered products and equipment permit a person to seek a waiver from the test procedure requirements for covered commercial equipment if at least one of the following conditions is met: (1) The petitioner's basic model contains one or more design characteristics that prevent testing according to the prescribed test procedures; or (2) the prescribed test procedures may evaluate the basic model in a manner so unrepresentative of its true energy consumption as to provide materially inaccurate comparative data. 10 CFR 431.401(a)(1). Petitioners must include in their petition any alternate test procedures known to the petitioner to evaluate the basic model in a manner representative of its energy consumption. The Assistant Secretary for Energy Efficiency and Renewable Energy (Assistant Secretary) may grant a waiver subject to conditions, including adherence to alternate test procedures. 10 CFR 431.401(f)(4). Waivers remain in effect according to the provisions of 10 CFR 431.401(g).

II. Hussmann's Petition for Waiver: Assertions and Determinations

On January 12, 2012, Hussmann submitted a petition for waiver from the DOE test procedure applicable to commercial refrigerators, freezers and refrigerator-freezers set forth in 10 CFR 431.64. Hussmann requested the waiver for its commercial refrigerators intended for short term display of frozen meat (separate from a frozen food case). This equipment is classified as a commercial freezer with a remote condensing unit designed for low temperature applications (category (ix)) in the table listing some of the applicable test procedure requirements at 10 CFR 431.64(b)(3)). The applicable test procedure for this equipment is specified in 10 CFR 431.64(b), which incorporates by reference ARI Standard 1200–2006, section 3, ''Definitions,'' section 4, ''Test Requirements,'' section 7, ''Symbols and Subscripts,'' and, section 5, ''Rating Requirements for Remote Commercial Refrigerated Display Merchandisers and Storage Cabinets.''

Hussmann sought a waiver from the applicable test procedure under 10 CFR 431.64 on the grounds that its commercial refrigerators contain design characteristics that prevent testing according to the current DOE test procedure. Specifically, Hussmann asserts that particular basic models are not able to operate at the specified integrated average temperature of 0 °F, which is required for testing and rating purposes. Instead, Hussmann asserts that the equipment can only operate from 8–18 °F. Consequently, Hussmann requested that DOE grant a waiver from the applicable test procedure, allowing the specified products to be tested at an integrated average temperature of 12 °F, which Hussmann asserts is an acceptable temperature at which to test the specified basic models.

The Department articulated its position regarding basic models of commercial refrigeration equipment that are not capable of operating at the required integrated average temperature specified by the DOE test procedure in a test procedure final rule published on February 21, 2012. 77 FR 10292. Specifically, to qualify to use the lowest application product temperature for a certain piece of equipment, a manufacturer should be confident that any case tested under that equipment rating could achieve the specified lowest application product temperature within ± °F and could not be tested at the rating temperature (i.e., integrated average temperature specified by the DOE test procedure) for the given equipment class. Further, in the final rule, DOE clarified that, for many pieces of equipment, the lowest application product temperature that should be used for testing will be the lowest temperature setting on the unit's thermostat. 77 FR 10292, 10303 (February 21, 2012).

DOE agrees with Hussmann's assertion that the basic models identified in its petition cannot be operated at the associated rating conditions currently specified for commercial freezers in the DOE test procedures given the available data. DOE has confirmed with Hussmann that the lowest temperature these basic models are capable of operating would be 8 °F. In light of this and DOE's position in the February 2012 final rule, DOE has concluded that Hussmann's request to test these basic models of commercial freezers at an integrated average temperature of 12 °F is inappropriate. Instead, DOE has determined that the basic models of commercial freezers listed in Hussmann's petition should be tested at their lowest application product temperature as defined at 10 CFR 431.62, which corresponds to an integrated average temperature of 8 °F.

DOE notes that use of the amended test procedure set forth in the aforementioned final rule will be required on the compliance date of any

[1] For editorial reasons, upon codification in the U.S. Code, Part C was re-designated Part A–1.

amended standards for this equipment. (77 FR 10292, February 21, 2012)

III. Conclusion

After careful consideration of all the material that was submitted by Hussmann, it is ordered that:

(1) The petition for waiver submitted by the Hussmann (Case No. CR–003) is hereby granted as set forth in paragraphs (2), (3), (4) and (5).

(2) Hussmann shall be required to test and rate the following basic models according to the alternate test procedure set forth in paragraph (3) of this section. M1XL–4GE, M1XL–6GE, M1XL–8GE, M1XL–12GE, M1XLD–4GE, M1XLD–6GE, M1XLD–8GE, M1XLD–12GE

(3) Alternate Test Procedure. Hussmann shall test the equipment listed in paragraph (2) per the DOE test procedure set forth in 10 CFR 431.64, except that instead of testing at 0 °F ± 2 °F (as set forth in the table at 10 CFR 431.64(b)(3)), DOE requires Hussmann to test and rate the commercial freezers specified in its January 12, 2012 petition and listed above at their lowest integrated average temperature of −8 ± 2 °F, which DOE confirmed is the lowest temperature at which those models can operate and which is consistent with the lowest application product temperature provision in the DOE test procedure.

DOE notes that it has published an amended test procedure for commercial refrigeration equipment. (77 FR 10292, Feb. 21, 2012). The amended test procedure addresses the testing issue addressed in this waiver, requiring products to be tested at their lowest application product temperature. *Id.* Use of the amended test procedure will be required on the compliance date of any amended standards for this equipment.

(4) *Representations.* In making representations about the energy efficiency of its refrigerated display merchandisers listed in paragraph (2), for compliance, marketing, or other purposes, Hussmann must fairly disclose the results of testing under the alternate test procedure specified in this waiver.

(5) This waiver amendment shall remain in effect from the date this Decision and Order is issued, consistent with the provisions of 10 CFR 431.401(g). DOE notes that it has published an amended test procedure for commercial refrigeration equipment. (77 FR 10292, Feb. 21, 2012). The amended test procedure addresses the testing issue addressed in this waiver, requiring products to be tested at their lowest application product temperature. *Id.* Use of the amended test procedure will be required on the compliance date of any amended standards for this equipment.

(6) This waiver is granted for only those models specifically set out in Hussmann's petition, not future models that may be manufactured by Hussmann. Hussmann may submit a new or amended petition for waiver and request for grant of interim waiver, as appropriate, for additional models for which it seeks a waiver from the DOE test procedure. Grant of this waiver also does not release Hussmann from the certification requirements set forth at 10 CFR part 431.

(7) This waiver is issued on the condition that the statements, representations, and documentary materials provided by the petitioner are valid. DOE may revoke or modify this waiver at any time if it determines the factual basis underlying the petition for waiver is incorrect, or the results from the alternate test procedure are unrepresentative of the basic models' true energy consumption characteristics.

Issued in Washington, DC, on November 25, 2013.

Kathleen B. Hogan,

Deputy Assistant Secretary for Energy Efficiency, Energy Efficiency and Renewable Energy.

[FR Doc. 2013–28772 Filed 11–29–13; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Office of Energy Efficiency and Renewable Energy

[Case No. CR–005]

Decision and Order Granting a Waiver to Felix Storch, Inc. (FSI) From the Department of Energy Commercial Refrigerator, Freezer and Refrigerator-Freezer Test Procedures

AGENCY: Office of Energy Efficiency and Renewable Energy, Department of Energy.

ACTION: Decision and order.

SUMMARY: The U.S. Department of Energy (DOE) gives notice of the decision and order (Case No. CR–005) that grants Felix Storch, Inc. (FSI) a waiver from the DOE test procedures for determining the energy consumption of its commercial ice cream freezers for the basic models set forth in its petition for waiver (petition). FSI claims in its petition that the specified basic models cannot be tested in accordance with the DOE test procedure for commercial ice cream freezer equipment because the equipment cannot operate at the integrated average product temperature of −15 ± 2 °F, specified in DOE's test procedures. Under today's decision and order, FSI shall be required to test and rate the commercial ice cream freezers specified in the petition at the lowest integrated average temperature of −8 ± 2 °F, which DOE confirmed is the lowest temperature at which those models can operate and which is consistent with the lowest application product temperature provision in the DOE test procedures.

DATES: This Decision and Order is effective December 2, 2013.

FOR FURTHER INFORMATION CONTACT: Mr. Bryan Berringer, U.S. Department of Energy, Building Technologies Program, Mail Stop EE–2J, Forrestal Building, 1000 Independence Avenue SW., Washington, DC 20585–0121. Telephone: (202) 586–0371. Email: *Bryan.Berringer@ee.doe.gov.*

Ms. Jennifer Tiedeman, U.S. Department of Energy, Office of the General Counsel, Mail Stop GC–71, Forrestal Building, 1000 Independence Avenue SW., Washington, DC 20585–0103. Telephone: (202) 287–6111. Email: *mailto:Jennifer.Tiedeman@hq.doe.gov.*

SUPPLEMENTARY INFORMATION: DOE issues notice of this Decision and Order in accordance with Title 10 of the Code of Federal Regulations (10 CFR) 431.401(f)(4). In this Decision and Order, DOE grants FSI a waiver for the commercial ice cream refrigerators specified in its petition submitted on January 31, 2013. FSI must test and rate this equipment at the lowest integrated average temperature of −8 ± 2 °F, which is consistent with the lowest application product temperature provision in the DOE test procedure at 10 CFR 431.64(b)(3)(A).

Today's decision requires FSI to make representations concerning the energy efficiency of this equipment consistent with the provisions and restrictions of the alternate test procedure in the Decision and Order below, and the representations must fairly disclose the test results. (42 U.S.C. 6314(d)) The same standard applies to distributors, retailers, and private labelers when making representations of the energy efficiency of this equipment.

Issued in Washington, DC, on November 25, 2013.

Kathleen B. Hogan,

Deputy Assistant Secretary for Energy Efficiency, Energy Efficiency and Renewable Energy.

Decision and Order

In the Matter of: Felix Storch, Inc. (FSI) (Case No. CR–005).

I. Background and Authority

Title III, Part C of the Energy Policy and Conservation Act of 1975 (EPCA), Pub. L. 94–163 (42 U.S.C. 6311–6317), established the Energy Conservation Program for certain industrial equipment, which includes commercial refrigeration equipment, the focus of this notice.[1] Part C specifically includes definitions (42 U.S.C. 6311), energy conservation standards (42 U.S.C. 6313), test procedures (42 U.S.C. 6314), labeling provisions (42 U.S.C. 6315), and the authority to require information and reports from manufacturers. (42 U.S.C. 6316) With respect to test procedures, Part C authorizes the Secretary of Energy (the Secretary) to prescribe test procedures that are reasonably designed to produce results that measure energy efficiency, energy use, and estimated annual operating costs, and that are not unduly burdensome to conduct. (42 U.S.C. 6314(a)(2))

Section 343(a)(6)(C) of EPCA directs DOE to develop test procedures to establish the appropriate rating temperatures for products for which standards will be established under section 343(a)(6), including (1) Ice-cream freezers; (2) commercial refrigerators, freezers, and refrigerator-freezers with a self-contained condensing unit without doors; and (3) commercial refrigerators, freezers, and refrigerator-freezers with a remote condensing unit. Other provisions of section 343(a)(6) provide DOE with additional authority to establish and amend test procedures for commercial refrigeration equipment. (42 U.S.C. 6314(a)(6)(C)) On December 8, 2006, DOE published a final rule adopting test procedures for commercial refrigeration equipment. 71 FR 71340. Title 10 of the Code of Federal Regulations (10 CFR) 431.64 directs manufacturers of commercial refrigerators, freezers and refrigerator-freezers to use certain sections of Air-Conditioning and Refrigeration Institute (ARI) Standard 1200–2006, ''Performance Rating of Commercial Refrigerated Display Merchandisers and Storage Cabinets'' when measuring the energy consumption of this equipment. On January 9, 2009, DOE established energy conservation standards for certain classes of commercial refrigerators, effective January 1, 2012, and provided that the test procedures at 10 CFR 431.64 apply to that equipment. 74 FR 1092. The basic models included in FSI's petition are subject to the applicable standards established in that rulemaking and are therefore required to be tested and rated according to the prescribed DOE test procedure as of January 1, 2012.

DOE's regulations for covered products and equipment permit a person to seek a waiver from the test procedure requirements for covered commercial equipment if at least one of the following conditions is met: (1) The petitioner's basic model contains one or more design characteristics that prevent testing according to the prescribed test procedures; or (2) the prescribed test procedures may evaluate the basic model in a manner so unrepresentative of its true energy consumption as to provide materially inaccurate comparative data. 10 CFR 431.401(a)(1). Petitioners must include in their petition any alternate test procedures known to the petitioner to evaluate the basic model in a manner representative of its energy consumption. 10 CFR 431.401(b)(1)(iii). The Assistant Secretary for Energy Efficiency and Renewable Energy (Assistant Secretary) may grant a waiver subject to conditions, including adherence to alternate test procedures. 10 CFR 431.401(f)(4). Waivers remain in effect according to the provisions of 10 CFR 431.401(g).

II. FSI's Petition for Waiver: Assertions and Determinations

In its January 31, 2013 petition, FSI sought a waiver from the DOE test procedures applicable to commercial refrigerators, freezers and refrigerator-freezers set forth in 10 CFR 431.64, as well as an application for interim waiver. FSI requested the waiver for certain basic models of its commercial ice cream freezers. This equipment is classified as a commercial ice cream freezer (category (vii)) in the table listing some of the applicable test procedure requirements at 10 CFR 431.64(b)(3)). The applicable test procedure for this equipment is specified in 10 CFR 431.64(b), which incorporates by reference ARI Standard 1200–2006, section 3, ''Definitions,'' section 4, ''Test Requirements,'' section 7, ''Symbols and Subscripts,'' and, section 5, ''Rating Requirements for Remote Commercial Refrigerated Display Merchandisers and Storage Cabinets.''

FSI sought a waiver from the applicable test procedure under 10 CFR 431.64 on the grounds that its commercial ice cream freezers contain design characteristics that prevent testing according to the current DOE test procedure. Specifically, FSI asserts that particular basic models of commercial ice cream freezers are not able to operate at the specified integrated average temperature of -5 °F ± 2 °F, which is required for testing and rating purposes. Instead, FSI asserts that the equipment can only operate from 0 °F to -5 °F. Consequently, FSI requested that DOE grant a waiver from the applicable test procedure, allowing the specified products to be tested at an integrated average temperature of 0 °F, which FSI asserts is an acceptable temperature at which to test the specified basic models. FSI further asserts that these basic models of commercial ice cream freezers are designed to maintain the frozen state of an already frozen product, not to lower the temperature of non-frozen products to the 0 °F to -5 °F operating temperature.

In addition, FSI asserts that the commercial ice cream freezers subject to the petition also have significantly greater volumes per unit of total display area (TDA) than do other commercial freezers of a similar type and function. FSI believes the current method of measurement of TDA in the DOE test procedure does not provide a fair and accurate representation of the display area and, therefore, the energy use of its products. FSI is requesting an adjustment or allowance for the measurement of TDA.

The Department articulated its position regarding basic models of commercial refrigeration equipment that are not capable of operating at the required integrated average temperature specified by the DOE test procedure in a test procedure final rule published on February 21, 2012. 77 FR 10292. Specifically, to qualify to use the lowest application product temperature for a certain piece of equipment, a manufacturer should be confident that any case tested under that provision could achieve the specified lowest application product temperature within ±2 °F and could not be tested at the rating temperature (i.e., integrated average temperature specified by the DOE test procedure) for the given equipment class. Further, in the final rule, DOE clarified that, for many pieces of equipment, the lowest application product temperature that should be used for testing will be the lowest temperature setting on the unit's thermostat. 77 FR 10292, 10303 (Feb. 21, 2012).

DOE agrees with FSI's assertion that the basic models identified in its petition cannot be operated at the associated rating conditions currently specified for commercial ice cream freezers in the DOE test procedures given the available data. However, when the temperature knob is set to the coldest setting as described in the

[1] For editorial reasons, upon codification in the U.S. Code, Part C was re-designated Part A–1.

February 2012 final rule, DOE has confirmed that the corresponding integrated average temperature achieved during operation by these basic models is approximately −8 °F. In light of this fact and DOE's position in the February 2012 final rule, DOE has concluded that FSI's request to test these basic models of commercial ice cream freezers at an integrated average temperature of 0 °F is inappropriate. Instead, DOE has determined that the basic models of commercial ice cream freezers listed in FSI's petition should be tested at their lowest application product temperature as defined at 10 CFR 431.62, which corresponds to an integrated average temperature of −8 ± 2 °F.

DOE rejects FSI's request regarding the use of an alternative calculation and use an adjustment to the TDA metric to characterize the display area of the commercial ice cream freezer. During the previous rulemaking considering energy conservation standards for commercial refrigeration equipment, TDA was chosen as the display metric because DOE found through its own investigation and research and after receiving public comment on the issue that it is most representative of the heat loads that define the performance of transparent-door equipment—namely radiation and conduction through glass doors. 74 FR 1092 (Jan. 9, 2009). Additionally, since commercial ice cream freezers are used for merchandising in the retail environment, ''face area'' (or area of visible product), which is analogous to TDA, is often used by retailers as the metric of equipment capacity. In the ongoing rulemaking it was reconfirmed that TDA should be the metric of choice. Consequently, DOE does not believe that the commercial ice cream freezers described in the petition contain design characteristics that make the methods of determination and the TDA metric unrepresentative and is denying this portion of the petition.

DOE received three comments following publication of FSI's notice of petition for waiver, notice granting interim waiver, and request for comments. 78 FR 26006 (May 3, 2013) One comment from FSI stated that the company disagrees with DOE's requirement that testing be conducted at an integrated average temperature of −8 ± 2 °F, as well as the use of total display area (TDA). Instead, FSI requested the use of an integrated average temperature of −5 ± 2 °F and an adjustment factor to accommodate for the extra volume not considered by DOE's TDA-based procedures. The two other comments DOE received were from Elcold Frysere Hobro ApS and Vestfrost Solutions, manufacturers that build the freezers described in FSI's petition. Both of these commenters stated that the freezers should be tested at an average operating temperature of 0 °F and that testing at −8 °F, as specified in the interim waiver, would cause the compressor to not cycle and would not be representative of typical use. Further, the commenters objected to the fact that DOE's conclusion was based on only one test by a contracting laboratory.

As stated in the notice granting FSI an interim waiver (May 3, 2013, 78 FR 26006), DOE agrees with FSI's assertion that the basic models identified in its petition cannot be operated at the associated rating conditions currently specified for commercial ice cream freezers in the DOE test procedures given the available data. However, when the temperature knob is set to the coldest setting as described in the February 2012 final rule, DOE has confirmed that the corresponding integrated average temperature achieved during operation by these basic models is approximately −8 °F. In light of this fact and DOE's position in the February 2012 final rule, DOE has concluded that FSI's request to test these basic models of commercial ice cream freezers at an integrated average temperature of 0 °F or −5 °F is inappropriate. FSI has not provided any information (i.e., test data) showing that −5 °F (or 0 °F) is the coldest temperature at which its equipment can operate. On the other hand, DOE test data demonstrate that the minimum operating temperature of the equipment is −8 °F. Neither FSI nor other commenters have claimed that DOE tested defective units or that FSI has modified its control strategy. Absent any other information, DOE must rely on the data that it has obtained through testing of units. Therefore, DOE has determined that the basic models of commercial ice cream freezers listed in FSI's petition should be tested at their lowest application product temperature as defined at 10 CFR 431.62, which corresponds to an integrated average temperature of −8 ± 2 °F.

DOE rejects FSI's request regarding the use of an alternative calculation and use of an adjustment to the TDA metric to characterize the display area of the commercial ice cream freezer. During the previous rulemaking considering energy conservation standards for commercial refrigeration equipment, TDA was chosen as the display metric because DOE found, through its own investigation and research and after receiving public comment on the issue, that it is most representative of the heat loads that define the performance of transparent-door equipment—namely radiation and conduction through glass doors. 74 FR 1092 (Jan. 9, 2009). Additionally, since commercial ice cream freezers are used for merchandising in the retail environment, ''face area'' (or area of visible product), which is analogous to TDA, is often used by retailers as the metric of equipment capacity. In the ongoing rulemaking, DOE has reconfirmed TDA as the metric of choice for commercial refrigeration equipment. 78 FR 55890 (Sept. 11, 2013). Consequently, DOE is not swayed by FSI's argument and does not believe that the commercial ice cream freezers described in the petition contain design characteristics that make the methods of determination and the TDA metric unrepresentative, and is denying this portion of the petition.

III. Conclusion

After careful consideration of all the material that was submitted by FSI and the additional comments received, it is ordered that:

(1) The petition for waiver submitted by the FSI (Case No. CR–005) is hereby granted as set forth in paragraphs (2), (3), (4), and (5).

(2) FSI shall be required to test and rate the following basic models according to the alternate test procedure set forth in paragraph (3) of this section. SCF694, SCF695S, SCF1094, SCF1095S, SCF1494, SCF1495S, SCF1694, SCF1695S, SCF1894, SCF1895S, SCF630, SCF940, SCF1310, SF1710.

(3) Alternate Test Procedure. FSI shall test the equipment listed in paragraph (2) according to the DOE test procedure set forth in 10 CFR 431.64, except that instead of testing at −15 °F ± 2 °F (as set forth in the table at 10 CFR 431.64(b)(3)), DOE requires FSI to test the commercial ice cream freezers specified in its January 31, 2013 petition and listed above according to the test procedure specified at 10 CFR 431.64, FSI shall test the specified basic models at an integrated average temperature of −8 ± 2 °F, which DOE has determined is the lowest temperature at which those models can operate.

DOE notes that it has published an amended test procedure for commercial refrigeration equipment. (77 FR 10292, Feb. 21, 2012). The amended test procedure addresses the testing issue addressed in this waiver, requiring products to be tested at their lowest application product temperature. *Id.* Use of the amended test procedure will be required on the compliance date of any amended standards for this equipment.

(4) *Representations.* In making representations about the energy

efficiency of its commercial ice cream freezers listed in paragraph (2), for compliance, marketing, or other purposes, FSI must fairly disclose the results of testing under the alternate test procedure specified in this waiver.

(5) This waiver amendment shall remain in effect from the date this Decision and Order is issued, consistent with the provisions of 10 CFR 431.401(g). DOE notes that it has published an amended test procedure for commercial refrigeration equipment. (77 FR 10292, Feb. 21, 2012). The amended test procedure addresses the testing issue addressed in this waiver, requiring products to be tested at their lowest application product temperature. *Id.* Use of the amended test procedure will be required on the compliance date of any amended standards for this equipment.

(6) This waiver is granted for only those models specifically set out in FSI's petition, not future models that may be manufactured by FSI. FSI may submit a new or amended petition for waiver and request for grant of interim waiver, as appropriate, for additional models for which it seeks a waiver from the DOE test procedure. Grant of this waiver also does not release FSI from the certification requirements set forth at 10 CFR part 431.

(7) This waiver is issued on the condition that the statements, representations, and documentary materials provided by the petitioner are valid. DOE may revoke or modify this waiver at any time if it determines the factual basis underlying the petition for waiver is incorrect, or the results from the alternate test procedure are unrepresentative of the basic models' true energy consumption characteristics.

Issued in Washington, DC, on November 25, 2013.

Kathleen B. Hogan,

Deputy Assistant Secretary for Energy Efficiency, Energy Efficiency and Renewable Energy.

[FR Doc. 2013–28764 Filed 11–29–13; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Office of Energy Efficiency and Renewable Energy

[Docket No. EERE–2013–BT–DET–0017]

Energy Efficiency Program for Industrial Equipment: Final Determination Classifying UL Verification Services Inc. as a Nationally Recognized Certification Program for Small Electric Motors

AGENCY: Office of Energy Efficiency and Renewable Energy, Department of Energy.

ACTION: Notice of final determination.

SUMMARY: This notice announces a final determination by the U.S. Department of Energy (DOE) classifying UL Verification Services (UL) as a nationally recognized certification program under 10 CFR 431.447 and 431.448.

DATES: This final determination is effective December 2, 2013.

ADDRESSES: The docket for this matter is available for review at *www.regulations.gov,* including **Federal Register** notices, public meeting attendee lists and transcripts, comments, and other supporting documents/materials. All documents in the docket are listed in the *www.regulations.gov* index. However, not all documents listed in the index may be publicly available, such as information that is exempt from public disclosure.

A link to the docket Web page can be found at: *http://www.regulations.gov/#!searchResults;rpp=25;po=0;s=EERE-2013-BT-DET-0017;fp=true;ns=true.* This Web page contains a link to the docket for this matter on the *www.regulations.gov* site. The *www.regulations.gov* Web page contains simple instructions on how to access all documents, including public comments, in the docket.

For further information on how to review the docket, contact Ms. Brenda Edwards at (202) 586–2945 or by email: *Brenda.Edwards@ee.doe.gov.*

FOR FURTHER INFORMATION CONTACT: Mr. Lucas Adin, U.S. Department of Energy, Building Technologies Office, Mail Stop EE–2J, Forrestal Building, 1000 Independence Avenue SW., Washington, DC 20585–0121. Telephone: (202) 287–1317. Email: *Lucas.Adin@ee.doe.gov.*

Mr. Michael Kido, U.S. Department of Energy, Office of the General Counsel, Mail Stop GC–71, Forrestal Building, 1000 Independence Avenue SW., Washington, DC 20585–0103. Telephone: (202) 586–8145. Email: *Michael.Kido@hq.doe.gov.*

SUPPLEMENTARY INFORMATION:

I. Background and Authority

Part C of Title III of the Energy Policy and Conservation Act contains energy conservation requirements for, among other things, electric motors and small electric motors, including test procedures, energy efficiency standards, and compliance certification requirements. 42 U.S.C. 6311–6316.[1] Section 345(c) of EPCA directs the Secretary of Energy to require manufacturers of electric motors ''to certify through an independent testing or certification program nationally recognized in the United States, that [each electric motor subject to EPCA efficiency standards] meets the applicable standard.'' 42 U.S.C. 6316(c).

Regulations to implement this statutory directive are codified in Title 10 of the Code of Federal Regulations Part 431 (10 CFR Part 431) at sections 431.36, Compliance Certification, 431.20, Department of Energy recognition of nationally recognized certification programs, and 431.21, Procedures for recognition and withdrawal of recognition of accreditation bodies and certification programs. Sections 431.20 and 431.21 set forth the criteria and procedures for national recognition of an energy efficiency certification program for electric motors by DOE. With the support of a variety of interests, including industry and energy efficiency advocacy groups, DOE published a final rule on May 4, 2012, that established requirements for small electric motors that are essentially identical to the criteria and procedures for national recognition of an energy efficiency certification program for electric motors. See 77 FR 26608, 26629 (codifying provisions parallel to electric motors for small electric motors at 10 CFR 431.447 and 431.448).

For a certification program to be classified by the DOE as being nationally recognized in the United States for the testing and certification of small electric motors, the organization operating the program must submit a petition to the Department requesting such classification, in accordance with sections 431.447 and 431.448. In sum, for the Department to grant such a petition, the certification program must: (1) Have satisfactory standards and procedures for conducting and administering a certification system, and for granting a certificate of

[1] For editorial reasons, upon codification in the U.S. Code, Part C was re-designated Part A–1.

conformity; (2) be independent of small electric motor manufacturers, importers, distributors, private labelers or vendors; (3) be qualified to operate a certification system in a highly competent manner; and (4) be expert in the test procedures and methodologies in IEEE Standard 112–2004 Test Methods A and B, IEEE Standard 114–2010, CSA Standard C390–10, and CSA C747 or similar procedures and methodologies for determining the energy efficiency of small electric motors, and have satisfactory criteria and procedures for selecting and sampling small electric motors for energy efficiency testing. 10 CFR 431.447(b).

Each petition requesting classification as a nationally recognized certification program must contain a narrative statement as to why the organization meets the above criteria, be accompanied by documentation that supports the narrative statement, and be signed by an authorized representative. 10 CFR 431.447(c).

II. Discussion

Pursuant to sections 431.447 and 431.448, on February 20, 2013, UL submitted to the Department a Petition for ''Classification in Accordance with 10 CFR 431.447 and 431.448'' (''Petition'' or ''UL Petition''). The Petition was accompanied by a cover letter from UL to the Department, containing five separate sections that included narrative statements for each—(1) Overview, (2) Standards and Procedures, (3) Independent Status, (4) Qualification of UL LCC and UL Verification Services, Inc. to Operate a Certification System, and (5) Expertise in Small Motor Test Procedures. In accordance with the requirements of § 431.448(b), DOE published UL's petition in the **Federal Register** on May 16, 2013 and requested public comments. 78 FR 28812.

In response to that notice, the National Electrical Manufacturers Association (NEMA), a trade association representing manufacturers of electrical products including small electric motors, submitted comments to DOE in a letter dated June 17, 2013 (Comment response to the published Notice of Petition, No. 5). In these comments, NEMA cited several concerns regarding UL's petition, listing them in the order in which DOE requested comments in the notice. UL then submitted a letter to DOE dated June 26, 2013 responding to NEMA's comments (Comment responding to NEMA's comments on UL petition, No. 6).

As required by 10 CFR 431.448(d), DOE published on September 17, 2013 an interim notice of determination regarding UL's petition. 78 FR 57137. In that notice, DOE provided a description of the comments submitted by NEMA and the responses to those comments from UL. In reviewing the comments and responses, DOE found no cause to deny UL's petition and concluded that UL could be classified as a nationally recognized certification program for small electric motors on an interim basis pending a 30-day period of public comment.

Having received no comments on the interim determination, the Department hereby announces its final determination pursuant to 10 CFR 431.448(e) that UL is classified as a nationally recognized certification program for small electric motors.

Issued in Washington, DC, on November 25, 2013.

Kathleen B. Hogan,

Deputy Assistant Secretary for Energy Efficiency, Energy Efficiency and Renewable Energy.

[FR Doc. 2013–28763 Filed 11–29–13; 8:45 am]

BILLING CODE 6450–01–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OECA–2013–0314; FRL–9903–59–OEI]

Information Collection Request Submitted to OMB for Review and Approval; Comment Request; NSPS for Phosphate Rock Plants (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency has submitted an information collection request (ICR), ''NSPS for Phosphate Rock Plants (40 CFR Part 60, Subpart NN) (Renewal)'' (EPA ICR No. 1078.10, OMB Control No. 2060–0111), to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq*). This is a proposed extension of the ICR, which is currently approved through March 31, 2014. Public comments were previously requested via the **Federal Register** (78 *FR* 33409) on June 4, 2013, during a 60-day comment period. This notice allows for an additional 30 days for public comments. A fuller description of the ICR is given below, including its estimated burden and cost to the public. An Agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number.

DATES: Additional comments may be submitted on or before January 2, 2014.

ADDRESSES: Submit your comments, referencing Docket ID Number EPA–HQ–OECA–2013–0314, to: (1) EPA online using *www.regulations.gov* (our preferred method), by email to: *docket.oeca@epa.gov,* or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW., Washington, DC 20460; and (2) OMB via email to *oira_submission@omb.eop.gov.* Address comments to OMB Desk Officer for EPA.

EPA's policy is that all comments received will be included in the public docket without change including any personal information provided, unless the comment includes profanity, threats, information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute.

FOR FURTHER INFORMATION CONTACT: Learia Williams, Monitoring, Assistance, and Media Programs Division, Office of Compliance, Mail Code 2227A, Environmental Protection Agency, 1200 Pennsylvania Ave. NW., Washington, DC 20460; telephone number: (202) 564–4113; fax number: (202) 564–0050; email address: *williams.learia@epa.gov.*

SUPPLEMENTARY INFORMATION: Supporting documents which explain in detail the information that the EPA will be collecting are available in the public docket for this ICR. The docket can be viewed online at *www.regulations.gov* or in person at the EPA Docket Center, WJC West, Room 3334, 1301 Constitution Ave. NW., Washington, DC. The telephone number for the Docket Center is 202–566–1744. For additional information about EPA's public docket, visit: *http://www.epa.gov/dockets.*

Abstract: The affected entities are subject to the General Provisions of the NSPS at 40 CFR part 60, subpart A, and any changes, or additions to the Provisions specified at 40 CFR part 60, subpart NN. Owners or operators of the affected facilities must submit a onetime-only report of any physical or operational changes, initial performance tests, and periodic reports and results. Owners or operators are also required to maintain records of the occurrence and duration of any startup, shutdown, or malfunction in the operation of an affected facility, or any period during which the monitoring system is inoperative. Reports are required semiannually at a minimum.

Form Numbers: None.

Respondents/affected entities: Owners or operators of phosphate rock plants.

Respondent's obligation to respond: Mandatory (40 CFR part 60, subpart NN).

Estimated number of respondents: 14 (total).

Frequency of response: Initially and semiannually.

Total estimated burden: 1,724 hours (per year). Burden is defined at 5 CFR 1320.3(b).

Total estimated cost: $301,256 (per year), which includes $132,582 annualized capital and/or operation & maintenance costs.

Changes in the Estimates: The increase in burden from the most recently approved ICR is due to an increase in the number of new or modified sources and an increase in labor costs. This ICR uses updated labor rates from the Bureau of Labor Statistics to calculate burden costs.

John Moses,

Director, Collection Strategies Division.

[FR Doc. 2013–28781 Filed 11–29–13; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OECA–2013–0019; FRL–9903–31–OEI]

Information Collection Request Submitted to OMB for Review and Approval; Comment Request; NSPS for Electric Utility Steam Generating Units (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency has submitted an information collection request (ICR), ''NSPS for Electric Utility Steam Generating Units (40 CFR Part 60, Subpart Da) (Renewal)'' (EPA ICR No. 1053.11, OMB Control No. 2060–0023), to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq*). This is a proposed extension of the ICR, which is currently approved through March 31, 2014. Public comments were previously requested via the **Federal Register** (78 *FR* 33409) on June 4, 2013, during a 60-day comment period. This notice allows for an additional 30 days for public comments. A fuller description of the ICR is given below, including its estimated burden and cost to the public. An Agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number.

DATES: Additional comments may be submitted on or before January 2, 2014.

ADDRESSES: Submit your comments, referencing Docket ID Number EPA–HQ–OECA–2013–0019, to: (1) EPA online, using *www.regulations.gov* (our preferred method), by email to: *docket.oeca@epa.gov,* or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW., Washington, DC 20460; and (2) OMB via email to *oira_submission@omb.eop.gov.* Address comments to OMB Desk Officer for EPA.

EPA's policy is that all comments received will be included in the public docket without change including any personal information provided, unless the comment includes profanity, threats, information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute.

FOR FURTHER INFORMATION CONTACT: Learia Williams, Monitoring, Assistance, and Media Programs Division, Office of Compliance, Mail Code 2227A, Environmental Protection Agency, 1200 Pennsylvania Ave. NW., Washington, DC 20460; telephone number: (202) 564–4113; fax number: (202) 564–0050; email address: *williams.learia@epa.gov.*

SUPPLEMENTARY INFORMATION: Supporting documents which explain in detail the information that the EPA will be collecting are available in the public docket for this ICR. The docket can be viewed either online at *www.regulations.gov,* or in person at the EPA Docket Center, WJC West, Room 3334, 1301 Constitution Ave. NW., Washington, DC. The telephone number for the Docket Center is 202–566–1744. For additional information about EPA's public docket, visit: *http://www.epa.gov/dockets.*

Abstract: The affected entities are subject to the General Provisions of the NESHAP at 40 CFR part 60, subpart A, and any changes, or additions to the Provisions, are specified at 40 CFR part 60, subpart Da. Owners or operators of the affected facilities must submit a onetime-only report of any physical or operational changes, initial performance tests, and periodic reports and results. Owners or operators are also required to maintain records of the occurrence and duration of any startup, shutdown, or malfunction in the operation of an affected facility, or any period during which the monitoring system is inoperative. Reports are required semiannually at a minimum.

Form Numbers: None.

Respondents/affected entities: Owners or operators of electric utility steam generating units.

Respondent's obligation to respond: Mandatory (40 CFR part 60, subpart Da).

Estimated number of respondents: 710 (total).

Frequency of response: Initially, quarterly, and semiannually.

Total estimated burden: 168,258 hours (per year). ''Burden'' is defined at 5 CFR 1320.3(b).

Total estimated cost: $29,143,496 (per year), includes $12,685,000 annualized capital or operation & maintenance costs.

Changes in the Estimates: There is an increase of 7,419 hours in the total estimated respondent burden compared with the ICR currently approved by OMB. There is also an increase in capital/startup and O&M costs as compared to the previous ICR. All changes from the most recently approved ICR are due to an increase in the number of existing sources subject to the standard, and are not due to any program changes. The number of existing sources has been increased to account for industry growth that has occurred since the most recent ICR was approved.

There is also an increase in respondent and Agency burden costs from the most-recently approved ICR due to the use of updated labor rates. This ICR references labor rates from the Bureau of Labor Statistics to calculate respondent burden costs, and references labor rates from OPM to calculate Agency burden costs.

John Moses,

Director, Collection Strategies Division.

[FR Doc. 2013–28783 Filed 11–29–13; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OAR–2008–0531; FRL 9903–39–OEI]

Information Collection Request Submitted to OMB for Review and Approval; Comment Request; Restructuring of the Stationary Source Audit Program (Renewal)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency has submitted an information collection request (ICR), Restructuring

of the Stationary Source Audit Program (Renewal), to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act. This is a proposed extension of the ICR, which is currently approved through January 31, 2014. Public comments were previously requested via the **Federal Register** (78 FR 51183) on August 20, 2013 during a 60-day comment period. This notice allows for an additional 30 days for public comments. A fuller description of the ICR is given below, including its estimated burden and cost to the public. An agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number.

DATES: Additional comments may be submitted on or before January 2, 2014.

ADDRESSES: Submit your comments, referencing Docket ID number EPA–HQ–OAR–2008–0531, to: (1) The EPA online using *www.regulations.gov* (our preferred method), by email to *a-and-r-docket@epa.gov,* or by mail to: EPA Docket Center, Environmental Protection Agency, Air and Radiation Docket, Mail Code 28221T, 1200 Pennsylvania Avenue NW., Washington, DC 20460; and (2) OMB by mail to: Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: Desk Officer for EPA, 725 17th Street NW., Washington, DC 20503.

The EPA's policy is that all comments received will be included in the public docket without change including any personal information provided, unless the comment includes profanity, threats, information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute.

FOR FURTHER INFORMATION CONTACT: Candace Sorrell, Air Quality Analysis Division (E143–2), Environmental Protection Agency; telephone number (919) 541–1064; fax number: (919) 541–0516; email address: *sorrell.candace@epa.gov.*

SUPPLEMENTARY INFORMATION: Supporting documents, which explain in detail the information that the EPA will be collecting, are available in the public docket for this ICR. The docket can be viewed online at *www.regulations.gov* or in person at the EPA Docket Center, WJC West, Room 3334, 1301 Constitution Ave., NW., Washington, DC. The telephone number for the Docket Center is (202) 566–1744. For further information about the EPA's public docket, visit *http://www.epa.gov/dockets.*

EPA ICR Number: 2355.03

OMB Control Number: 2060–0652

Abstract: This ICR concerns the reporting of the true value of the audit sample to the compliance authority (state, local or EPA Regional Office) by the accredited audit sample provider (AASP) as required in the General Provisions of Parts 51, 60, 61 and 63. This ICR covers the period of 2014–2016.

The required audit program started on June 16, 2013. A regulated emisson source conducting a compliance test would purchase an audit sample from an AASP. The AASP would report the true value of the audit sample to the compliance authority (state, local or EPA Regional Office). The AASP would, in most cases, make the report by electronic mail. A report would be made for each audit sample that the AASP sold to a regulated emission source that was conducting an emissions test to determine compliance with an emission limit.

Form Numbers: None.

Respondents/affected entities: Laboratories that supply audit samples.

Respondent's obligation to respond: Voluntary.

Estimated total number of potential respondents: 9

Frequency of response: There is no regular schedule for collecting information. The information is event driven and information is collected only when an AASP supplies an audit sample to a user.

Total estimated burden: 2,646 hours per year. Burden is defined at 5 CFR 1320.3(b).

Total estimated cost: $201,116 per year. This includes the cost of preparing, validating, disturbing and reporting the audit results.

Changes in the Estimates: There are no changes in the hours in the total estimated respondent burden compared with the ICR currently approved by OMB.

John Moses,

Director, Collection Strategies Division.

[FR Doc. 2013–28782 Filed 11–29–13; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–9903–65–Region–6]

Draft NPDES General Permit Modification for Discharges From the Oil and Gas Extraction Point Source Category to Coastal Waters in Texas and Onshore Stripper Well Category East of The 98th Meridian (TXG330000)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice; Proposal of NPDES general permit modification.

SUMMARY: EPA Region 6 today proposes modifications for the National Pollutant Discharge Elimination System (NPDES) general permit regulating discharges from oil and gas wells in the Coastal Subcategory in Texas and in the Stripper Subcategory which discharge into waters in Texas. These modifications would restore coverage eligibility for certain inland discharges that existed in the previous permit and require freshwater whole effluent toxicity species for discharges to freshwater receiving waters.

DATES: Comments must be received by January 16, 2014.

ADDRESSES: Comments should be sent to: Ms. Diane Smith (6WQ–NP), U.S. Environmental Protection Agency, Region 6, 1445 Ross Avenue, Dallas, Texas 75202–2733.

Comments may also be submitted via email to the following address: *smith.diane@epa.gov*

FOR FURTHER INFORMATION CONTACT: Ms. Diane Smith, Region 6, U.S. Environmental Protection Agency, 1445 Ross Avenue, Dallas, Texas 75202–2733. Telephone: (214) 665–2145.

A complete draft permit and a fact sheet more fully explaining the proposal may be obtained online from the Web site below or from Ms. Smith. In addition, the Agency's current administrative record on the proposal is available for examination at the Region's Dallas offices during normal working hours after providing Ms. Smith 24 hours advance notice. A copy of the proposed permit, fact sheet, and this **Federal Register** Notice may be found on the EPA Region 6 Web site at: *http://www.epa.gov/region6/water/npdes/genpermit/index.htm.*

SUPPLEMENTARY INFORMATION: This permit modification action proposes to clarify the coverage of discharges from stripper wells located east of the 98th meridian whose produced water comes from the Carrizo/Wilcox, Reklaw or Bartosh formations in Texas and whose produced water does not exceed 3000

mg/l total dissolved solids. The modification also adds WET testing requirements using freshwater species for produced waters which discharge to freshwater receiving waters. To determine whether your facility, company, business, organization, etc. is regulated by this action, you should carefully examine the applicability criteria in Part I, Section A.1 of this permit. If you have questions regarding the applicability of this action to a particular entity, consult the person listed in the preceding **FOR FURTHER INFORMATION CONTACT** section. (Note that previous permit was noticed in the **Federal Register** at 77 FR 47380 on August 8, 2012.)

Other Legal Requirements

A. State Certification

Under section 401(a)(1) of the CWA, EPA may not issue an NPDES permit until the State in which the discharge will occur grants or waives certification to ensure compliance with appropriate requirements of the CWA and State law. EPA will seek certification from the Railroad Commission of Texas prior to issuing a final permit.

B. Other Regulatory Requirements

When EPA issued the general permit in 2012, EPA had conducted evaluations required by Coastal Zone Management Act, National Environmental Policy Act, Endangered Species Act, Magnuson-Stevens Fishery Conservation and Management Act, Historic Preservation Act, Paperwork Reduction Act, and Regulatory Flexibility Act. The scope of Today's permit modification action does not trigger requirements for new evaluations for compliance with those regulatory requirements. These requirements were discussed in the fact sheet dated March 7, 2012, when EPA proposed the permit.

Dated: November 20, 2013.

William K. Honker,

Director, Water Quality Protection Division, EPA Region 6.

[FR Doc. 2013–28819 Filed 11–29–13; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

[AU Docket No. 13–268; DA 13–2168]

Closed Auction of AM Broadcast Construction Permits Scheduled for May 6, 2014; Comment Sought on Competitive Bidding Procedures for Auction 84

AGENCY: Federal Communications Commission.

ACTION: Notice.

SUMMARY: This document announces the auction of certain AM broadcast construction permits. Auction 84 will be a ''closed'' auction; only those entities listed in Attachment A to the *Auction 84 Comment Public Notice* will be eligible to participate in this auction. This document also seeks comment on competitive bidding procedures for Auction 84.

DATES: Comments are due on or before December 6, 2013, and reply comments are due on or before December 20, 2013.

ADDRESSES: All filings in response to this notice must refer to AU Docket No. 13–268. The Wireless Telecommunications and Media Bureaus strongly encourage interested parties to file comments electronically, and request that an additional copy of all comments and reply comments be submitted electronically to the following address: *auction84@fcc.gov.* Comments may be submitted by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Federal Communications Commission's Web site: http://fjallfoss.fcc.gov/ecfs2/.* Follow the instructions for submitting comments.
- *Paper Filers:* Parties who choose to file by paper must file an original and four copies of each filing. Filings can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the Commission's Secretary, Attn: WTB/ASAD, Office of the Secretary, Federal Communications Commission.
- All hand-delivered or messenger-delivered paper filings for the Commission's Secretary must be delivered to FCC Headquarters at 445 12th Street SW., Room TW–A325, Washington, DC 20554. All hand deliveries must be held together with rubber bands or fasteners. Any envelopes must be disposed of before entering the building.
- Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743.
- U.S. Postal Service first-class, Express, and Priority mail must be addressed to 445 12th Street SW., Washington, DC 20554.
- *People with Disabilities:* Contact the FCC to request reasonable accommodations (accessible format documents, sign language interpreters, CART, etc.) by email: *FCC504@fcc.gov* or phone: 202–418–0530 or TTY: 202–418–0432.

FOR FURTHER INFORMATION CONTACT: *Wireless Telecommunications Bureau, Auctions and Spectrum Access Division:* For auction legal questions: Lynne Milne at (202) 418–0660; for general auction questions: Jeff Crooks at (202) 418–0660 or Linda Sanderson at (717) 338–2868. *Media Bureau, Audio Division:* For AM service rule questions: Lisa Scanlan or Tom Nessinger (202) 418–2700.

SUPPLEMENTARY INFORMATION: This is a summary of the *Auction 84 Comment Public Notice* released on November 18, 2013. The complete text of the *Auction 84 Comment Public Notice,* including all attachments and related Commission documents, is available for public inspection and copying from 8:00 a.m. to 4:30 p.m. Eastern Time (ET) Monday through Thursday or from 8:00 a.m. to 11:30 a.m. ET on Fridays in the FCC Reference Information Center, 445 12th Street SW., Room CY–A257, Washington, DC 20554. The *Auction 84 Comment Public Notice* and its attachments, as well as related Commission documents, also may be purchased from the Commission's duplicating contractor, Best Copy and Printing, Inc. (BCPI), 445 12th Street SW., Room CY–B402, Washington, DC 20554, telephone 202–488–5300, fax 202–488–5563, or you may contact BCPI at its Web site: *http://www.BCPIWEB.com.* When ordering documents from BCPI, please provide the appropriate FCC document number, for example, DA 13–2168. The *Auction 84 Comment Public Notice* and related documents also are available on the Internet at the Commission's Web site: *http://wireless.fcc.gov/auctions/84/,* or by using the search function for AU Docket No. 13–268 on the Commission's Electronic Comment Filing System (ECFS) Web page at *http://www.fcc.gov/cgb/ecfs/.*

I. Background

1. On November 6, 2003, the Bureaus announced an auction filing window for applications for new AM stations and major modifications to authorized AM stations. By Public Notice dated June 15, 2005, the Bureaus provided a list of all applications received during that filing window that were mutually exclusive with other applications submitted in the filing window from January 26 through January 30, 2004. In the *AM Auction 84 MX Public Notice,* applicants in several of the listed groups of mutually exclusive applications (''MX groups'') were given the opportunity to eliminate their mutual exclusivity with other

applicants by means of settlement or technical modification to their proposals. In addition, for each MX group in which applicants proposed to serve different communities, an analysis under Section 307(b) of the Communications Act of 1934, as amended, was required. Any MX group consisting of only new commercial AM station applications for the same community did not require a section 307(b) analysis and was deemed ready to proceed to auction. On August 30, 2007, the Bureaus announced a limited, supplemental auction filing window to permit the filing of applications for a new AM station on 1700 kHz in a community located in Rockland County, New York.

II. Construction Permits In Auction 84

2. The Bureaus will proceed to auction for 22 new commercial AM stations for the pending groups of mutually exclusive applications identified in Attachment A of the *Auction 84 Comment Public Notice.* A list of the locations and frequencies of these stations is included as Attachment A of the *Auction 84 Comment Public Notice.* Attachment A also lists proposed minimum opening bids and upfront payments for permits being offered in this auction.

3. An applicant listed in Attachment A may become qualified to bid only if it meets the additional filing, qualification and payment requirements. Each qualified bidder will be eligible to bid on only those construction permits specified for that qualified bidder in Attachment A to the *Auction 84 Comment Public Notice.* All applicants within each MX group are directly mutually exclusive with one another; therefore, no more than one construction permit will be awarded for each MX group identified in Attachment A.

III. Due Diligence

4. Each potential bidder is solely responsible for investigating and evaluating all technical and marketplace factors that may have a bearing on the value of the construction permits for AM broadcast facilities that it is seeking in this auction. Each bidder is responsible for assuring that, if it wins a construction permit, it will be able to build and operate facilities in accordance with the Commission's rules. The FCC makes no representations or warranties about the use of this spectrum for particular services. Each applicant should be aware that an FCC auction represents an opportunity to become an FCC permittee in the broadcast service, subject to certain conditions and regulations. An FCC auction does not constitute an endorsement by the FCC of any particular service, technology, or product, nor does an FCC construction permit or license constitute a guarantee of business success.

5. An applicant should perform its due diligence research and analysis before proceeding, as it would with any new business venture. Each potential bidder should perform technical analyses and/or refresh any previous analyses to assure itself that, should it become a winning bidder for any Auction 84 construction permit, it will be able to build and operate facilities that will fully comply with all applicable technical and legal requirements. The Bureaus strongly encourage each applicant to inspect any prospective transmitter sites located in, or near, the service area for which it plans to bid; confirm the availability of such sites; and familiarize itself with the Commission's rules regarding the National Environmental Policy Act.

6. The Bureaus also strongly encourage each applicant to conduct its own research prior to Auction 84 in order to determine the existence of pending administrative or judicial proceedings that might affect its decisions regarding participation in the auction.

7. The Bureaus strongly encourage participants in Auction 84 to continue such research throughout the auction. The due diligence considerations mentioned in the *Auction 84 Comment Public Notice* does not comprise an exhaustive list of steps that should be undertaken prior to participating in this auction. As always, the burden is on the potential bidder to determine how much research to undertake, depending upon the specific facts and circumstances related to its interests.

IV. Short-Form Application Requirements

8. After evaluating any comments received in response to the *Auction 84 Comment Public Notice,* the Bureaus will release a public notice that will specify procedures pursuant to which the listed applicants may qualify to participate and bid in Auction 84. Those procedures will include instructions on how an applicant can submit any new or updated information in the Commission's Integrated Spectrum Auction System (ISAS) to comply with current short-form application (FCC Form 175) requirements, including any changes to be reported pursuant to 47 CFR 1.65. Each applicant is reminded that certain changes may be considered a ''major modification'' and could result in dismissal of its application and its disqualification from participation in Auction 84.

V. Bureaus Seek Comment On Auction 84 Procedures

A. Auction Structure

9. *Simultaneous Multiple-Round Auction Design.* The Bureaus propose to auction all construction permits included in Auction 84 using the Commission's standard simultaneous multiple-round auction format. This type of auction offers every construction permit for bid at the same time and consists of successive bidding rounds in which eligible bidders may place bids on individual construction permits. Typically, bidding remains open on all construction permits until bidding stops on every construction permit. The Bureaus seek comment on this proposal.

10. *Bidding Rounds.* Auction 84 will consist of sequential bidding rounds, each followed by the release of round results. The initial bidding schedule will be announced in a public notice to be released at least one week before the start of the auction. Details on viewing round results, including the location and format of downloadable round results files, will be included in the same public notice.

11. The Commission will conduct Auction 84 over the Internet using the FCC Auction System. Bidders will also have the option of placing bids by telephone through a dedicated Auction Bidder Line. The toll-free telephone number for the Auction Bidder Line will be provided to qualified bidders prior to the start of the auction.

12. The Bureaus propose to retain the discretion to change the bidding schedule in order to foster an auction pace that reasonably balances speed with the bidders' need to study round results and adjust their bidding strategies. Under this proposal, the Bureaus may change the amount of time for the bidding rounds, the amount of time between rounds, or the number of rounds per day, depending upon bidding activity and other factors. The Bureaus seek comment on this proposal. Commenters on this issue should address the role of the bidding schedule in managing the pace of the auction, specifically discussing the tradeoffs in managing auction pace by bidding schedule changes, by changing the activity requirements or bid amount parameters, or by using other means.

13. *Stopping Rule.* The Bureaus have discretion to establish stopping rules before or during multiple round auctions in order to complete the auction within a reasonable time. The

Bureaus propose to employ a simultaneous stopping rule approach, which means all construction permits remain available for bidding until bidding stops on every construction permit. More specifically, bidding will close on all construction permits after the first round in which no bidder submits any new bids, applies a proactive waiver, or withdraws any provisionally winning bids (if bid withdrawals are permitted in this auction). Thus, unless the Bureaus announce alternative procedures, the simultaneous stopping rule will be used in this auction, and bidding will remain open on all construction permits until bidding stops on every construction permit. Consequently, it is not possible to determine in advance how long the bidding in this auction will last.

14. The Bureaus propose to retain the discretion to exercise any of the following options during Auction 84: (1) Use a modified version of the simultaneous stopping rule that would close the auction for all construction permits after the first round in which no bidder applies a waiver, withdraws a provisionally winning bid (if withdrawals are permitted in this auction), or places any new bids on a construction permit for which it is not the provisionally winning bidder. Thus, absent any other bidding activity, a bidder placing a new bid on a construction permit for which it is the provisionally winning bidder would not keep the auction open under this modified stopping rule; (2) Use a modified version of the simultaneous stopping rule that would close the auction for all construction permits after the first round in which no bidder applies a waiver, withdraws a provisionally winning bid (if withdrawals are permitted in this auction), or places any new bids on a construction permit that is not FCC held. Thus, absent any other bidding activity, a bidder placing a new bid on a construction permit that does not already have a provisionally winning bid (an FCC-held construction permit) would not keep the auction open under this modified stopping rule; (3) Use a modified version of the simultaneous stopping rule that combines (1) and (2); (4) Declare that the auction will end after a specified number of additional rounds (special stopping rule). If the Bureaus invoke this special stopping rule, they will accept bids in the specified final round(s), after which the auction will close; and (5) Keep the auction open even if no bidder places any new bids, applies a waiver, or withdraws any provisionally winning bids (if withdrawals are permitted in this auction). In this event, the effect will be the same as if a bidder had applied a waiver. The activity rule will apply as usual, and a bidder with insufficient activity will either lose bidding eligibility or use a waiver.

15. The Bureaus propose to exercise these options only in certain circumstances, for example, where the auction is proceeding unusually slowly or quickly, there is minimal overall bidding activity, or it appears likely that the auction will not close within a reasonable period of time or will close prematurely. Before exercising these options, the Bureaus are likely to attempt to change the pace of the auction. For example, the Bureaus may adjust the pace of bidding by changing the number of bidding rounds per day and/or the minimum acceptable bids. The Bureaus propose to retain the discretion to exercise any of these options with or without prior announcement during the auction. The Bureaus seek comment on these proposals.

16. *Information Relating to Auction Delay, Suspension, or Cancellation.* For Auction 84, the Bureaus may delay, suspend, or cancel the auction in the event of a natural disaster, technical obstacle, administrative or weather necessity, evidence of an auction security breach or unlawful bidding activity, or for any other reason that affects the fair and efficient conduct of competitive bidding. The Bureaus will notify participants of any such delay, suspension or cancellation by public notice and/or through the FCC Auction System's announcement function. If the auction is delayed or suspended they may, in their sole discretion, elect to resume the auction starting from the beginning of the current round or from some previous round, or cancel the auction in its entirety. Network interruption may cause the Bureaus to delay or suspend the auction. The Bureaus emphasize that they will exercise this authority solely at their discretion, and not as a substitute for situations in which bidders may wish to apply their activity rule waivers. The Bureaus seek comment on this proposal.

B. Auction Procedures

17. *Upfront Payments and Bidding Eligibility.* The Bureaus have delegated authority and discretion to determine an appropriate upfront payment for each construction permit being auctioned, taking into account such factors as the efficiency of the auction process and the potential value of similar construction permits. The upfront payment is a refundable deposit made by each bidder to establish eligibility to bid on construction permits. Upfront payments that are related to the specific construction permits being auctioned protect against frivolous or insincere bidding and provide the Commission with a source of funds from which to collect payments owed at the close of the auction. With these considerations in mind, the Bureaus propose the upfront payments set forth in Attachment A of the *Auction 84 Comment Public Notice.* The Bureaus seek comment on the upfront payments specified in Attachment A.

18. The Bureaus further propose that the amount of the upfront payment submitted by a bidder will determine its initial bidding eligibility in bidding units. The Bureaus propose to assign each construction permit a specific number of bidding units, equal to one bidding unit per dollar of the upfront payment listed in Attachment A. The number of bidding units for a given construction permit is fixed and does not change during the auction as prices change. A bidder may place bids on multiple construction permits, provided that (1) each such construction permit is designated for that bidder in Attachment A to the *Auction 84 Comment Public Notice,* and (2) the total number of bidding units associated with those construction permits does not exceed its current eligibility. A bidder cannot increase its eligibility during the auction; it can only maintain its eligibility or decrease its eligibility. Thus, in calculating its upfront payment amount and hence its initial bidding eligibility, an applicant must determine the maximum number of bidding units on which it may wish to bid (or hold provisionally winning bids) in any single round, and submit an upfront payment amount covering that total number of bidding units. The Bureaus request comment on these proposals.

19. *Activity Rule.* In order to ensure that the auction closes within a reasonable period of time, an activity rule requires bidders to bid actively throughout the auction, rather than wait until late in the auction before participating. The Bureaus propose a single stage auction with the following activity requirement: In each round of the auction, a bidder desiring to maintain its current bidding eligibility is required to be active on 100 percent of its bidding eligibility. A bidder's activity in a round will be the sum of the bidding units associated with any construction permits upon which it places bids during the current round and the bidding units associated with any construction permits for which it holds provisionally winning bids.

Failure to maintain the requisite activity level will result in the use of an activity rule waiver, if any remain, or a reduction in the bidder's eligibility, possibly curtailing or eliminating the bidder's ability to place additional bids in the auction. The Bureaus seek comment on this proposal.

20. *Activity Rule Waivers and Reducing Eligibility.* When a bidder's eligibility in the current round is below the required minimum level, it may preserve its current level of eligibility through an activity rule waiver. An activity rule waiver applies to an entire round of bidding, not to a particular construction permit. Activity rule waivers can be either proactive or automatic. Activity rule waivers are principally a mechanism for a bidder to avoid the loss of bidding eligibility in the event that exigent circumstances prevent it from bidding in a particular round.

21. The FCC Auction System assumes that a bidder that does not meet the activity requirement would prefer to use an activity rule waiver (if available) rather than lose bidding eligibility. Therefore, the system will automatically apply a waiver at the end of any bidding round in which a bidder's activity level is below the minimum required unless (1) the bidder has no activity rule waivers remaining; or (2) the bidder overrides the automatic application of a waiver by reducing eligibility, thereby meeting the activity requirement. If a bidder has no waivers remaining and does not satisfy the required activity level, the bidder's current eligibility will be permanently reduced, possibly curtailing or eliminating the ability to place additional bids in the auction.

22. A bidder with insufficient activity may wish to reduce its bidding eligibility rather than use an activity rule waiver. If so, the bidder must affirmatively override the automatic waiver mechanism during the bidding round by using the ''reduce eligibility'' function in the FCC Auction System. In this case, the bidder's eligibility is permanently reduced to bring it into compliance with the activity rule. Reducing eligibility is an irreversible action; once eligibility has been reduced, a bidder will not be permitted to regain its lost bidding eligibility, even if the round has not yet closed.

23. Under the proposed simultaneous stopping rule, a bidder may apply an activity rule waiver proactively as a means to keep the auction open without placing a bid. If a bidder proactively applies an activity rule waiver (using the ''apply waiver'' function in the FCC Auction System) during a bidding round in which no bids are placed or withdrawn (if bid withdrawals are permitted in this auction), the auction will remain open and the bidder's eligibility will be preserved. An automatic waiver applied by the FCC Auction System in a round in which there are no new bids, withdrawals (if bid withdrawals are permitted in this auction), or proactive waivers will not keep the auction open. A bidder cannot apply a proactive waiver after bidding in a round, and applying a proactive waiver will preclude it from placing any bids in that round. Applying a waiver is irreversible; once a proactive waiver is submitted, it cannot be unsubmitted, even if the round has not yet closed.

24. Consistent with recent FCC spectrum auctions, the Bureaus propose that each bidder in Auction 84 be provided with three activity rule waivers that may be used at the bidder's discretion during the course of the auction. The Bureaus seek comment on this proposal.

25. *Reserve Price or Minimum Opening Bids.* The Bureaus seek comment on the use of a minimum opening bid amount and/or reserve price for Auction 84. Normally, a reserve price is an absolute minimum price below which an item will not be sold in a given auction. A minimum opening bid, on the other hand, is the minimum bid price set at the beginning of the auction below which no bids are accepted. It is generally used to accelerate the competitive bidding process.

26. The Bureaus propose to establish minimum opening bid amounts for Auction 84. The Bureaus believe that a minimum opening bid amount, which has been used in other broadcast auctions, is an effective bidding tool for accelerating the competitive bidding process. The Bureaus do not propose to establish separate reserve prices for the construction permits to be offered in Auction 84.

27. For Auction 84, the Bureaus propose minimum opening bid amounts determined by taking into account the type of service and class of facility offered, market size, population covered by the proposed broadcast facility, and recent broadcast transaction data. Attachment A of the *Auction 84 Comment Public Notice* lists a proposed minimum opening bid amount for each construction permit available in Auction 84. The Bureaus seek comment on the minimum opening bid amounts specified in Attachment A.

28. If commenters believe that these minimum opening bid amounts will result in unsold construction permits, are not reasonable amounts, or should instead operate as reserve prices, they should explain why this is so and comment on the desirability of an alternative approach. The Bureaus ask commenters to support their claims with valuation analyses and suggested amounts or formulas for reserve prices or minimum opening bids. In establishing the minimum opening bid amounts, the Bureaus particularly seek comment on factors that could reasonably have an impact on valuation of the broadcast spectrum, including the type of service and class of facility offered, market size, population covered by the proposed AM broadcast facility and any other relevant factors.

29. *Bid Amounts.* The Bureaus propose that, if the bidder has sufficient eligibility, an eligible bidder will be able to place a bid on a given construction permit in each round in any of up to nine different amounts. Under this proposal, the FCC Auction System interface will list the acceptable bid amounts for each construction permit. In the event of duplicate bid amounts due to rounding, however, the FCC Auction System will omit the duplicates and will list fewer than nine acceptable bid amounts for the construction permit.

30. The first of the acceptable bid amounts is called the minimum acceptable bid amount. The minimum acceptable bid amount for a construction permit will be equal to its minimum opening bid amount until there is a provisionally winning bid for the construction permit. After there is a provisionally winning bid for a construction permit, the minimum acceptable bid amount will be a certain percentage higher. That is, the FCC will calculate the minimum acceptable bid amount by multiplying the provisionally winning bid amount times one plus the minimum acceptable bid percentage. If, for example, the minimum acceptable bid percentage is 10 percent, the minimum acceptable bid amount will equal (provisionally winning bid amount) * (1.10), rounded. If bid withdrawals are permitted in this auction, in the case of a construction permit for which the provisionally winning bid has been withdrawn, the minimum acceptable bid amount will equal the second highest bid received for the construction permit.

31. The FCC will calculate the eight additional bid amounts using the minimum acceptable bid amount and a bid increment percentage, which need not be the same as the percentage used to calculate the minimum acceptable bid amount. The first additional acceptable bid amount equals the minimum acceptable bid amount times one plus the bid increment percentage, rounded. If, for example, the bid

increment percentage is 5 percent, the calculation is (minimum acceptable bid amount) * (1 + 0.05), rounded, or (minimum acceptable bid amount) * 1.05, rounded; the second additional acceptable bid amount equals the minimum acceptable bid amount times one plus two times the bid increment percentage, rounded, or (minimum acceptable bid amount) * 1.10, rounded; etc. The Bureaus will round the results using the Commission's standard rounding procedures for auctions.

32. For Auction 84, the Bureaus propose to use a minimum acceptable bid percentage of 10 percent. This means that the minimum acceptable bid amount for a construction permit will be approximately 10 percent greater than the provisionally winning bid amount for the construction permit. To calculate the additional acceptable bid amounts, the Bureaus propose to use a bid increment percentage of 5 percent. The Bureaus seek comment on these proposals.

33. The Bureaus retain the discretion to change the minimum acceptable bid amounts, the minimum acceptable bid percentage, the bid increment percentage, and the number of acceptable bid amounts if the Bureaus determine that circumstances so dictate. Further, the Bureaus retain the discretion to do so on a construction permit-by-construction permit basis. The Bureaus also retain the discretion to limit (a) the amount by which a minimum acceptable bid for a construction permit may increase compared with the corresponding provisionally winning bid, and (b) the amount by which an additional bid amount may increase compared with the immediately preceding acceptable bid amount. For example, the Bureaus could set a $10,000 limit on increases in minimum acceptable bid amounts over provisionally winning bids. Thus, if calculating a minimum acceptable bid using the minimum acceptable bid percentage results in a minimum acceptable bid amount that is $12,000 higher than the provisionally winning bid on a construction permit, the minimum acceptable bid amount would instead be capped at $10,000 above the provisionally winning bid. The Bureaus seek comment on the circumstances under which to employ such a limit, factors to consider when determining the dollar amount of the limit, and the tradeoffs in setting such a limit or changing other parameters, such as changing the minimum acceptable bid percentage, the bid increment percentage, or the number of acceptable bid amounts. If the Bureaus exercise this discretion, they will alert bidders by announcement in the FCC Auction System during the auction.

34. *Provisionally Winning Bids.* Provisionally winning bids are bids that would become final winning bids if the auction were to close in that given round. At the end of a bidding round, the FCC Auction System determines a provisionally winning bid for each construction permit based on the highest bid amount received. If identical high bid amounts are submitted on a construction permit in any given round (i.e., tied bids), the FCC Auction System will use a random number generator to select a single provisionally winning bid from among the tied bids. (The Auction System assigns a random number to each bid when the bid is entered. The tied bid with the highest random number wins the tiebreaker.) The remaining bidders, as well as the provisionally winning bidder, can submit higher bids in subsequent rounds. However, if the auction were to end with no other bids being placed, the winning bidder would be the one that placed the provisionally winning bid. If the construction permit receives any bids in a subsequent round, the provisionally winning bid again will be determined by the highest bid amount received for the construction permit.

35. A provisionally winning bid will be retained until there is a higher bid on the construction permit at the close of a subsequent round, unless the provisionally winning bid is withdrawn (if bid withdrawals are permitted in this auction). The Bureaus remind bidders that provisionally winning bids count toward activity for purposes of the activity rule.

36. *Bid Removal and Bid Withdrawal.* For Auction 84, the Bureaus propose the following bid removal procedures. Before the close of a bidding round, a bidder has the option of removing any bid placed in that round. By removing a selected bid in the FCC Auction System, a bidder may effectively ''unsubmit'' any bid placed within that round. In contrast to the bid withdrawal provisions, a bidder removing a bid placed in the same round is not subject to a withdrawal payment. Once a round closes, a bidder may no longer remove a bid. The Bureaus seek comment on this bid removal proposal.

37. The Bureaus also seek comment on whether bid withdrawals should be permitted in Auction 84. When permitted in an auction, bid withdrawals provide a bidder with the option of withdrawing bids placed in prior rounds that have become provisionally winning bids. If permitted, a bidder may withdraw its provisionally winning bids using the ''withdraw bids'' function in the FCC Auction System. A bidder that withdraws its provisionally winning bid(s), if permitted, is subject to the bid withdrawal payment provisions of the Commission rules.

38. The Commission has recognized that bid withdrawals may be a helpful tool for bidders seeking to efficiently aggregate licenses or implement backup strategies in certain auctions. The stand-alone nature of AM facilities, however, suggests that it is not necessary for bidders to aggregate facilities being offered in the same auction in order to realize full value from those facilities, or to put the spectrum to effective and efficient use.

39. Based on the nature of the permits being offered and on experience with past auctions of broadcast construction permits, the Bureaus propose to prohibit bidders from withdrawing any bids after the close of the round in which bids were placed. The Bureaus make this proposal in light of the site- and applicant-specific nature and wide geographic dispersion of the permits available in this closed auction, which suggests that potential applicants for this auction will have limited opportunity to aggregate construction permits through the auction process (as compared with bidders in many auctions of wireless licenses) because of the pre-established closed MX groups. Thus, the Bureaus believe that it is unlikely that bidders will have a need to withdraw bids in this auction. The Bureaus also remain mindful that bid withdrawals, particularly those made late in this auction, could result in delays in licensing new AM stations and attendant delays in the offering of new broadcast service to the public. The Bureaus seek comment on their proposal to prohibit bid withdrawals.

C. Post-Auction Payments

40. *Interim Withdrawal Payment Percentage.* In the event the Bureaus allow bid withdrawals in Auction 84, they propose the interim bid withdrawal payment be 20 percent of the withdrawn bid. A bidder that withdraws a bid during an auction is subject to a withdrawal payment equal to the difference between the amount of the withdrawn bid and the amount of the winning bid in the same or a subsequent auction. However, if a construction permit for which a bid has been withdrawn does not receive a subsequent higher bid or winning bid in the same auction, the FCC cannot calculate the final withdrawal payment until that construction permit receives a higher bid or winning bid in a subsequent auction. In such cases, when

that final withdrawal payment cannot yet be calculated, the FCC imposes on the bidder responsible for the withdrawn bid an interim bid withdrawal payment, which will be applied toward any final bid withdrawal payment that is ultimately assessed.

41. The amount of the interim bid withdrawal payment may range from three percent to twenty percent of the withdrawn bid amount, with the percentage generally being higher where there is greater risk of bid withdrawals being used for anti-competitive purposes, such as in Auction 84 when there is little need for bidders to aggregate permits. In light of these considerations, the Bureaus propose to use the maximum interim bid withdrawal payment percentage allowed by 47 CFR 1.2104(g)(1) in the event bid withdrawals are allowed. The Bureaus request comment on using twenty percent for calculating an interim bid withdrawal payment amount in Auction 84. Commenters advocating the use of bid withdrawals should also address the percentage of the interim bid withdrawal payment.

42. *Additional Default Payment Percentage.* Any winning bidder that defaults or is disqualified after the close of an auction (i.e., fails to remit the required down payment within the prescribed period of time, fails to submit a timely long-form application, fails to make full and timely final payment, or is otherwise disqualified) is liable for a default payment under 47 CFR 1.2104(g)(2). This payment consists of a deficiency payment, equal to the difference between the amount of the Auction 84 bidder's winning bid and the amount of the winning bid the next time a construction permit covering the same spectrum is won in an auction, plus an additional payment equal to a percentage of the defaulter's bid or of the subsequent winning bid, whichever is less.

43. The Commission's rules provide that, in advance of each auction, it will establish a percentage between three percent and twenty percent of the applicable bid to be assessed as an additional default payment. As the Commission has indicated, the level of this additional payment in each auction will be based on the nature of the service and the construction permits being offered.

44. For Auction 84, the Bureaus propose to establish an additional default payment of twenty percent. Defaults weaken the integrity of the auction process and may impede the deployment of service to the public, and an additional twenty percent default payment will be more effective in deterring defaults than the three percent used in some earlier auctions. In light of these considerations, the Bureaus propose for Auction 84 an additional default payment of twenty percent of the relevant bid. Moreover, a twenty percent additional default payment amount is consistent with the percentage used in recent auctions of FM permits. The Bureaus seek comment on this proposal.

Federal Communications Commission.

Gary D. Michaels,

Deputy Chief, Auctions and Spectrum Access Division, WTB.

[FR Doc. 2013–28821 Filed 11–29–13; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL ELECTION COMMISSION

Sunshine Act Meetings

AGENCY: Federal Election Commission.

DATE & TIME: *Thursday, December 5, 2013 at 10:00 a.m.*

PLACE: 999 E Street NW., Washington, DC (Ninth Floor).

STATUS: This meeting will be open to the public.

ITEMS TO BE DISCUSSED:

Correction and Approval of Minutes for October 31, 2013

Draft Interpretive Rule Regarding Date of Political Party Nominations of Candidates for Special Primary Elections in New York

Draft Advisory Opinion 2013–19: Yamaha Motor Corporation, U.S.A.

Audit Division Recommendation Memorandum on the Caesars Entertainment Corporation Political Action Committee (A12–01)

Management and Administrative Matters

Individuals who plan to attend and require special assistance, such as sign language interpretation or other reasonable accommodations, should contact Shawn Woodhead Werth, Secretary and Clerk, at (202)694–1040, at least 72 hours prior to the meeting date.

PERSON TO CONTACT FOR INFORMATION: Judith Ingram, Press Officer, Telephone: (202) 694–1220.

Shawn Woodhead Werth,

Secretary and Clerk of the Commission.

[FR Doc. 2013–28920 Filed 11–27–13; 4:15 pm]

BILLING CODE 6715–01–P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The applications will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than December 26, 2013.

A. Federal Reserve Bank of St. Louis (Yvonne Sparks, Community Development Officer) P.O. Box 442, St. Louis, Missouri 63166–2034:

1. *First Bancshares, Inc.,* Mountain Grove, Missouri; to become a bank holding company through the conversion of its wholly-owned subsidiary bank, First Home Savings Bank, Mountain Grove, Missouri, from a state chartered savings bank to a state chartered nonmember bank.

B. Federal Reserve Bank of Dallas (E. Ann Worthy, Vice President) 2200 North Pearl Street, Dallas, Texas 75201–2272:

1. *The 2013 Monte Hulse Family Irrevocable Trust I,* Waco, Texas; to acquire at least 19 percent of the voting shares of FCT Bancshares, Inc., and thereby indirectly acquire voting shares of First National Bank of Central Texas, both in Waco, Texas.

Board of Governors of the Federal Reserve System, November 26, 2013.

Michael J. Lewandowski,

Associate Secretary of the Board.

[FR Doc. 2013–28777 Filed 11–29–13; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day–14–0881]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–7570 or send comments to Leroy Richardson, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email to *omb@cdc.gov.*

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Data Calls for the Laboratory Response Network (0920–0881, Expiration 03/31/2014)—Extension-National Center for Emerging and Zoonotic Infectious Diseases (NCEZID, Centers for Disease Control and Prevention (CDC).)

Background and Brief Description

The Laboratory Response Network (LRN) was established by the Department of Health and Human Services, Centers for Disease Control and Prevention (CDC) in accordance with Presidential Decision Directive 39, which outlined national anti-terrorism policies and assigned specific missions to Federal departments and agencies. The LRN's mission is to maintain an integrated national and international network of laboratories that can respond to acts of biological, chemical, or radiological terrorism and other public health emergencies. Federal, state and local public health laboratories voluntarily join the LRN.

The LRN Program Office maintains a database of information for each member laboratory that includes contact information as well as staff and equipment inventories. However, semiannually or during emergency response the LRN Program Office may conduct a Special Data Call to obtain additional information from LRN Member Laboratories in regards to biological or chemical terrorism preparedness. Special Data Calls may be conducted via queries that are distributed by broadcast emails or by survey tools (i.e. Survey Monkey). This is a request for an extension to this generic clearance. The only cost to respondents is their time to respond to the data call.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	No. of respondents	No. of responses per respondent	Avg. burden per response (in hrs.)	Total burden (in hrs.)
Public Health Laboratorians	Special Data Call	200	4	30/60	600
Total					400

LeRoy Richardson,

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

[FR Doc. 2013–28755 Filed 11–29–13; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30 Day–14–0010]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call (404) 639–7570 or send an email to *omb@cdc.gov.* Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC 20503 or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

Birth Defects Study To Evaluate Pregnancy exposureS (BD–STEPS) (formerly titled The National Birth Defects Prevention Study (NBDPS)), (OMB # 0920–0010, Expiration 04/30/2015)—Revision—National Center on Birth Defects and Developmental Disabilities (NCBDDD), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

CDC has been monitoring the occurrence of serious birth defects and genetic diseases in Atlanta since 1967 through the Metropolitan Atlanta Congenital Defects Program (MACDP). The MACDP is a population-based surveillance system for birth defects currently covering three counties in Metropolitan Atlanta.

Since 1997, CDC has funded case-control studies of major birth defects that utilize existing birth defect surveillance registries (including MACDP) to identify cases and study birth defects causes in participating states/municipalities across the United States.

BD–STEPS is a case-control study that is similar to the previous CDC-funded birth defects case-control study, NBDPS, which stopped interviewing participants in 2013. As with NBDPS,

control infants will be randomly selected from birth certificates or birth hospital records; mothers of case and control infants will be interviewed using a computer-assisted telephone interview.

The BD–STEPS interview takes approximately forty-five minutes to complete. A maximum of 275 interviews are planned per year per center, 200 cases and 75 controls. With seven centers planned, the maximum interview burden for all centers combined would be approximately 1,444 hours. As with NBDPS, parents in BD–STEPS will be asked to collect deoxyribonucleic acid (DNA) samples from themselves and their infants. The collection of saliva cells by the mother, father and infant takes about 15 minutes per person. For the infant sample, the parent will rub long-handled sponges between the infant's cheek and gum; parents will be asked to swab a total of five sponges per infant. The infant's mother and father will be asked to provide their own saliva samples by spitting into a funnel connected to small collection tubes. Collection of the saliva samples takes approximately 2–5 minutes per person, but the estimate of burden is 15 minutes per person to account for reading and understanding the consent form and specimen collection instructions and mailing back the completed kits. The anticipated maximum burden for collection of the saliva samples for all centers combined would be approximately 1,444 hours.

Information gathered from both the interviews and the DNA specimens has been and will continue to be used to study independent genetic and environmental factors as well as gene-environment interactions for a broad range of carefully classified birth defects. The total estimated annualized burden is 2,888 hours.

This request is submitted to obtain Office of Management and Budget (OMB) clearance for three additional years.

There are no costs to the respondents other than their time.

ESTIMATES OF ANNUALIZED BURDEN HOURS

Respondents	Activity	Number of respondents	Number of responses per respondent	Avg. burden per response (In hours)
Mothers (interview)	Telephone consent and BD–STEPS questionnaire.	1,925	1	45/60
Mothers, fathers, infants (saliva samples)	Written consent for saliva collection and collection of saliva samples.	5,775	1	15/60

LeRoy Richardson,

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

[FR Doc. 2013–28756 Filed 11–29–13; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day–14–0770]

Agency Information Collection Activities; Proposals, Submissions, and Approvals; Withdrawal

AGENCY: Centers for Disease Control and Prevention (CDC) Center for HIV, Hepatitis, STD, and TB Prevention (NCHHSTP), Department of Health and Human Services (HHS).

ACTION: Notice withdrawal.

SUMMARY: The Centers for Disease Control and Prevention requests withdrawal from publication the 60-Day **Federal Register** Notice (FRN) 14 0770 concerning the *National HIV Behavioral Surveillance System (NHBS)* (FR Doc. 2013–28281), which was submitted on November 21, 2013 for public inspection in the **Federal Register**.

The purpose behind this notice withdrawal request is that an original 60-day FRN previously published on November 26, 2013 (Document Number—2013–28280). A duplicate 60-day FRN was inadvertently published on November 26, 2013. Please disregard the duplicate FRN.

DATES: The duplicate FRN published on [11/26/13] at [Vol. 78, No. 228 Page 70561–70562] is withdrawn as of [11/26/13].

FOR FURTHER INFORMATION CONTACT: (404) 639–7570 or send comments to CDC LeRoy Richardson, 1600 Clifton Road, MS D–74, Atlanta, GA 30333 or send an email to *omb@cdc.gov.*

SUPPLEMENTARY INFORMATION: N/A

LeRoy A. Richardson,

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

[FR Doc. 2013–28767 Filed 11–29–13; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Statement of Organization, Functions, and Delegations of Authority

Part C (Centers for Disease Control and Prevention) of the Statement of Organization, Functions, and Delegations of Authority of the Department of Health and Human Services (45 FR 67772–76, dated October 14, 1980, and corrected at 45 FR 69296, October 20, 1980, as amended most recently at 78 FR 58309, dated September 23, 2013) is amended to reflect the title change for the CIMS Program Management Office within the Office of the Chief Information Officer, Office of the Chief Operating Officer, Centers for Disease Control and Prevention.

Section C–B, Organization and Functions, is hereby amended as follows:

Delete in its entirety the title for the CIMS Program Management Office (CAJR14) and insert the Acquisition Program Management Office (CAJR14).

Dated: November 8, 2013.

Sherri A. Berger,

Chief Operating Officer, Centers for Disease Control and Prevention.

[FR Doc. 2013–28754 Filed 11–29–13; 8:45 am]

BILLING CODE 4160–18–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6051–N]

Medicare, Medicaid, and Children's Health Insurance Programs; Provider Enrollment Application Fee Amount for Calendar Year 2014

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

ACTION: Notice.

SUMMARY: This notice announces a $542.00 calendar year (CY) 2014 application fee for institutional providers that are initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP); revalidating their Medicare, Medicaid or CHIP enrollment; or adding a new Medicare practice location. This fee is required with any enrollment application submitted on or after January 1, 2014 and on or before December 31, 2014.

DATES: *Effective Date:* This notice is effective on January 1, 2014.

FOR FURTHER INFORMATION CONTACT: Frank Whelan, (410) 786–1302 for Medicare enrollment issues. Alvin Anderson, (410) 786–2188 for Medicaid and CHIP enrollment issues.

SUPPLEMENTARY INFORMATION:

I. Background

In the February 2, 2011 **Federal Register** (76 FR 5862), we published a final rule with comment period entitled ''Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers.'' This rule finalized, among other things, provisions related to the submission of application fees as part of the Medicare, Medicaid, and CHIP provider enrollment processes. As stated in 42 CFR 424.514, ''institutional providers'' that are initially enrolling in the Medicare, Medicaid or CHIP program, revalidating their enrollment, or adding a new Medicare practice location are required to submit a fee with their enrollment application. An ''institutional provider'' is defined at 42 CFR 424.502 as ''(a)ny provider or supplier that submits a paper Medicare enrollment application using the CMS–855A, CMS–855B (not including physician and non-physician practitioner organizations), CMS–855S, or associated Internet-based PECOS enrollment application.'' As we explained in the February 2011 final rule (76 FR 5914), ''In addition to the providers and suppliers subject to the application fee under Medicare, Medicaid-only and CHIP-only institutional providers include nursing facilities, intermediate care facilities for persons with mental retardation (ICF/MR), psychiatric residential treatment facilities, and may include other institutional provider types designated by a State in accordance with their approved State plan.''.

As indicated in 42 CFR 424.514 and 455.460, the application fee is not required for either of the following:

- A Medicare physician or non-physician practitioner submitting a CMS–855I.
- A prospective or re-enrolling Medicaid or CHIP provider—

++ Who is an individual physician or non-physician practitioner; or

++ That is enrolled in Title XVIII of the Act or another state's Title XIX or XXI plan and has paid the application fee to a Medicare contractor or another state.

II. Provisions of the Notice

A. CY 2013 Fee Amount

In the November 30, 2012 **Federal Register** (77 FR 71423), we published a notice announcing a fee amount for the period of January 1, 2013 through December 31, 2013 of $532.00. This figure was calculated as follows:

- Section 1866(j)(2)(C)(i)(I) of the Social Security Act (the Act) established a $500 application fee for institutional providers in CY 2010.
- Consistent with section 1866(j)(2)(C)(i)(II) of the Act, 42 CFR 424.514(d)(2) states that for CY 2011 and subsequent years, the fee will be adjusted by the percentage change in the consumer price index (CPI) for all urban consumers (all items; United States city average, CPI–U) for the 12-month period ending in June of the previous year.
- The CPI–U increase for CY 2011 was 1.0 percent, based on data obtained from the Bureau of Labor Statistics (BLS). This resulted in an application fee amount for CY 2011 of $505 (or $500 × 1.01).
- The CPI–U increase for the period of July 1, 2010 through June 30, 2011 was 3.54 percent, based on BLS data. This resulted in an application fee amount for CY 2012 of $522.87 (or $505 × 1.0354). In the aforementioned February 2, 2011 final rule, we stated that if the adjustment sets the fee at an uneven dollar amount, we would round the fee to the nearest whole dollar amount. Accordingly, the application fee amount for CY 2012 was rounded to the nearest whole dollar amount, or $523.00.
- The CPI–U increase for the period of July 1, 2011 through June 30, 2012 was 1.664 percent, based on BLS data. This resulted in an application fee amount for CY 2013 of $531.70 ($523 × 1.01664). Rounding this figure to the nearest whole dollar amount resulted in a CY 2013 application fee amount of $532.00.

B. CY 2014 Fee Amount

Using BLS data, the CPI–U increase for the period of July 1, 2012 through June 30, 2013 was 1.8 percent. This results in a CY 2014 application fee amount of $541.576 ($532 × 1.018). As we must round this to the nearest whole dollar amount, the resultant application fee amount for CY 2014 is $542.00. This represents a $6.00 difference from the $536 application fee amount that we had originally projected for CY 2014 in the February 2, 2011 final rule.

III. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). However, it does reference currently approved information collections. Form CMS–855A, and CMS–855I are approved under OMB control number 0938–0685. Form CMS–855B is approved under OMB control number 0938–1198. Form CMS–855S is approved under OMB control number 0938–1056.

IV. Regulatory Impact Statement

We have examined the impact of this notice as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

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 rules with economically significant effects ($100 million or more in any 1 year). As explained in this section of the notice (section IV.), we estimate that the total cost of the increase in the application fee will not exceed $100 million. This notice therefore does not reach the $100 million economic threshold and is not considered a major notice.

The RFA requires agencies to analyze options for regulatory relief of small businesses. 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 $7.0 million to $35.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. As we stated in the RIA for the February 2, 2011 final rule with comment period (76 FR 5952), we do not believe that the application fee will have a significant impact on small entities.

In addition, section 1102(b) of the 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. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this notice would 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 2013, that threshold is approximately $141 million. The Agency has determined that there will be minimal impact from the costs of this notice, as the threshold is not met under the UMRA.

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 substantial direct costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

The costs associated with this notice involve the increase in the application fee that certain providers and suppliers must pay in CY 2014. As indicated earlier, in the RIA for the February 2, 2011 final rule, we estimated the total amount of application fees for CYs 2011 through 2015. For CY 2014, and based on a $536 application fee amount, we projected in Tables 11 and 12 (76 FR 5955 and 5956) a total cost in fees of $62,189,400 ($16,723,200 + $45,466,200) for 116,025 affected Medicare institutional providers (31,200 newly enrolling + 84,825 re-enrolling). We also projected in Tables 13 and 14 (76 FR 5957 and 5958) a total cost in CY 2014 application fees of $13,471,824 ($4,522,768 + $8,949,056) for 25,134 affected Medicaid and CHIP providers (8,438 newly enrolling + 16,696 re-enrolling).

In the November 30, 2012 application fee notice, we stated in part that we were—

- Increasing the estimated number of affected Medicaid and CHIP providers in CY 2013 from 25,134 to 27,859, based on CY 2009 and CY 2010 data furnished by State Medicaid agencies through the annual State Program Integrity Assessment; and

- Reducing the estimated number of affected Medicare institutional providers from 116,025 to 84,120. This was due to a much-lower-than-expected number of affected newly-enrolling institutional providers. We had projected in the February 2, 2011 final rule that 31,200 newly-enrolling institutional providers would be subject to an application fee in CY 2013. We reduced this figure to 4,120 based on CMS data.

Our statistics indicate that roughly the same number of Medicaid and CHIP providers that we projected in the November 30, 2012 fee notice would be subject to an application fee in CY 2013 will be similarly affected in CY 2014. We will therefore use the CY 2013 figures in our calculations of the fee costs for CY 2014. However, as explained later in this section, we project that the number of affected Medicare institutional providers in CY 2014 will be higher than the CY 2013 projection we used in the November 30, 2012 fee notice.

1. Medicare

a. Newly-Enrolling Institutional Providers

Based on CMS statistics for the final quarter of CY 2012, we estimate that 4,800 newly-enrolling institutional providers will be subject to an application fee in CY 2014. This represents an increase of 670 from the CY 2013 projection we used in the November 30, 2012 fee notice.

b. Revalidating Institutional Providers

Again based on CMS data, we estimate that approximately 580,000 Medicare providers and suppliers will be subject to revalidation in CY 2014. (This represents an increase of 180,000 from the CY 2013 projection we used in the November 30, 2012 fee notice.) Of this total, and based on our experience, we believe that roughly 80 percent of them will be exempt from the application fee requirement because the provider or supplier: (1) Is of a type (for example, a physician) that is exempt from the requirement; or (2) qualifies for a hardship exception under 42 CFR 424.514(c). This leaves 116,000 revalidating institutional providers that will have to pay the fee. Using a figure of 120,800 (116,000 revalidating + 4,800 newly-enrolling) institutional providers, we estimate an increase in the cost of the Medicare application fee requirement in CY 2014 of $ 724,800 (or 120,800 x $6.00) from the CY 2014 projections we had made in the February 2, 2011 final rule.

2. Medicaid and CHIP

We estimate that 27,859 (8,438 newly enrolling + 19,421 re-enrolling) Medicaid and CHIP providers would be subject to an application fee in CY 2014. Using this figure, we estimate an increase in the cost of the Medicaid and CHIP application fee requirements in CY 2014 of $167,154 (27,859 x $6.00) from the CY 2014 projections we had made in the February 2, 2011 final rule.

3. Total

Based on the foregoing, we estimate the total increase in the cost of the application fee requirement for Medicare, Medicaid, and CHIP providers and suppliers in CY 2014 to be $891,954 ($724,800 + $167,154) from the CY 2014 projections we had made in the February 2, 2011 final rule.

In accordance with the provisions of Executive Order 12866, this notice was/was not reviewed by the Office of Management and Budget.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital

Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 7, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2013–28733 Filed 11–29–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–N–0719]

Agency Information Collection Activities; Submission for Office of Management and Budget Review; Comment Request; Guidance for Industry on Planning for the Effects of High Absenteeism To Ensure Availability of Medically Necessary Drug Products

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a proposed collection of information has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Fax written comments on the collection of information by January 2, 2014.

ADDRESSES: To ensure that comments on the information collection are received, OMB recommends that written comments be faxed to the Office of Information and Regulatory Affairs, OMB, Attn: FDA Desk Officer, FAX: 202–395–7285, or emailed to *oira_submission@omb.eop.gov.* All comments should be identified with the OMB control number 0910–0675. Also include the FDA docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: FDA PRA Staff, Office of Operations, Food and Drug Administration, 1350 Piccard Dr., PI50–400B, Rockville, MD 20850, *PRAStaff@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

Guidance for Industry on Planning for the Effects of High Absenteeism To Ensure Availability of Medically Necessary Drug Products—(OMB Control Number 0910–0675)—Extension

The guidance recommends that manufacturers of drug and therapeutic biological products and manufacturers of raw materials and components used in those products develop a written Emergency Plan (Plan) for maintaining an adequate supply of medically necessary drug products (MNPs) during an emergency that results in high employee absenteeism. The guidance discusses the issues that should be covered by the Plan, such as: (1) Identifying a person or position title (as well as two designated alternates) with the authority to activate and deactivate the Plan and make decisions during the emergency; (2) prioritizing the manufacturer's drug products based on medical necessity; (3) identifying actions that should be taken prior to an anticipated period of high absenteeism; (4) identifying criteria for activating the Plan; (5) performing quality risk assessments to determine which manufacturing activities may be reduced to enable the company to meet a demand for MNPs; (6) returning to normal operations and conducting a post-execution assessment of the execution outcomes; and (7) testing the Plan. The guidance recommends developing a Plan for each individual manufacturing facility as well as a broader Plan that addresses multiple sites within the organization. For purposes of this information collection analysis, we consider the Plan for an individual manufacturing facility as well as the broader Plan to comprise one Plan for each manufacturer. Based on FDA's data on the number of manufacturers that would be covered by the guidance, we estimate that approximately 70 manufacturers will develop a Plan as recommended by the guidance (i.e., one Plan per manufacturer to include all manufacturing facilities, sites, and drug products), and that each Plan will take approximately 500 hours to develop, maintain, and update.

The guidance also encourages manufacturers to include a procedure in their Plan for notifying the Center for Drug Evaluation and Research (CDER) when the Plan is activated and when returning to normal operations. The guidance recommends that these notifications occur within 1 day of a Plan's activation and within 1 day of a Plan's deactivation. The guidance specifies the information that should be included in these notifications, such as which drug products will be manufactured under altered procedures, which products will have manufacturing temporarily delayed, and any anticipated or potential drug shortages. We expect that approximately 2 notifications (for purposes of this analysis, we consider an activation and a deactivation notification to equal one notification) will be sent to CDER by approximately 2 manufacturers each year, and that each notification will take approximately 16 hours to prepare and submit.

The guidance also refers to previously approved collections of information found in FDA regulations. Under the guidance, if a manufacturer obtains information after releasing an MNP under its Plan, leading to suspicion that the product might be defective, CDER should be contacted immediately at *drugshortages@fda.hhs.gov* in adherence to existing recall reporting regulations (21 CFR 7.40; OMB control number 0910–0249), or defect reporting requirements for drug application products (21 CFR 314.81(b)(1)) and therapeutic biological products regulated by CDER (21 CFR 600.14) (OMB control numbers 0910–0001 and 0910–0458, respectively).

In addition, the following collections of information found in FDA current good manufacturing practice (CGMP) regulations in part 211 (21 CFR part 211) are approved under OMB control number 0910–0139. The guidance encourages manufacturers to maintain records, in accordance with the CGMP requirements (*see,* e.g., § 211.180) that support decisions to carry out changes to approved procedures for manufacturing and release of products under the Plan. The guidance states that a Plan should be developed, written, reviewed, and approved within the site's change control quality system in accordance with the requirements in §§ 211.100(a) and 211.160(a); execution of the Plan should be documented in accordance with the requirements described in § 211.100(b); and standard operating procedures should be reviewed and revised or supplementary procedures developed and approved to enable execution of the Plan.

In the **Federal Register** of June 21, 2013 (78 FR 37548), FDA published a 60-day notice requesting public comment on the proposed collection of information. No comments were received.

FDA estimates the burden of this information collection as follows:

TABLE 1—ESTIMATED ANNUAL REPORTING BURDEN [1]

Absenteeism guidance	Number of respondents	Number of responses per respondent	Total annual responses	Average burden per response	Total hours
Notify FDA of Plan Activation and Deactivation	2	1	2	16	32

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

TABLE 2—ESTIMATED RECORDKEEPING BURDEN [1]

Absenteeism guidance	Number of recordkeepers	Number of records per recordkeeper	Total annual records	Average burden per recordkeeping	Total hours
Develop Initial Plan	70	1	70	500	35,000

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

Dated: November 25, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–28735 Filed 11–29–13; 8:45 am]

BILLING CODE 4160–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–N–0748]

Agency Information Collection Activities; Submission for Office of Management and Budget Review; Comment Request; Focus Groups About Drug Products as Used by the Food and Drug Administration

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a proposed collection of information has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Fax written comments on the collection of information by January 2, 2014.

ADDRESSES: To ensure that comments on the information collection are received, OMB recommends that written comments be faxed to the Office of Information and Regulatory Affairs, OMB, Attn: FDA Desk Officer, FAX: 202–395–7285, or emailed to *oira_submission@omb.eop.gov.* All comments should be identified with the OMB control number 0910–0677. Also include the FDA docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: FDA PRA Staff, Office of Operations, Food and Drug Administration, 1350 Piccard Dr., PI50–400B, Rockville, MD 20850, *PRAStaff@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

Focus Groups About Drug Products as Used by the Food and Drug Administration—(OMB Control Number 0910–0677)—Extension

Focus groups provide an important role in gathering information because they allow for a more in-depth understanding of individuals' attitudes, beliefs, motivations, and feelings than do quantitative studies. Focus groups serve the narrowly defined need for direct and informal opinion on a specific topic and as a qualitative research tool have three major purposes:

- To obtain information that is useful for developing variables and measures for quantitative studies,
- To better understand people's attitudes and emotions in response to topics and concepts, and
- To further explore findings obtained from quantitative studies.

FDA will use focus group findings to test and refine its ideas and to help develop messages and other communications, but will generally conduct further research before making important decisions such as adopting new policies and allocating or redirecting significant resources to support these policies.

FDA's Center for Drug Evaluation and Research, Office of the Commissioner, and any other Centers or Offices conducting focus groups about regulated drug products may need to conduct focus groups on a variety of subjects related to consumer, patient, or healthcare professional perceptions and use of drug products and related materials, including but not limited to:

- Direct-to-consumer prescription drug promotion,
- physician labeling of prescription drugs,
- Medication Guides,
- over-the-counter drug labeling,
- emerging risk communications,
- patient labeling,
- online sales of medical products, and
- consumer and professional education.

Annually, FDA projects about 20 focus group studies using 160 focus groups with an average of 9 persons per group, and lasting an average of 1.75 hours each. FDA is requesting this burden for unplanned focus groups so as not to restrict the Agency's ability to gather information on public sentiment for its proposals in its regulatory and communications programs.

In the **Federal Register** of June 28, 2013 (78 FR 38993), FDA published a 60-day notice requesting public comment on the proposed collection of information. No comments were received.

FDA estimates the burden of this information collection as follows:

TABLE 1—ESTIMATED ANNUAL REPORTING BURDEN [1]

Activity	Number of respondents	Number of responses per respondent	Total annual responses	Average burden per response	Total hours
Focus Groups About Drug Products	1,440	1	1,440	1.75	2,520

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

Dated: November 25, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–28736 Filed 11–29–13; 8:45 am]

BILLING CODE 4160–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Mental Health; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Mental Health Special Emphasis Panel NIMH HIV/AIDS R34 Review.

Date: December 2, 2013.

Time: 1:00 p.m. to 3:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Neuroscience Center, 6001 Executive Boulevard, Rockville, MD 20852 (Telephone Conference Call).

Contact Person: David W. Miller, Ph.D., Scientific Review Officer, Division of Extramural Activities, National Institute of Mental Health, NIH Neuroscience Center, 6001 Executive Blvd., Room 6140, MSC 9608, Bethesda, MD 20892–9608, 301–443–9734, *millerda@mail.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute of Mental Health, Special Emphasis Panel, Mental Health Services 2.

Date: December 4, 2013.

Time: 2:00 p.m. to 3:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Neuroscience Center, 6001 Executive Boulevard, Rockville, MD 20852 (Telephone Conference Call).

Contact Person: Aileen Schulte, Ph.D., Scientific Review Officer, Division of Extramural Activities, National Institute of Mental Health, NIH Neuroscience Center, 6001 Executive Blvd., Room 6140, MSC 9608, Bethesda, MD 20892–9608, 301–443–1225, *aschulte@mail.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program No. 93.242, Mental Health Research Grants, National Institutes of Health, HHS)

Dated: November 25, 2013.

Carolyn Baum,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2013–28727 Filed 11–29–13; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4155–DR; Docket ID FEMA–2013–0001]

South Dakota; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of South Dakota (FEMA–4155–DR), dated November 8, 2013, and related determinations.

DATES: *Effective Date:* November 8, 2013.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW., Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated November 8, 2013, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), as follows:

I have determined that the damage in certain areas of the State of South Dakota resulting from a severe winter storm, snowstorm, and flooding during the period of October 3–16, 2013, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 et seq. (the ''Stafford Act''). Therefore, I declare that such a major disaster exists in the State of South Dakota.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Disaster Unemployment Assistance and Public Assistance in the designated areas and Hazard Mitigation throughout the State. You are further authorized to provide snow assistance under the Public Assistance program for a limited time during or proximate to the incident period. Consistent with the requirement that Federal assistance be supplemental, any Federal funds provided under the Stafford Act for Hazard Mitigation will be limited to 75 percent of the total eligible costs. Federal funds provided under the Stafford Act for Public Assistance also will be limited to 75 percent of the total eligible costs, with the exception of projects that meet the eligibility criteria for a higher Federal cost-sharing percentage under the Public Assistance Alternative Procedures Pilot Program for Debris Removal implemented pursuant to section 428 of the Stafford Act.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Gary R. Stanley, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the State of South Dakota have been designated as adversely affected by this major disaster:

Butte, Corson, Custer, Dewey, Fall River, Haakon, Harding, Jackson, Lawrence, Meade, Pennington, Perkins, Shannon, and Ziebach Counties and the Cheyenne River Sioux Tribe of the Cheyenne River Reservation within Dewey and Ziebach Counties and the Oglala Sioux Tribe within Jackson and Shannon

Counties for Disaster Employment Assistance.

Butte, Corson, Custer, Dewey, Fall River, Haakon, Harding, Jackson, Lawrence, Meade, Pennington, Perkins, Shannon, and Ziebach Counties and the Cheyenne River Sioux Tribe of the Cheyenne River Reservation within Dewey and Ziebach Counties and the Oglala Sioux Tribe within Jackson and Shannon Counties for Public Assistance.

Butte, Custer, Fall River, Lawrence, Meade, and Pennington Counties for snow assistance under the Public Assistance program for any continuous 48-hour period during or proximate to the incident period.

All counties within the State of South Dakota are eligible to apply for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

W. Craig Fugate,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2013–28784 Filed 11–29–13; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4149–DR; Docket ID FEMA–2013–0001]

Pennsylvania; Amendment No. 1 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the Commonwealth of Pennsylvania (FEMA–4149–DR), dated October 1, 2013, and related determinations.

DATES: *Effective Date:* November 22, 2013.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW., Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the Commonwealth of Pennsylvania is hereby amended to include the following area among those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of October 1, 2013.

Allegheny County for Public Assistance.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

W. Craig Fugate,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2013–28773 Filed 11–29–13; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Docket ID FEMA–2008–0010]

Board of Visitors for the National Fire Academy

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Committee Management; Notice of Open Federal Advisory Committee Meeting.

SUMMARY: The Board of Visitors for the National Fire Academy (Board) will meet on December 17–18, 2013. The meeting will be open to the public.

Authority: 15 U.S.C. 2206(j)

DATES: The meeting will take place on Tuesday, December 17, 8:30 a.m. to 3:30 p.m. EST and on Wednesday, December 18, 8:30 a.m. to 11:30 a.m. EST. Please note that the meeting may close early if the Board has completed its business.

ADDRESSES: The meeting will be held at the National Emergency Training Center, Building H, Room 300, Emmitsburg, Maryland. Members of the public who wish to obtain details on how to gain access to the facility and directions may contact Cindy Wivell as listed in the **FOR FURTHER INFORMATION CONTACT** section by close of business December 9, 2013. A picture identification is needed for access. Members of the public may also participate by teleconference and may contact Cindy Wivell to obtain the call-in number and access code. For information on services for individuals with disabilities or to request special assistance, contact Cindy Wivell as soon as possible.

To facilitate public participation, we are inviting public comment on the issues to be considered by the Board as listed in the **SUPPLEMENTARY INFORMATION** section. Comments must be submitted in writing no later than December 9, 2013, and must be identified by docket ID FEMA–2008–0010 and may be submitted by *one* of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Mail/Hand Delivery:* Cindy Wivell, 16825 South Seton Avenue, Emmitsburg, Maryland 21727.

Instructions: All submissions received must include the words ''Department of Homeland Security'' and the docket ID for this action. Comments received will be posted without alteration at *http://www.regulations.gov*, including any personal information provided.

Docket: For access to the docket to read background documents or comments received by the National Fire Academy Board of Visitors, go to *http://www.regulations.gov*, click on ''Advanced Search,'' then enter ''FEMA–2008–0010'' in the ''By Docket ID'' box, then select ''FEMA'' under ''By Agency,'' and then click ''Search.'' Prior to the meeting, handouts for the meeting will be posted at *http://www.usfa.fema.gov/nfa/about/bov.shtm* as soon as they are available.

There will be a 10-minute comment period after each agenda item; each speaker will be given no more than 2 minutes to speak. Please note that the public comment period may end before the time indicated, following the last call for comments. Contact Cindy Wivell to register as a speaker.

FOR FURTHER INFORMATION CONTACT:

Alternate Designated Federal Officer: Denis G. Onieal, telephone (301) 447–1117.

Logistical Information: Cindy Wivell, telephone (301) 447–1157, fax (301) 447–1834, and email *Cindy.Wivell@fema.dhs.gov*.

SUPPLEMENTARY INFORMATION: Notice of this meeting is given under the Federal

Advisory Committee Act, 5 U.S.C. App. (Pub. L. 92–463).

Purpose of the Board

The purpose of the Board is to review annually the programs of the National Fire Academy (NFA) and advise the Administrator of the Federal Emergency Management Agency (FEMA), through the United States Fire Administrator, of the operation of the NFA and any improvements therein that the Board deems appropriate. In carrying out its responsibilities, the Board examines NFA programs to determine whether these programs further the basic missions that are approved by the Administrator of FEMA, examines the physical plant of the NFA to determine the adequacy of the NFA's facilities, and examines the funding levels for NFA programs. The Board submits an annual report through the United States Fire Administrator to the Administrator of FEMA, in writing. The report provides detailed comments and recommendations regarding the operation of the NFA.

Agenda

On the first day of the meeting, the Board will swear in new members, select a Chairperson and Vice Chairperson for Fiscal Year 2014, and review and approve the minutes of the May 15, 2013, teleconference meeting.

The Board will then review and give feedback on NFA program activities, including: NFA Online, the NFA's web-based learning platform for distance learning courses; NFA's mediated course deliveries, which provide NFA training through an instructor facilitated web-based learning environment; NFA's course material download for the Regions and States, which enables direct access to NFA course materials through a web-based interface; NFA's Bring-Your-Own-Device initiative, which allows students to download the student manual to their own personal electronic devices and eliminates the use of paper-based student materials; the American Council on Education's report on its academic review of Academy classes and courses; NFA's curriculum for emergency medical services; NFA's curriculum Enterprise Shared Workspace, a database system developed to capture and track course development and revision activities; and Company Officer Development, a proposal for an on- and off-campus company officer development program modeled after the current Executive Fire Officer Program. The Board will also review and give feedback on NFA's status of course development at the end of FY 2013; NFA's curriculum development plan for the FY 2014 curriculum; and NFA's Smart Practices/Lessons Learned Report to Congress, which provides Congress with a snapshot of the lessons learned and best practices that have been incorporated into the NFA's curriculum and program areas.

The Board will discuss the Professional Development Subcommittee activities, including the Professional Development Symposium that will bring national training and education audiences together for their annual conference and support initiatives, the Fire and Emergency Services Higher Education (FESHE)/Professional Development Subcommittee restructuring, and the FESHE Recognition Update that will include a list of the colleges and universities that have been approved and that have adopted the FESHE curriculum.

The Board will receive updates on U.S. Fire Administration data, research, and response support initiatives, and discuss deferred maintenance and capital improvements on the National Emergency Training Center (NETC) campus and FY 2014 Budget Request/Budget Planning.

On the second day, the Board will engage in an annual report working session.

Dated: November 22, 2013

Denis G. Onieal,

Superintendent, National Fire Academy, United States Fire Administration, Federal Emergency Management Agency.

[FR Doc. 2013–28779 Filed 11–29–13; 8:45 am]

BILLING CODE 9111–45–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5629–FA–01]

Announcement of Funding Awards for Fiscal Year 2013 Research Partnerships Program

AGENCY: Office of the Assistant Secretary for Policy Development and Research, HUD.

ACTION: Announcement of funding awards.

SUMMARY: In accordance with Section 102(a)(4)(C) of the Department of Housing and Urban Development (HUD) Reform Act of 1989, this document notifies the public of funding awards for the Fiscal Year (FYs) 2012–2013 Authority to Accept Unsolicited Research Proposals. The purpose of this document is to announce the names and addresses of the award winners and the amount of the awards to address one of the following research priorities: (1) HUD demonstrations; (2) using housing as a platform for improving quality of life; (3) the American Housing Survey data; or (4) housing technology.

FOR FURTHER INFORMATION CONTACT: Madlyn Wohlman-Rodriguez, Office of University Partnerships, U.S. Department of Housing and Urban Development, Room 8226, 451 Seventh Street SW., Washington, DC 20410, Telephone (202) 402–5939. To provide service for persons who are hearing- or speech-impaired, this number may be reached via TTY by dialing the Federal Information Relay Service on (800) 877–8339 or (202) 708–1455. (Telephone numbers, other than ''800'' TTY numbers, are not toll free).

SUPPLEMENTARY INFORMATION: The Consolidated and Further Continuing Appropriation Act, 2012 (Pub. L. 112–55, approved November 18, 2011, and the Consolidated and Further Continuing Appropriations Act, 2013 Pub. L. 113–6 enacted March 26, 2013, (The 2012 Appropriations Act) authorizes the Office of Policy Development and Research (PD&R) to enter into non-competitive cooperative agreements for projects that are aligned with PD&R's research priorities and where HUD can gain value by having substantial involvement in the research activity.

The Office of University Partnerships under the Assistant Secretary for Policy Development and Research (PD&R) administers this program.

The Catalog of Federal Domestic Assistance number for this program is 14.506.

On Friday, April 13, 2012, a Notice of Authority to Accept Unsolicited Research Proposals was published in the **Federal Register** Vol. 77, No. 72. The Department reviews and evaluates the proposals based on the criteria in the **Federal Register**. As a result, HUD has funded the applications announced below, and in accordance with Section 102(a)(4)(C) of the Department of Housing and Urban Development Reform Act of 1989 (103 Stat. 1987, U.S.C. 3545). More information about the winners can be found at *www.huduser.org.*

Dated: November 21, 2013.

Jean Lin Pao,

General Deputy Assistant Secretary for Policy, Development and Research.

List of Awardees For Research Partnerships Under the Fiscal Year (Fy) 2012–2013 Authority To Accept Unsolicited Research Proposals for Funding by Name of Institution or Funded Agency, Address and Grant Amount

Region I

1. Middlebury College, ''High Cost of Lending in Rural America and the Great Recession.'' Dr. Peter Nelson, Principal Investigator, 38 College Street, Middlebury, VT 05753. Grant Award: $21,519.

2. Boston Medical Center, ''Bringing Life Course Home: Improving Health Through Housing Stability and Support.'' Dr. Emily Feinberg, Principal Investigator, 1 Boston Medical Place, Boston, MA 02118. Grant Award: $222,904.

Region II

3. Mayor's Fund to Advance NYC, ''Jobs-Plus Cost Study.'' Kate Dempsey, Recipient Project Manager, 253 Broadway 8th Floor, New York, NY 10007. Grant Award: $343,100.

4. MDRC, ''Re-Thinking How to Increase Work and Self-Sufficiency Among Recipients of Section 8 Housing Choice Vouchers.'' Dr. James Riccio, Principal Investigator, 16 East 34th Street, New York, NY 10016. Grant Award: $100,000.

Region III

5. Urban Institute, ''Mining MTO: Housing Assistance Leavers and Vulnerable Female Youth.'' Robin Smith, Principal Investigator, 2100 M Street NW., Washington, DC 20037. Grant Award: $25,000.

6. Urban Institute, ''The Housing Opportunity and Service Together (HOST) Demonstration.'' Elsa Falkenburger, Principal Investigator, 2100 M Street NW., Washington, DC 20037. Grant Award: $100,000.

7. University of Maryland—College Park, ''The Impact of Children's Housing on the Long-Term Economic Outlook.'' Dr. John Haitiwanger, Principal Investigator, 3112 Lee Building, College Park, MD 20742. Grant Award: $246,197.

8. John Hopkins University/ Bloomberg School of Public Health, ''The Effects of Housing on Young Children.'' Dr. Sandra Newman, Principal Investigator, 615 North Wolfe Street, W1600, Baltimore, MD 21205. Grant Award: $2,000,000.

9. John Hopkins University/Harvard University, ''Brokering the Geography of Opportunity: How Landlords Affect Access to Housing and Neighborhood Quality Among HUD Assisted Renters.'' Dr. Stephanie DeLuca, Principal Investigator, Wyman Park Center Suite N600, Baltimore, MD 21218. Grant Award: $401,104.

Region IV

10. University of Florida, Shimberg Center for Housing Studies, ''Using Parcel and Household Data to Evaluate the Low-Income Housing Choice Voucher Programs: Accessibility, Opportunity and Tenant Choice.'' Dr. Anne Ray, Principal Investigator, 219 Ginter Hall, Gainesville, FL 32611. Grant Award: $170,000.

Region V

11. Ohio State University, ''Aging in Place: Managing the Use of Reverse Mortgages to Enable Housing Stability.'' Dr. Stephanie Moulton, Principal Investigator, 1960 Kenny Road, Columbus, Ohio 43210. Grant Award: $555,004.

Region IX

12. RAND Corporation, ''Evaluation of the Chicago Regional Housing Choice Initiative.'' Heather Schwartz, Principal Investigator, 650 Poydras Avenue, New Orleans, LA 70130. Grant Award: $10,000.

Region X

13. Washington State Department of Social and Health Services, ''Relationship Between Receipt of Housing Assistance and Social and Health Outcomes.'' Dr. Martha Galvez, Principal Investigator, 1115 Washington Street SE., Olympia, WA 98504. Grant Award: $16,000.

[FR Doc. 2013–28786 Filed 11–29–13; 8:45 am]

BILLING CODE 4210–67–P

INTER-AMERICAN FOUNDATION

Sunshine Act Meetings

TIME AND DATE: December 9, 2013, 9:00 a.m.–1:00 p.m.

PLACE: Baker & McKenzie, 815 Connecticut Avenue NW., Washington, DC 20006.

STATUS: Open session.

MATTERS TO BE CONSIDERED:

- Approval of the Minutes of the June 24, 2013, Meeting of the Board of Directors
- Management Report
- Advisory Council Report
- Donor Engagement

PORTIONS TO BE OPEN TO THE PUBLIC:

- Approval of the Minutes of June 24, 2013, Meeting of the Board of Directors
- Management Report
- Advisory Council Report
- Donor Engagement

CONTACT PERSON FOR MORE INFORMATION: Paul Zimmerman, General Counsel, (202) 683–7118

Paul Zimmerman,

General Counsel.

[FR Doc. 2013–28892 Filed 11–27–13; 4:15 pm]

BILLING CODE 7025–01–P

DEPARTMENT OF THE INTERIOR

Bureau of Ocean Energy Management

[MMAA104000]

Environmental Documents Prepared for Oil, Gas, and Mineral Operations by the Gulf of Mexico Outer Continental Shelf (OCS) Region

AGENCY: Bureau of Ocean Energy Management (BOEM), Interior.

ACTION: Notice of the availability of environmental documents prepared for OCS mineral proposals by the Gulf of Mexico OCS Region.

SUMMARY: BOEM, in accordance with Federal regulations that implement the National Environmental Policy Act (NEPA), announces the availability of NEPA-related Site-Specific Environmental Assessments (SEAs) and Findings of No Significant Impact (FONSIs). These documents were prepared during the period July 1, 2013, through September 30, 2013, for oil, gas, and mineral-related activities that were proposed in the Gulf of Mexico, and are more specifically described in the Supplementary Information Section of this notice.

FOR FURTHER INFORMATION CONTACT: Bureau of Ocean Energy Management, Gulf of Mexico OCS Region, Attention: Public Information Office (GM 250E), 1201 Elmwood Park Boulevard, Room 250, New Orleans, Louisiana 70123–2394, or by calling 1–800–200–GULF.

SUPPLEMENTARY INFORMATION: BOEM prepares SEAs and FONSIs for certain proposals that relate to exploration, development, production, and transport of oil, gas, and mineral resources on the Federal OCS. These SEAs examine the potential environmental effects of the proposed activities and any alternatives and present BOEM conclusions regarding the significance of those effects. SEAs are used as a basis for determining whether or not approval of

the proposal constitutes a major Federal action that significantly affects the quality of the human environment in accordance with NEPA Section 102(2)(C). A FONSI is prepared in those instances where BOEM finds that approval will not result in significant effects on the quality of the human environment. The FONSI briefly presents the basis for that finding and includes a summary or copy of the SEA.

This notice constitutes the public notice of availability of environmental documents required under the NEPA regulations.

Activity/operator	Location	Date
Chevron U.S.A. Inc., Exploration Plan, SEA R–5894	Central Planning Ares of the Gulf of Mexico	7/5/2013
CSA Ocean Sciences, Inc., Geological & Geophysical Survey, SEA L13–021.	Central Planning Area of the Gulf of Mexico	7/8/2013
Noble Energy, Inc., Exploration Plan, SEA N–9714	Mississippi Canyon, Block 782, Lease OCS–G 33755 & OCS–G 33757, located 74 miles from the nearest Louisiana shoreline.	7/8/2013
LLOG Exploration Offshore, L.L.C., Exploration Plan, SEA R–5900.	Mississippi Canyon, Block 208, Lease OCS–G 24055, located 46 miles from the nearest Louisiana shoreline.	7/9/2013
Stone Energy Corporation, Development Operations Coordination Document, SEA S–7609.	Mississippi Canyon, Block 29, Lease OCS–G 13997, located 31 miles from the nearest shoreline in Plaquemines Parish, Louisiana.	7/10/2013
CSA Ocean Services, Inc., Geological & Geophysical Survey, SEA T13–003.	Western Planning Area of the Gulf of Mexico	7/10/2013
ATP Oil & Gas Corporation, Structure Removal, SEA ES/SR 2013–093.	Brazos, Block 544, Lease OCS–G 10226, located 31 miles from the nearest Texas shoreline.	7/11/2013
Plains Exploration & Production Company, Geological & Geophysical Survey, SEA L13–022.	Central Planning Area of the Gulf of Mexico	7/11/2013
Anadarko Petroleum Corporation, Exploration Plan, SEA R–5895.	East Breaks, Block 645, Lease OCS–G 32822, located 118 miles from the nearest Texas shoreline.	7/11/2013
Century Exploration New Orleans, LLC, Structure Removal, SEA ES/SR 2013–126.	West Cameron, Block 540, Lease OCS–G15110, located 95 miles from the nearest Louisiana shoreline.	7/11/2013
Mariner Energy Resources, Inc., Structure Removal, SEA ES/SR 13–098.	Eugene Island, Block 273, Lease OCS–G 00987, located 59 miles from the nearest Louisiana shoreline.	7/12/2013
Chevron U.S.A. Inc., Exploration Plan, SEA N–9704	Keathley Canyon, Block 953, Lease OCS–G 27770, located 229 miles from the nearest Louisiana shoreline.	7/12/2013
Hall-Houston Exploration III, L.P., Structure Removal, SEA ES/SR 13–128.	Galveston, Block A40, Lease OCS–G 26487, located 39 miles from the nearest Texas shoreline.	7/15/2013
McMoRan Oil & Gas LLC, Structure Removal, SEA ES/SR 13–145.	Eugene Island, Block 26, Lease OCS–G 27904, located 11 miles from the nearest Louisiana shoreline.	7/16/2013
Mariner Energy Resources, Inc., Structure Removal, SEA ES/SR 13–099.	Eugene Island, Block 284, Lease OCS–G 00991, located 60 miles from the nearest Louisiana shoreline.	7/17/2013
Murphy Exploration & Production Company—USA, Exploration Plan, SEA N–9697.	Mississippi Canyon, Block 692, Lease OCS–G 34455, located 63 miles from the nearest Louisiana shoreline.	7/17/2013
Stone Energy Corporation, Structure Removal, SEA ES/SR 13–147.	Ship Shoal, Block 134, Lease OCS–G 22701, located 20 miles from the nearest Louisiana shoreline.	7/17/2013
EPL Oil & Gas, Inc., Structure Removal, SEA ES/SR 13–139, 142, 143, 144, & 09–198.	West Cameron, Block 28, Leases OCS–G 00694 and 00353, located 3–4 miles from the nearest Louisiana shoreline.	7/19/2013
Shell Offshore Inc., Exploration Plan, SEA S–7608	Green Canyon, Block 200, Lease OCS–G 12209, located 88 miles from the nearest shoreline in Terrebonne Parish, Louisiana.	7/22/2013
Cobalt International Energy, L.P., Exploration Plan, SEA R–5902.	Keathley Canyon, Block 163, Lease OCS–G 32606, located 177 miles from the nearest Louisiana shoreline.	7/22/2013
ConocoPhillips Company, Exploration Plan, SEA N–9725	Mississippi Canyon, Block 118, Lease OCS–G 27994, located 38 miles from the nearest Louisiana shoreline.	7/22/2013
Stone Energy Corporation, Structure Removal, SEA ES/SR 13–148.	Ship Shoal, Block 135, Lease OCS–G 22702, located 19 miles from the nearest Louisiana shoreline.	7/22/2013
Stone Energy Corporation, Structure Removal, SEA ES/SR 13–141.	South Marsh Island, Block 108, Lease OCS–G 00792, located 70 miles from the nearest Louisiana shoreline.	7/22/2013
Stone Energy Corporation, Structure Removal, SEA ES/SR 13–146.	Ship Shoal, Block 134, Lease OCS–G 2270, located 20 miles from the nearest Louisiana shoreline.	7/23/2013
W & T Offshore, Inc., Structure Removal, SEA ES/SR 06–138	Ship Shoal, Block 148, Lease OCS–G 11983, located 26 miles from the nearest Louisiana shoreline.	7/24/2013
Global Geophysical Services, Inc., Geological & Geophysical Survey, SEA L13–009.	Central Planning Area of the Gulf of Mexico	7/25/2013
EPL Oil & Gas, Inc., Structure Removal, SEA ES/SR 13–149	South Pass A, Block 28, Lease OCS–G 00353, located 4 miles from the nearest Louisiana shoreline.	7/25/2013
Petrobas America Inc., Exploration Plan, SEA R–5923	Walker Ridge, Block 425, Lease OCS–G 16987, located 172 miles from the nearest Louisiana shoreline.	7/29/2013
Murphy Exploration & Production Company—USA, Exploration Plan, SEA N–9708.	De Soto Canyon, Block 178, Lease OCS–G 25850, located 75 miles from the nearest Louisiana shoreline.	8/1/2013
Noble Energy, Inc., Exploration Plan, SEA R–5919	Mississippi Canyon, Block 782, Lease OCS–G 33757, located 74 miles from the nearest Louisiana shoreline.	8/5/2013
Exxon Mobil Corporation, Exploration Plan, SEA R–5940	Walker Ridge, Block 282, Lease OCS–G 33364, located 162 miles from the nearest Louisiana shoreline.	8/6/2013
Stone Energy Corporation, Structure Removal, SEA ES/SR 13–151.	Eugene Island, Block 243, Lease OCS–G 02899, located 55 miles from the nearest Louisiana shoreline.	8/8/2013

Activity/operator	Location	Date
Merit Energy Company, LLC, Structure Removal, SEA ES/SR 04–116.	High Island, Block A270, Lease OCS–G 26556, located 83 miles from the nearest Louisiana shoreline.	8/8/2013
Merit Energy Company, LLC, Structure Removal, SEA ES/SR 04–117.	High Island, Block A270, Lease OCS–G 26556, located 83 miles from the nearest Louisiana shoreline.	8/8/2013
Walter Oil & Gas Corporation, Structure Removal, SEA ES/SR 13–150.	South Timbalier, Block 220, Lease OCS–G 24980, located 55 miles from the nearest Louisiana shoreline.	8/8/2013
Statoil USA E&P Inc., Exploration Plan, SEA S–7610	Atwater Valley, Block 64, Lease OCS–G 28104, located south of Venice, Louisiana, 76 miles from the nearest Louisiana shoreline.	8/12/2013
Apache Corporation, Structure Removal, SEA ES/SR 13–102 ...	Mustang Island, Block A 121, Lease OCS–G 04699, located 47 miles from the nearest Texas shoreline.	8/12/2013
Apache Corporation, Structure Removal, SEA ES/SR 13–103 ...	Mustang Island, Block A111, Lease OCS–G 03068, located 46 miles from the nearest Texas shoreline.	8/13/2013
Stone Energy Corporation, Structure Removal, SEA ES/SR 13–021 & 13–023.	Vermilion, Block 255, Lease OCS–G 01152, located 68 miles from the nearest Louisiana shoreline.	8/14/2013
Chevron U.S.A. Inc., Geological & Geophysical Survey, SEA L13–025.	Walker Ridge, located 176 miles from the nearest shoreline	8/14/2013
Murphy Exploration & Production Company—USA, Exploration Plan, SEA N–9687.	Mississippi Canyon, Blocks 600 & 601, Lease OCS–G 34449 & 34450, located 53 miles from the nearest Louisiana shoreline.	8/15/2013
Black Elk Energy Offshore Operations, LLC, Structure Removal, SEA ES/SR 13.	High Island, Block A283, Lease OCS–G 02404, located 82 miles from the nearest Texas shoreline.	8/16/2013
BP Exploration & Production Inc., Exploration Plan, SEA R–5944.	Keathley Canyon, Block 93, Lease OCS–G 25780, located 172 miles from the nearest Louisiana shoreline.	8/19/2013
Shell Offshore Inc., Exploration Plan, SEA R–5954	Mississippi Canyon, Block 721, Lease OCS–G 33171, located 51 miles from the nearest Louisiana shoreline.	8/19/2013
Apache Deepwater LLC, Exploration Plan, SEA R–5953	Mississippi Canyon, Block 983, Lease OCS–G 34468, located 66 miles from the nearest Louisiana shoreline.	8/19/2013
Stone Energy Corporation, Structure Removal, SEA ES/SR 13–022.	South Marsh Island, Block 108, Lease OCS–G 00792, located 70 miles from the nearest Louisiana shoreline.	8/19/2013
EPL Oil & Gas, Inc., Structure Removal, SEA ES/SR 13–154	South Pass, Block 28, Lease OCS–G 00353, located 4 miles from the nearest Louisiana shoreline.	8/19/2013
Shell Offshore Inc., Exploration Plan, SEA N–9727	Mississippi Canyon, Blocks 768 and 812, Lease OCS–G 34458 & 34461, located 56 miles from the nearest shoreline in Plaquemines Parish, Louisiana.	8/23/2013
Dynamic Data Services Inc., Geological & Geophysical Survey, SEA L13–024.	Central Planning Area of the Gulf of Mexico, located 80 miles from the nearest shoreline.	8/26/2013
Anadarko Petroleum Corporation, Exploration Plan, SEA S–7615.	East Breaks, Block 646, Lease OCS–G 20725, located 117 miles from the nearest Texas shoreline.	8/27/2013
Gulf Ocean Services, Inc., Geological & Geophysical Survey, SEA L13–028.	Eugene Island Area, Central Planning Area of the Gulf of Mexico, located 35 miles from the nearest shoreline.	8/27/2013
Exxon Mobil Corporation, Development Operations Coordination Document, SEA N–9699.	Walker Ridge, Block 584, Lease OCS–G 20351, located 185 miles from the nearest Louisiana shoreline.	8/27/2013
Shell Offshore Inc., Development Operations Coordination Document, SEA R–5873.	Mississippi Canyon, Block 809, Lease OCS–G 05868 & Block 810, Lease OCS–G 09873, located 53 miles from the nearest Louisiana shoreline.	8/29/2013
Stone Energy Corporation, Structure Removal, SEA ES/SR 98–078.	Eugene Island, Block 243, Lease OCS–G 02899, located 56 miles from the nearest Louisiana shoreline.	9/5/2013
Hall-Houston Exploration III, L.P., Structure Removal, SEA ES/SR 13–158.	High Island, Block 88, Lease OCS–G 33408, located 41 miles from the nearest Texas shoreline.	9/12/2013
Hall-Houston Exploration III, L.P., Structure Removal, SEA ES/SR 13–157.	West Cameron, Block 431, Lease OCS–G 10584, located 65 miles from the nearest Louisiana shoreline.	9/16/2013
Chevron U.S.A. Inc., Structure Removal, SEA ES/SR 13–156 ...	West Cameron, Block 18, Lease OCS–G 21530, located 3 miles from the nearest Louisiana shoreline.	9/17/2013
Shell Offshore Inc., Exploration Plan, SEA S–7621	Mississippi Canyon Block 809, Lease OCS–G 05868, located 55 miles from the nearest Louisiana shoreline.	9/20/2013
Apache Corporation, Structure Removal, SEA ES/SR 13–107 ...	Eugene Island, Block 273, Lease OCS–G 00987, located 56 miles from the nearest Louisiana shoreline.	9/24/2013
Apache Corporation, Structure Removal, SEA ES/SR 13–106 ...	Eugene Island, Block 273, Lease OCS–G 00987, located 58 miles from the nearest Louisiana shoreline.	9/25/2013
Fairfield Nodal, Geological & Geophysical Survey, SEA L13–023	Central Planning Area of the Gulf of Mexico	9/26/2013
Fairfield Nodal, Geological & Geophysical Survey, SEA L13–027	Central Planning Area of the Gulf of Mexico	9/26/2013
Apache Deepwater LLC, Exploration Plan, SEA R–5906	Central Planning Area, located 112 miles from the nearest shoreline in Terrebonne Parish, Louisiana.	9/27/2013
Walter Oil & Gas Corporation, Development Operations Coordination Document, SEA N–9688.	Ewing Bank, Block 834, Lease OCS- G27982, located 62 miles from the nearest shoreline in Plaquemines Parish, Louisiana.	9/27/2013
Anadarko Petroleum Corporation, Exploration Plan, SEA S–7623.	Green Canyon, Block 683, Lease OCS–G 18421, located 122 miles from the nearest Louisiana shoreline.	9/27/2013
EPL Oil & Gas, Inc., Structure Removal, SEA ES/SR 13–155	South Pass, Block 28, Lease OCS–G 00353, located 13 miles from the nearest Louisiana shoreline.	9/27/2013
Stone Energy Corporation, Structure Removal, SEA ES/SR 13–160.	South Timbalier. Block 164, Lease OCS–G 1250, located 45 miles from the nearest Louisiana shoreline.	9/27/2013

Persons interested in reviewing environmental documents for the proposals listed above or obtaining information about the SEAs and FONSIs prepared by the Gulf of Mexico OCS Region are encouraged to contact BOEM at the address or telephone listed in the **FOR FURTHER INFORMATION CONTACT** section.

Dated: November 4, 2013.

John L. Rodi,

Regional Director, Gulf of Mexico OCS Region.

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BILLING CODE 4310–MR–P

DEPARTMENT OF THE INTERIOR

Office of Natural Resources Revenue

[Docket No. ONRR–2012–0006; DS63610300 DR2PS0000.CH7000 134D0102R2]

Agency Information Collection Activities: Submitted for Office of Management and Budget Review; Comment Request

AGENCY: Office of the Secretary, Office of Natural Resources Revenue (ONRR).

ACTION: Notice of a revision of currently approved information collection (OMB Control Number 1012–0005).

SUMMARY: To comply with the Paperwork Reduction Act of 1995 (PRA), the Office of Natural Resources Revenue (ONRR) is notifying the public that we have submitted to the Office of Management and Budget (OMB) an information collection request (ICR) to renew approval of the paperwork requirements in the regulations under title 30, *Code of Federal Regulations* (CFR), parts 1202, 1204, and 1206. This ICR pertains to (1) Federal oil and gas valuation regulations, which include transportation and processing regulatory allowance limits; and (2) accounting and auditing relief for marginal properties. This ICR also includes Form ONRR–4393, Request to Exceed Regulatory Allowance Limitation. Effective January 1, 2014, ONRR will discontinue the information collection requirements of the Stripper Oil royalty rate reductions in this ICR. The revised title of this ICR is ''Federal Oil and Gas Valuation—30 CFR Parts 1202, 1204, and 1206.''

DATES: OMB has up to 60 days to approve or disapprove the information collection request but may respond after 30 days; therefore, you should submit your public comments to OMB by January 2, 2014 for the assurance of consideration.

ADDRESSES: Submit comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: Desk Officer for the Department of the Interior (1012–0005), by telefax at (202) 395–5806 or via email to *OIRA_Submission@omb.eop.gov.* Also, please send a copy of your comments to Armand Southall, Regulatory Specialist, Office of Natural Resources Revenue, P.O. Box 25165, MS 61030A, Denver, Colorado 80225. Please reference ''ICR 1012–0005'' in your comments.

FOR FURTHER INFORMATION CONTACT: Armand Southall, Regulatory Specialist, email *Armand.Southall@onrr.gov.* You may also contact Mr. Southall to obtain copies, at no cost, of (1) The ICR, (2) any associated form, and (3) the regulations that require us to collect the information. To see a copy of the entire ICR submitted to OMB, go to *http://www.reginfo.gov/public/PRAMain* and select ''Information Collection Review,'' then select ''Department of the Interior'' in the drop-down box under ''Currently Under Review.''

SUPPLEMENTARY INFORMATION:

Title: Federal Oil and Gas Valuation—30 CFR Parts 1202, 1204, and 1206.

OMB Control Number: 1012–0005.

Bureau Form Number: Form ONRR–4393.

Abstract: The Secretary of the United States Department of the Interior is responsible for overseeing mineral resource development on Federal and Indian lands and the Outer Continental Shelf (OCS). The Secretary's responsibility, under various laws, is to manage mineral resource production from Federal and Indian lands and the OCS, collect the royalties and other mineral revenues due, and distribute the funds collected under those laws. We have posted those laws pertaining to mineral leases on Federal and Indian lands and the OCS at *http://www.onrr.gov/Laws_R_D/PublicLawsAMR.htm.*

Effective October 1, 2010, ONRR reorganized and transferred our regulations from chapter II to chapter XII in title 30 CFR, resulting in a change to our citations. You can find the information collections covered in this ICR at 30 CFR part 1202, subparts C and D, which pertain to Federal oil and gas royalties; part 1204, subpart C, which pertains to accounting and auditing relief for marginal properties; and part 1206, subparts C and D, which pertain to Federal oil and gas product valuation.

I. General Information

When a company or an individual enters into a lease to explore, develop, produce, and dispose of minerals from Federal or Indian lands, that company or individual agrees to pay the lessor a share in a value of production from the leased lands. The lessee, or designee, must report various kinds of information to the lessor relative to the disposition of the leased minerals. Such information is generally available within the records of the lessee or others involved in developing, transporting, processing, purchasing, or selling of such minerals.

II. Information Collections

ONRR uses the information that we collect in this ICR to ensure that lessees accurately value and appropriately pay royalties on oil and gas produced from Federal onshore and offshore leases. Please refer to the chart for all reporting requirements and associated burden hours. All data submitted is subject to subsequent audit and adjustment.

A. Federal Oil and Gas Valuation Regulations

The valuation regulations at 30 CFR part 1206, subparts C and D, mandate that lessees collect and/or submit information used to value their Federal oil and gas, including (1) transportation and processing allowances and (2) regulatory allowance limit information. Lessees report certain data on Form ONRR–2014, Report of Sales and Royalty Remittance (OMB Control Number 1012–0004). The information that we request is the minimum necessary to carry out our mission and places the least possible burden on respondents. If ONRR does not collect this information, both Federal and State governments may incur a loss of royalties.

Transportation and Processing Regulatory Allowance Limits: Lessees may deduct the reasonable, actual costs of transportation and processing from Federal royalties. The lessees report these allowances on Form ONRR–2014. For oil and gas, regulations establish the allowable limit on transportation allowance deductions at 50 percent of the value of the oil or gas. For gas only, regulations establish the allowable limit on processing allowance deductions at 66⅔ percent of the value of each gas plant product.

Request to Exceed Regulatory Allowance Limitation, Form ONRR–4393: Lessees may request to exceed regulatory limitations. Upon proper application from the lessee, ONRR may approve oil or gas transportation allowance in excess of 50 percent or gas processing allowance in excess of 66⅔ percent on Federal leases. Lessees must complete and submit Form ONRR–4393, including a letter and supporting documentation, for both Federal and

Indian leases to request to exceed allowance limitations. This ICR covers only Federal leases; therefore, we have not included burden hours of Form ONRR–4393 for Indian leases in this ICR. We include burden hours of Form ONRR–4393 for Indian leases in OMB Control Number 1012–0002.

B. Accounting and Auditing Relief for Marginal Properties

In 2004, we amended our regulations to comply with section 7 of the Federal Oil and Gas Royalty Simplification and Fairness Act of 1996. The regulations provide guidance for lessees and designees seeking accounting and auditing relief for qualifying Federal marginal properties. Under the regulations, both ONRR and the State concerned must approve any relief granted for a marginal property.

C. Stripper Oil Royalty Rate Reduction Program

Under 43 CFR 3103.4–2, the Bureau of Land Management (BLM), the surface management agency for Federal onshore leases, established the Stripper Oil Royalty Rate Reduction Program (Stripper Oil Program). ONRR, who administered the Stripper Oil Program for BLM, approved royalty rate reductions for operators of stripper oil properties for applicable sales periods from October 1, 1992, through January 31, 2006. Effective February 1, 2006, BLM terminated the reduced royalty rates under this program. On October 6, 2010, BLM published a final rule (75 FR 61624) that removed this citation from their regulations. This change is not currently reflected in title 30 CFR, chapter XII.

For production through January 31, 2006, lessees submitted Form MMS–4377, Stripper Royalty Rate Reduction Notification, to notify ONRR of royalty rate changes. Although BLM terminated the royalty rate reductions, ONRR continues to verify previously submitted notifications and may require the operator to submit an amended Form ONRR–4377 through December 31, 2013. However, effective January 1, 2014, ONRR will discontinue the Stripper Oil Program; therefore, ONRR will not request OMB approval for the Stripper Oil information collection requirements in this ICR.

III. OMB Approval

We will request OMB approval to continue to collect, from companies and/or lessees and designees, information used (1) to value their Federal oil and gas, including (a) transportation and processing allowances and (b) the request to exceed regulatory allowance limitation and (2) to request accounting and auditing relief approval for qualifying Federal marginal properties. If ONRR does not collect this information, this would limit the Secretary's ability to discharge fiduciary duties and may also result in loss of royalty payments. ONRR protects the proprietary information that we receive, and we do not collect items of a sensitive nature.

ONRR requires lessees to respond to information collections relating to valuing Federal oil and gas, including (a) transportation and processing allowances and (b) the request to exceed regulatory allowance limit information [Form ONRR–4393]. ONRR also requires that lessees submit the allowance information and form to obtain benefits for claiming allowances on Form ONRR–2014. In addition, ONRR requires lessees to respond to information collections in regards to requesting approval for accounting and auditing relief.

Frequency: Annually and on occasion.

Estimated Number and Description of Respondents: 120 Federal lessees/designees and 7 States for Federal oil and gas.

Estimated Annual Reporting and Recordkeeping ''Hour'' Burden: 9,198 hours.

We have not included in our estimates certain requirements performed in the normal course of business and considered as usual and customary. We display the estimated annual burden hours by CFR section and paragraph in the following chart:

RESPONDENTS' ESTIMATED ANNUAL BURDEN HOURS

30 CFR 1202, 1204, and 1206	Reporting and recordkeeping requirement	Hour burden	Average number of annual responses	Annual burden hours
PART 1202—ROYALTIES				
Subpart C—Federal and Indian Oil				
1202.101	**Standards for reporting and paying royalties.** Oil volumes are to be reported in barrels of clean oil of 42 standard U.S. gallons (231 cubic inches each) at 60 °F. . . .	Burden covered under OMB Control Number 1012–0004.		
Subpart D—Federal Gas				
1202.152(a) and (b)	**Standards for reporting and paying royalties on gas**	Burden covered under OMB Control Number 1012–0004.		
	(a)(1) If you are responsible for reporting production or royalties you must: (i) Report gas volumes and British thermal unit (Btu) heating values, if applicable, under the same degree of water saturation; (ii) Report gas volumes in units of 1,000 cubic feet (mcf); and (iii) Report gas volumes and Btu heating value at a standard pressure base of 14.73 pounds per square inch absolute (psia) and a standard temperature base of 60 °F . . . (b) Residue gas and gas plant product volumes shall be reported as specified in this paragraph. . . .			

RESPONDENTS' ESTIMATED ANNUAL BURDEN HOURS—Continued

30 CFR 1202, 1204, and 1206	Reporting and recordkeeping requirement	Hour burden	Average number of annual responses	Annual burden hours
	PART 1204—ALTERNATIVES FOR MARGINAL PROPERTIES			
	Subpart C—Accounting and Auditing Relief			
1204.202(b)(1)	**What is the cumulative royalty reports and payments relief option?** (b) To use the cumulative royalty reports and payments relief option, you must do all of the following: (1) Notify ONRR in writing by January 31 of the calendar year for which you begin taking your relief. . . .	40	1	40
1204.202(b)(2) and (b)(3)	(b)(2) Submit your royalty report and payment . . . by the end of February of the year following the calendar year for which you reported annually. . . . If you have an estimated payment on file, you must submit your royalty report and payment by the end of March of the year following the calendar year for which you reported annually; (3) Use the sales month prior to the month that you submit your annual report and payment . . . for the entire previous calendar year's production for which you are paying annually. . . .	Burden covered under OMB Control Number 1012–0004.		
1204.202(b)(4), (b)(5), (c), (d)(1), (d)(2), (e)(1), and (e)(2).	(b)(4) Report one line of cumulative royalty information on Form ONRR–2014 for the calendar year . . . And (5) Report allowances on Form ONRR–2014 on the same annual basis as the royalties for your marginal property production.	Burden covered under OMB Control Number 1012–0004.		
	(c) If you do not pay your royalty by the date due in paragraph (b) of this section, you will owe late payment interest . . . from the date your payment was due under this section until the date ONRR receives it. . . . (d) If you take relief you are not qualified for, you may be liable for civil penalties. Also you must: (1) Pay ONRR late payment interest determined under 30 CFR 1218.54 . . .(2) Amend your Form ONRR–2014 . . . (e) If you dispose of your ownership interest in a marginal property for which you have taken relief . . . you must: (1) Report and pay royalties for the portion of the calendar year for which you had an ownership interest; and (2) Make the report and payment by the end of the month after you dispose of the ownership interest in the marginal property. If you do not report and pay timely, you will owe interest . . . from the date the payment was due. . . .			
1204.203(b), 1204.205(a) and (b), and 1204.206(a)(3)(i) and (b)(1).	**What is the other relief option?** (b) You must request approval from ONRR . . . before taking relief under this option.	200	1	200
1204.208 (c)(1), (d)(1), and (e)	**May a State decide that it will or will not allow one or both of the relief options under this subpart?** (c) If a State decides . . . that it will or will not allow one or both of the relief options . . . within 30 days . . . the State must: (1) Notify the Director for Office of Natural Resources Revenue, in writing, of its intent to allow or not allow one or both of the relief options . . . (d) If a State decides in advance . . . that it will not allow one or both of the relief options . . . the State must: (1) Notify the Director for Office of Natural Resources Revenue, in writing, of its intent to allow one or both of the relief options . . . (e) If a State does not notify ONRR . . . the State will be deemed to have decided not to allow either of the relief options. . .	40	7	280
1204.209(b)	**What if a property ceases to qualify for relief obtained under this subpart?**	6	1	6

RESPONDENTS' ESTIMATED ANNUAL BURDEN HOURS—Continued

30 CFR 1202, 1204, and 1206	Reporting and recordkeeping requirement	Hour burden	Average number of annual responses	Annual burden hours
	(b) If a property is no longer eligible for relief . . . the relief for the property terminates as of December 31 of that calendar year. You must notify ONRR in writing by December 31 that the relief for the property has terminated. . .			
1204.210(c) and (d)	**What if a property is approved as part of a nonqualifying agreement?**	Burden covered under OMB Control Number 1012–0004.		
	(c) . . . the volumes on which you report and pay royalty . . . must be amended to reflect all volumes produced on or allocated to your lease under the nonqualifying agreement as modified by BLM. . . . Report and pay royalties for your production using the procedures in § 1204.202(b). (d) If you owe additional royalties based on the retroactive agreement approval and do not pay your royalty by the date due in § 1204.202(b), you will owe late payment interest determined under § 1218.54 from the date your payment was due under § 1204.202(b)(2) until the date ONRR receives it.			
1204.214(b)(1) and (b)(2)	**Is minimum royalty due on a property for which I took relief?**	Burden covered under OMB Control Number 1012–0004.		
	(b) If you pay minimum royalty on production from a marginal property during a calendar year for which you are taking cumulative royalty reports and payment relief, and: (1) The annual payment you owe under this subpart is greater than the minimum royalty you paid, you must pay the difference between the minimum royalty you paid and your annual payment due under this subpart; or (2) The annual payment you owe under this subpart is less than the minimum royalty you paid, you are not entitled to a credit because you must pay at least the minimum royalty amount on your lease each year.			
Accounting and Auditing Relief Subtotal			10	526
	Part 1206—Product Valuation			
	Subpart C—Federal Oil			
1206.102(e)(1)	**How do I calculate royalty value for oil that I or my affiliate sell(s) under an arm's-length contract?**	AUDIT PROCESS. See note.		
	(e) If you value oil under paragraph (a) of this section: (1) ONRR may require you to certify that your or your affiliate's arm's-length contract provisions include all of the consideration the buyer must pay, either directly or indirectly, for the oil.			
1206.103(a)(1), (a)(2), and (a)(3).	**How do I value oil that is not sold under an arm's-length contract?** This section explains how to value oil that you may not value under § 1206.102 or that you elect under § 1206.102(d) to value under this section. First determine whether paragraph (a), (b), or (c) of this section applies to production from your lease, or whether you may apply paragraph (d) or (e) with ONRR approval. (a) Production from leases in California or Alaska. Value is the average of the daily mean ANS spot prices published in any ONRR-approved publication during the trading month most concurrent with the production month. . . . (1) To calculate the daily mean spot price . . . (2) Use only the days . . . (3) You must adjust the value.	45	5	225
1206.103(a)(4)	(a)(4) After you select an ONRR-approved publication, you may not select a different publication more often than once every 2 years, . . .	8	2	16

RESPONDENTS' ESTIMATED ANNUAL BURDEN HOURS—Continued

30 CFR 1202, 1204, and 1206	Reporting and recordkeeping requirement	Hour burden	Average number of annual responses	Annual burden hours
1206.103(b)(1)	(b) *Production from leases in the Rocky Mountain Region.* . . . (1) If you have an ONRR-approved tendering program, you must value oil . . .	400	2	800
1206.103(b)(1)(ii)	(b)(1)(ii) If you do not have an ONRR-approved tendering program, you may elect to value your oil under either paragraph (b)(2) or (b)(3) of this section.	400	2	800
1206.103(b)(4)	(4) If you demonstrate to ONRR's satisfaction that paragraphs (b)(1) through (b)(3) of this section result in an unreasonable value for your production as a result of circumstances regarding that production, the ONRR Director may establish an alternative valuation method.	400	2	800
1206.103(c)(1)	(c) *Production from leases not located in California, Alaska or the Rocky Mountain Region.* (1) Value is the NYMEX price, plus the roll, adjusted for applicable location and quality differentials and transportation costs under § 1206.112.	50	10	500
1206.103(e)(1) and (e)(2)	(e) *Production delivered to your refinery and the NYMEX price or ANS spot price is an unreasonable value.* (1) . . . you may apply to the ONRR Director to establish a value (2) You must provide adequate documentation and evidence demonstrating the market value at the refinery. . . . representing the market at the refinery if: . . .	330	2	660
1206.105	**What records must I keep to support my calculations of value under this subpart?**	Burden covered under OMB Control Number 1012–0004.		
	If you determine the value of your oil under this subpart, you must retain all data relevant to the determination of royalty value . . .			
1206.107(a)	**How do I request a value determination?** (a) You may request a value determination from ONRR . . .	40	10	400
1206.109(c)(2)	**When may I take a transportation allowance in determining value?** (c) Limits on transportation allowances. (2) You may ask ONRR to approve a transportation allowance in excess of the limitation in paragraph (c)(1) of this section. . . . Your application for exception (using Form ONRR–4393, Request to Exceed Regulatory Allowance Limitation) must contain all relevant and supporting documentation necessary for ONRR to make a determination . . .	8	2	16
1206.110(a)	**How do I determine a transportation allowance under an arm's-length transportation contract?**	AUDIT PROCESS. See note.		
	(a) . . . You must be able to demonstrate that your or your affiliate's contract is at arm's length . . .			
1206.110(d)(3)	(d) If your arm's-length transportation contract includes more than one liquid product, and the transportation costs attributable to each product cannot be determined . . . (3) You may propose to ONRR a cost allocation method . . .	20	2	40
1206.110(e)	(e) If your arm's-length transportation contract includes both gaseous and liquid products, and the transportation costs attributable to each product cannot be determined from the contract, then you must propose an allocation procedure to ONRR.	20	1	20
1206.110(e)(1) and (e)(2)	(e)(1) . . . If ONRR rejects your cost allocation, you must amend your Form ONRR–2014 . . .	Burden covered under OMB Control Number 1012–0004.		
	(2) You must submit your initial proposal, including all available data, within 3 months after first claiming the allocated deductions on Form ONRR–2014.			
1206.110(g)(2)	(g) If your arm's-length sales contract includes a provision reducing the contract price by a transportation factor, . . . (2) You must obtain ONRR approval before claiming a transportation factor in excess of 50 percent of the base price of the product.	5	1	5

RESPONDENTS' ESTIMATED ANNUAL BURDEN HOURS—Continued

30 CFR 1202, 1204, and 1206	Reporting and recordkeeping requirement	Hour burden	Average number of annual responses	Annual burden hours
1206.111(g)	**How do I determine a transportation allowance if I do not have an arm's-length transportation contract or arm's-length tariff?** (g) To compute depreciation, you may elect to use either . . . After you make an election, you may not change methods without ONRR approval . . .	30	1	30
1206.111(k)(2)	(k)(2) You may propose to ONRR a cost allocation method on the basis of the values . . .	30	1	30
1206.111(l)(1) and (l)(3)	(l)(1) Where you transport both gaseous and liquid products through the same transportation system, you must propose a cost allocation procedure to ONRR . . . (3) You must submit your initial proposal, including all available data, within 3 months after first claiming the allocated deductions on Form ONRR–2014.	20	1	20
1206.111(l)(2)	(l)(2) . . . If ONRR rejects your cost allocation, you must amend your Form ONRR–2104 for the months that you used the rejected method and pay any additional royalty and interest due.	Burden covered under OMB Control Number 1012–0004.		
1206.112(a)(1)(ii)	**What adjustments and transportation allowances apply when I value oil production from my lease using NYMEX prices or ANS spot prices?** (a)(1)(ii) . . . under an exchange agreement that is not at arm's length, you must obtain approval from ONRR for a location and quality differential.	80	1	80
1206.112(a)(1)(ii)	(a)(1)(ii) . . . If ONRR prescribes a different differential, you must apply . . . You must pay any additional royalties owed . . . plus the late payment interest from the original royalty due date, or you may report a credit.	20	2	40
1206.112(a)(3) and (a)(4)	(a)(3) If you transport or exchange at arm's length (or both transport and exchange) at least 20 percent, but not all, of your oil produced from the lease to a market center, determine the adjustment between the lease and the market center for the oil that is not transported or exchanged (or both transported and exchanged) to or through a market center as follows: . . . (4) If you transport or exchange (or both transport and exchange) less than 20 percent of your crude oil produced from the lease between the lease and a market center, you must propose to ONRR an adjustment between the lease and the market center for the portion of the oil that you do not transport or exchange (or both transport and exchange) to a market center. . . . If ONRR prescribes a different adjustment. . . . You must pay any additional royalties owed . . . plus the late payment interest from the original royalty due date, or you may report a credit.	80	4	320
1206.112(b)(3)	(b)(3) . . . you may propose an alternative differential to ONRR. . . . If ONRR prescribes a different differential. . . . You must pay any additional royalties owed . . . plus the late payment interest from the original royalty due date, or you may report a credit . . .	80	4	320
1206.112(c)(2)	(c)(2) . . . If quality bank adjustments do not incorporate or provide for adjustments for sulfur content, you may make sulfur adjustments, based on the quality of the representative crude oil at the market center, of 5.0 cents per one-tenth percent difference in sulfur content, unless ONRR approves a higher adjustment.	80	2	160
1206.114	**What are my reporting requirements under an arm's-length transportation contract?**			
	You or your affiliate must use a separate entry on Form ONRR–2014 to notify ONRR of an allowance based on transportation costs you or your affiliate incur.	Burden covered under OMB Control Number 1012–0004.		
	ONRR may require you or your affiliate to submit arm's-length transportation contracts, production agreements, operating agreements, and related documents . . .	AUDIT PROCESS. See note.		

RESPONDENTS' ESTIMATED ANNUAL BURDEN HOURS—Continued

30 CFR 1202, 1204, and 1206	Reporting and recordkeeping requirement	Hour burden	Average number of annual responses	Annual burden hours
1206.115(a)	**What are my reporting requirements under a non-arm's-length transportation arrangement?**	Burden covered under OMB Control Number 1012–0004.		
	(a) You or your affiliate must use a separate entry on Form ONRR–2014 to notify ONRR of an allowance based on transportation costs you or your affiliate incur.			
1206.115(c)	(c) ONRR may require you or your affiliate to submit all data used to calculate the allowance deduction. . . .	AUDIT PROCESS. See note.		
	Subpart D—Federal Gas			
1206.152(b)(1)(i) and (b)(1)(iii)	**Valuation standards—unprocessed gas.**	AUDIT PROCESS. See note.		
	(b)(1)(i) . . . The lessee shall have the burden of demonstrating that its contract is arm's-length. . . . (iii) . . . When ONRR determines that the value may be unreasonable, ONRR will notify the lessee and give the lessee an opportunity to provide written information justifying the lessee's value.			
1206.152(b)(2)	(b)(2) . . . The lessee must request a value determination in accordance with paragraph (g) of this section for gas sold pursuant to a warranty contract;	80	1	80
1206.152(b)(3)	(b)(3) ONRR may require a lessee to certify that its arm's-length contract provisions include all of the consideration to be paid by the buyer, either directly or indirectly, for the gas.	AUDIT PROCESS. See note.		
1206.152(e)(1)	(e)(1) Where the value is determined pursuant to paragraph (c) of this section, the lessee shall retain all data relevant to the determination of royalty value . . .	Burden covered under OMB Control Number 1012–0004.		
1206.152(e)(2)	Any Federal lessee will make available upon request to the authorized ONRR or State representatives, to the Office of the Inspector General of the department of the Interior, or other person authorized to receive such information, arm's-length sales and volume data for like-quality production sold, purchased or otherwise obtained by the lessee from the field or area or from nearby fields or areas.	AUDIT PROCESS. See note.		
1206.152(e)(3)	(e)(3) A lessee shall notify ONRR if it has determined value pursuant to paragraph (c)(2) or (c)(3) of this section . . .	10	10	100
1206.152(g)	(g) The lessee may request a value determination from ONRR. . . . The lessee shall submit all available data relevant to its proposal. . . .	40	5	200
1206.153(b)(1)(i) and (b)(1)(iii)	**Valuation standards—processed gas.**	AUDIT PROCESS. See note.		
	(b)(1)(i) . . . The lessee shall have the burden of demonstrating that its contract is arm's-length. . . . (iii) . . . When ONRR determines that the value may be unreasonable, ONRR will notify the lessee and give the lessee an opportunity to provide written information justifying the lessee's value.			
1206.153(b)(2)	(b)(2) . . . The lessee must request a value determination in accordance with paragraph (g) of this section for gas sold pursuant to a warranty contract;	80	1	80
1206.153(b)(3)	(b)(3) ONRR may require a lessee to certify that its arm's-length contract provisions include all of the consideration to be paid by the buyer, either directly or indirectly, for the residue gas or gas plant product.	AUDIT PROCESS. See note.		
1206.153(e)(1)	(e)(1) Where the value is determined pursuant to paragraph (c) of this section, the lessee shall retain all data relevant to the determination of royalty value . . .	Burden covered under OMB Control Number 1012–0004.		

RESPONDENTS' ESTIMATED ANNUAL BURDEN HOURS—Continued

30 CFR 1202, 1204, and 1206	Reporting and recordkeeping requirement	Hour burden	Average number of annual responses	Annual burden hours
1206.153(e)(2)	(e)(2) Any Federal lessee will make available upon request to the authorized ONRR or State representatives, to the Office of the Inspector General of the Department of the Interior, or other persons authorized to receive such information, arm's-length sales and volume data for like-quality residue gas and gas plant products sold, purchased or otherwise obtained by the lessee from the same processing plant or from nearby processing plants.	AUDIT PROCESS. See note.		
1206.153(e)(3)	(e)(2) A lessee shall notify ONRR if it has determined any value pursuant to paragraph (c)(2) or (c)(3) of this section . . .	10	2	20
1206.153(g)	206.153(g) The lessee may request a value determination from ONRR. . . The lessee shall submit all available data relevant to its proposal. . . .	80	15	1,200
1206.154(c)(4)	**Determination of quantities and qualities for computing royalties.** (c)(4) . . . A lessee may request ONRR approval of other methods for determining the quantity of residue gas and gas plant products allocable to each lease. . . .	40	1	40
1206.156(c)(3)	**Transportation allowances—general.** (c)(3) Upon request of a lessee, ONRR may approve a transportation allowance deduction in excess of the limitation prescribed by paragraphs (c)(1) and (c)(2) of this section. . . . An application for exception (using Form ONRR–4393, Request to Exceed Regulatory Allowance Limitation) must contain all relevant and supporting documentation necessary for ONRR to make a determination. . . .	40	3	120
1206.157(a)(1)(i).	**Determination of transportation allowances** (a) *Arm's-length transportation contracts.* (1)(i) . . . The lessee shall have the burden of demonstrating that its contract is arm's-length. . . .	AUDIT PROCESS. See note.		
	The lessee must claim a transportation allowance by reporting it on a separate line entry on the Form ONRR–2014.	Burden covered under OMB Control Number 1012–0004.		
1206.157(a)(1)(iii)	(a)(1)(iii) . . . When ONRR determines that the value of the transportation may be unreasonable, ONRR will notify the lessee and give the lessee an opportunity to provide written information justifying the lessee's transportation costs.	AUDIT PROCESS. See note.		
1206.157(a)(2)(ii)	(a)(2)(ii) . . . the lessee may propose to ONRR a cost allocation method on the basis of the values of the products transported. . . .	40	1	40
1206.157(a)(3)	(a)(3) If an arm's-length transportation contract includes both gaseous and liquid products and the transportation costs attributable to each cannot be determined from the contract, the lessee shall propose an allocation procedure to ONRR. . . . The lessee shall submit all relevant data to support its proposal. . . .	40	1	40
1206.157(a)(5)	(a)(5) . . . The transportation factor may not exceed 50 percent of the base price of the product without ONRR approval.	10	3	30
1206.157(b)(1)	(b) *Non-arm's-length or no contract.* (1) The lessee must claim a transportation allowance by reporting it on a separate line entry on the Form ONRR–2014.	Burden covered under OMB Control Number 1012–0004.		
1206.157 (b)(2)(iv) and (b)(2)(iv)(A)	(b)(2)(iv) . . . After a lessee has elected to use either method for a transportation system, the lessee may not later elect to change to the other alternative without approval of the ONRR. (A) . . . After an election is made, the lessee may not change methods without ONRR approval. . . .	100	1	100
1206.157(b)(3)(i)	(b)(3)(i) . . . Except as provided in this paragraph, the lessee may not take an allowance for transporting a product which is not royalty bearing without ONRR approval.	100	1	100

RESPONDENTS' ESTIMATED ANNUAL BURDEN HOURS—Continued

30 CFR 1202, 1204, and 1206	Reporting and recordkeeping requirement	Hour burden	Average number of annual responses	Annual burden hours
1206.157(b)(3)(ii)	(b)(3)(ii) . . . the lessee may propose to the ONRR a cost allocation method on the basis of the values of the products transported. . . .	100	1	100
1206.157(b)(4)	(b)(4) Where both gaseous and liquid products are transported through the same transportation system, the lessee shall propose a cost allocation procedure to ONRR. . . . The lessee shall submit all relevant data to support its proposal. . . .	100	1	100
1206.157(b)(5)	(b)(5) You may apply for an exception from the requirement to compute actual costs under paragraphs (b)(1) through (b)(4) of this section.	100	1	100
1206.157(c)(1)(i)	(c) *Reporting Requirements.* (1) *Arm's-length contracts.* (i) You must use a separate entry on Form ONRR–2014 to notify ONRR of a transportation allowance.	Burden covered under OMB Control Number 1012–0004.		
1206.157(c)(1)(ii)	(c)(1)(ii) ONRR may require you to submit arm's-length transportation contracts, production agreements, operating agreements, and related documents. . . .	AUDIT PROCESS. See note.		
1206.157(c)(2)(i)	(c)(2) *Non-arm's-length or no contract.* (i) You must use a separate entry on Form ONRR–2014 to notify ONRR of a transportation allowance.	Burden covered under OMB Control Number 1012–0004.		
1206.157(c)(2)(iii)	(c)(2)(iii) ONRR may require you to submit all data used to calculate the allowance deduction. . . .	AUDIT PROCESS. See note.		
1206.157(e)(2), (e)(3), and (f)(1).	(e) *Adjustments.* (2) For lessees transporting production from onshore Federal leases, the lessee must submit a corrected Form ONRR–2014 to reflect actual costs, together with any payment, in accordance with instructions provided by ONRR. (3) For lessees transporting gas production from leases on the OCS, if the lessee's estimated transportation allowance exceeds the allowance based on actual costs, the lessee must submit a corrected Form ONRR–2014 to reflect actual costs, together with its payments, in accordance with instructions provided by ONRR	Burden covered under OMB Control Number 1012–0004.		
	(f) Allowable costs in determining transportation allowances. . . . (1) Firm demand charges paid to pipelines. . . . if you receive a payment or credit from the pipeline for penalty refunds, rate case refunds, or other reasons, you must reduce the firm demand charge claimed on the Form ONRR–2014 by the amount of that payment. You must modify Form ONRR–2014 by the amount received or credited for the affected reporting period and pay any resulting royalty and late payment interest due;			
1206.158(c)(3)	**Processing allowances—general**	80	8	640
	(c)(3) Upon request of a lessee, ONRR may approve a processing allowance in excess of the limitation prescribed by paragraph (c)(2) of this section. . . . An application for exception (using Form ONRR–4393, Request to Exceed Regulatory Allowance Limitation) shall contain all relevant and supporting documentation for ONRR to make a determination.			
1206.158(d)(2)(i)	(d)(2)(i) If the lessee incurs extraordinary costs for processing gas production from a gas production operation, it may apply to ONRR for an allowance for those costs. . .	80	1	80
1206.158(d)(2)(ii)	(d)(2)(ii) . . . to retain the authority to deduct the allowance the lessee must report the deduction to ONRR in a form and manner prescribed by ONRR.	Burden covered under OMB Control Number 1012–0004.		
1206.159(a)(1)(i)	**Determination of processing allowances**			
	(a) *Arm's-length processing contracts*	AUDIT PROCESS. See note.		
	(1)(i) . . . The lessee shall have the burden of demonstrating that its contract is arm's-length. . . .			
	The lessee must claim a processing allowance by reporting it on a separate line entry on the Form ONRR–2014.	Burden covered under OMB Control Number 1012–0004.		

RESPONDENTS' ESTIMATED ANNUAL BURDEN HOURS—Continued

30 CFR 1202, 1204, and 1206	Reporting and recordkeeping requirement	Hour burden	Average number of annual responses	Annual burden hours
1206.159(a)(1)(iii)	(a)(1)(iii) . . . When ONRR determines that the value of the processing may be unreasonable, ONRR will notify the lessee and give the lessee an opportunity to provide written information justifying the lessee's processing costs.	AUDIT PROCESS. See note.		
1206.159(a)(3)	(a)(3) If an arm's-length processing contract includes more than one gas plant product and the processing costs attributable to each product cannot be determined from the contract, the lessee shall propose an allocation procedure to ONRR. . . The lessee shall submit all relevant data to support its proposal. . . .	20	1	20
1206.159(b)(1)	(b) *Non-arm's-length or no contract.* (1). . . The lessee must claim a processing allowance by reflecting it as a separate line entry on the Form ONRR–2014. . . .	Burden covered under OMB Control Number 1012–0004.		
1206.159(b)(2)(iv) and (b)(2)(iv)(A).	(b)(2)(iv) . . . When a lessee has elected to use either method for a processing plant, the lessee may not later elect to change to the alternative without approval of the ONRR. (A) . . . After an election is made, the lessee may not change methods without ONRR approval . . .	100	1	100
1206.159(b)(4)	(b)(4) A lessee may apply to ONRR for an exception from the requirements that it compute actual costs in accordance with paragraphs (b)(1) through (b)(3) of this section. . . .	100	1	100
1206.159(c)(1)(i)	(c) *Reporting requirements*—(1) *Arm's-length contracts.* (i) The lessee must notify ONRR of an allowance based on incurred costs by using a separate line entry on the Form ONRR–2014.	Burden covered under OMB Control Number 1012–0004.		
1206.159(c)(1)(ii)	(c)(1)(ii) ONRR may require that a lessee submit arm's-length processing contracts and related documents. . . .	AUDIT PROCESS. See note.		
1206.159(c)(2)(i)	(c)(2) *Non-arm's-length or no contract.* (i) The lessee must notify ONRR of an allowance based on incurred costs by using a separate line entry on the Form ONRR–2014.	Burden covered under OMB Control Number 1012–0004.		
1206.159(c)(2)(iii)	(c)(2)(iii) Upon request by ONRR, the lessee shall submit all data used to prepare the allowance deduction. . . .	AUDIT PROCESS. See note.		
1206.159(e)(2) and (e)(3)	(e) *Adjustments* . . . (2) For lessees processing production from onshore Federal leases, the lessee must submit a corrected Form ONRR–2014 to reflect actual costs, together with any payment, in accordance with instructions provided by ONRR. (3) For lessees processing gas production from leases on the OCS, if the lessee's estimated processing allowance exceeds the allowance based on actual costs, the lessee must submit a corrected Form ONRR–2014 to reflect actual costs, together with its payment, in accordance with instructions provided by ONRR . . .	Burden covered under OMB Control Number 1012–0004.		
Oil and Gas Valuation Subtotal			**117**	**8,672**
TOTAL			**127**	**9,198**

Note: AUDIT PROCESS—The Office of Regulatory Affairs determined that the audit process is exempt from the Paperwork Reduction Act of 1995 because ONRR staff asks non-standard questions to resolve exceptions.

Estimated Annual Reporting and Recordkeeping "Non-hour" Cost Burden: We have identified no "non-hour" cost burden associated with the collection of information.

Public Disclosure Statement: The PRA (44 U.S.C. 3501 *et seq.*) provides that an agency may not conduct or sponsor, and a person does not have to respond to, a collection of information unless it displays a currently valid OMB control number.

Comments: Section 3506(c)(2)(A) of the PRA requires each agency to "* * * provide 60-day notice in the **Federal Register** * * * and otherwise consult with members of the public and affected agencies concerning each proposed collection of information * * *." Agencies must specifically solicit comments to (a) Evaluate whether the proposed collection of information is necessary for the agency to perform its duties, including whether the information is useful; (b) evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) enhance the quality, usefulness, and clarity of the information that ONRR collects; and (d)

minimize the burden on the respondents, including the use of automated collection techniques or other forms of information technology.

To comply with the public consultation process, we published a notice in the **Federal Register** on March 7, 2013 (78 FR 14824), announcing that we would submit this ICR to OMB for approval. The notice provided the required 60-day comment period. We received no unsolicited comments in response to the notice.

If you wish to comment in response to this notice, you may send your comments to the offices listed under the **ADDRESSES** section of this notice. OMB has up to 60 days to approve or disapprove the information collection, but they may respond after 30 days. Therefore, in order to ensure maximum consideration, OMB should receive public comments by January 2, 2014.

Public Comment Policy: We will post all comments, including names and addresses of respondents, at *http://www.regulations.gov.* Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that we may make your entire comment—including your personal identifying information—publicly available at any time. While you can ask us in your comment to withhold from public view your personal identifying information, we cannot guarantee that we will be able to do so.

Office of the Secretary, Information Collection Clearance Officer: David Alspach (202) 219–8526.

Dated: November 1, 2013.

Gregory J. Gould,

Director, Office of Natural Resources Revenue.

[FR Doc. 2013–27084 Filed 11–29–13; 8:45 am]

BILLING CODE 4310–T2–P

DEPARTMENT OF THE INTERIOR

Bureau of Reclamation

[G63–0982–9832–100–96–76, 84–55000]

Quarterly Status Report of Water Service, Repayment, and Other Water-Related Contract Actions

AGENCY: Bureau of Reclamation, Interior.

ACTION: Notice.

SUMMARY: Notice is hereby given of contractual actions that have been proposed to the Bureau of Reclamation (Reclamation) and are new, modified, discontinued, or completed since the last publication of this notice. This notice is one of a variety of means used to inform the public about proposed contractual actions for capital recovery and management of project resources and facilities consistent with section 9(f) of the Reclamation Project Act of 1939. Additional announcements of individual contract actions may be published in the **Federal Register** and in newspapers of general circulation in the areas determined by Reclamation to be affected by the proposed action.

ADDRESSES: The identity of the approving officer and other information pertaining to a specific contract proposal may be obtained by calling or writing the appropriate regional office at the address and telephone number given for each region in the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Michelle Kelly, Water and Environmental Resources Division, Bureau of Reclamation, P.O. Box 25007, Denver, Colorado 80225–0007; telephone 303–445–2888.

SUPPLEMENTARY INFORMATION: Consistent with section 9(f) of the Reclamation Project Act of 1939, and the rules and regulations published in 52 FR 11954, April 13, 1987 (43 CFR 426.22), Reclamation will publish notice of proposed or amendatory contract actions for any contract for the delivery of project water for authorized uses in newspapers of general circulation in the affected area at least 60 days prior to contract execution. Please use the first quarter notice, 78 FR 21969, dated April 12, 2013, as a reference. Announcements may be in the form of news releases, legal notices, official letters, memorandums, or other forms of written material. Meetings, workshops, and/or hearings may also be used, as appropriate, to provide local publicity. The public participation procedures do not apply to proposed contracts for the sale of surplus or interim irrigation water for a term of 1 year or less. Either of the contracting parties may invite the public to observe contract proceedings. All public participation procedures will be coordinated with those involved in complying with the National Environmental Policy Act. Pursuant to the ''Final Revised Public Participation Procedures'' for water resource-related contract negotiations, published in 47 FR 7763, February 22, 1982, a tabulation is provided of all proposed contractual actions in each of the five Reclamation regions. When contract negotiations are completed, and prior to execution, each proposed contract form must be approved by the Secretary of the Interior, or pursuant to delegated or redelegated authority, the Commissioner of Reclamation or one of the regional directors. In some instances, congressional review and approval of a report, water rate, or other terms and conditions of the contract may be involved.

Public participation in and receipt of comments on contract proposals will be facilitated by adherence to the following procedures:

1. Only persons authorized to act on behalf of the contracting entities may negotiate the terms and conditions of a specific contract proposal.

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LCWSP Lower Colorado Water Supply Project
M&I Municipal and Industrial
NMISC New Mexico Interstate Stream Commission
O&M Operation and Maintenance
OM&R Operation, maintenance, and replacement
P–SMBP Pick-Sloan Missouri Basin Program
PPR Present Perfected Right
RRA Reclamation Reform Act of 1982
SOD Safety of Dams
SRPA Small Reclamation Projects Act of 1956
USACE U.S. Army Corps of Engineers
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Dated: September 27, 2013.

Roseann Gonzales,

Director, Policy and Administration.

[FR Doc. 2013–28765 Filed 11–29–13; 8:45 am]

BILLING CODE 4310–MN–P

DEPARTMENT OF THE INTERIOR

Bureau of Reclamation

[G63–0982–9832–100–96–76, 84–55000]

Quarterly Status Report of Water Service, Repayment, and Other Water-Related Contract Actions

AGENCY: Bureau of Reclamation, Interior.

ACTION: Notice.

SUMMARY: Notice is hereby given of contractual actions that have been proposed to the Bureau of Reclamation (Reclamation) and are new, modified, discontinued, or completed since the last publication of this notice. This notice is one of a variety of means used to inform the public about proposed contractual actions for capital recovery and management of project resources and facilities consistent with section 9(f) of the Reclamation Project Act of 1939. Additional announcements of individual contract actions may be published in the **Federal Register** and in newspapers of general circulation in the areas determined by Reclamation to be affected by the proposed action.

ADDRESSES: The identity of the approving officer and other information pertaining to a specific contract proposal may be obtained by calling or writing the appropriate regional office at the address and telephone number given for each region in the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Michelle Kelly, Water and Environmental Resources Division, Bureau of Reclamation, P.O. Box 25007,

Denver, Colorado 80225–0007; telephone 303–445–2888.

SUPPLEMENTARY INFORMATION: Consistent with section 9(f) of the Reclamation Project Act of 1939, and the rules and regulations published in 52 FR 11954, April 13, 1987 (43 CFR 426.22), Reclamation will publish notice of proposed or amendatory contract actions for any contract for the delivery of project water for authorized uses in newspapers of general circulation in the affected area at least 60 days prior to contract execution. Please use the first quarter notice, 78 FR 21969, dated April 12, 2013, as a reference.

Announcements may be in the form of news releases, legal notices, official letters, memorandums, or other forms of written material. Meetings, workshops, and/or hearings may also be used, as appropriate, to provide local publicity. The public participation procedures do not apply to proposed contracts for the sale of surplus or interim irrigation water for a term of 1 year or less. Either of the contracting parties may invite the public to observe contract proceedings. All public participation procedures will be coordinated with those involved in complying with the National Environmental Policy Act. Pursuant to the ''Final Revised Public Participation Procedures'' for water resource-related contract negotiations, published in 47 FR 7763, February 22, 1982, a tabulation is provided of all proposed contractual actions in each of the five Reclamation regions. When contract negotiations are completed, and prior to execution, each proposed contract form must be approved by the Secretary of the Interior, or pursuant to delegated or redelegated authority, the Commissioner of Reclamation or one of the regional directors. In some instances, congressional review and approval of a report, water rate, or other terms and conditions of the contract may be involved.

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Dated: September 27, 2013.

Roseann Gonzales,

Director, Policy and Administration.

[FR Doc. 2013–28760 Filed 11–29–13; 8:45 am]

BILLING CODE 4310–MN–P

INTERNATIONAL TRADE COMMISSION

[Investigation Nos. 701–TA–455 and 731–TA–1149 (Review)]

Circular Welded Carbon Quality Steel Line Pipe From China; Institution of Five-Year Reviews

AGENCY: United States International Trade Commission.

ACTION: Notice.

SUMMARY: The Commission hereby gives notice that it has instituted reviews pursuant to section 751(c) of the Tariff Act of 1930 (19 U.S.C. 1675(c)) (the Act) to determine whether revocation of the antidumping and countervailing duty orders on circular welded carbon quality steel line pipe from China would be likely to lead to continuation or recurrence of material injury. Pursuant to section 751(c)(2) of the Act, interested parties are requested to respond to this notice by submitting the information specified below to the Commission; [1] to be assured of consideration, the deadline for responses is January 2, 2014. Comments on the adequacy of responses may be filed with the Commission by February 13, 2014. For further information concerning the conduct of this review and rules of general application, consult the Commission's Rules of Practice and Procedure, part 201, subparts A through E (19 CFR part 201), and part 207, subparts A, D, E, and F (19 CFR part 207).

DATES: *Effective Date:* December 2, 2013.

FOR FURTHER INFORMATION CONTACT: Mary Messer (202–205–3193), Office of Investigations, U.S. International Trade Commission, 500 E Street SW., Washington, DC 20436. Hearing-impaired persons can obtain information on this matter by contacting the Commission's TDD terminal on 202–205–1810. Persons with mobility impairments who will need special assistance in gaining access to the Commission should contact the Office of the Secretary at 202–205–2000. General information concerning the Commission may also be obtained by accessing its internet server (*http://www.usitc.gov*). The public record for these reviews may be viewed on the Commission's electronic docket (EDIS) at *http://edis.usitc.gov.*

SUPPLEMENTARY INFORMATION:

Background—On January 23, 2009, the Department of Commerce issued a countervailing duty order on imports of circular welded carbon quality steel line pipe from China (74 FR 4136). On May 13, 2009, the Department of Commerce issued an antidumping duty order on imports of circular welded carbon quality steel line pipe from China (74 FR 22515). The Commission is conducting a review to determine whether revocation of the orders would be likely to lead to continuation or recurrence of material injury to the domestic industry within a reasonably foreseeable time. It will assess the adequacy of interested party responses to this notice of institution to determine whether to conduct full or expedited reviews. The Commission's determinations in any expedited reviews will be based on the facts available, which may include information provided in response to this notice.

Definitions—The following definitions apply to these reviews:

(1) *Subject Merchandise* is the class or kind of merchandise that is within the scope of the five-year reviews, as defined by the Department of Commerce.

(2) The *Subject Country* in this review is China.

(3) The *Domestic Like Product* is the domestically produced product or products which are like, or in the absence of like, most similar in characteristics and uses with, the *Subject Merchandise.* In its original determination, the Commission defined a single *Domestic Like Product* consisting of circular welded carbon quality steel line pipe, 16 inches or less in outside diameter.

(4) The *Domestic Industry* is the U.S. producers as a whole of the *Domestic Like Product,* or those producers whose collective output of the *Domestic Like Product* constitutes a major proportion of the total domestic production of the product. In its original determination, the Commission defined the *Domestic Industry* as producers of line pipe 16 inches or less in outside diameter.

(5) The *Order Date* is the date that the antidumping and countervailing duty orders under review became effective. In the review of the countervailing duty order, the *Order Date* is January 23, 2009. In the review of the antidumping duty order, the *Order Date* is May 13, 2009.

(6) An *Importer* is any person or firm engaged, either directly or through a

[1] No response to this request for information is required if a currently valid Office of Management and Budget (OMB) number is not displayed; the OMB number is 3117–0016/USITC No. 14–5–301, expiration date June 30, 2014. Public reporting burden for the request is estimated to average 15 hours per response. Please send comments regarding the accuracy of this burden estimate to the Office of Investigations, U.S. International Trade Commission, 500 E Street SW., Washington, DC 20436.

parent company or subsidiary, in importing the *Subject Merchandise* into the United States from a foreign manufacturer or through its selling agent.

Participation in the reviews and public service list—Persons, including industrial users of the *Subject Merchandise* and, if the merchandise is sold at the retail level, representative consumer organizations, wishing to participate in the reviews as parties must file an entry of appearance with the Secretary to the Commission, as provided in section 201.11(b)(4) of the Commission's rules, no later than 21 days after publication of this notice in the **Federal Register**. The Secretary will maintain a public service list containing the names and addresses of all persons, or their representatives, who are parties to the reviews.

Former Commission employees who are seeking to appear in Commission five-year reviews are advised that they may appear in a review even if they participated personally and substantially in the corresponding underlying original investigation. The Commission's designated agency ethics official has advised that a five-year review is not considered the ''same particular matter'' as the corresponding underlying original investigation for purposes of 18 U.S.C. 207, the post employment statute for Federal employees, and Commission rule 201.15(b) (19 CFR 201.15(b)), 73 FR 24609 (May 5, 2008). This advice was developed in consultation with the Office of Government Ethics. Consequently, former employees are not required to seek Commission approval to appear in a review under Commission rule 19 CFR 201.15, even if the corresponding underlying original investigation was pending when they were Commission employees. For further ethics advice on this matter, contact Carol McCue Verratti, Deputy Agency Ethics Official, at 202–205–3088.

Limited disclosure of business proprietary information (BPI) under an administrative protective order (APO) and APO service list—Pursuant to section 207.7(a) of the Commission's rules, the Secretary will make BPI submitted in these reviews available to authorized applicants under the APO issued in the review, provided that the application is made no later than 21 days after publication of this notice in the **Federal Register**. Authorized applicants must represent interested parties, as defined in 19 U.S.C. 1677(9), who are parties to the reviews. A separate service list will be maintained by the Secretary for those parties authorized to receive BPI under the APO.

Certification—Pursuant to section 207.3 of the Commission's rules, any person submitting information to the Commission in connection with these reviews must certify that the information is accurate and complete to the best of the submitter's knowledge. In making the certification, the submitter will be deemed to consent, unless otherwise specified, for the Commission, its employees, and contract personnel to use the information provided in any other reviews or investigations of the same or comparable products which the Commission conducts under Title VII of the Act, or in internal audits and investigations relating to the programs and operations of the Commission pursuant to 5 U.S.C. Appendix 3.

Written submissions—Pursuant to section 207.61 of the Commission's rules, each interested party response to this notice must provide the information specified below. The deadline for filing such responses is January 2, 2014. Pursuant to section 207.62(b) of the Commission's rules, eligible parties (as specified in Commission rule 207.62(b)(1)) may also file comments concerning the adequacy of responses to the notice of institution and whether the Commission should conduct expedited or full reviews. The deadline for filing such comments is February 13, 2014. All written submissions must conform with the provisions of sections 201.8 and 207.3 of the Commission's rules and any submissions that contain BPI must also conform with the requirements of sections 201.6 and 207.7 of the Commission's rules. Regarding electronic filing requirements under the Commission's rules, see also the Commission's *Handbook on E-Filing,* available on the Commission's Web site at *http://edis.usitc.gov.* Also, in accordance with sections 201.16(c) and 207.3 of the Commission's rules, each document filed by a party to the reviews must be served on all other parties to the reviews (as identified by either the public or APO service list as appropriate), and a certificate of service must accompany the document (if you are not a party to the reviews you do not need to serve your response).

Inability to provide requested information—Pursuant to section 207.61(c) of the Commission's rules, any interested party that cannot furnish the information requested by this notice in the requested form and manner shall notify the Commission at the earliest possible time, provide a full explanation of why it cannot provide the requested information, and indicate alternative forms in which it can provide equivalent information. If an interested party does not provide this notification (or the Commission finds the explanation provided in the notification inadequate) and fails to provide a complete response to this notice, the Commission may take an adverse inference against the party pursuant to section 776(b) of the Act (19 U.S.C. 1677e(b)) in making its determinations in the reviews.

Information To Be Provided in Response To This Notice of Institution: As used below, the term ''firm'' includes any related firms.

(1) The name and address of your firm or entity (including World Wide Web address) and name, telephone number, fax number, and Email address of the certifying official.

(2) A statement indicating whether your firm/entity is a U.S. producer of the *Domestic Like Product,* a U.S. union or worker group, a U.S. importer of the *Subject Merchandise,* a foreign producer or exporter of the *Subject Merchandise,* a U.S. or foreign trade or business association, or another interested party (including an explanation). If you are a union/worker group or trade/business association, identify the firms in which your workers are employed or which are members of your association.

(3) A statement indicating whether your firm/entity is willing to participate in these reviews by providing information requested by the Commission.

(4) A statement of the likely effects of the revocation of the antidumping and countervailing duty orders on the *Domestic Industry* in general and/or your firm/entity specifically. In your response, please discuss the various factors specified in section 752(a) of the Act (19 U.S.C. 1675a(a)) including the likely volume of subject imports, likely price effects of subject imports, and likely impact of imports of *Subject Merchandise* on the *Domestic Industry.*

(5) A list of all known and currently operating U.S. producers of the *Domestic Like Product.* Identify any known related parties and the nature of the relationship as defined in section 771(4)(B) of the Act (19 U.S.C. 1677(4)(B)).

(6) A list of all known and currently operating U.S. importers of the *Subject Merchandise* and producers of the *Subject Merchandise* in the *Subject Country* that currently export or have exported *Subject Merchandise* to the United States or other countries since the *Order Date.*

(7) A list of 3–5 leading purchasers in the U.S. market for the *Domestic Like Product* and the *Subject Merchandise*

(including street address, World Wide Web address, and the name, telephone number, fax number, and Email address of a responsible official at each firm).

(8) A list of known sources of information on national or regional prices for the *Domestic Like Product* or the *Subject Merchandise* in the U.S. or other markets.

(9) If you are a U.S. producer of the *Domestic Like Product,* provide the following information on your firm's operations on that product during calendar year 2012, except as noted (report quantity data in short tons and value data in U.S. dollars, f.o.b. plant). If you are a union/worker group or trade/business association, provide the information, on an aggregate basis, for the firms in which your workers are employed/which are members of your association.

(a) Production (quantity) and, if known, an estimate of the percentage of total U.S. production of the *Domestic Like Product* accounted for by your firm's(s') production;

(b) Capacity (quantity) of your firm to produce the *Domestic Like Product* (i.e., the level of production that your establishment(s) could reasonably have expected to attain during the year, assuming normal operating conditions (using equipment and machinery in place and ready to operate), normal operating levels (hours per week/weeks per year), time for downtime, maintenance, repair, and cleanup, and a typical or representative product mix);

(c) the quantity and value of U.S. commercial shipments of the *Domestic Like Product* produced in your U.S. plant(s);

(d) the quantity and value of U.S. internal consumption/company transfers of the *Domestic Like Product* produced in your U.S. plant(s); and

(e) the value of (i) net sales, (ii) cost of goods sold (COGS), (iii) gross profit, (iv) selling, general and administrative (SG&A) expenses, and (v) operating income of the *Domestic Like Product* produced in your U.S. plant(s) (include both U.S. and export commercial sales, internal consumption, and company transfers) for your most recently completed fiscal year (identify the date on which your fiscal year ends).

(10) If you are a U.S. importer or a trade/business association of U.S. importers of the *Subject Merchandise* from the *Subject Country,* provide the following information on your firm's(s') operations on that product during calendar year 2012 (report quantity data in short tons and value data in U.S. dollars). If you are a trade/business association, provide the information, on an aggregate basis, for the firms which are members of your association.

(a) The quantity and value (landed, duty-paid but not including antidumping or countervailing duties) of U.S. imports and, if known, an estimate of the percentage of total U.S. imports of *Subject Merchandise* from the *Subject Country* accounted for by your firm's(s') imports;

(b) the quantity and value (f.o.b. U.S. port, including antidumping and/or countervailing duties) of U.S. commercial shipments of *Subject Merchandise* imported from the *Subject Country;* and

(c) the quantity and value (f.o.b. U.S. port, including antidumping and/or countervailing duties) of U.S. internal consumption/company transfers of *Subject Merchandise* imported from the *Subject Country.*

(11) If you are a producer, an exporter, or a trade/business association of producers or exporters of the *Subject Merchandise* in the *Subject Country,* provide the following information on your firm's(s') operations on that product during calendar year 2012 (report quantity data in short tons and value data in U.S. dollars, landed and duty-paid at the U.S. port but not including antidumping or countervailing duties). If you are a trade/business association, provide the information, on an aggregate basis, for the firms which are members of your association.

(a) Production (quantity) and, if known, an estimate of the percentage of total production of *Subject Merchandise* in the *Subject Country* accounted for by your firm's(s') production;

(b) Capacity (quantity) of your firm(s) to produce the *Subject Merchandise* in the *Subject Country* (i.e., the level of production that your establishment(s) could reasonably have expected to attain during the year, assuming normal operating conditions (using equipment and machinery in place and ready to operate), normal operating levels (hours per week/weeks per year), time for downtime, maintenance, repair, and cleanup, and a typical or representative product mix); and

(c) the quantity and value of your firm's(s') exports to the United States of *Subject Merchandise* and, if known, an estimate of the percentage of total exports to the United States of *Subject Merchandise* from the *Subject Country* accounted for by your firm's(s') exports.

(12) Identify significant changes, if any, in the supply and demand conditions or business cycle for the *Domestic Like Product* that have occurred in the United States or in the market for the *Subject Merchandise* in the *Subject Country* since the *Order Date,* and significant changes, if any, that are likely to occur within a reasonably foreseeable time. Supply conditions to consider include technology; production methods; development efforts; ability to increase production (including the shift of production facilities used for other products and the use, cost, or availability of major inputs into production); and factors related to the ability to shift supply among different national markets (including barriers to importation in foreign markets or changes in market demand abroad). Demand conditions to consider include end uses and applications; the existence and availability of substitute products; and the level of competition among the *Domestic Like Product* produced in the United States, *Subject Merchandise* produced in the *Subject Country,* and such merchandise from other countries.

(13) (OPTIONAL) A statement of whether you agree with the above definitions of the *Domestic Like Product* and *Domestic Industry;* if you disagree with either or both of these definitions, please explain why and provide alternative definitions.

Authority: These reviews are being conducted under authority of Title VII of the Tariff Act of 1930; this notice is published pursuant to section 207.61 of the Commission's rules.

By order of the Commission.

Issued: November 26, 2013.

Lisa R. Barton,

Acting Secretary to the Commission.

[FR Doc. 2013–28791 Filed 11–29–13; 8:45 am]

BILLING CODE 7020–02–P

INTERNATIONAL TRADE COMMISSION

[Investigation No. 731–TA–1092 (Review)]

Diamond Sawblades and Parts Thereof From China Institution of a Five-Year Review.

AGENCY: United States International Trade Commission.

ACTION: Notice.

SUMMARY: The Commission hereby gives notice that it has instituted a review pursuant to section 751(c) of the Tariff Act of 1930 (19 U.S.C. 1675(c)) (the Act) to determine whether revocation of the antidumping duty order on diamond sawblades and parts thereof from China would be likely to lead to continuation or recurrence of material injury. Pursuant to section 751(c)(2) of the Act, interested parties are requested to respond to this notice by submitting the

information specified below to the Commission;[1] to be assured of consideration, the deadline for responses is January 2, 2014. Comments on the adequacy of responses may be filed with the Commission by February 13, 2014. For further information concerning the conduct of this review and rules of general application, consult the Commission's Rules of Practice and Procedure, part 201, subparts A through E (19 CFR part 201), and part 207, subparts A, D, E, and F (19 CFR part 207).

DATES: Effective December 2, 2013.

FOR FURTHER INFORMATION CONTACT: Mary Messer (202–205–3193), Office of Investigations, U.S. International Trade Commission, 500 E Street SW., Washington, DC 20436. Hearing-impaired persons can obtain information on this matter by contacting the Commission's TDD terminal on 202–205–1810. Persons with mobility impairments who will need special assistance in gaining access to the Commission should contact the Office of the Secretary at 202–205–2000. General information concerning the Commission may also be obtained by accessing its internet server (*http://www.usitc.gov*). The public record for this review may be viewed on the Commission's electronic docket (EDIS) at *http://edis.usitc.gov.*

SUPPLEMENTARY INFORMATION:

Background.—Effective January 23, 2009, the Department of Commerce issued an antidumping duty order on imports of diamond sawblades and parts thereof from China (74 FR 57145, November 4, 2009). The Commission is conducting a review to determine whether revocation of the order would be likely to lead to continuation or recurrence of material injury to the domestic industry within a reasonably foreseeable time. It will assess the adequacy of interested party responses to this notice of institution to determine whether to conduct a full review or an expedited review. The Commission's determination in any expedited review will be based on the facts available, which may include information provided in response to this notice.

Definitions.—The following definitions apply to this review:

(1) *Subject Merchandise* is the class or kind of merchandise that is within the scope of the five-year review, as defined by the Department of Commerce.

(2) The *Subject Country* in this review is China.

(3) The *Domestic Like Product* is the domestically produced product or products which are like, or in the absence of like, most similar in characteristics and uses with, the *Subject Merchandise.* In its original determination, the Commission defined the *Domestic Like Product* as diamond sawblades and parts thereof, coextensive with Commerce's scope.

(4) The *Domestic Industry* is the U.S. producers as a whole of the *Domestic Like Product,* or those producers whose collective output of the *Domestic Like Product* constitutes a major proportion of the total domestic production of the product. In its original determination, the Commission determined that the *Domestic Industry* comprised the assemblers in addition to all domestic producers of finished diamond sawblades and component parts.

(5) The *Order Date* is the date that the antidumping duty order under review became effective. In this review, the *Order Date* is January 23, 2009.

(6) An *Importer* is any person or firm engaged, either directly or through a parent company or subsidiary, in importing the *Subject Merchandise* into the United States from a foreign manufacturer or through its selling agent.

Participation in the review and public service list.—Persons, including industrial users of the *Subject Merchandise* and, if the merchandise is sold at the retail level, representative consumer organizations, wishing to participate in the review as parties must file an entry of appearance with the Secretary to the Commission, as provided in section 201.11(b)(4) of the Commission's rules, no later than 21 days after publication of this notice in the **Federal Register**. The Secretary will maintain a public service list containing the names and addresses of all persons, or their representatives, who are parties to the review.

Former Commission employees who are seeking to appear in Commission five-year reviews are advised that they may appear in a review even if they participated personally and substantially in the corresponding underlying original investigation. The Commission's designated agency ethics official has advised that a five-year review is not considered the ''same particular matter''a as the corresponding underlying original investigation for purposes of 18 U.S.C. 207, the post employment statute for Federal employees, and Commission rule 201.15(b) (19 CFR 201.15(b)), 73 FR 24609 (May 5, 2008). This advice was developed in consultation with the Office of Government Ethics. Consequently, former employees are not required to seek Commission approval to appear in a review under Commission rule 19 CFR 201.15, even if the corresponding underlying original investigation was pending when they were Commission employees. For further ethics advice on this matter, contact Carol McCue Verratti, Deputy Agency Ethics Official, at 202–205–3088.

Limited disclosure of business proprietary information (BPI) under an administrative protective order (APO) and APO service list.—Pursuant to section 207.7(a) of the Commission's rules, the Secretary will make BPI submitted in this review available to authorized applicants under the APO issued in the review, provided that the application is made no later than 21 days after publication of this notice in the **Federal Register**. Authorized applicants must represent interested parties, as defined in 19 U.S.C. 1677(9), who are parties to the review. A separate service list will be maintained by the Secretary for those parties authorized to receive BPI under the APO.

Certification.—Pursuant to section 207.3 of the Commission's rules, any person submitting information to the Commission in connection with this review must certify that the information is accurate and complete to the best of the submitter's knowledge. In making the certification, the submitter will be deemed to consent, unless otherwise specified, for the Commission, its employees, and contract personnel to use the information provided in any other reviews or investigations of the same or comparable products which the Commission conducts under Title VII of the Act, or in internal audits and investigations relating to the programs and operations of the Commission pursuant to 5 U.S.C. Appendix 3.

Written submissions.—Pursuant to section 207.61 of the Commission's rules, each interested party response to this notice must provide the information specified below. The deadline for filing such responses is January 2, 2014. Pursuant to section 207.62(b) of the Commission's rules, eligible parties (as specified in Commission rule 207.62(b)(1)) may also file comments concerning the adequacy of responses to the notice of institution and whether the Commission should conduct an expedited or full review. The deadline

[1] No response to this request for information is required if a currently valid Office of Management and Budget (OMB) number is not displayed; the OMB number is 3117–0016/USITC No. 14–5–302, expiration date June 30, 2014. Public reporting burden for the request is estimated to average 15 hours per response. Please send comments regarding the accuracy of this burden estimate to the Office of Investigations, U.S. International Trade Commission, 500 E Street SW., Washington, DC 20436.

for filing such comments is February 13, 2014. All written submissions must conform with the provisions of sections 201.8 and 207.3 of the Commission's rules and any submissions that contain BPI must also conform with the requirements of sections 201.6 and 207.7 of the Commission's rules. Regarding electronic filing requirements under the Commission's rules, see also the Commission's *Handbook on E-Filing,* available on the Commission's Web site at *http://edis.usitc.gov.* Also, in accordance with sections 201.16(c) and 207.3 of the Commission's rules, each document filed by a party to the review must be served on all other parties to the review (as identified by either the public or APO service list as appropriate), and a certificate of service must accompany the document (if you are not a party to the review you do not need to serve your response).

Inability to provide requested information.—Pursuant to section 207.61(c) of the Commission's rules, any interested party that cannot furnish the information requested by this notice in the requested form and manner shall notify the Commission at the earliest possible time, provide a full explanation of why it cannot provide the requested information, and indicate alternative forms in which it can provide equivalent information. If an interested party does not provide this notification (or the Commission finds the explanation provided in the notification inadequate) and fails to provide a complete response to this notice, the Commission may take an adverse inference against the party pursuant to section 776(b) of the Act (19 U.S.C. 1677e(b)) in making its determination in the review.

Information to be Provided in Response to this Notice of Institution: As used below, the term ''firm'' includes any related firms.

(1) The name and address of your firm or entity (including World Wide Web address) and name, telephone number, fax number, and Email address of the certifying official.

(2) A statement indicating whether your firm/entity is a U.S. producer of the *Domestic Like Product,* a U.S. union or worker group, a U.S. importer of the *Subject Merchandise,* a foreign producer or exporter of the *Subject Merchandise,* a U.S. or foreign trade or business association, or another interested party (including an explanation). If you are a union/worker group or trade/business association, identify the firms in which your workers are employed or which are members of your association.

(3) A statement indicating whether your firm/entity is willing to participate in this review by providing information requested by the Commission.

(4) A statement of the likely effects of the revocation of the antidumping duty order on the *Domestic Industry* in general and/or your firm/entity specifically. In your response, please discuss the various factors specified in section 752(a) of the Act (19 U.S.C. 1675a(a)) including the likely volume of subject imports, likely price effects of subject imports, and likely impact of imports of *Subject Merchandise* on the *Domestic Industry.*

(5) A list of all known and currently operating U.S. producers of the *Domestic Like Product.* Identify any known related parties and the nature of the relationship as defined in section 771(4)(B) of the Act (19 U.S.C. 1677(4)(B)).

(6) A list of all known and currently operating U.S. importers of the *Subject Merchandise* and producers of the *Subject Merchandise* in the *Subject Country* that currently export or have exported *Subject Merchandise* to the United States or other countries since the *Order Date.*

(7) A list of 3–5 leading purchasers in the U.S. market for the *Domestic Like Product* and the *Subject Merchandise* (including street address, World Wide Web address, and the name, telephone number, fax number, and Email address of a responsible official at each firm).

(8) A list of known sources of information on national or regional prices for the *Domestic Like Product* or the *Subject Merchandise* in the U.S. or other markets.

(9) If you are a U.S. producer of the *Domestic Like Product,* provide the following information on your firm's operations on that product during calendar year 2012, except as noted (report quantity data in units and value data in U.S. dollars, f.o.b. plant). If you are a union/worker group or trade/business association, provide the information, on an aggregate basis, for the firms in which your workers are employed/which are members of your association.

(a) Production (quantity) and, if known, an estimate of the percentage of total U.S. production of the *Domestic Like Product* accounted for by your firm's(s') production;

(b) Capacity (quantity) of your firm to produce the *Domestic Like Product* (i.e., the level of production that your establishment(s) could reasonably have expected to attain during the year, assuming normal operating conditions (using equipment and machinery in place and ready to operate), normal operating levels (hours per week/weeks per year), time for downtime, maintenance, repair, and cleanup, and a typical or representative product mix);

(c) the quantity and value of U.S. commercial shipments of the *Domestic Like Product* produced in your U.S. plant(s);

(d) the quantity and value of U.S. internal consumption/company transfers of the *Domestic Like Product* produced in your U.S. plant(s); and

(e) the value of (i) net sales, (ii) cost of goods sold (COGS), (iii) gross profit, (iv) selling, general and administrative (SG&A) expenses, and (v) operating income of the *Domestic Like Product* produced in your U.S. plant(s) (include both U.S. and export commercial sales, internal consumption, and company transfers) for your most recently completed fiscal year (identify the date on which your fiscal year ends).

(10) If you are a U.S. importer or a trade/business association of U.S. importers of the *Subject Merchandise* from the *Subject Country,* provide the following information on your firm's(s') operations on that product during calendar year 2012 (report quantity data in units and value data in U.S. dollars). If you are a trade/business association, provide the information, on an aggregate basis, for the firms which are members of your association.

(a) The quantity and value (landed, duty-paid but not including antidumping duties) of U.S. imports and, if known, an estimate of the percentage of total U.S. imports of *Subject Merchandise* from the *Subject Country* accounted for by your firm's(s') imports;

(b) the quantity and value (f.o.b. U.S. port, including antidumping duties) of U.S. commercial shipments of *Subject Merchandise* imported from the *Subject Country;* and

(c) the quantity and value (f.o.b. U.S. port, including antidumping duties) of U.S. internal consumption/company transfers of *Subject Merchandise* imported from the *Subject Country.*

(11) If you are a producer, an exporter, or a trade/business association of producers or exporters of the *Subject Merchandise* in the *Subject Country,* provide the following information on your firm's(s') operations on that product during calendar year 2012 (report quantity data in units and value data in U.S. dollars, landed and duty-paid at the U.S. port but not including antidumping duties). If you are a trade/business association, provide the information, on an aggregate basis, for the firms which are members of your association.

(a) Production (quantity) and, if known, an estimate of the percentage of total production of *Subject Merchandise*

in the *Subject Country* accounted for by your firm's(s') production;

(b) Capacity (quantity) of your firm(s) to produce the *Subject Merchandise* in the *Subject Country* (i.e., the level of production that your establishment(s) could reasonably have expected to attain during the year, assuming normal operating conditions (using equipment and machinery in place and ready to operate), normal operating levels (hours per week/weeks per year), time for downtime, maintenance, repair, and cleanup, and a typical or representative product mix); and

(c) the quantity and value of your firm's(s') exports to the United States of *Subject Merchandise* and, if known, an estimate of the percentage of total exports to the United States of *Subject Merchandise* from the *Subject Country* accounted for by your firm's(s') exports.

(12) Identify significant changes, if any, in the supply and demand conditions or business cycle for the *Domestic Like Product* that have occurred in the United States or in the market for the *Subject Merchandise* in the *Subject Country* since the *Order Date,* and significant changes, if any, that are likely to occur within a reasonably foreseeable time. Supply conditions to consider include technology; production methods; development efforts; ability to increase production (including the shift of production facilities used for other products and the use, cost, or availability of major inputs into production); and factors related to the ability to shift supply among different national markets (including barriers to importation in foreign markets or changes in market demand abroad). Demand conditions to consider include end uses and applications; the existence and availability of substitute products; and the level of competition among the *Domestic Like Product* produced in the United States, *Subject Merchandise* produced in the *Subject Country,* and such merchandise from other countries.

(13) (OPTIONAL) A statement of whether you agree with the above definitions of the *Domestic Like Product* and *Domestic Industry;* if you disagree with either or both of these definitions, please explain why and provide alternative definitions.

Authority: This review is being conducted under authority of Title VII of the Tariff Act of 1930; this notice is published pursuant to section 207.61 of the Commission's rules.

By order of the Commission. Issued: November 26, 2013.

Lisa R. Barton,

Acting Secretary to the Commission.

[FR Doc. 2013–28793 Filed 11–29–13; 8:45 am]

BILLING CODE 7020–02–P

NATIONAL SCIENCE FOUNDATION

Agency Information Collection Activities: Comment Request

AGENCY: National Science Foundation.

ACTION: Submission for OMB review; comment request.

SUMMARY: The National Science Foundation (NSF) has submitted the following information collection requirement to OMB for review and clearance under the Paperwork Reduction Act of 1995, Pub. L. 104–13. This is the second notice for public comment; the first was published in the **Federal Register** at 78 FR 3453, and one comment was received. NSF is forwarding the proposed submission to the Office of Management and Budget (OMB) for clearance simultaneously with the publication of this second notice. The full submission (including comments) may be found at: *http://www.reginfo.gov/public/do/PRAMain.*

Comments: Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the Foundation, including whether the information will have practical utility; (b) the accuracy of the Foundation's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of automated collection techniques or other forms of information technology.

DATES: Written comments on this notice must be received by January 2, 2014, to be assured consideration. Comments received after that date will be considered to the extent practicable. Send comments to address below.

FOR FURTHER INFORMATION CONTACT: Ms. Suzanne H. Plimpton, Reports Clearance Officer, National Science Foundation, 4201 Wilson Boulevard, Suite 295, Arlington, Virginia 22230; telephone (703) 292–7556; or send email to *splimpto@nsf.gov.* Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339, which is accessible 24 hours a day, 7 days a week, 365 days a year (including federal holidays).

NSF may not conduct or sponsor a collection of information unless the collection of information displays a currently valid OMB control number and the agency informs potential persons who are to respond to the collection of information that such persons are not required to respond to the collection of information unless it displays a currently valid OMB control number.

SUPPLEMENTARY INFORMATION:

Comments: As required by 5 CFR 1320.8(d), comments on the information collection activities as part of this study were solicited through publication of a 60-Day Notice in the **Federal Register** on January 17, 2013, at 78 FR 3453. We received one comment, to which we here respond.

Comment and Response: The Council on Governmental Relations (COGR). The concerns raised by COGR were addressed by the Engineering Directorate at the National Science Board Task Force on Administrative Burdens meeting held on April 22, 2013. The Engineering Directorate acknowledged that, given the current guidelines, the original **Federal Register** notice for this EFRI project contained an error in using the word ''required'' and that it has since changed the request to the respondents from required to voluntary. In addition, the data collection requested here for the purpose of the pilot aims to undertake testing of the EFRI questionnaire by an objective, independent, third party to ensure that the questions asked have a format and scope that minimizes the burden on the respondents.

After consideration of this comment and action taken to mitigate the concerns raised, we are moving forward with our submission to OMB.

Title of Collection: Grantee Reporting Requirements for the Emerging Frontiers in Research and Innovation program.

OMB Number: 3145–NEW.

Type of Request: Intent to seek approval to establish an information collection system.

Abstract

Proposed Project: The Office of Emerging Frontiers in Research and Innovation (EFRI) has been established as a result of strategic planning and reorganization of NSF Engineering Directorate (ENG). Motivated by the vision of the Directorate for Engineering to be the global leader in advancing the frontiers of fundamental engineering research, Emerging Frontiers in Research and Innovation (EFRI) EFRI serves a critical role in focusing research

on important emerging areas in a timely manner. EFRI awards receive support of up to a total of $2,000,000 spread over four years. The EFRI program has awarded 215 research proposals since 2007.

The EFRI program is a relatively new and substantial funding initiative. Therefore, it is of great value to determine the effectiveness and outcomes of the program. This request for OMB approval is in reference to a pilot project to test the design and implementation of a questionnaire developed by the EFRI/ENG and OAD/ENG team. The EFRI/ENG team is seeking the assistance of an objective, independent, third party to evaluate that the questionnaire has a format and scope that minimizes the burden on the respondents. The questionnaire shall be evaluated for its effectiveness in capturing the data detailed in the EFRI logic model while streamlining the collection process and minimizing the burden to the PI, including eliminating any redundancies and overlap with indicators already collected in the NSF's standard reporting mechanism, the Research Performance Progress Report (RPPR). The purpose of the questionnaire being tested is to obtain, on a voluntary basis, the best data available on the outcomes of the funded research. Because of the very unique and innovative nature of the EFRI grants, we are seeking to collect additional longitudinal information from the grantees about their research that allows us to capture the unique goals and purpose of the program. This is very important to enable appropriate and accurate evaluation of the program and to determine whether or not the specific goals of the program are being met.

The questionnaire, built to reflect upon the EFRI logic model, address the following categories of activities: (1) Knowledge transfer across disciplines, (2) innovation of ideas in areas of greater opportunity, (3) potential for translational research, (4) project results advance the frontier/creation of new fields of study, (5) innovative research methods or discoveries are introduced to the classroom, and (6) fostering participation of underrepresented groups in science. For each of the categories the questionnaire collects information from the grantees on specific project outputs and outcomes.

Grantees will be asked to provide responses to the questions asked in the questionnaire on their progress, on a voluntary basis. To track the activity of EFRI grants, the questionnaire collects information on impact indicators. These indicators are both quantitative and descriptive and may include, for example, the achievements of EFRI investigators and students; characteristics of industrial and/or other sector participation; research, educational, and knowledge transfer impacts; patents, licenses; publications; new methods, significant advances, achievements and other outcomes of the EFRI effort.

Use of the Information: The data collected will be used for NSF internal reports, historical data, program level studies and evaluations, and for securing future funding for continued EFRI program maintenance and growth.

Estimate of Burden: No more than 8.5 hours per grant for no greater than 20 grants (including the time to collect the data and information).

Respondents: Principle Investigators that lead the EFRI grants, students and post-docs.

Estimated Number of Responses per Report: There are 14 questions in the questionnaire and an additional 7 questions in a student satisfaction survey.

Dated: November 26, 2013.

Suzanne H. Plimpton,

Reports Clearance Officer, National Science Foundation.

[FR Doc. 2013–28738 Filed 11–29–13; 8:45 am]

BILLING CODE 7555–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 50–391; Permit No. CPPR–92; NRC–2008–0369]

Tennessee Valley Authority Watts Bar Nuclear Plant Unit No. 2; Order Approving Extension of Construction Permit

I

Tennessee Valley Authority (TVA, the permittee) is the current holder of Construction Permit (CP) No. CPPR–92, issued by the Atomic Energy Commission (now the U.S. Nuclear Regulatory Commission (NRC or the Commission)) on January 23, 1973 (NRC's Agencywide Documents Access and Management System (ADAMS) Accession No. ML020780293), for construction of the Watts Bar Nuclear Plant (WBN), Unit 2. The NRC also issued CP No. CPPR–91 for construction of WBN Unit 1 on January 23, 1973 (ADAMS Accession No. ML020780293), and Facility Operating License NPF–90 was issued for operation of Unit 1 on February 7, 1996 (ADAMS Accession No. ML073460320). The WBN Unit 2 is currently partially completed. These facilities are at the permittee's site on the west branch of the Tennessee River, approximately 50 miles northeast of Chattanooga, Tennessee.

On May 17, 2012 (ADAMS Accession No. ML12143A346), TVA filed a request pursuant to Section 50.55(b) of Title 10 of the *Code of Federal Regulations* (10 CFR) for an extension of the CP completion date for WBN Unit 2 to September 30, 2016. The TVA requested this extension to the WBN Unit 2 construction permit for the following reasons, as stated in its application:

> In March 2012, TVA completed a detailed review of the status of WBN Unit 2 construction and developed a revised estimate of the time and resources necessary to complete the unit. This revised estimate was formed after months of analyses and consideration of numerous lessons learned as well as detailed analyses of remaining work associated with the Project. The estimate was then subjected to rigorous internal and independent external review which provided additional assurance and high confidence in a most likely WBN Unit 2 completion estimate of December 2015.

The letter also states:

> The only modification requested to Construction Permit CPPR–92 is the extension of the latest completion date. The extension would only allow TVA more time to complete the construction and testing of WBN Unit 2 that is already authorized under the existing construction permit. The extension would not allow any work of a type not previously authorized by the existing construction permit to be performed.

II

The NRC reviewed the request dated May 17, 2012. As discussed more fully in the staff's related safety evaluation, good cause has been shown for the delay, and the requested extension involves no significant hazards consideration.

The NRC staff has prepared an environmental assessment and made a final finding of no significant impact, which was published in the **Federal Register** on October 22, 2013 (78 FR 62,709). The NRC staff determined that extending the construction completion date will not have significant effect on the quality of the human environment and therefore, an environmental impact statement for the proposed action would not be prepared.

For further details regarding this action, see TVA's letter dated May 17, 2012, and the NRC staff's letter and safety evaluation of the requested extension dated November 21, 2013 (ADAMS Accession No. ML13175A308).

III

In accordance with 10 CFR 2.202, the Licensee, and any other person adversely affected by this Order, may

submit an answer to this Order within twenty (20) days of its publication in the **Federal Register**. In addition, the Licensee and any other person adversely affected by this Order may request a hearing of this Order within twenty (20) days of its publication in the **Federal Register**. Where good cause is shown, consideration will be given to extending the time to request a hearing. A request for extension of time must be made, in writing, to the Director, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, and include a statement of good cause for the extension.

The answer may consent to this Order. If an answer includes a request for a hearing, it shall, under oath or affirmation, specifically set forth the matters of fact and law on which the Licensee, or other adversely affected person, relies and the reasons as to why the Order should not have been issued. If a person other than the Licensee requests a hearing, that person shall set forth with particularity the manner in which his interest is adversely affected by this Order and shall address the criteria set forth in 10 CFR 2.309(d). The scope of a construction permit extension proceeding is limited to direct challenges to the permit holder's asserted reasons that show ''good cause'' justification for the delay.

If a hearing is requested by a licensee or a person whose interest is adversely affected, the Commission will issue an Order designating the time and place of any hearings. If a hearing is held, the issue to be considered at such hearing shall be whether this Order should be sustained. In the absence of any request for hearing, or any written approval of an extension of time in which to request a hearing, the provisions of this Order shall be final 20 days from the date this Order is published in the **Federal Register** without further order or proceedings. If an extension of time for requesting a hearing has been approved, the provisions specified in this Order shall be final when the extension expires if a hearing request has not been received.

IV

Described in 10 CFR 2.302 are the requirements for filing of documents. All documents filed in NRC adjudicatory proceedings, including a request for hearing, a petition for leave to intervene, any motion or other document filed in the proceeding prior to the submission of a request for hearing or petition to intervene, and documents filed by interested governmental entities participating under 10 CFR 2.315(c), must be filed in accordance with the NRC E-Filing rule (72 FR 49139, August 28, 2007). The E-Filing process requires participants to submit and serve all adjudicatory documents over the internet, or in some cases to mail copies on electronic storage media. Participants may not submit paper copies of their filings unless they seek an exemption in accordance with the procedures described below.

To comply with the procedural requirements of E-Filing, at least ten 10 days prior to the filing deadline, the participant should contact the Office of the Secretary by email at *hearing.docket@nrc.gov,* or by telephone at 301–415–1677, to request (1) a digital identification (ID) certificate, which allows the participant (or its counsel or representative) to digitally sign documents and access the E-Submittal server for any proceeding in which it is participating; and (2) advise the Secretary that the participant will be submitting a request or petition for hearing (even in instances in which the participant, or its counsel or representative, already holds an NRC-issued digital ID certificate). Based upon this information, the Secretary will establish an electronic docket for the hearing in this proceeding if the Secretary has not already established an electronic docket.

Information about applying for a digital ID certificate is available on the NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals/apply-certificates.html.* System requirements for accessing the E-Submittal server are detailed in the NRC's ''Guidance for Electronic Submission,'' which is available on the agency's public Web site at *http://www.nrc.gov/site-help/e-submittals.html.* Participants may attempt to use other software not listed on the Web site, but should note that the NRC's E-Filing system does not support unlisted software, and the NRC Meta System Help Desk will not be able to offer assistance in using unlisted software.

If a participant is electronically submitting a document to the NRC in accordance with the E-Filing rule, the participant must file the document using the NRC's online, Web-based submission form. In order to serve documents through the Electronic Information Exchange System, users will be required to install a Web browser plug-in from the NRC's Web site. Further information on the Web-based submission form, including the installation of the Web browser plug-in, is available on the NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals.html.*

Once a participant has obtained a digital ID certificate and a docket has been created, the participant can then submit a request for hearing or petition for leave to intervene. Submissions should be in Portable Document Format (PDF) in accordance with NRC guidance available on the NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals.html.* A filing is considered complete at the time the documents are submitted through the NRC's E-Filing system. To be timely, an electronic filing must be submitted to the E-Filing system no later than 11:59 p.m. Eastern Time on the due date. Upon receipt of a transmission, the E-Filing system time-stamps the document and sends the submitter an email notice confirming receipt of the document. The E-Filing system also distributes an email notice that provides access to the document to the NRC's Office of the General Counsel and any others who have advised the Office of the Secretary that they wish to participate in the proceeding, so that the filer need not serve the documents on those participants separately. Therefore, applicants and other participants (or their counsel or representative) must apply for and receive a digital ID certificate before a hearing request/petition to intervene is filed so that they can obtain access to the document via the E-Filing system.

A person filing electronically using the NRC's adjudicatory E-Filing system may seek assistance by contacting the NRC Meta System Help Desk through the ''Contact Us'' link located on the NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals.html,* by email to *MSHD.Resource@nrc.gov,* or by a toll-free call at 866–672–7640. The NRC Meta System Help Desk is available between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday, excluding government holidays.

Participants who believe that they have a good cause for not submitting documents electronically must file an exemption request, in accordance with 10 CFR 2.302(g), with their initial filing requesting authorization to continue to use alternate format and transmission of documents. Such filings must be submitted by: (1) First class mail addressed to the Office of the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, Attention: Rulemakings and Adjudications Staff, or (2) courier, express mail, or expedited delivery service to the Office of the Secretary, 16th Floor, One White Flint North,

11555 Rockville Pike, Rockville, MD 20852, Attention: Rulemakings and Adjudications Staff. Participants filing a document in this manner are responsible for serving the document on all other participants. Filing is considered complete by first-class mail as of the time of deposit in the mail, or by courier, express mail, or expedited delivery service upon depositing the document with the provider of the service. A presiding officer, having granted an exemption request from using E-Filing, may require a participant or party to use E-Filing if the presiding officer subsequently determines that the reason for granting the exemption from use of E-Filing no longer exists.

Documents submitted in adjudicatory proceedings will appear in the NRC's electronic hearing docket which is available to the public at *http://ehd1.nrc.gov/ehd/,* unless excluded pursuant to an order of the Commission, or the presiding officer. Participants are requested not to include personal privacy information, such as social security numbers, home addresses, or home phone numbers in their filings, unless an NRC regulation or other law requires submission of such information. With respect to copyrighted works, except for limited excerpts that serve the purpose of the adjudicatory filings and would constitute a Fair Use application, participants are requested not to include copyrighted materials in their submission.

V

Copies of the application to extend the completion date in the CP for WBN Unit 2 are available for public inspection at the NRC's PDR, located at One White Flint North, Room O1–F21, 11555 Rockville Pike (first floor), Rockville, MD 20852. The application may be accessed in ADAMS through the NRC Library at *http://www.nrc.gov/reading-rm/adams.html* under ADAMS Accession No. ML12143A346. Persons who do not have access to ADAMS or who encounter problems in accessing the documents located in ADAMS, should contact the NRC's PDR reference staff by telephone at 1–800–397–4209, or 301–415–4737, or by email to *PDR.Resource@nrc.gov.*

Attorney for the permit holder: Ralph Rodgers, Executive Vice President and General Counsel, Tennessee Valley Authority, 400 West Summit Hill Drive, Knoxville, TN 37902.

VI

It is hereby ordered that the latest completion date for CP No. CPPR–92 is extended from March 31, 2013, to September 30, 2016.

Dated at Rockville, Maryland, this 21st day of November 2013.

For the Nuclear Regulatory Commission.

Eric J. Leeds,

Director, Office of Nuclear Reactor Regulation.

[FR Doc. 2013–28813 Filed 11–29–13; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2013–0262]

Draft Emergency Preparedness Frequently Asked Questions

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of availability and opportunity for public comment.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is making available for comment Emergency Preparedness Frequently Asked Question (EPFAQ) No. 2013–008. This EPFAQ will be used to provide clarification of guidance documents related to the development and maintenance of emergency preparedness program elements. The NRC is publishing these preliminary results to inform the public and solicit comments.

DATES: Submit comments by January 2, 2014. Comments submitted after this date will be considered if it is practical to do so, but assurance of consideration cannot be given except for comments received on or before this date.

ADDRESSES: You may submit comments by any of the following methods (unless this document describes a different method for submitting comments on a specific subject):

- *Federal Rulemaking Web site:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2013–0262. Address questions about NRC dockets to Carol Gallagher; telephone: 301–287–3422; email: *Carol.Gallagher@nrc.gov.* For technical questions, contact the individual(s) listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.
- *Mail comments to:* Cindy Bladey, Chief, Rules, Announcements, and Directives Branch (RADB), Office of Administration, Mail Stop: 3WFN–06–44M, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.

For additional direction on accessing information and submitting comments, see ''Accessing Information and Submitting Comments'' in the SUPPLEMENTARY INFORMATION section of this document.

FOR FURTHER INFORMATION CONTACT: Carolyn Kahler, Office of Nuclear Security and Incident Response, telephone: 301–287–3722 or by email at: *carolyn.kahler@nrc.gov;* U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.

SUPPLEMENTARY INFORMATION:

I. Accessing Information and Submitting Comments

A. Accessing Information

Please refer to Docket ID NRC–2013–0262 when contacting the NRC about the availability of information regarding this document. You may access publicly-available information related to this document by any of the following methods:

- *Federal Rulemaking Web site:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2013–0262.
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may access publicly available documents online in the NRC Library at *http://www.nrc.gov/reading-rm/adams.html.* To begin the search, select ''*ADAMS Public Documents''* and then select ''*Begin Web-based ADAMS Search.''* For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, 301–415–4737, or by email to *pdr.resource@nrc.gov.* The ADAMS accession number for each document referenced in this document (if that document is available in ADAMS) is provided the first time that a document is referenced. The draft EPFAQ is available electronically under ADAMS Accession Number ML13323B458, and is available on the NRC's Web site at *http://www.nrc.gov/about-nrc/emerg-preparedness/faq/faq-contactus.html.*
- *NRC's PDR:* You may examine and purchase copies of public documents at the NRC's PDR, Room O1–F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852.

B. Submitting Comments

Please include Docket ID NRC–2013–0262 in the subject line of your comment submission, in order to ensure that the NRC is able to make your comment submission available to the public in this docket.

The NRC cautions you not to include identifying or contact information that you do not want to be publicly disclosed in you comment submission. The NRC will post all comment submissions at *http://www.regulations.gov* as well as enter the

comment submissions into ADAMS. The NRC does not routinely edit comment submissions to remove identifying or contact information.

If you are requesting or aggregating comments from other persons for submission to the NRC, then you should inform those persons not to include identifying or contact information that they do not want to be publicly disclosed in their comment submission. Your request should state that the NRC does not routinely edit comment submissions to remove such information before making the comment submissions available to the public or entering the comment submissions into ADAMS.

II. Background

The NRC is requesting comment on this draft EPFAQ. This process is intended to describe the manner in which the NRC may provide interested outside parties an opportunity to share their individual views with NRC staff regarding the appropriate response to questions raised on the interpretation or applicability of emergency preparedness guidance issued or endorsed by the NRC, before the NRC issues an official response to such questions.

Dated at Rockville, Maryland on November 22, 2013.

For the Nuclear Regulatory Commission.

Scott Morris,

Deputy Director, Division of Preparedness and Response, Office of Nuclear Security and Incident Response.

[FR Doc. 2013–28816 Filed 11–29–13; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Request To Amend a License to Export High-Enriched Uranium

Pursuant to 10 CFR 110.70 (b) ''Public Notice of Receipt of an Application,'' please take notice that the Nuclear Regulatory Commission (NRC) has received the following request for an export license amendment. Copies of the request are available electronically through ADAMS and can be accessed through the Public Electronic Reading Room (PERR) link *http://www.nrc.gov/reading-rm.html* at the NRC Homepage.

A request for a hearing or petition for leave to intervene may be filed within thirty days after publication of this notice in the **Federal Register**. Any request for hearing or petition for leave to intervene shall be served by the requestor or petitioner upon the applicant, the Office of the General Counsel, U.S. Nuclear Regulatory Commission, Washington, DC 20555; the Office of the Secretary, U.S. Nuclear Regulatory Commission, Washington, DC 20555; and the Executive Secretary, U.S. Department of State, Washington, DC 20520.

A request for a hearing or petition for leave to intervene may be filed with the NRC electronically in accordance with NRC's E-Filing rule promulgated in August 2007, 72 Fed. Reg 49139 (Aug. 28, 2007). Information about filing electronically is available on the NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals.html.* To ensure timely electronic filing, at least 5 (five) days prior to the filing deadline, the petitioner/requestor should contact the Office of the Secretary by email at *HEARINGDOCKET@NRC.GOV,* or by calling (301) 415–1677, to request a digital ID certificate and allow for the creation of an electronic docket.

In addition to a request for hearing or petition for leave to intervene, written comments, in accordance with 10 CFR 110.81, should be submitted within thirty (30) days after publication of this notice in the **Federal Register** to Office of the Secretary, U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Rulemaking and Adjudications.

The information concerning this export license amendment application follows.

NRC EXPORT LICENSE AMENDMENT APPLICATION

Name of Applicant, Date of Application, Date Received, Application No., Docket No.	Description of Material			
	Material type	Total quantity	End use	Recipient country
U.S. Department of Energy, National Nuclear Security Administration, October 16, 2013, October 18, 2013, XSNM3729/01, 11006053.	High-Enriched Uranium (HEU) (Maximum of 93.35%).	13.5 kilograms uranium (12.615 kilograms U–235).	To manufacture HEU targets in France for irradiation in research reactors for production of molybdenum-99 (Mo-99) medical isotopes in the Institute for Radioelements in Belgium. Amend to: 1) increase the quantity of HEU authorized for export from 5.8 kg of U–235 contained in 6.2 kg uranium to a new cumulative total of 12.615 kg of U–235 contained in 13.5 kg uranium; 2) increase maximum enriched uranium quantity from 93.2% to 93.35%; and 3) add LVR–15 Research Reactor in the Czech Republic and Maria Research Reactor in Poland to the list of ''Intermediate Foreign Consignees(s).''	Belgium.

For The Nuclear Regulatory Commission.

Dated this 25th day of November 2013 at Rockville, Maryland.

Stephen Dembek,

Acting Director, Office of International Programs.

[FR Doc. 2013–28820 Filed 11–29–13; 8:45 am]

BILLING CODE 7590–01–P

OVERSEAS PRIVATE INVESTMENT CORPORATION

Sunshine Act Cancellation Notice—OPIC December 4, 2013 Public Hearing

OPIC's Sunshine Act notice of its Public Hearing in Conjunction with each Board meeting was published in the **Federal Register** (Volume 78, Number 219, Page 68103) on November 13, 2013. No requests were received to provide testimony or submit written statements for the record; therefore, OPIC's public hearing scheduled for 2 p.m., December 4, 2013 in conjunction with OPIC's December 12, 2013 Board of Directors meeting has been cancelled.

Contact Person for Information: Information on the hearing cancellation may be obtained from Connie M. Downs at (202) 336–8438, or via email at *Connie.Downs@opic.gov.*

Dated: November 27, 2013.

Connie M. Downs,

OPIC Corporate Secretary.

[FR Doc. 2013–28901 Filed 11–27–13; 4:15 pm]

BILLING CODE 3210–01–P

PEACE CORPS

Information Collection Request; Submission for OMB Review

AGENCY: Peace Corps.

ACTION: 60-day notice and request for comments.

SUMMARY: The Peace Corps will be submitting the following information collection request to the Office of Management and Budget (OMB) for review and approval. The purpose of this notice is to allow 60 days for public comment in the **Federal Register** preceding submission to OMB. We are conducting this process in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

DATES: Comments must be submitted on or before January 31, 2014.

ADDRESSES: Comments should be addressed to Denora Miller, FOIA/Privacy Act Officer. Denora Miller can be contacted by telephone at 202–692–1236 or email at *pcfr@peacecorps.gov*. Email comments must be made in text and not in attachments.

FOR FURTHER INFORMATION CONTACT: Denora Miller at Peace Corps address above.

SUPPLEMENTARY INFORMATION:

Method: Applicants gain access to the form via a secure online portal. Applicants have to download the form for their health care provider to complete. The completed form can be scanned and uploaded back into the Applicant's secure Peace Corps online portal or they can be faxed or mailed to the Peace Corps Office of Medical Services.

Title: Peace Corps Report of Physical Examination (PC 1790S)

OMB Control Number: 0420–0549

Type of Request: Extension without change of a currently approved collection.

Affected Public: Individuals/Physicians.

Respondents Obligation to Reply: Voluntary.

Burden to the Public:

a. Estimated number of respondents/physicians: 4,000/4,000.
b. Estimated average burden per response: 90 minutes/45 minutes.
c. Frequency of response: one time.
d. Annual reporting burden: 6,000 hours/3,000 hours.
e. Estimated annual cost to respondents: Indeterminate

General Description of Collection: The Peace Corps Act requires that Volunteers receive health examinations prior to their service. The information collected is required for consideration for Peace Corps Volunteer service. After completion of the Health History Form and after passing preliminary non-health-related assessments, the Applicant will be ''nominated'' to a program. This nomination does not guarantee an invitation to serve, but it does hold a place so the Applicant may proceed with the process. After a review by the Peace Corps pre-service medical staff of the Health History Form and any supplemental forms that the Applicant is required to submit following nomination (covered under OMB control number 0420–0510), the Applicant may be medically pre-cleared. An Applicant who is medically pre-cleared and who accepts an invitation to serve as a Peace Corps Volunteer undergoes a final medical clearance. Final medical clearance is on the basis of a complete physical examination, as documented in a Report of Physical Examination (PC–1790S).

The information contained in the Report of Physical Examination will be used to make an individualized determination as to whether an Applicant for Volunteer service will, with reasonable accommodation, be able to perform the essential functions of a Peace Corps Volunteer and complete a tour of service without undue disruption due to health problems and, if so, to establish the level of medical and other support, if any, that may be required to reasonably accommodate the Applicant.

Request For Comment: Peace Corps invites comments on whether the proposed collections of information are necessary for proper performance of the functions of the Peace Corps, including whether the information will have practical use; the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the information to be collected; and, ways to minimize the burden of the collection of information on those who are to respond, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

This notice is issued in Washington, DC, on November 21, 2013.

Denora Miller,

FOIA/Privacy Act Officer, Management.

[FR Doc. 2013–28731 Filed 11–29–13; 8:45 am]

BILLING CODE 6051–01–P

PEACE CORPS

Information Collection Request; Submission for OMB Review

AGENCY: Peace Corps.

ACTION: 60-day notice and request for comments.

SUMMARY: The Peace Corps will be submitting the following information collection request to the Office of Management and Budget (OMB) for review and approval. The purpose of this notice is to allow 60 days for public comment in the **Federal Register** preceding submission to OMB. We are conducting this process in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

DATES: Comments must be submitted on or before January 31, 2014.

ADDRESSES: Comments should be addressed to Denora Miller, FOIA/Privacy Act Officer. Denora Miller can be contacted by telephone at 202–692–1236 or email at *pcfr@peacecorps.gov*. Email comments must be made in text and not in attachments.

FOR FURTHER INFORMATION CONTACT: Denora Miller at Peace Corps address above.

SUPPLEMENTARY INFORMATION:

Method: The Health History Form will be completed online in an interactive process in which only questions relevant to each Applicant's medical history (based on responses to previous questions) are presented.

Title: Peace Corps Volunteer Health History Form (PC 1789).

OMB Control Number: 0420–0510.

Type of Request: Extension without change of a currently approved collection.

Affected Public: Individuals.

Respondents Obligation to Reply: Voluntary.

Burden to the Public:

a. Estimated number of respondents: 10,000.
b. Estimated average burden per response: 45 minutes.
c. Frequency of response: one time.
d. Annual reporting burden: 7,500 hours.
e. Estimated annual cost to respondents: Indeterminate.

General Description of Collection: The Peace Corps Act requires that Volunteers receive health examinations prior to their service. The information collected is required for consideration for Peace Corps Volunteer service. The Health History Form is used to document the medical history of each individual Applicant. It is a self-report of pre-existing medical conditions and

is used to help determine whether the Applicant will, with reasonable accommodation, be able to perform the essential functions of a Peace Corps Volunteer and complete a tour of service without undue disruption due to health problems.

Request For Comment: Peace Corps invites comments on whether the proposed collections of information are necessary for proper performance of the functions of the Peace Corps, including whether the information will have practical use; the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the information to be collected; and, ways to minimize the burden of the collection of information on those who are to respond, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

This notice is issued in Washington, DC on November 21, 2013.

Denora Miller,

FOIA/Privacy Act Officer, Management.

[FR Doc. 2013–28732 Filed 11–29–13; 8:45 am]

BILLING CODE 6051–01–P

PEACE CORPS

Information Collection Request; Submission for OMB Review

AGENCY: Peace Corps.

ACTION: 60-Day notice and request for comments.

SUMMARY: The Peace Corps will be submitting the following information collection request to the Office of Management and Budget (OMB) for review and approval. The purpose of this notice is to allow 60 days for public comment in the **Federal Register** preceding submission to OMB. We are conducting this process in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

DATES: Comments must be submitted on or before January 31, 2014.

ADDRESSES: Comments should be addressed to Denora Miller, FOIA/Privacy Act Officer, Peace Corps, 1111 20th Street NW., Washington, DC 20526. Denora Miller can be contacted by telephone at 202–692–1236 or email at *pcfr@peacecorps.gov.* Email comments must be made in text and not in attachments.

FOR FURTHER INFORMATION CONTACT: Denora Miller at Peace Corps address above.

SUPPLEMENTARY INFORMATION: Volunteers serve in developing countries where western-style healthcare is often not available. Volunteers are placed in remote locations where they may suffer hardship because they have no access to running water and/or electricity. They also may be placed in locations with extreme environmental conditions related to cold, heat or high altitude and they may be exposed to diseases not generally found in the U.S. Volunteers may be placed many hours from the Peace Corps medical office and not have easy access to any health care provider. Therefore, a thorough review of an Applicant's past medical history is an essential first step to determine their suitability for service in Peace Corps.

The forms listed below may be sent to an individual Applicant at one of the following times in the medical review process: (1) After the Applicant completes the Health History Form and receives a nomination; (2) after a Peace Corps nurse reviews the Applicant's Health History Form and any completed forms previously requested; or (3) at the time of the Applicant's physical examination. The information contained in the specific medical evaluation forms will be used to make an individualized determination as to whether an Applicant for Volunteer service will, with reasonable accommodation, be able to meet the essential eligibility requirements for a Peace Corps Volunteer and complete a tour of service without undue disruption due to health problems.

Method: Applicants gain access to the forms via a secure online portal. Applicants will have to download the forms for their health care providers to complete. Completed forms can be scanned and uploaded back into the Applicant's secure Peace Corps online portal or they can be faxed or mailed to the Peace Corps Office of Medical Services.

Title: Individual Specific Medical Evaluation Forms (16).

OMB Control Number: 0420–0550.

Type of Request: Extension without change of a currently approved collection.

Affected Public: Individuals/Physicians.

Respondents' Obligation to Reply: Voluntary.

Burden to the Public

- Allergy Treatment Form

(a) Estimated number of Applicants/physicians: 100/100.

(b) Frequency of response: one time.

(c) Estimated average burden per response: 20 minutes/10 minutes.

(d) Estimated total reporting burden: 33.3 hours/16.7 hours.

(e) Estimated annual cost to respondents: Indeterminate.

General Description of Collection: When an Applicant reports that he or she is currently receiving allergy shot treatments, Peace Corps provides the Applicant with an Allergy Treatment Form for his or her treating physician to complete. The Peace Corps is not able to arrange for Volunteers to receive allergy shots during their Peace Corps service. Peace Corps Volunteers generally serve in areas that are isolated and have limited access to Western-trained providers and health care systems. The Applicant completes the form after discussing with his or her physician whether the Applicant will be able to live overseas for 27 months of Peace Corps service without receiving allergy shots. The Applicant is required to certify that the Applicant has discussed stopping allergy shots with his or her physician and that the physician agrees that the allergy shots can be stopped without unreasonable risk of substantial harm to the Applicant's health.

- Asthma Evaluation Form

(a) Estimated number of Applicants/physicians: 500/500.

(b) Frequency of response: One time.

(c) Estimated average burden per response: 75 minutes/30 minutes.

(d) Estimated total reporting burden: 625 hours/250 hours.

(e) Estimated annual cost to respondents: Indeterminate.

General Description of Collection: When an Applicant reports on the Health History Form symptoms of moderate persistent or severe persistent asthma in the past two years, he or she is provided an Asthma Evaluation Form for the treating physician to complete. The determination of whether the reported symptoms indicate moderate persistent or severe persistent asthma is based on recognized classifications of asthma severity. The Asthma Evaluation Form asks for the physician to document the Applicant's condition of asthma, including any asthma symptoms, triggers, treatments, or limitations or restrictions due to the condition, as well as to certify that the Applicant can safely serve 27 months overseas. This form is used as the basis for an individualized determination as to whether the Applicant will, with reasonable accommodation, be able to meet the essential eligibility requirements for a Peace Corps Volunteer and complete a tour of service without undue disruption due to health problems. This form is also used to determine the type of accommodation that may be needed, such as placement

of the Applicant within reasonable proximity to a hospital in case treatment is needed for a severe asthma attack.

• Diabetes Diagnosis Form

(a) Estimated number of Applicants/physicians: 36/36.
(b) Frequency of response: One time.
(c) Estimated average burden per response: 75 minutes/30 minutes.
(d) Estimated total reporting burden: 45 hours/18 hours.
(e) Estimated annual cost to respondents: Indeterminate.
General Description of Collection: When an Applicant reports the condition of diabetes Type 1 on the Health History Form, the Applicant is provided a Diabetes Diagnosis Form for the treating physician to complete. In certain cases, the Applicant may also be asked to have the treating physician complete a Diabetes Diagnosis Form if the Applicant reports the condition of diabetes Type 2 on the Health History Form. The Diabetes Diagnosis Form asks the physician to document the diabetes diagnosis, etiology, possible complications, and treatment, as well as to certify that the Applicant can safely serve 27 months overseas. This form is used as the basis for an individualized determination as to whether the Applicant will, with reasonable accommodation, be able to meet the essential eligibility requirements for a Peace Corps Volunteer and complete a tour of service without undue disruption due to health problems. This form is also used to determine the type of accommodation that may be needed, such as placement of an Applicant who requires the use of insulin in order to ensure that adequate insulin storage facilities are available at the Applicant's site.

• Disease Diagnosis Form

(a) Estimated number of Applicants/physicians: 400/400.
(b) Frequency of response: One time.
(c) Estimated average burden per response: 75 minutes/30 minutes.
(d) Estimated total reporting burden: 500 hours/200 hours.
(e) Estimated annual cost to respondents: Indeterminate.
General Description of Collection: When an Applicant reports on the Health History Form a medical condition of significant severity (other than one covered by another form), he or she may be provided a Disease Diagnosis Form for the treating physician to complete. The Disease Diagnosis Form may also be provided to an Applicant whose responses on the Health History Form indicate that the Applicant may have an unstable medical condition that requires ongoing treatment. The Disease Diagnosis Form asks the physician to document the diagnosis, etiology, possible complications and treatment, as well as to certify that the Applicant can safely serve 27 months overseas. This form is used as the basis for an individualized determination as to whether the Applicant will, with reasonable accommodation, be able to meet the essential eligibility requirements for a Peace Corps Volunteer and complete a tour of service without undue disruption due to health problems. This form is also used to determine the type of accommodation that may be needed, such as placement of an Applicant to take account of the Applicant's medical condition (e.g., avoidance of high altitudes or proximity to a hospital).

• Low Body Mass Index Evaluation Form

(a) Estimated number of Applicants/physicians: 50/50.
(b) Frequency of response: One time.
(c) Estimated average burden per response: 105 minutes/60 minutes.
(d) Estimated total reporting burden: 87.5 hours/50 hours.
(e) Estimated annual cost to respondents: Indeterminate.
General Description of Collection: When an Applicant reports a height and weight on the Health History Form consistent with a body mass index (BMI) that is below 17 for women and 18 for men, the Applicant will be provided a Low Body Mass Index Evaluation Form for a physician to complete. The Low Body Mass Index Evaluation Form asks the physician to indicate whether the Applicant's low BMI is indicative of any condition which could be exacerbated during Peace Corps service. This form is used as the basis for an individualized determination as to whether the Applicant will, with reasonable accommodation, be able to meet the essential eligibility requirements for a Peace Corps Volunteer and complete a tour of service without undue disruption due to health problems. Based on the information on the completed form, the Peace Corps may determine that further medical assessments are required.

• Mental Health Treatment Summary Form

(a) Estimated number of Applicants/physicians: 150/150.
(b) Frequency of response: One time.
(c) Estimated average burden per response: 105 minutes/60 minutes.
(d) Estimated total reporting burden: 262.5 hours/150 hours.
(e) Estimated annual cost to respondents: Indeterminate.
General Description of Collection: The Mental Health Treatment Form is used when an Applicant reports on the Health History Form a history of certain serious mental health conditions, such as bipolar disorder, schizophrenia, mental health hospitalization, attempted suicide or cutting, or treatments or medications related to these conditions. In these cases, an Applicant is provided a Mental Health Treatment Summary Form for a licensed mental health counselor, psychiatrist or psychologist to complete. The Mental Health Treatment Summary Form asks the counselor, psychiatrist or psychologist to document the dates and frequency of therapy sessions, clinical diagnoses, symptoms, course of treatment, psychotropic medications, mental health history, level of functioning, prognosis, risk of exacerbation or recurrence while overseas, recommendations for follow up and any concerns that would prevent the Applicant from completing 27 months of service without undue disruption. This form is used as the basis for an individualized determination as to whether the Applicant will, with reasonable accommodation, be able to meet the essential eligibility requirements for a Peace Corps Volunteer and complete a tour of service without undue disruption due to health problems. This form is also used to determine the type of accommodation that may be needed, such as placement of the Applicant in a country with appropriate mental health support.

• Eating Disorder Treatment Summary Form

(a) Estimated number of Applicants/physicians: 232/232.
(b) Frequency of response: One time.
(c) Estimated average burden per response: 105 minutes/60 minutes.
(d) Estimated total reporting burden: 406 hours/232 hours.
(e) Estimated annual cost to respondents: Indeterminate.
General Description of Collection: The Eating Disorder Treatment Summary Form is used when an Applicant reports a past or current eating disorder diagnosis in the Health History Form. In these cases the Applicant is provided an Eating Disorder Treatment Summary Form for a mental health specialist, preferably with eating disorder training, to complete. The Eating Disorder Treatment Summary Form asks the mental health specialist to document the dates and frequency of therapy sessions, clinical diagnoses, presenting problems and precipitating factors,

symptoms, Applicant's weight over the past three years, relevant family history, course of treatment, psychotropic medications, mental health history inclusive of eating disorder behaviors, level of functioning, prognosis, risk of recurrence in a stressful overseas environment, recommendations for follow up, and any concerns that would prevent the Applicant from completing 27 months of service without undue disruption due to the diagnosis. This form is used as the basis for an individualized determination as to whether the Applicant will, with reasonable accommodation, be able to meet the essential eligibility requirements for a Peace Corps Volunteer and complete a tour of service without undue disruption due to health problems. This form is also used to determine the type of accommodation that may be needed, such as placement of the Applicant in a country with appropriate mental health support.

• Mental Health Current Evaluation Form

(a) Estimated number of Applicants/professional: 439/439.

(b) Frequency of response: One time.

(c) Estimated average burden per response: 265 minutes/180 minutes.

(d) Estimated total reporting burden: 1,939 hours/1,317 hours.

(e) Estimated annual cost to respondents: Indeterminate.

General Description of Collection: The Mental Health Current Evaluation Form is used when an Applicant reports a mental health condition in the Health History Form and it is determined that a current mental health evaluation is needed. A current mental health evaluation might be needed if information on the condition is outdated or previous reports on the condition do not provide enough information to adequately assess the current status of the condition. In these cases, the Applicant will be provided a Mental Health Current Evaluation Form for a licensed mental health counselor, psychiatrist or psychologist to complete over one to three evaluation sessions. The Mental Health Current Evaluation Form asks the mental health professional to document the clinical diagnoses, presenting symptoms, risk of recurrence in a stressful overseas environment, coping strategies, evaluation of overall functioning, psychotropic medications, current psychological tests administered, recommendations for follow up, and any concerns that would prevent the Applicant from completing 27 months of service without undue disruption due to the diagnosis. This form is used as the basis for an individualized determination as to whether the Applicant will, with reasonable accommodation, be able to meet the essential eligibility requirements for a Peace Corps Volunteer and complete a tour of service without undue disruption due to health problems. This form is also used to determine the type of accommodation that may be needed, such as placement of the Applicant in a country with appropriate mental health support.

• Alcohol/Substance Abuse Evaluation Form

(a) Estimated number of Applicants/specialist: 100/100.

(b) Frequency of response: One time.

(c) Estimated average burden per response: 165 minutes/60 minutes.

(d) Estimated total reporting burden: 275 hours/100 hours.

(e) Estimated annual cost to respondents: Indeterminate.

General Description of Collection: The Alcohol/Substance Abuse Current Evaluation Form is used when an Applicant reports in the Health History Form a history of substance abuse (i.e., alcohol or drug related problems such as blackouts, daily or heavy drinking patterns or the misuse of illegal or prescription drugs) and that this substance abuse affects the Applicant's daily living or that the Applicant has ongoing symptoms of substance abuse. In these cases, the Applicant is provided an Alcohol/Substance Abuse Current Evaluation Form for a substance abuse specialist to complete. The Alcohol/Substance Abuse Current Evaluation Form asks the substance abuse specialist to document the history of alcohol/substance abuse, dates and frequency of any therapy sessions, which alcohol/substance abuse assessment tools were administered, mental health diagnoses, psychotropic medications, self-harm behavior, current clinical assessment of alcohol/substance use, clinical observations, risk of recurrence in a stressful overseas environment, recommendations for follow up, and any concerns that would prevent the Applicant from completing 27 months of service without undue disruption due to the diagnosis. This form is used as the basis for an individualized determination as to whether the Applicant will, with reasonable accommodation, be able to meet the essential eligibility requirements for a Peace Corps Volunteer and complete a tour of service without undue disruption due to health problems. This form is also used to determine the type of accommodation that may be needed, such as placement of the Applicant in a country with appropriate sobriety support or counseling support.

• Mammogram Form

(a) Estimated number of Applicants: 224.

(b) Frequency of response: One time.

(c) Estimated average burden per response: 105 minutes.

(d) Estimated total reporting burden: 392 hours.

(e) Estimated annual cost to respondents: Indeterminate.

General Description of Collection: The Mammogram Form is used with all female Applicants who will be 50 years of age or older, who have received invitations to serve as Volunteers. The purpose of the form is to provide the Peace Corps with results of the Applicant's latest mammogram and to record the wishes of the Applicant regarding routine mammogram screening during service. The Peace Corps uses the information in the Mammogram Form to determine if the Applicant currently has breast cancer and to ascertain whether the Applicant wishes to receive routine mammogram screening while in service. A female Applicant who wishes to receive routine mammogram screening during service will be limited to being placed in a country with mammogram screening capabilities. If the Applicant waives routine mammogram screening during service, the Applicant's physician also completes this form in order to confirm that the physician has reviewed the Applicant's risk factor assessment and discussed the results with the Applicant and concurs that foregoing screening mammography represents an acceptable risk.

• Pap Screening Form

(a) Estimated number of Applicants/physicians: 2,695/2,695.

(b) Frequency of response: One time.

(c) Estimated average burden per response: 25 minutes/15 minutes.

(d) Estimated total reporting burden: 1,123 hours/674 hours.

(e) Estimated annual cost to respondents: Indeterminate.

General Description of Collection: The Pap Screening Form is used with all female Applicants who have received invitations to serve as Volunteers. They are required to obtain a Pap examination within four months prior to their departure. This form assists the Peace Corps in determining whether a female Applicant with mildly abnormal Pap results will need to be placed in a country with appropriate Pap follow-up capabilities.

• Colon Cancer Screening Form

(a) Estimated number of Applicants: 354.
(b) Frequency of response: One time.
(c) Estimated average burden per response: 60 minutes—165 minutes.
(d) Estimated total reporting burden: 354 hours—973.5 hours.
(e) Estimated annual cost to respondents: Indeterminate.

General Description of Collection: The Colon Cancer Screening Form is used with all Applicants who are 50 years of age or older who have received invitations to serve as Volunteers. The purpose of the form is to provide the Peace Corps with the results of the Applicant's latest colon cancer screening. Any testing deemed appropriate by the American Cancer Society is accepted. The Peace Corps uses the information in the Colon Cancer Screening Form to determine if the Applicant currently has colon cancer. Additional instructions are included pertaining to abnormal test results.

• ECG Form

(a) Estimated number of Applicants/physicians: 354/354.
(b) Frequency of response: One time.
(c) Estimated average burden per response: 25 minutes/15 minutes.
(d) Estimated total reporting burden: 147.5 hours/88.5 hours.
(e) Estimated annual cost to respondents: Indeterminate.

General Description of Collection: The ECG Form is used with all Applicants who are 50 years of age or older, who have received invitations to serve as Volunteers. The purpose of the form is to provide the Peace Corps with the results of an electrocardiogram. The Peace Corps uses the information in the electrocardiogram to assess whether the Applicant has any cardiac abnormalities that might affect the Applicant's service. Additional instructions are included pertaining to abnormal test results. The electrocardiogram is performed as part of the Applicant's physical examination.

• Reactive Tuberculin Test Evaluation Form

(a) Estimated number of Applicants/physicians: 352/352.
(b) Frequency of response: One time.
(c) Estimated average burden per response: 75–105 minutes/30 minutes.
(d) Estimated total reporting burden: 440–616 hours/176 hours.
(e) Estimated annual cost to respondents: Indeterminate.

General Description of Collection: The Reactive Tuberculin Test Evaluation Form is used when an Applicant, who has received an invitation to serve as Volunteer, reports a history of reactivity to tuberculosis skin testing or a history of BCG vaccination in the Health History Form or if a reactivity is discovered as part of the Applicant's physical examination. In these cases, the Applicant is provided a Reactive Tuberculin Test Evaluation Form for the treating physician to complete. The treating physician is asked to document the type and date of a current TB test, TB test history, diagnostic tests if indicated, treatment history, risk assessment for developing active TB, current TB symptoms, and recommendations for further evaluation and treatment. In the case of a positive result on the TB test, a chest x-ray is also required, along with treatment for latent TB.

• Insulin Dependent Supplemental Documentation Form

(a) Estimated number of Applicants/physicians: 8/8.
(b) Frequency of response: One time.
(c) Estimated average burden per response: 70 minutes/60 minutes.
(d) Estimated total reporting burden: 9.3 hours/8 hours.
(e) Estimated annual cost to respondents: Indeterminate.

General Description of Collection: The Insulin Dependent Supplemental Documentation Form is used with Applicants, who have received invitations to serve as Volunteers, and who have reported on the Health History Form that they have insulin dependent diabetes. In these cases, the Applicant is provided an Insulin Dependent Supplemental Documentation Form for the treating physician to complete. The Insulin Dependent Supplemental Documentation Form asks the treating physician to document that he or she has discussed with the Applicant medication (insulin) management, including whether an insulin pump is required, as well as the care and maintenance of all required diabetes related monitors and equipment. This form assists the Peace Corps in determining whether the Applicant will be in need of insulin storage while in service and, if so, will assist the Peace Corps in determining an appropriate placement for the Applicant.

• Prescription for Eyeglasses Form

(a) Estimated number of Applicants/physicians: 2,432/2,432.
(b) Frequency of response: One time.
(c) Estimated average burden per response: 105 minutes/15 minutes.
(d) Estimated total reporting burden: 4,256 hours/608 hours.
(e) Estimated annual cost to respondents: Indeterminate.

General Description of Collection: The Prescription for Eyeglasses Form is used with Applicants, who have received invitations to serve as Volunteers, and who have reported on the Health History Form that they use corrective lenses or otherwise have uncorrected vision that is worse than 20/40. In these cases, Applicants are provided a Prescription for Eyeglasses Form for their prescriber to indicate eyeglasses frame measurements, lens instructions, type of lens, gross vision and any special instructions. This form is used in order to enable the Peace Corps to obtain replacement eyeglasses for a Volunteer during service.

Request for Comment: Peace Corps invites comments on whether the proposed collections of information are necessary for proper performance of the functions of the Peace Corps, including whether the information will have practical use; the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the information to be collected; and, ways to minimize the burden of the collection of information on those who are to respond, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

This notice is issued in Washington, DC, on November 21, 2013.

Denora Miller,

FOIA/Privacy Act Officer, Management.

[FR Doc. 2013–28729 Filed 11–29–13; 8:45 am]

BILLING CODE 6051–01–P

PENSION BENEFIT GUARANTY CORPORATION

Proposed Submission of Information Collections for OMB Review; Comment Request; Multiemployer Plan Regulations

AGENCY: Pension Benefit Guaranty Corporation.

ACTION: Notice of intention to request extension of OMB approval of information collections.

SUMMARY: The Pension Benefit Guaranty Corporation (PBGC) intends to request that the Office of Management and Budget (OMB) extend approval, under the Paperwork Reduction Act, of collections of information in PBGC's regulations on multiemployer plans under the Employee Retirement Income Security Act of 1974 (ERISA). This notice informs the public of PBGC's

intent and solicits public comment on the collections of information.

DATES: Comments must be submitted by January 31, 2014.

ADDRESSES: Comments may be submitted by any of the following methods:

Federal eRulemaking Portal: http://www.regulations.gov. Follow the Web site instructions for submitting comments.

Email: paperwork.comments@pbgc.gov.

Fax: 202–326–4224.

Mail or Hand Delivery: Regulatory Affairs Group, Office of the General Counsel, Pension Benefit Guaranty Corporation, 1200 K Street NW., Washington, DC 20005–4026.

PBGC will make all comments available on its Web site, *www.pbgc.gov.*

Copies of the collections of information may also be obtained without charge by writing to the Disclosure Division of the Office of the General Counsel of PBGC at the above address or by visiting the Disclosure Division or calling 202–326–4040 during normal business hours. (TTY and TDD users may call the Federal relay service toll-free at 1–800–877–8339 and ask to be connected to 202–326–4040.) PBGC's regulations on multiemployer plans may be accessed on PBGC's Web site at *www.pbgc.gov.*

FOR FURTHER INFORMATION CONTACT: Donald McCabe, Attorney, or Catherine B. Klion, Assistant General Counsel, Regulatory Affairs Group, Office of the General Counsel, Pension Benefit Guaranty Corporation, 1200 K Street NW., Washington, DC 20005–4026, 202–326–4024. (For TTY and TDD, call 800–877–8339 and request connection to 202–326–4024).

SUPPLEMENTARY INFORMATION: OMB has approved and issued control numbers for eleven collections of information in PBGC's regulations relating to multiemployer plans. These collections of information are described below.

OMB approvals for these collections of information expire March 31, 2014, April 30, 2014, or July 31, 2014 (as specified below). PBGC intends to request that OMB extend its approval of these collections of information for three years. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

PBGC is soliciting public comments to—

- evaluate whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- evaluate the accuracy of the agency's estimate of the burden of the proposed collections of information, including the validity of the methodologies and assumptions used;
- enhance the quality, utility, and clarity of the information to be collected; and
- minimize the burden of the collections of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Comments should identify the specific part number(s) of the regulation(s) they relate to.

1. Termination of Multiemployer Plans (29 CFR Part 4041A) (OMB control number 1212–0020) (expires March 31, 2014)

Section 4041A(f)(2) of ERISA authorizes PBGC to prescribe reporting requirements for and other ''rules and standards for the administration of'' terminated multiemployer plans. Section 4041A(c) and (f)(1) of ERISA prohibit the payment by a mass-withdrawal-terminated plan of lump sums greater than $1,750 or of nonvested plan benefits unless authorized by PBGC.

The regulation requires the plan sponsor of a terminated plan to submit a notice of termination to PBGC. It also requires the plan sponsor of a mass-withdrawal-terminated plan that is closing out to give notices to participants regarding the election of alternative forms of benefit distribution and, if the plan is not closing out, to obtain PBGC approval to pay lump sums greater than $1,750 or to pay nonvested plan benefits.

PBGC uses the information in a notice of termination to assess the likelihood that PBGC financial assistance will be needed. Plan participants and beneficiaries use the information on alternative forms of benefit to make personal financial decisions. PBGC uses the information in an application for approval to pay lump sums greater than $1,750 or to pay nonvested plan benefits to determine whether such payments should be permitted.

PBGC estimates that each year plan sponsors submit notices of termination for ten plans, distribute election notices to participants in five of those plans, and submit requests to pay benefits or benefit forms not otherwise permitted for one of those plans. The estimated annual burden of the collection of information is 19.2 hours and $18,436.50.

2. Extension of Special Withdrawal Liability Rules (29 CFR Part 4203) (OMB Control Number 1212–0023) (Expires March 31, 2014)

Sections 4203(f) and 4208(e)(3) of ERISA allow PBGC to permit a multiemployer plan to adopt special rules for determining whether a withdrawal from the plan has occurred, subject to PBGC approval.

The regulation specifies the information that a plan that adopts special rules must submit to PBGC about the rules, the plan, and the industry in which the plan operates. PBGC uses the information to determine whether the rules are appropriate for the industry in which the plan functions and do not pose a significant risk to the insurance system.

PBGC estimates that at most one plan sponsor submits a request each year under this regulation. The estimated annual burden of the collection of information is one hour and $5,600.

3. Variances for Sale of Assets (29 CFR Part 4204) (OMB Control Number 1212–0021) (Expires March 31, 2014)

If an employer's covered operations or contribution obligation under a plan ceases, the employer must generally pay withdrawal liability to the plan. Section 4204 of ERISA provides an exception, under certain conditions, where the cessation results from a sale of assets. Among other things, the buyer must furnish a bond or escrow, and the sale contract must provide for secondary liability of the seller.

The regulation establishes general variances (rules for avoiding the bond/escrow and sale-contract requirements) and authorizes plans to determine whether the variances apply in particular cases. It also allows buyers and sellers to request individual variances from PBGC. Plans and PBGC use the information to determine whether employers qualify for variances.

PBGC estimates that each year, eleven employers submit, and eleven plans respond to, variance requests under the regulation, and one employer submits a variance request to PBGC. The estimated annual burden of the collection of information is 2.75 hours and $5,513.

4. Reduction or Waiver of Complete Withdrawal Liability (29 CFR Part 4207) (OMB Control Number 1212–0044) (Expires March 31, 2014)

Section 4207 of ERISA allows PBGC to provide for abatement of an

employer's complete withdrawal liability, and for plan adoption of alternative abatement rules, where appropriate.

Under the regulation, an employer applies to a plan for an abatement determination, providing information the plan needs to determine whether withdrawal liability should be abated, and the plan notifies the employer of its determination. The employer may, pending plan action, furnish a bond or escrow instead of making withdrawal liability payments, and must notify the plan if it does so. When the plan then makes its determination, it must so notify the bonding or escrow agent.

The regulation also permits plans to adopt their own abatement rules and request PBGC approval. PBGC uses the information in such a request to determine whether the amendment should be approved.

PBGC estimates that each year, 100 employers submit, and 100 plans respond to, applications for abatement of complete withdrawal liability, and one plan sponsor requests approval of plan abatement rules from PBGC. The estimated annual burden of the collection of information is 25.5 hours and $35,000.

5. Reduction or Waiver of Partial Withdrawal Liability (29 CFR Part 4208) (OMB Control Number 1212–0039) (Expires July 31, 2014)

Section 4208 of ERISA provides for abatement, in certain circumstances, of an employer's partial withdrawal liability and authorizes PBGC to issue additional partial withdrawal liability abatement rules.

Under the regulation, an employer applies to a plan for an abatement determination, providing information the plan needs to determine whether withdrawal liability should be abated, and the plan notifies the employer of its determination. The employer may, pending plan action, furnish a bond or escrow instead of making withdrawal liability payments, and must notify the plan if it does so. When the plan then makes its determination, it must so notify the bonding or escrow agent.

The regulation also permits plans to adopt their own abatement rules and request PBGC approval. PBGC uses the information in such a request to determine whether the amendment should be approved.

PBGC estimates that each year, 1,000 employers submit, and 1,000 plans respond to, applications for abatement of partial withdrawal liability and one plan sponsor requests approval of plan abatement rules from PBGC. The estimated annual burden of the collection of information is 250.5 hours and $350,000.

6. Allocating Unfunded Vested Benefits to Withdrawing Employers (29 CFR Part 4211) (OMB Control Number 1212–0035) (Expires April 30, 2014)

Section 4211(c)(5)(A) of ERISA requires PBGC to prescribe how plans can, with PBGC approval, change the way they allocate unfunded vested benefits to withdrawing employers for purposes of calculating withdrawal liability.

The regulation prescribes the information that must be submitted to PBGC by a plan seeking such approval. PBGC uses the information to determine how the amendment changes the way the plan allocates unfunded vested benefits and how it will affect the risk of loss to plan participants and PBGC.

PBGC estimates that ten plan sponsors submit approval requests each year under this regulation. The estimated annual burden of the collection of information is 20 hours.

7. Notice, Collection, and Redetermination of Withdrawal Liability (29 CFR Part 4219) (OMB Control Number 1212–0034) (Expires April 30, 2014)

Section 4219(c)(1)(D) of ERISA requires that PBGC prescribe regulations for the allocation of a plan's total unfunded vested benefits in the event of a ''mass withdrawal.'' ERISA section 4209(c) deals with an employer's liability for de minimis amounts if the employer withdraws in a ''substantial withdrawal.''

The reporting requirements in the regulation give employers notice of a mass withdrawal or substantial withdrawal and advise them of their rights and liabilities. They also provide notice to PBGC so that it can monitor the plan, and they help PBGC assess the possible impact of a withdrawal event on participants and the multiemployer plan insurance program.

PBGC estimates that there are six mass withdrawals and three substantial withdrawals per year. The plan sponsor of a plan subject to a withdrawal covered by the regulation provides notices of the withdrawal to PBGC and to employers covered by the plan, liability assessments to the employers, and a certification to PBGC that assessments have been made. (For a mass withdrawal, there are two assessments and two certifications that deal with two different types of liability. For a substantial withdrawal, there is one assessment and one certification (combined with the withdrawal notice to PBGC).) The estimated annual burden of the collection of information is 18.43 hours and $50,744.95.

8. Procedures for PBGC Approval of Plan Amendments (29 CFR Part 4220) (OMB Control Number 1212–0031) (Expires March 31, 2014)

Under section 4220 of ERISA, a plan may within certain limits adopt special plan rules regarding when a withdrawal from the plan occurs and how the withdrawing employer's withdrawal liability is determined. Any such special rule is effective only if, within 90 days after receiving notice and a copy of the rule, PBGC either approves or fails to disapprove the rule.

The regulation provides rules for requesting PBGC's approval of an amendment. PBGC needs the required information to identify the plan, evaluate the risk of loss, if any, posed by the plan amendment, and determine whether to approve or disapprove the amendment.

PBGC estimates that at most one plan sponsor submits an approval request per year under this regulation. The estimated annual burden of the collection of information is 0.5 hours and zero dollars.

9. Mergers and Transfers Between Multiemployer Plans (29 CFR Part 4231) (OMB Control Number 1212–0022) (Expires March 31, 2014)

Section 4231(a) and (b) of ERISA requires plans that are involved in a merger or transfer to give PBGC 120 days' notice of the transaction and provides that if PBGC determines that specified requirements are satisfied, the transaction will be deemed not to be in violation of ERISA section 406(a) or (b)(2) (dealing with prohibited transactions).

This regulation sets forth the procedures for giving notice of a merger or transfer under section 4231 and for requesting a determination that a transaction complies with section 4231.

PBGC uses information submitted by plan sponsors under the regulation to determine whether mergers and transfers conform to the requirements of ERISA section 4231 and the regulation.

PBGC estimates that there are 21 transactions each year for which plan sponsors submit notices and approval requests under this regulation. The estimated annual burden of the collection of information is 5.25 hours and $6,903.75.

10. Notice of Insolvency (29 CFR Part 4245) (OMB Control Number 1212–0033) (Expires April 30, 2014)

If the plan sponsor of a plan in reorganization under ERISA section

4241 determines that the plan may become insolvent, ERISA section 4245(e) requires the plan sponsor to give a ''notice of insolvency'' to PBGC, contributing employers, and plan participants and their unions in accordance with PBGC rules.

For each insolvency year under ERISA section 4245(b)(4), ERISA section 4245(e) also requires the plan sponsor to give a ''notice of insolvency benefit level'' to the same parties.

This regulation establishes the procedure for giving these notices. PBGC uses the information submitted to estimate cash needs for financial assistance to troubled plans. Employers and unions use the information to decide whether additional plan contributions will be made to avoid the insolvency and consequent benefit suspensions. Plan participants and beneficiaries use the information in personal financial decisions.

PBGC estimates that at most one plan sponsor of an ongoing plan gives notices each year under this regulation. The estimated annual burden of the collection of information is one hour and $2,693.

11. Duties of Plan Sponsor Following Mass Withdrawal (29 CFR Part 4281) (OMB Control Number 1212–0032) (Expires May 31, 2014)

Section 4281 of ERISA provides rules for plans that have terminated by mass withdrawal. Under section 4281, if nonforfeitable benefits exceed plan assets, the plan sponsor must amend the plan to reduce benefits. If the plan nevertheless becomes insolvent, the plan sponsor must suspend certain benefits that cannot be paid. If available resources are inadequate to pay guaranteed benefits, the plan sponsor must request financial assistance from PBGC.

The regulation requires a plan sponsor to give notices of benefit reduction, notices of insolvency and annual updates, and notices of insolvency benefit level to PBGC and to participants and beneficiaries and, if necessary, to apply to PBGC for financial assistance.

PBGC uses the information it receives to make determinations required by ERISA, to identify and estimate the cash needed for financial assistance to terminated plans, and to verify the appropriateness of financial assistance payments. Plan participants and beneficiaries use the information to make personal financial decisions.

PBGC estimates that plan sponsors of terminated plans each year give benefit reduction notices for three plans and give notices of insolvency benefit level and annual updates, and submit requests for financial assistance, for 54 plans. Of those 54 plans, PBGC estimates that plan sponsors each year will submit 255 requests (ranging from monthly to annual) for financial assistance. PBGC estimates that plan sponsors each year give notices of insolvency for seven plans. The estimated annual burden of the collection of information is one hour and $694,089.

Issued in Washington, DC, this 21st day of November, 2013.

Judith R. Starr,

General Counsel, Pension Benefit Guaranty Corporation.

[FR Doc. 2013–28680 Filed 11–29–13; 8:45 am]

BILLING CODE 7709–02–P

POSTAL SERVICE

Sunshine Act Meeting; Board of Governors

DATES AND TIMES: December 10, 2013, at 11:00 a.m.

PLACE: Washington, DC, via Teleconference.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

Tuesday, December 10, 2013 at 11:00 a.m.

1. Strategic Issues.
2. Financial Matters.
3. Pricing.
4. Personnel Matters and Compensation Issues.
5. Governors' Executive Session—Discussion of prior agenda items and Board Governance.

CONTACT PERSON FOR MORE INFORMATION: Julie S. Moore, Secretary of the Board, U.S. Postal Service, 475 L'Enfant Plaza SW., Washington, DC 20260–1000 ; Telephone (202) 268–4800.

Julie S. Moore,

Secretary.

[FR Doc. 2013–28822 Filed 11–26–13; 4:15 pm]

BILLING CODE 7710–12–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. IC–30804]

Notice of Applications for Deregistration Under Section 8(f) of the Investment Company Act of 1940

November 22, 2013.

The following is a notice of applications for deregistration under section 8(f) of the Investment Company Act of 1940 for the month of November. A copy of each application may be obtained via the Commission's Web site by searching for the file number, or for an applicant using the Company name box, at *http://www.sec.gov/search/search.htm* or by calling (202) 551–8090. An order granting each application will be issued unless the SEC orders a hearing. Interested persons may request a hearing on any application by writing to the SEC's Secretary at the address below and serving the relevant applicant with a copy of the request, personally or by mail. Hearing requests should be received by the SEC by 5:30 p.m. on December 17, 2013, and should be accompanied by proof of service on the applicant, in the form of an affidavit or, for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by writing to the Secretary, U.S. Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

FOR FURTHER INFORMATION CONTACT: Diane L. Titus at (202) 551–6810, SEC, Division of Investment Management, Chief Counsel's Office, 100 F Street NE., Washington, DC 20549–8010.

Blue Rock Market Neutral Fund, LLC [File No. 811–21564]

Summary: Applicant, a closed-end investment company, seeks an order declaring that it has ceased to be an investment company. Applicant has never made a public offering of its securities and does not propose to make a public offering or engage in business of any kind.

Filing Dates: The application was filed on October 7, 2013, and amended on October 31, 2013.

Applicant's Address: 445 East Lake St., Suite 120, Wayzata, MN 55391.

Eaton Vance Managed Income Term Trust [File No. 811–22306]

Summary: Applicant seeks an order declaring that it has ceased to be an investment company. Applicant has never made a public offering of its securities and does not propose to make a public offering or engage in business of any kind.

Filing Dates: The application was filed on October 3, 2013, and amended on October 31, 2013.

Applicant's Address: Two International Place, Boston, MA 02110.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–28726 Filed 11–29–13; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. IC–30808; 812–14232]

RBS Securities Inc. and Citizens Investment Advisors; Notice of Application and Temporary Order

November 25, 2013.

AGENCY: Securities and Exchange Commission (''Commission'').

ACTION: Temporary order and notice of application for a permanent order under section 9(c) of the Investment Company Act of 1940 (''Act'').

SUMMARY OF APPLICATION: Applicants have received a temporary order exempting them from section 9(a) of the Act, with respect to an injunction entered against RBS Securities Inc. (''RBS Securities'') on November 25, 2013, by the United States District Court for the District of Connecticut (the ''District Court'') until the Commission takes final action on an application for a permanent order. Applicants also have applied for a permanent order.

APPLICANTS: RBS Securities and Citizens Investment Advisors (''Citizens IA''), a separately identifiable department of RBS Citizens, N.A. (each an ''Applicant'' and collectively, the ''Applicants'').[1]

DATES: *Filing Date:* The application was filed on November 7, 2013, and amended on November 25, 2013.

HEARING OR NOTIFICATION OF HEARING: An order granting the application will be issued unless the Commission orders a hearing. Interested persons may request a hearing by writing to the Commission's Secretary and serving applicants with a copy of the request, personally or by mail. Hearing requests should be received by the Commission by 5:30 p.m. on December 20, 2013, and should be accompanied by proof of service on applicants, in the form of an affidavit or, for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by writing to the Commission's Secretary.

ADDRESSES: Elizabeth M. Murphy, Secretary, U.S. Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090; Applicants: RBS Securities, 600 Washington Boulevard, Stamford, CT 06901; Citizens IA, c/o RBS Citizens Financial Group Inc., 101 Park Avenue, 10th Floor, New York, NY 10178.

FOR FURTHER INFORMATION CONTACT: David J. Marcinkus, Senior Counsel, at 202–551–6882 or David P. Bartels, Branch Chief, at 202–551–6821 (Division of Investment Management, Chief Counsel's Office).

SUPPLEMENTARY INFORMATION: The following is a temporary order and summary of the application. The complete application may be obtained via the Commission's Web site by searching for the file number, or for an applicant using the Company name box, at *http://www.sec.gov/search/search.htm,* or by calling (202) 551–8090.

Applicants' Representations

1. RBS Securities, a Delaware corporation, is registered as a broker-dealer under the Securities Exchange Act of 1934, as amended (the ''Exchange Act''), and is an indirect wholly-owned subsidiary of the Royal Bank of Scotland Group plc (''RBSG''). RBS Securities does not serve as investment adviser, depositor or principal underwriter to any registered investment company. Citizens IA, an investment adviser registered under the Investment Advisers Act of 1940, is a separately identifiable department of RBS Citizens, N.A., which is an indirect wholly-owned subsidiary of RBSG and bank subsidiary of RBS Citizens Financial Group, Inc. (''CFG''). CFG is a wholly-owned subsidiary of RBSG. Citizens IA serves as investment sub-adviser to one management investment company registered under the Act, Aquila Narragansett Tax-Free Income Fund (the ''Fund''). The Applicants and other Covered Persons may, if the relief is granted, in the future act in any of the capacities contemplated by section 9(a) of the Act subject to the conditions of the temporary order and the permanent order.

2. On November 7, 2013, the Commission filed a complaint (the ''Complaint'') against RBS Securities in the District Court in a civil action captioned *Securities and Exchange Commission v. RBS Securities Inc.* The Complaint alleged that RBS Securities violated sections 17(a)(2) and (3) of the Securities Act of 1933 (the ''Securities Act'') arising out of a single offering of residential mortgage-backed securities in 2007 (the ''Conduct''). In settlement of this action, RBS Securities submitted an executed Consent of Defendant RBS Securities Inc. (the ''Consent''). In the Consent, RBS Securities agreed to the entry of a final judgment, without admitting or denying the allegations made in the Complaint (other than those relating to the jurisdiction of the District Court over it and the subject matter, solely for the purposes of this action). On November 25, 2013, the District Court entered a judgment against RBS Securities (the ''Judgment'')[2] that enjoined RBS Securities from violating, directly or indirectly, sections 17(a)(2) and (a)(3) of the Securities Act (the ''Injunction''). Additionally, pursuant to the Judgment, RBS Securities will pay disgorgement, prejudgment interest and a civil monetary penalty.

Applicants' Legal Analysis

1. Section 9(a)(2) of the Act, in relevant part, prohibits a person who has been enjoined from engaging in or continuing any conduct or practice in connection with the purchase or sale of a security, or in connection with activities as an underwriter, broker or dealer, from acting, among other things, as an investment adviser or depositor of any registered investment company, or a principal underwriter for any registered open-end investment company, registered UIT, or registered face-amount certificate company (such activities, collectively, ''Fund Services Activities''). Section 9(a)(3) of the Act makes the prohibition in section 9(a)(2) applicable to a company, any Affiliated Person of which has been disqualified under the provisions of section 9(a)(2). Section 2(a)(3) of the Act defines ''affiliated person'' to include, among others: (A) any person directly or indirectly owning, controlling, or holding with power to vote, five per centum or more of the outstanding voting securities of such other person; (B) any person five per centum or more of whose outstanding voting securities are directly or indirectly owned, controlled, or held with power to vote, by such other person; and (C) any person directly or indirectly controlling, controlled by, or under common control, with the other person.

[1] Applicants request that any relief granted pursuant to the application also apply to any existing company of which RBS Securities is an affiliated person within the meaning of section 2(a)(3) of the Act (an ''Affiliated Person'') and to any other company of which RBS Securities may become an Affiliated Person in the future (together with the Applicants, the ''Covered Persons'') with respect to any activity contemplated by Section 9(a) of the Act.

[2] *Securities and Exchange Commission v. RBS Securities Inc.,* Case Number 1:13–cv–01643–WWE (D. Conn. Nov. 25, 2013).

Applicants state that RBS Securities is an Affiliated Person of Citizens IA. Applicants state that, taken together, sections 9(a)(2) and 9(a)(3) would have the effect of precluding Citizens IA from acting as a sub-adviser to the Fund.

2. Section 9(c) of the Act provides that, upon application, the Commission shall grant an application for exemption from the disqualification provisions of section 9(a) of the Act if it is established that these provisions, as applied to the Applicants, are unduly or disproportionately severe or that the conduct of the Applicants has been such as not to make it against the public interest or the protection of investors to grant the exemption. Applicants have filed an application pursuant to section 9(c) seeking a temporary and permanent order exempting them and other Covered Persons from the disqualification provisions of section 9(a).

3. Applicants believe they meet the standard for exemption specified in section 9(c). Applicants state that the prohibitions of section 9(a) as applied to them would be unduly and disproportionately severe and that the conduct of the Applicants has been such as not to make it against the public interest or the protection of investors to grant the exemption from section 9(a).

4. Applicants state that the Conduct did not involve any of the Applicants' Fund Service Activities. Applicants state that RBS Securities does not serve in any of the capacities described in section 9(a) of the Act. In addition, Applicants state that the Conduct did not involve the Fund, or the assets of the Fund, with respect to which the Applicants provided Fund Service Activities.

5. Applicants also state to the best of their knowledge (i) none of the current directors, officers, or employees of Citizens IA that are involved in providing Fund Service Activities (or any other persons in such roles during the time period covered by the Complaint) had knowledge of or participated in the conduct alleged in the Complaint to have constituted the violations that provide a basis for the Injunction; (ii) the directors, officers and employees at RBS Securities who participated in the conduct alleged in the Complaint to have constituted the violations that provide a basis for the Injunction have had no, and will not have any, involvement in providing Fund Service Activities on behalf of the Applicants or other Covered Persons; and (iii) because the personnel of Citizens IA did not participate in the conduct alleged in the Complaint to have constituted the violations that provide a basis for the Injunction, the shareholders of the Fund were not affected any differently than if the Fund had received services from any other non-affiliated investment adviser or principal underwriter.

6. Applicants submit that they have taken sufficient remedial actions to address the conduct that served as the basis for the Injunction and that granting the exemption requested is consistent with the public interest and the protection of investors.

7. Applicants state that the inability of Citizens IA to continue providing Fund Service Activities to the Fund would result in the Fund and its shareholders facing potential hardship. Applicants state that they will distribute to the board of trustees of the Fund (the ''Board'') written materials describing the circumstances that led to the Injunction, any impact on the Fund, and the application. The written materials will include an offer to discuss the materials at an in-person meeting with the Board, including the directors who are not ''interested persons'' of the Fund as defined in section 2(a)(19) of the Act, and their independent legal counsel as defined in rule 0–1(a)(6) under the Act. Applicants state that they will provide the Board with the information concerning the Injunction and the application that is necessary for the Fund to fulfill its disclosure and other obligations under the federal securities laws.

8. Applicants state that if Citizens IA were barred from providing investment advisory services to the Fund, the effect on its businesses and employees would be severe. Applicants state that Citizens IA has committed substantial capital and other resources to establish an expertise in sub-advising registered investment companies. Applicants further state that prohibiting Citizens IA from providing Fund Service Activities would not only adversely affect its business, but would also adversely affect its employees that are involved in those activities. Applicants state that many of these employees could experience significant difficulties in finding alternative fund-related employment.

9. Applicants state that Applicants and certain other affiliated persons of the Applicants have previously received an order under section 9(c) of the Act, as the result of conduct that triggered section 9(a), as described in greater detail in the application.

Applicants' Condition

Applicants agree that any order granting the requested relief will be subject to the following condition:

Any temporary exemption granted pursuant to the application shall be without prejudice to, and shall not limit the Commission's rights in any manner with respect to, any Commission investigation of, or administrative proceedings involving or against, Covered Persons, including without limitation, the consideration by the Commission of a permanent exemption from section 9(a) of the Act requested pursuant to the application or the revocation or removal of any temporary exemptions granted under the Act in connection with the application.

Temporary Order

The Commission has considered the matter and finds that the Applicants have made the necessary showing to justify granting a temporary exemption.

Accordingly,

It is hereby ordered, pursuant to section 9(c) of the Act, that Applicants and any other Covered Persons are granted a temporary exemption from the provisions of section 9(a), solely with respect to the Injunction, subject to the condition in the application, from November 25, 2013, until the Commission takes final action on their application for a permanent order.

By the Commission.

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–28759 Filed 11–29–13; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

Sunshine Act Meeting.

Notice is hereby given, pursuant to the provisions of the Government in the Sunshine Act, Public Law 94–409, that the Securities and Exchange Commission will hold a Closed Meeting on Wednesday, December 4, 2013 at 10:30 a.m.

Commissioners, Counsel to the Commissioners, the Secretary to the Commission, and recording secretaries will attend the Closed Meeting. Certain staff members who have an interest in the matters also may be present.

The General Counsel of the Commission, or her designee, has certified that, in her opinion, one or more of the exemptions set forth in 5 U.S.C. 552b(c)(3), (5), (7), 9(B) and (10) and 17 CFR 200.402(a)(3), (5), (7), 9(ii) and (10), permit consideration of the scheduled matter at the Closed Meeting.

Commissioner Stein, as duty officer, voted to consider the items listed for the Closed Meeting in a closed session and

determined that no earlier notice thereof was possible.

The subject matter of the Closed Meeting will be:

Institution and settlement of injunctive actions;

Institution and settlement of administrative proceedings; and

Other matters relating to enforcement proceedings.

At times, changes in Commission priorities require alterations in the scheduling of meeting items.

For further information and to ascertain what, if any, matters have been added, deleted or postponed, please contact the Office of the Secretary at (202) 551–5400.

Dated: November 26, 2013.

Elizabeth M. Murphy,

Secretary.

[FR Doc. 2013–28837 Filed 11–27–13; 11:15 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–70936; File No. SR–CBOE–2013–112]

Self-Regulatory Organizations; Chicago Board Options Exchange, Incorporated; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Increase the Class Quoting Limit for Options on Twitter

November 25, 2013.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (the ''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on November 15, 2013, Chicago Board Options Exchange, Incorporated (the ''Exchange'' or ''CBOE'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to increase the Class Quoting Limit (''CQL'') for options on Twitter. The text of the proposed rule change is available on the Exchange's Web site (*http://www.cboe.com/AboutCBOE/CBOELegalRegulatoryHome.aspx*), at the Exchange's Office of the Secretary, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

A CQL is the maximum number of Trading Permit Holders (''TPHs'') that may quote electronically in a given product.[3] CBOE Rule 8.3A, Interpretation .01 states that the CQL for products trading on the Exchange's Hybrid Trading System (''Hybrid'') is 50.[4] However, the President of the Exchange may increase the CQL for an existing or new product if he determines that it would be appropriate.[5] Such an increase can be accomplished by submitting to the Securities and Exchange Commission (the ''Commission'') a rule filing pursuant to Section 19b(3)(A) of the Act and announcing the increase to TPHs via Information Circular.[6] The Exchange has previously increased the CQLs for other products via rule filing.[7]

The Exchange intends to begin to allow the trading of options on Twitter on November 15, 2013. The Exchange has already noticed substantial interest in the product, specifically from Market-Makers desiring to quote in that class. As such, CBOE's President has determined that it would be appropriate to increase the CQL for Twitter to 75. The Exchange has prepared an Information Circular to inform TPHs of this change, and hereby submits this proposed rule filing to effect such change. The Exchange has the system capacity to manage the proposed increase.

2. Statutory Basis

The Exchange believes the proposed rule change is consistent with the Act and the rules and regulations thereunder applicable to the Exchange and, in particular, the requirements of Section 6(b) of the Act.[8] Specifically, the Exchange believes the proposed rule change is consistent with the Section 6(b)(5)[9] requirements that the rules of an exchange be designed to promote just and equitable principles of trade, to prevent fraudulent and manipulative acts, to remove impediments to and to perfect the mechanism for a free and open market and a national market system, and, in general, to protect investors and the public interest. Increasing the CQL for Twitter allows more Market-Makers to quote in that product, which provides greater volume and more trading activity for all market participants, thereby perfecting the mechanism for a free and open market.

B. Self-Regulatory Organization's Statement on Burden on Competition

CBOE does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. The Exchange does not believe that the proposed rule change will impose any burden on intramarket competition that is not necessary or appropriate in furtherance of the purposes of the Act because it will be applied to all Market-Makers in accordance with CBOE Rule 8.3A. The Exchange does not believe that the proposed rule change will impose any burden on intermarket competition that is not necessary or appropriate in furtherance of the purposes of the Act because it only affects Market-Maker quoting on CBOE. Further, increasing the CQL for Twitter on CBOE will allow more Market-Makers to quote in that product, which provide [sic] for greater trading opportunities greater volume and more trading activity for CBOE market participants, thereby enhancing competition. To the extent that the proposed change makes CBOE a more attractive trading venue for market participants at other exchanges, such market participants may elect to become CBOE market participants.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* CBOE Rule 8.3A.

[4] *See* CBOE Rule 8.3A, Interpretation .01(a).

[5] *See* CBOE Rule 8.3A, Interpretation .01(b).

[6] *See* CBOE Rule 8.3A, Interpretation .01(c).

[7] *See* Securities Exchange Act Release No. 55664 (April 24, 2007), 72 FR 23867 (May 1, 2007) (SR–CBOE–2007–36), which increased the CQLs for Apple Inc. and Research In Motion to 60. *See also* Securities Exchange Act Release No. 67231 (June 21, 2012), 77 FR 38362 (June 27, 2012) (SR–CBOE–2012–057), which increased the CQL for Facebook to 60.

[8] 15 U.S.C. 78f(b).

[9] 15 U.S.C. 78f(b)(5).

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Exchange neither solicited nor received comments on the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate, it has become effective pursuant to 19(b)(3)(A) of the Act [10] and Rule 19b–4(f)(6) [11] thereunder.

A proposed rule change filed under Rule 19b–4(f)(6) [12] normally does not become operative prior to 30 days after the date of the filing. However, pursuant to Rule 19b–4(f)(6)(iii),[13] the Commission may designate a shorter time if such action is consistent with the protection of investors and the public interest. The Exchange has asked the Commission to waive the 30-day operative delay so that the proposal may become operative immediately upon filing. The Exchange notes that waiving the 30-day operative delay would allow more TPHs to start quoting on Twitter immediately, thereby providing greater volume and more trading activity in that product. The Commission believes that waiving the 30-day operative delay is consistent with the protection of investors and the public interest, as it will allow CBOE to respond without delay to what it has identified to be current market demand for increased quoting capacity in options overlying Twitter stock and thereby will help accommodate current market interest. Further, the Exchange has represented that it has the systems capacity to accommodate the additional quotation activity. Accordingly, the Commission designates the proposed rule change to be operative upon filing with the Commission.[14]

At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include File Number SR–CBOE–2013–112 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–CBOE–2013–112. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–CBOE–2013–112 and should be submitted on or before December 23, 2013.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[15]

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–28722 Filed 11–29–13; 8:45 am]

BILLING CODE 8011–01–P

[10] 15 U.S.C. 78s(b)(3)(A).

[11] 17 CFR 240.19b–4(f)(6).

[12] 17 CFR 240.19b–4(f)(6).

[13] 17 CFR 240.19b–4(f)(6)(iii).

[14] For purposes only of waiving the operative delay for this proposal, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. See 15 U.S.C. 78c(f).

[15] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–70935; File No. SR–OCC–2013–20]

Self-Regulatory Organizations; The Options Clearing Corporation; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Clarify OCC's Existing Policy Regarding Use of Clearing Fund Assets in Anticipation of a Clearing Member Default

November 25, 2013.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] notice is hereby given that, on November 15, 2013, The Options Clearing Corporation (''OCC'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I, II and III below, which Items have been prepared primarily by OCC. OCC filed the proposed rule change pursuant to Section 19(b)(3)(A)(i) [3] of the Act and Rule 19b–4(f)(4)(1) [4] thereunder, so that the proposal was effective upon filing with the Commission. The Commission is publishing this notice to solicit comments on the rule change from interested parties.

I. Clearing Agency's Statement of the Terms of Substance of the Proposed Rule Change

The purpose of this proposed rule change is to clarify OCC's existing policy regarding use of clearing fund assets in anticipation of a clearing member default. Specifically, OCC proposes to add an interpretation and policy to Article VIII, Section 5 of OCC's By-Laws to make clear that OCC has the authority to use cash or securities deposited by clearing members in OCC's clearing fund to borrow, or to otherwise obtain, funds from third parties in anticipation of a potential default by, or suspension of, a clearing member.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A)(i).

[4] 17 CFR 240.19b–4(f)(1).

II. Clearing Agency's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, OCC included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. OCC has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of these statements.

(A) Clearing Agency's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

(1) Purpose

The purpose of this proposed rule change is to clarify OCC's existing policy regarding use of clearing fund assets in anticipation of a clearing member default. Specifically, OCC is proposing to add an interpretation and policy to Article VIII, Section 5 of its By-Laws to provide greater transparency for clearing members and others regarding an existing by-law and to clarify its authority to use cash or securities deposited by clearing members in OCC's clearing fund to borrow, or otherwise obtain, funds from third parties in anticipation of a clearing member default.[5]

Article VIII, Section 5 of OCC's By-Laws concerns application of OCC's clearing fund. Section 5(e)(i) permits OCC to use assets in the clearing fund to borrow, or otherwise obtain, funds from third parties in the event that OCC deems it necessary or advisable to meet obligations arising out of the default or suspension of a Clearing Member or any action taken by OCC pursuant to Chapter XI of the Rules or otherwise.[6] OCC has interpreted Article VIII, Section 5(e)(i) to provide OCC with the authority to use clearing fund assets to borrow, or otherwise obtain, funds from third parties in anticipation of a clearing member default or suspension should OCC deem such use of assets necessary or advisable to meet obligations that may arise from such potential clearing member default or suspension.[7] However, OCC believes that it would be helpful to clarify such authority and, accordingly, proposes to add Interpretation and Policy .06 to Article VIII, Section 5. Interpretation and Policy .06 will clarify that OCC's authority under Section 5(e)(i) of Article VIII applies to both situations in which a clearing member default or suspension that has already occurred, and in anticipation of potential default or suspension of a clearing member.

(2) Statutory Basis

OCC believes the proposed rule change is consistent with Section 17A(b)(3)(F) of the Act[8] and the rules and regulations thereunder because it will increase the protection of investors and the public interest by allowing OCC to use clearing fund assets to borrow or otherwise obtain funds from third parties in anticipation of a clearing member default or suspension, in addition to a default or suspension that actually occurred, and thereby limit systemic risk. In addition, OCC believes that the proposed rule is consistent with Rule 17Ad–22(b)(3)[9] because by providing additional flexibility with respect to the timing of borrowings it will enhance OCC's ability to maintain sufficient financial resources to withstand a significant clearing member default. The proposed rule change is not inconsistent with the existing rules of OCC, including any other rules proposed to be amended.

(B) Clearing Agency's Statement on Burden on Competition

OCC does not believe that the proposed rule change would impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.[10] This proposed rule change clarifies long standing policy regarding the conditions under which OCC may use securities or cash that clearing members deposit in OCC's clearing fund, and will apply to all clearing members. Accordingly, OCC believes that the proposed modifications would not disadvantage or favor any particular user in relationship to another user.

For the foregoing reasons, OCC believes that the proposed rule change is in the public interest, would be consistent with the requirements of the Act applicable to clearing agencies, and would not impose a burden on competition that not necessary or appropriate in furtherance of the purposes of the Act.

(C) Clearing Agency's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

Written comments on the proposed rule change were not and are not intended to be solicited with respect to the proposed rule change and none have been received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Pursuant to Section 19(b)(3)(A)(i) of the Act[11] and Rule 19b–4(f)(1)[12] thereunder, the proposed rule change is filed for immediate effectiveness because it constitutes a stated policy, practice or interpretation with respect to the meaning, administration or enforcement of an existing rule. Notwithstanding the foregoing, implementation of this rule change will be delayed until it is deemed certified under CFTC Regulation § 40.6. At any time within 60 days of the filing of such rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.[13]

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include File Number SR–OCC–2013–20 on the subject line.

[5] OCC, in connection with the renewal of its credit facility, represented to the Commission that it will add such a clarification to its By-Laws. *See* Exchange Act Release No. 34–70596 (October 2, 2013), 78 FR 62719 (October 22, 2013), (SR–OCC–2013–806).

[6] Chapter XI sets out rules pertaining to suspension of OCC Clearing Members.

[7] OCC has long believed that it should not have to make the decision to suspend a clearing member as a precondition to borrowing against the clearing fund. Accordingly, in 2004, OCC amended Article VIII, Section 5(e) to clarify that OCC may use clearing fund assets as collateral for loans whenever OCC deems such borrowings to be necessary or advisable in order to meet obligations arising out of the default or suspension of a clearing member or any action taken by OCC in connection therewith pursuant to Chapter XI of its Rules *or otherwise* (emphasis added). OCC has consistently interpreted the ''or otherwise'' language in the preceding sentence that was added to the By-Laws in 2004 to allow OCC to borrow against the clearing fund prior to a clearing member default or suspension. *See* Securities Exchange Act Release No. 34–50526 (October 13, 2004), 69 FR 61701 (October 20, 2004), (SR–OCC–2004–13).

[8] 15 U.S.C. 78q–1(b)(3)(F).

[9] 17 CFR 240.17Ad–22(b)(3).

[10] 15 U.S.C. 78q–1(b)(3)(I).

[11] 15 U.S.C. 78s(b)(3)(A)(i).

[12] 17 CFR 240.19b–4(f)(1).

[13] 15 U.S.C. 78s(b)(3)(C).

Paper Comments

• Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–OCC–2013–20. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method of submission. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Section, 100 F Street NE., Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of such filing also will be available for inspection and copying at the principal office of OCC and on OCC's Web site at *http://www.theocc.com/components/docs/legal/rules_and_bylaws/sr_occ_13_20.pdf.* All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly.

All submissions should refer to File Number SR–OCC–2013–20 and should be submitted on or before December 23, 2013.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[14]

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–28721 Filed 11–29–13; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–70943; File No. SR–CBOE–2013–115]

Self-Regulatory Organizations; Chicago Board Options Exchange, Incorporated; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend the CBSX Fees Schedule

November 25, 2013.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (the ''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on November 21, 2013, Chicago Board Options Exchange, Incorporated (the ''Exchange'' or ''CBOE'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend the Fees Schedule of its CBOE Stock Exchange. The text of the proposed rule change is available on the Exchange's Web site (*http://www.cboe.com/AboutCBOE/CBOELegalRegulatoryHome.aspx*), at the Exchange's Office of the Secretary, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

CBSX proposes to amend its Maker fees for transactions in all other securities (securities other than the ''Select Symbols'', of which there currently are none) priced $1 or greater. Currently, such fees are assessed on the following scale: [3]

Maker (adds less than 0.08% of TCV of liquidity in one day) (1)(5)	$0.0018 per share
Maker (adds at least 0.08% but less than 0.16% of TCV of liquidity in one day) (1)(5)	$0.0017 per share
Maker (adds at least 0.16% but less than 0.24% of TCV of liquidity in one day) (1)(5)	$0.0016 per share
Maker (adds at least 0.24% but less than 0.42% of TCV of liquidity in one day) (1)(5)	$0.0015 per share
Maker (adds 0.42% or more of TCV of liquidity in one day) (1)(5)	$0.0014 per share

The Exchange proposes to break up the 0.24%–0.42% tier into two separate tiers at 0.33%, with Maker transactions in the 0.33%–0.42% tier being assessed a lower fee of $0.0014 per share (currently, Maker transactions in such tier would be assessed the same fee as in the 0.24%–0.33% tier, which is $0.0015 per share). The Exchange also proposes to add a 0.42%–0.52% tier, with Maker transactions in that tier being assessed a fee of $0.0013 per share (which is lower than the $0.0014 per share fee that Maker transactions in that tier currently are assessed). Finally, the Exchange proposes to add a tier for Makers who add 0.52% of TCV of liquidity in one day or more, with such transactions being assessed a lower fee of $0.0012 per share (which is lower than the $0.0014 per share fee that

[14] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] The parentheticals (1) and (5) in the scale refer to footnotes in the CBSX Fees Schedule. Footnote (1) reads:

These rates apply to all transactions in securities priced $1 or greater made by the same market participant in any day in which such participant adds (for Makers) or removes (for Takers) the established amount of shares (or percentage of TCV, as applicable) or more of liquidity that is determined in the chart above for each tier. Market participants who share a trading acronym or MPID may aggregate their trading activity for purposes of these rates. Qualification for these rates will require that a market participant appropriately indicate his trading acronym and/or MPID in the appropriate field on the order.

Footnote (5) reads:

''TCV'' means total consolidated volume calculated as the volume reported by all exchanges and trade reporting facilities to a consolidated transaction reporting plan. Volume from Maker executions in the Select Symbols (priced $1 or greater) will count towards a market participant's % of TCV.

The Exchange does not propose to amend either Footnotes (1) or (5).

Maker transactions in that tier currently are assessed). As such, upon effectiveness of the proposed changes, the Maker fees for transactions in all other securities priced $1 or greater will be as follows:

Maker (adds less than 0.08% of TCV of liquidity in one day) (1)(5)	$0.0018 per share
Maker (adds at least 0.08% but less than 0.16% of TCV of liquidity in one day) (1)(5)	$0.0017 per share
Maker (adds at least 0.16% but less than 0.24% of TCV of liquidity in one day) (1)(5)	$0.0016 per share
Maker (adds at least 0.24% but less than 0.33% of TCV of liquidity in one day) (1)(5)	$0.0015 per share
Maker (adds at least 0.33% but less than 0.42% of TCV of liquidity in one day) (1)(5)	$0.0014 per share
Maker (adds at least 0.42% but less than 0.52% of TCV of liquidity in one day) (1)(5)	$0.0013 per share
Maker (adds 0.52% or more of TCV of liquidity in one day) (1)(5)	$0.0012 per share

The proposed changes are aspirational. The Exchange believes that the proposed new tiers will provide liquidity targets for CBSX market participants to aspire to reach, and the lowered fees in these new tiers will provide incentives for such CBSX market participants. The Exchange believes that the increased liquidity that results will benefit all market participants, and perhaps enable some such market participants to reach higher tiers (with the corresponding lower transaction fees) than they otherwise might.

The proposed changes are to take effect on December 2, 2013.

2. Statutory Basis

The Exchange believes the proposed rule change is consistent with the Act and the rules and regulations thereunder applicable to the Exchange and, in particular, the requirements of Section 6(b) of the Act.[4] Specifically, the Exchange believes the proposed rule change is consistent with Section 6(b)(4) of the Act,[5] which requires that Exchange rules provide for the equitable allocation of reasonable dues, fees, and other charges among its Trading Permit Holders and other persons using its facilities. The Exchange believes the proposed fee (and tier) changes are reasonable because all the proposed changes involve lowering fees from their current levels (in the tiers created/affected). There are no fee increases proposed by this proposed rule change, the affected market participants will certainly prefer to be assessed lower fees. The Exchange believes that the proposed changes are equitable and not unfairly discriminatory because, while they provide for lower fees for market participants who hit certain liquidity levels than others, the proposed new tiers (and corresponding lowered fees) are intended to provide liquidity targets for CBSX market participants to aspire to reach. The Exchange believes that the increased liquidity that results will benefit all market participants, and perhaps enable some such market participants to reach higher tiers (with the corresponding lower transaction fees) than they otherwise might. Finally, the proposed new fee tiers will be applied equally to all CBSX market participants.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. CBSX does not believe that the proposed rule change will impose any burden on intramarket competition that is not necessary or appropriate in furtherance of the purposes of the Act because, while they provide for lower fees for market participants who hit certain liquidity levels than others, the proposed new tiers (and corresponding lowered fees) are intended to provide liquidity targets for CBSX market participants to aspire to reach. The Exchange believes that the increased liquidity that results will benefit all market participants, and perhaps enable some such market participants to reach higher tiers (with the corresponding lower transaction fees) than they otherwise might. Finally, the proposed new fee tiers will be applied equally to all CBSX market participants. The Exchange does not believe that the proposed rule change will impose any burden on intermarket competition that is not necessary or appropriate in furtherance of the purposes of the Act because the proposed changes are intended to attract greater liquidity and make CBSX a more attractive marketplace for market participants on all exchanges (thereby enhancing competition). To the extent that the proposed changes make CBSX a more attractive marketplace for market participants on other exchanges, such market participants may elect to become CBSX market participants. Also, the proposed changes only apply to trading on CBSX.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Exchange neither solicited nor received comments on the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change has become effective pursuant to Section 19(b)(3)(A) of the Act[6] and paragraph (f) of Rule 19b–4[7] thereunder. At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission will institute proceedings to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include File Number SR–CBOE–2013–115 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–CBOE–2013–115. This file

[4] 15 U.S.C. 78f(b).

[5] 15 U.S.C. 78f(b)(4).

[6] 15 U.S.C. 78s(b)(3)(A).

[7] 17 CFR 240.19b–4(f).

number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of such filing also will be available for inspection and copying at the principal offices of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File

Number SR–CBOE–2013–115, and should be submitted on or before December 23, 2013.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[8]

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–28725 Filed 11–29–13; 8:45 am]

BILLING CODE 8011–01–P

[8] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[File No. 500–1]

Nevada Gold Corp.; Order of Suspension of Trading

November 27, 2013.

It appears to the Securities and Exchange Commission that there is a lack of current and accurate information concerning the securities of Nevada Gold Corp. (''Nevada Gold'') because of questions regarding the accuracy of assertions by Nevada Gold, and by others, to investors in press releases and promotional material concerning, among other things, the company's assets, operations, and financial condition. Nevada Gold is a Delaware corporation based in Del Mar, California. The company's common stock is dually quoted on the OTCBB and OTC Link under the symbol NVGC.

The Commission is of the opinion that the public interest and the protection of investors require a suspension of trading in the securities of the above-listed company.

Therefore, it is ordered, pursuant to Section 12(k) of the Securities Exchange Act of 1934, that trading in the securities of the above-listed company is suspended for the period from 9:30 a.m. EST on November 27, 2013 through 11:59 p.m. EST, on December 11, 2013.

By the Commission.

Lynn M. Powalski,

Deputy Secretary.

[FR Doc. 2013–28871 Filed 11–27–13; 4:15 pm]

BILLING CODE 8011–01–P

SELECTIVE SERVICE SYSTEM

Forms Submitted to the Office of Management and Budget for Extension of Clearance

AGENCY: Selective Service System.

ACTION: Notice.

The following forms have been submitted to the Office of Management and Budget (OMB) for extension of clearance in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35):

SSS FORM—402

Title: Uncompensated Registrar Appointment Form.

Purpose: Is used to verify the official status of applicants for the position of Uncompensated Registrars and to establish authority for those appointed to perform as Selective Service System Registrars.

Respondents: United States citizens over the age of 18.

Frequency: One time.

Burden: The reporting burden is three minutes or less per respondent.

Copies of the above identified form can be obtained upon written request to the Selective Service System, Reports Clearance Officer, 1515 Wilson Boulevard, Arlington, Virginia 22209–2425.

Written comments and recommendations for the proposed extension of clearance of the form should be sent within 30 days of the publication of this notice to the Selective Service System, Reports Clearance Officer, 1515 Wilson Boulevard, Arlington, Virginia 22209–2425.

A copy of the comments should be sent to the Office of Information and Regulatory Affairs, Attention: Desk Officer, Selective Service System, Office of Management and Budget, New Executive Office Building, Room 3235, Washington, DC 20503.

Dated: November 21, 2013.

Lawrence Romo,

Director.

[FR Doc. 2013–28740 Filed 11–29–13; 8:45 am]

BILLING CODE 8015–01–P

SMALL BUSINESS ADMINISTRATION

Reporting and Recordkeeping Requirements Under OMB Review

AGENCY: Small Business Administration.

ACTION: Notice of 30-day information collection submitted for OMB review.

SUMMARY: The Small Business Administration (SBA) is publishing this notice to comply with requirements of the Paperwork Reduction Act (PRA) (44 U.S.C. Chapter 35), which requires agencies to submit proposed reporting and recordkeeping requirements to OMB for review and approval, and to publish a notice in the **Federal Register** notifying the public that the agency has made such a submission. This notice also allows an additional 30 days for public comments.

DATES: Submit comments on or before January 2, 2014. If you intend to comment but cannot prepare comments promptly, please advise the OMB Reviewer and the Agency Clearance Officer before the deadline.

Copies: Request for clearance (OMB 83–1), supporting statement, and other documents submitted to OMB for review may be obtained from the Agency Clearance Officer.

ADDRESSES: Comments should refer to the information collection by name and/or OMB Control Number (3245–0348) and should be sent to: *Agency Clearance Officer,* Curtis Rich, Small Business Administration, 409 3rd Street SW., 5th Floor, Washington, DC 20416; and *SBA Desk Officer,* Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office Building, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Curtis Rich, Agency Clearance Officer, (202) 205–7030 *curtis.rich@sba.gov*.

SUPPLEMENTARY INFORMATION:

(a) *Abstract:*

SBA is proposing to make several changes to this information collection (Form 1919, Form 1920SX (B & C) and Forms 2237 and 2238-Control Number

3245–0348). These changes, which are related to the application process for loan application and processing methods for the Agency's 7(a) loan program, are necessary to conform to recent updates to SBA's Standard Operating Procedures (SOP), *Lender and Development Company Loan Programs,* designated as SOP 50 10 5(F). The update resulted in changes related to franchise eligibility, character determinations, credit standards, and appraisal and business valuation requirements, among others. The update to the SOP also simplifies the application process for all SBA-guaranteed loans in the 7(a) Loan Program by consolidating the various forms used into one set of forms. Specifically, SBA proposes to use this information collection to collect the application related information currently collected by various other collections of information (OMB Control Numbers 3245–0016 and 3245–0361), which will subsequently be discontinued. The new consolidated 3245–0348 information collection will be revised to ensure that all of the non-duplicative and necessary information is captured by the consolidated forms. SBA will make the revised forms available on its Web site immediately after the Agency receives OMB's approval. The Agency will also provide notice of the forms' availability to the affected lending community though its usual communication channels.

SBA also notes that these changes are in addition to the ones that the Agency proposed in the February 25, 2013, publication of *504 and 7(a) Loan Program Updates* notice of proposed rulemaking. (78 FR 12633). That rulemaking is still pending final review and approval. As soon as SBA receives that approval it will make any additional and necessary changes to conform to the rule.

(b) *Solicitation of Public Comments:*

SBA is requesting comments on (a) Whether the collection of information is necessary for the agency to properly perform its functions; (b) whether the burden estimates are accurate; (c) whether there are ways to minimize the burden, including through the use of automated techniques or other forms of information technology; and (d) whether there are ways to enhance the quality, utility, and clarity of the information.

(c) *Overview of Information Collection:*

Title: SBA Express, Export Express, Small Loan Advantage, PLP-Caplines, and Pilot Loan Programs (Patriot Express and Dealer Floor Plan)

Description of Respondents: Small businesses applying for an SBA 7(a) loan and lenders participating in that program.

Form Numbers: (i) *Form 1919:* SBA Express, Export Express, Small Loan Advantage, PLP–CAPLines, and Pilot Loan Programs (Patriot Express And Dealer Floor Plan) Borrower Information Form. This form collects identifying information regarding the applicant, loan request, indebtedness, information about the principals, information about current or previous government financing, and certain other disclosures.

(ii) *Form 1920SX (Part A):* SBA Express, Export Express, Small Loan Advantage, PLP–CAPLines and Pilot Loan Programs (Patriot Express and Dealer Floor Plan) Guaranty Request. This form will no longer be used as it is a fax coversheet and all applications will be submitted to SBA electronically.

(iii) *Form 1920SX (Part B):* Supplemental Information for SBA Express, Export Express, Small Loan Advantage, Pilot Loan Programs and PLP Processing. This form is completed by the 7(a) Lender. This form includes, among other things, identifying information regarding the lender, loan terms, and use of proceeds.

(iv) *Form 1920SX (Part C):* Eligibility Information Required for SBA Express, Export Express, Small Loan Advantage, PLP–CAPLines and Pilot Loan Programs (Patriot Express and Dealer Floor Plan). This form is completed by the 7(a) Lender. It consolidates eligibility criteria regarding the loan applicants, including use of proceeds and general rules applicable to SBA Express, Export Express, Small Loan Advantage, PLP-CAPLines, Patriot Express and Dealer Floor Plan.

(v) *Form 2237:* 7(a) Loan Post Approval Action Checklist. This form is completed by the Lender and submitted to SBA for post-approval changes to the loan.

(vi) *Form 2238:* Supplemental Information for SBA Express/Patriot Express Guaranty Request (Eligibility Authorized). This form is completed by the Lender that has been designated as ''eligibility authorized.'' This form will no longer be used.

Total Estimated Annual Responses: 165,930

Total Estimated Annual Hour Burden: 275,055

Curtis Rich,

Management Analyst.

[FR Doc. 2013–28805 Filed 11–29–13; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration # 13823 and # 13824]

Texas Disaster # TX–00417

AGENCY: U.S. Small Business Administration

ACTION: Notice

SUMMARY: This is a notice of an Administrative declaration of a disaster for the State of Texas dated 11/22/2013.

Incident: Severe Storms and Flooding

Incident Period: 10/30/2013 through 10/31/2013

Effective Date: 11/22/2013

Physical Loan Application Deadline Date: 01/21/2014

Economic Injury (EIDL) Loan Application Deadline Date: 08/22/2014

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the Administrator's disaster declaration, applications for disaster loans may be filed at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Caldwell, Hays, Travis.

Contiguous Counties: Texas: Bastrop, Blanco, Burnet, Comal, Fayette, Gonzales, Guadalupe, Williamson.

The Interest Rates are:

	Percent
For Physical Damage:	
Homeowners With Credit Available Elsewhere	4.500
Homeowners Without Credit Available Elsewhere	2.250
Businesses With Credit Available Elsewhere	6.000
Businesses Without Credit Available Elsewhere	4.000
Non-Profit Organizations With Credit Available Elsewhere	2.625
Non-Profit Organizations Without Credit Available Elsewhere	2.625
For Economic Injury:	
Businesses & Small Agricultural Cooperatives Without Credit Available Elsewhere	4.000
Non-Profit Organizations Without Credit Available Elsewhere	2.625

The number assigned to this disaster for physical damage is 13823 6 and for economic injury is 13824 0.

The State which received an EIDL Declaration # is Texas.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

Dated: November 22, 2013.

Jeanne Hulit,

Acting Administrator.

[FR Doc. 2013–28803 Filed 11–29–13; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration # 13787 and # 13788]

New Mexico Disaster Number NM–00037

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 1.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for Public Assistance Only for the State of New Mexico (FEMA–4148–DR), dated 09/30/2013.

Incident: Severe Storms and Flooding

Incident Period: 07/23/2013 through 07/28/2013

Effective Date: 11/20/2013

Physical Loan Application Deadline Date: 11/29/2013

Economic Injury (EIDL) Loan Application Deadline Date: 06/30/2014

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing And Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: Alan Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street SW., Suite 6050, Washington, DC 20416

SUPPLEMENTARY INFORMATION: The notice of the President's major disaster declaration for Private Non-Profit organizations in the State of New Mexico, dated 09/30/2013, is hereby amended to include the following areas as adversely affected by the disaster.

Primary Counties and Areas: Sierra, And The Navajo Nation.

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

James E. Rivera,

Associate Administrator for Disaster Assistance.

[FR Doc. 2013–28796 Filed 11–29–13; 8:45 am]

BILLING CODE 8025–01–P

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

[Docket No. USTR–2013–0023]

Notice of Determination to Extend Section 301 Investigation of Ukraine

AGENCY: Office of the United States Trade Representative.

ACTION: Notice.

SUMMARY: The United States Trade Representative (Trade Representative) has determined to extend for three months the ongoing Section 301 investigation of certain acts, policies, and practices of the Government of Ukraine with respect to intellectual property rights.

FOR FURTHER INFORMATION CONTACT: Questions regarding this investigation should be directed as appropriate to: Elizabeth Kendall, Director for Intellectual Property and Innovation, Office of the United States Trade Representative, at (202) 395–3580; Isabella Detwiler, Director for Europe, at (202) 395–6146; or Shannon Nestor, Assistant General Counsel, at (202) 395–3150. Additional information on the investigation may be posted at *www.ustr.gov,* under Trade Topics—Enforcement—Section 301 Investigations.

SUPPLEMENTARY INFORMATION: On May 30, 2013, the Trade Representative initiated a Section 301 investigation of certain acts, policies, and practices of the Government of Ukraine with respect to intellectual property rights. See Identification of Ukraine as a Priority Foreign Country and Initiation of Section 301 Investigation, 78 FR 33886 (June 5, 2013).

Section 304(a)(3)(B) of the Trade Act of 1974, as amended, provides that the Trade Representative may extend this type of investigation for an additional three months upon a determination that the investigation involves complex or complicated issues that require additional time. Pursuant to this provision, the Trade Representative has determined to extend the investigation of certain acts, policies, and practices of the Government of Ukraine with respect to intellectual property rights. Accordingly, the determinations in the investigations will be made by no later than February 28, 2014.

William Busis,

Chair, Section 301 Committee.

[FR Doc. 2013–28806 Filed 11–29–13; 8:45 am]

BILLING CODE 3290–F4–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Aviation Rulemaking Advisory Committee; Meeting

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of Aviation Rulemaking Advisory Committee (ARAC) meeting.

SUMMARY: The FAA is issuing this notice to advise the public of a meeting of the ARAC.

DATES: The meeting will be held on December 19, 2013, starting at 1:00 p.m. Eastern Standard Time. Arrange oral presentations by December 12, 2013.

ADDRESSES: The meeting will take place at the Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591, 10th floor, MacCracken Room.

FOR FURTHER INFORMATION CONTACT: Renee Butner, Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591, telephone (202) 267–5093; fax (202) 267–5075; email *Renee.Butner@faa.gov.*

SUPPLEMENTARY INFORMATION: Pursuant to Section 10(a)(2) of the Federal Advisory Committee Act (5 U.S.C. App. 2), we are giving notice of a meeting of the ARAC taking place on December 19, 2013, at the Federal Aviation Administration, 800 Independence Avenue SW., Washington, DC 20591.

The Agenda includes:

1. Recommendation Report
   a. Flight Controls Harmonization Working Group (Transport Airplane and Engine Subcommittee [TAE])
2. Status Reports From Active Working Groups
   a. AC 120–17A Maintenance Control by Reliability Methods (ARAC)
   b. Flight Test Harmonization Working Group (TAE)
   c. Airworthiness Assurance Working Group (TAE)
   d. Engine Harmonization Working Group (TAE)
   e. Engine Endurance Testing Requirements—Revision of Section 33.87
3. New Task
   a. Airman Certification System Working Group
4. Status Report from the FAA
   a. Rulemaking Prioritization Working Group (RPWG)

Attendance is open to the interested public but limited to the space available. Please confirm your attendance with the person listed in the **FOR FURTHER INFORMATION CONTACT** section no later than December 12, 2013. Please provide the following

information: Full legal name, country of citizenship, and name of your industry association, or applicable affiliation. If you are attending as a public citizen please indicate so.

For persons participating by telephone, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section by email or phone for the teleconference call-in number and passcode. Callers outside the Washington metropolitan area are responsible for paying long-distance charges.

The public must arrange by December 12, 2013 to present oral statements at the meeting. The public may present written statements to the Aviation Rulemaking Advisory Committee by providing 25 copies to the Designated Federal Officer, or by bringing the copies to the meeting.

If you are in need of assistance or require a reasonable accommodation for this meeting, please contact the person listed under the heading **FOR FURTHER INFORMATION CONTACT**. Sign and oral interpretation, as well as a listening device, can be made available if requested 10 calendar days before the meeting.

Issued in Washington, DC, on November 25, 2013.

Brenda Courtney,

Designated Federal Officer, Aviation Rulemaking Advisory Committee.

[FR Doc. 2013–28720 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

[Docket No FAA–2005–22842]

Notice of Opportunity To Participate; Criteria and Application Procedures for Participation in the Military Airport Program

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of criteria and application procedures.

SUMMARY: This document announces the criteria, application procedures, and schedule to be applied by the Secretary of Transportation in designating or redesignating, and funding capital development for up to 15 current joint-use or former military airports seeking first time designation or redesignation to participate in the MAP.

DATES: Applications must be received on or before January 31, 2014.

ADDRESSES: Submit an original and two copies of *Standard Form (SF) 424,* ''Application for Federal Assistance,'' prescribed by the Office of Management and Budget Circular A–102, available at *http://www.faa.gov/airports/resources/forms/media/aip_sf424_2010.pdf* along with all supporting and justifying documentation required by this notice. Applicant should specifically request to be considered for designation or redesignation to participate in the fiscal year 2014 MAP. Submission should be sent to the Regional FAA Airports Division or Airports District Office that serves the airport. Applicants may find the proper office on the *FAA Web* site *http://www.faa.gov/airports/news_information/contact_info/regional/* or may contact the office below.

FOR FURTHER INFORMATION CONTACT: Mr. Kendall Ball (*Kendall.Ball@faa.gov*), Airports Financial Assistance Division (APP–500), Office of Airport Planning and Programming, Federal Aviation Administration (FAA), 800 Independence Avenue SW., Washington, DC 20591, (202) 267–7436.

SUPPLEMENTARY INFORMATION:

General Description of the Program

The MAP allows the Secretary to designate current joint-use or former military airports to receive grants from the Airport Improvement Program (AIP). The Secretary is authorized to designate an airport (other than an airport designated before August 24, 1994) only if:

(1) The airport is a former military installation closed or realigned under the Title 10 U.S.C. Sec. 2687 (announcement of closures of large Department of Defense installations after September 30, 1977), or under Section 201 or 2905 of the Defense Authorization Amendments and Base Closure and Realignment Acts; or

(2) the airport is a military installation with both military and civil aircraft operations.

The Secretary shall consider for designation only those current joint-use or former military airports, at least partly converted to civilian airports as part of the national air transportation system, that will reduce delays at airports with more than 20,000 hours of annual delays in commercial passenger aircraft takeoffs and landings, or will enhance airport and air traffic control system capacity in metropolitan areas, or reduce current and projected flight delays (49 U.S.C. 47118(c)).

The MAP provides capital development assistance to civil airport sponsors of designated current joint-use military airfields or former military airports that are included in the FAA's National Plan of Integrated Airport Systems (NPIAS). Airports designated to the MAP may be able to receive grant funds from a set-aside (currently four percent of AIP discretionary funds) for airport development, including certain projects not otherwise eligible for AIP assistance. These airports are also eligible to receive grants from other categories of AIP funding.

Number of Airports

A maximum of 15 airports per fiscal year may participate in the MAP, of which 3 may be General Aviation (GA) airports. There are 8 slots available for designation or redesignation in FY 2014. There are no GA slots available in FY 2014.

Term of Designation

The maximum term is five fiscal years following designation. The FAA can designate airports for a period of less than five years. The FAA will evaluate the conversion needs of the airport in its capital development plan to determine the appropriate length of designation.

Redesignation

Previously designated airports may apply for redesignation of an additional term not to exceed five years. Those airports must meet current eligibility requirements in 49 U.S.C. 47118(a) at the beginning of each grant period and have MAP eligible projects. The FAA will evaluate applications for redesignation primarily in terms of warranted projects fundable only under the MAP as these candidates tend to have fewer conversion needs than new candidates. The FAA's goal is to graduate MAP airports to regular AIP participation by successfully converting these airports to civilian airport operations.

Eligible Projects

In addition to eligible AIP projects, MAP can fund fuel farms, utility systems, surface automobile parking lots, hangars, and air cargo terminals up to 50,000 square feet. A designated or redesignated military airport can receive not more than $7,000,000 each fiscal year to construct, improve, and repair terminal building facilities. In addition a designated or redesignated military airports can receive not more than $7,000,000 each fiscal year for MAP eligible projects that include hangars, cargo facilities, fuel farms, automobile surface parking, and utility work.

Designation Considerations

In making designations of new candidate airports, the Secretary of Transportation may only designate an airport (other than an airport so

designated before August 24, 1994) if it meets the following general requirements:

(1) The airport is a former military installation closed or realigned under:

(A) Section 2687 of Title 10;

(B) Section 201 of the Defense Authorization Amendments and Base Closure and Realignment Act (BRAC) (10 U.S.C. 2687 note); or

(C) Section 2905 of the Defense Base Closure and Realignment Act of 1990 (10 U.S.C. 2687 note); or

(2) The airport is a military installation with both military and civil aircraft operations; and

(3) The airport is classified as a commercial service or reliever airport in the NPIAS. (See 49 U.S.C. 47105(b)(2)). In addition, three of the designated airports, if included in the NPIAS, may be a GA airport that was a former military installation closed or realigned under BRAC, as amended, or 10 U.S.C. 2687. (See 49 U.S.C. 47118(g)). Therefore, a GA airport can only qualify under (1) above. ''General aviation airport'' means a public airport that is located in a State that, as determined by the Secretary: (A) Does not have scheduled service; or (B) has scheduled service with less than 2,500 passenger boardings each year. However, as noted under ''Number of Airports,'' there are no GA slots available in FY 2014.

In designating new candidate airports, the Secretary shall consider if a grant will:

(1) Reduce delays at an airport with more than 20,000 hours of annual delays in commercial passenger aircraft takeoffs and landings; or

(2) Enhance airport and air traffic control system capacity in a metropolitan area or reduce current and projected flight delays.

The application for new designations will be evaluated in terms of how the proposed projects will contribute to reducing delays and/or how the airport will enhance air traffic or airport system capacity and provide adequate user services.

Project Evaluation

Recently realigned or closed military airports, as well as active military airfields with new joint-use agreements, have the greatest need of funding to convert to, or to incorporate, civil airport operations. Newly converted airports and new joint-use locations frequently have minimal capital development resources and will therefore receive priority consideration for designation and MAP funding. The FAA will evaluate the need for eligible projects based upon information in the candidate airport's five-year Capital Improvement Plan (CIP).

1. The FAA will evaluate candidate airports and/or the airports such candidate airports will relieve based on the following specific factors:

- Compatibility of airport roles and the ability of the airport to provide an adequate airport facility;
- The capability of the candidate airport and its airside and landside complex to serve aircraft that otherwise must use a congested airport;
- Landside surface access;
- Airport operational capability, including peak hour and annual capacities of the candidate airport;
- Potential of other metropolitan area airports to relieve the congested airport;
- Ability to satisfy, relieve, or meet air cargo demand within the metropolitan area;
- Forecasted aircraft and passenger levels, type of commercial service anticipated, i.e., scheduled or charter commercial service;
- Type and capacity of aircraft projected to serve the airport and level of operations at the congested airport and the candidate airport;
- The potential for the candidate airport to be served by aircraft or users, including the airlines, serving the congested airport;
- Ability to replace an existing commercial service or reliever airport serving the area; and
- Any other documentation to support the FAA designation of the candidate airport.

2. The FAA will evaluate the extent to which development needs funded through MAP will make the airport a viable civil airport that will enhance system capacity or reduce delays.

Application Procedures and Required Documentation

Airport sponsors applying for designation or redesignation must complete and submit an SF 424, Application for Federal Assistance, and provide supporting documentation to the appropriate FAA Airports regional or district office serving that airport.

Standard Form 424

Sponsors may obtain this fillable form at *http://www.faa.gov/airports/resources/forms/media/aip_sf424_2010.pdf.* Applicants should fill this form out completely, including the following:

- Mark Item 1, Type of Submission as a ''pre-application'' and indicate it is for ''construction''.
- Mark item 8, Type of Application as ''new'', and in ''other'', fill in ''Military Airport Program''.
- Fill in Item 11, Descriptive Title of Applicant's Project. ''Designation (or redesignation) to the Military Airport Program''.
- In Item 15a, Estimated Funding, indicate the total amount of funding requested from the MAP during the entire term for which you are applying.

Supporting Documentation

(A) Identification as a Current or Former Military Airport. The application must identify the airport as either a current or former military airport and indicate whether it was:

(1) Closed or realigned under Section 201 of the Defense Authorization Amendments and Base Closure and Realignment Act, and/or Section 2905 of the Defense Base Closure and Realignment Act of 1990 (Installations Approved for Closure by the Defense Base Realignment and Closure Commissions), or

(2) Closed or realigned pursuant to 10 U.S.C. 2687 as excess property (bases announced for closure by Department of Defense (DOD) pursuant to this title after September 30, 1977 (this is the date of announcement for closure)), or

(3) A military installation with both military and civil aircraft operations. A general aviation airport applying for the MAP may be joint-use but must also qualify under (1) or (2) above.

(B) Qualifications for MAP:

Submit documents for (1) through (8) below:

(1) Documentation that the airport meets the definition of a ''public airport'' as defined in 49 U.S.C. Sec. 47102(20).

(2) Documentation indicating the required environmental review for civil reuse or joint-use of the military airfield has been completed. This environmental review need not include review of the individual projects to be funded by the MAP. Rather, the documentation should reflect that the environmental review necessary to convey the property, enter into a long-term lease, or finalize a joint-use agreement has been completed. The military department conveying or leasing the property, or entering into a joint-use agreement, has the lead responsibility for this environmental review. To meet AIP requirements the environmental review and approvals must indicate that the operator or owner of the airport has good title, satisfactory to the Secretary, or assures to the FAA's satisfaction that good title will be acquired.

(3) For a former military airport, documentation that the eligible airport sponsor holds or will hold satisfactory title, a long-term lease in furtherance of

conveyance of property for airport purposes, or a long-term interim lease for 25 years or longer to the property on which the civil airport is being located. Documentation that an application for surplus or BRAC airport property has been accepted by the Federal Government is sufficient to indicate the eligible airport sponsor holds or will hold satisfactory title or a long-term lease.

(4) For a current military airport, documentation that the airport sponsor has an existing joint-use agreement with the military department having jurisdiction over the airport. For all first time applicants a copy of the existing joint-use agreement must be submitted with the application. This is necessary so the FAA can legally issue grants to the sponsor. Here and in (3) directly above, the airport must possess the necessary property rights in order to accept a grant for its proposed projects during FY 2014.

(5) Documentation that the airport is classified as a ''commercial service airport'' or a ''reliever airport'' as defined in 49 U.S.C. 47102(7) and 47102(23).

(6) Documentation that the airport owner is an eligible airport ''sponsor'' as defined in 49 U.S.C. 47102(26).

(7) Documentation that the airport has a five-year Capital Improvement Plan (CIP) indicating all eligible grant projects requested to be funded either from the MAP or other portions of the AIP and an FAA approved Airport Layout Plan (ALP).

(8) For commercial service airports a business/marketing plan or equivalent must be submitted with the application. For relievers or general aviation airports other planning documents may be submitted.

(C) Evaluation Factors:

Submit information on the items below to assist in our evaluation:

(1) Information identifying the existing and potential levels of visual or instrument operations and aeronautical activity at the current or former military airport and, if applicable, the congested airport. Also, if applicable, information on how the airport contributes to air traffic system or airport system capacity. If served by commercial air carriers, the revenue passenger and cargo levels should be provided.

(2) A description of the airport's projected civil role and development needs for transitioning from use as a military airfield to a civil airport. Include how development projects would serve to reduce delays at an airport with more than 20,000 hours of annual delays in commercial passenger aircraft takeoffs and landings; or enhance capacity in a metropolitan area or reduce current and projected flight delays.

(3) A description of the existing airspace capacity. Describe how anticipated new operations would affect the surrounding airspace and air traffic flow patterns in the metropolitan area in or near the airport. Include a discussion of whether operations at this airport create airspace conflicts that may cause congestion or whether air traffic works into the flow of other air traffic in the area.

(4) A description of the airport's five-year CIP, including a discussion of major projects, their priorities, projected schedule for project accomplishment, and estimated costs. The CIP must specifically identify the safety, capacity, and conversion related projects, associated costs, and projected five-year schedule of project construction, including those requested for consideration for MAP funding.

(5) A description of those projects that are consistent with the role of the airport and effectively contribute to the joint-use or conversion of the airfield to a civil airport. The projects can be related to various improvement categories depending on what is needed to convert from military to civil airport use, to meet required civil airport standards, and/or to provide capacity to the airport and/or airport system. The projects selected (e.g., safety-related, conversion-related, and/or capacity-related), must be identified and fully explained based on the airport's planned use. Those projects that may be eligible under MAP, if needed for conversion or capacity-related purposes, must be clearly indicated, and include the following information:

Airside

- Modification of airport or military airfield for safety purposes, including airport pavement modifications, marking, lighting, strengthening, drainage or modifying other structures or features in the airport environs to meet civil standards for approach, departure and other protected airport surfaces as described in *14 CFR part 77* or standards set forth in FAA Advisory Circular 150/5300–13.
- Construction of facilities or support facilities such as passenger terminal gates, aprons for passenger terminals, taxiways to new terminal facilities, aircraft parking, and cargo facilities to accommodate civil use.
- Modification of airport or military utilities (electrical distribution systems, communications lines, water, sewer, storm drainage) to meet civil standards. Also, modifications that allow utilities on the civil airport to operate independently, where other portions of the base are conveyed to entities other than the airport sponsor or retained by the Government.
- Purchase, rehabilitation, or modification of airport and airport support facilities and equipment, including snow removal, aircraft rescue, firefighting buildings and equipment, airport security, lighting vaults, and reconfiguration or relocation of eligible buildings for more efficient civil airport operations.
- Modification of airport or military airfield fuel systems and fuel farms to accommodate civil aviation use.
- Acquisition of additional land for runway protection zones, other approach protection, or airport development.
- Cargo facility requirements.
- Modifications, which will permit the airfield to accommodate general aviation users.

Landside

- Construction of surface parking areas and access roads to accommodate automobiles in the airport terminal and air cargo areas and provide an adequate level of access to the airport.
- Construction or relocation of access roads to provide efficient and convenient movement of vehicular traffic to, on, and from the airport, including access to passenger, air cargo, fixed base operations, and aircraft maintenance areas.
- Modification or construction of facilities such as passenger terminals, surface automobile parking lots, hangars, air cargo terminal buildings, and access roads to cargo facilities to accommodate civil use.

(6) An evaluation of the ability of surface transportation facilities (e.g., road, rail, high-speed rail, and/or maritime) to provide intermodal connections.

(7) A description of the type and level of aviation and community interest in the civil use of a current or former military airport.

(8) One copy of the FAA-approved ALP for each copy of the application. The ALP or supporting information should clearly show capacity and conversion related projects. Other information such as project costs, schedule, project justification, other maps and drawings showing the project locations, and any other supporting documentation that would make the application easier to understand should also be included. You may also provide photos, which would further describe the airport, projects, and otherwise clarify certain aspects of this

application. These maps and ALP's should be cross-referenced with the project costs and project descriptions.

Redesignation of Airports Previously Designated and Applying for Up to an Additional Five Years in the Program

Airports applying for redesignation to the Military Airport Program must submit the same information required by new candidate airports applying for a new designation. On the SF 424, Application for Federal Assistance, prescribed by the Office of Management and Budget Circular A–102, airports must indicate their application is for redesignation to the MAP. In addition to the information required for new candidates, airports requesting redesignation must also explain:

(1) Why a redesignation and additional MAP eligible project funding is needed to accomplish the conversion to meet the civil role of the airport and the preferred time period for redesignation not to exceed five years;

(2) Why funding of eligible work under other categories of AIP or other sources of funding would not accomplish the development needs of the airport; and

(3) Why, based on the previously funded MAP projects, the projects and/or funding level were insufficient to accomplish the airport conversion needs and development goals.

In addition to the information requested above, airports applying for redesignation must provide a reanalysis of their original business/marketing plans (for example, a plan previously funded by the Office of Economic Adjustment or the original Master Plan for the airport) and prepare a report. If there is not an existing business/marketing plan a business/marketing plan or strategy must be developed. The report must contain:

(1) Whether the original business/marketing plan is still appropriate;

(2) Is the airport continuing to work towards the goals established in the business/marketing plan;

(3) Discuss how the MAP projects contained in the application contribute to the goals of the sponsor and their plans; and

(4) If the business/marketing plan no longer applies to the current goals of the airport, how has the airport altered the business/marketing plan to establish a new direction for the facility and how do the projects contained in the MAP application aid in the completion of the new direction and goals and by what date does the sponsor anticipate graduating from the MAP.

This notice is issued pursuant to Title 49 U.S.C. 47118.

Dated: Issued at Washington, DC, on November 22, 2013.

Mary Walsh,

Acting Director, Office of Airport Planning and Programming.

[FR Doc. 2013–28748 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

[Docket No. FMCSA–2013–0312]

Agency Information Collection Activities; Extension of an Approved Information Collection: Training Certification for Drivers of Longer Combination Vehicles

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Notice; request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, FMCSA announces its plan to submit the Information Collection Request (ICR) described below to the Office of Management and Budget (OMB) for approval and invites public comment. FMCSA requests approval to renew the ICR entitled ''*Training Certification for Drivers of Longer Combination Vehicles (LCVs).*'' This ICR relates to Agency requirements for drivers to be certified to operate LCVs, and that motor carriers must satisfy before permitting their drivers to operate LCVs. Motor carriers, upon inquiry by authorized Federal, State or local officials, must produce an LCV driver-training certificate for each of their LCV drivers.

DATES: We must receive your comments on or before January 31, 2014.

ADDRESSES: You may submit comments identified by Federal Docket Management System Number FMCSA–2013–0312 by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the online instructions for submitting comments.
- *Fax:* 1–202–493–2251.
- *Mail:* Docket Management Facility, U.S. Department of Transportation, 1200 New Jersey Avenue SE., West Building, Ground Floor, Room W12–140, Washington, DC 20590–0001.
- *Hand Delivery or Courier:* West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., between 9 a.m. and 5 p.m. E.T., Monday through Friday, except Federal holidays.

Instructions: All submissions must include the Agency name and docket number. For detailed instructions on submitting comments and additional information on the exemption process, see the Public Participation heading below. Note that all comments received will be posted without change to *www.regulations.gov*, including any personal information provided. Please see the Privacy Act heading below.

Docket: For access to the docket to read background documents or comments received, go to *www.regulations.gov*, and follow the online instructions for accessing the dockets, or go to the street address listed above.

Privacy Act: Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's Privacy Act Statement for the Federal Docket Management System published in the **Federal Register** on January 17, 2008 (73 FR 3316), or you may visit *http://edocket.access.gpo.gov/2008/pdfE8-794.pdf.*

Public participation: The Federal eRulemaking Portal is available 24 hours each day, 365 days each year. You can obtain electronic submission and retrieval help and guidelines under the ''help'' section of the Federal eRulemaking Portal Web site. If you want us to notify you that we received your comments, please include a self-addressed, stamped envelope or postcard, or print the acknowledgement page that appears after submitting comments online. Comments received after the comment closing date will be included in the docket and will be considered to the extent practicable.

FOR FURTHER INFORMATION CONTACT: Mr. Thomas Yager, Chief, Driver and Carrier Operations Division, Department of Transportation, Federal Motor Carrier Safety Administration, West Building 6th Floor, 1200 New Jersey Avenue SE., Washington, DC 20590. Telephone: 202–366–4325; email *tom.yager@dot.gov.*

SUPPLEMENTARY INFORMATION:

Background

An LCV is any combination of a truck-tractor and two or more semi-trailers or trailers that operates on the National System of Interstate and Defense Highways (according to 23 CFR 470.107) and has a gross vehicle weight greater than 80,000 pounds. To enhance the safety of LCV operations on our nation's highways, Section 4007(b) of the Motor Carrier Act of 1991 directed the Secretary of Transportation to establish Federal minimum training requirements for drivers of LCVs [Intermodal Surface

Transportation Efficiency Act of 1991 (ISTEA), Pub. L. 102–240, 105 Stat. 1914, 2152]. The Secretary of Transportation delegated responsibility for establishing these requirements to FMCSA (49 CFR 1.87), and on March 30, 2004, after appropriate notice and solicitation of public comment, FMCSA established the current training requirements for operators of LCVs (69 FR 16722). The regulations bar motor carriers from permitting their drivers to operate an LCV if they have not been properly trained in accordance with the requirements of 49 CFR 380.113. Drivers receive an LCV Driver-Training Certificate upon successful completion of these training requirements. Motor carriers employing an LCV driver must verify the driver's qualifications to operate an LCV, and must maintain a copy of the LCV Driver-Training Certificate to present to authorized Federal, State or local officials upon request.

Title: Training Certification for Drivers of LCVs.

OMB Control Number: 2126–0026.

Type of Request: Extension of a currently-approved information collection.

Respondents: Drivers who complete LCV training each year, current LCV drivers who submit their LCV Driver-Training Certificate to prospective employers, and employers (motor carriers) receiving and maintaining copies of the LCV Driver-Training certificates of their drivers.

Estimated Number of Respondents: 50,880, consisting of 940 newly-certified LCV drivers plus 24,500 currently-certified LCV drivers plus 25,440 motor carriers employing LCV drivers.

Estimated Time per Response: 10 minutes for preparation of LCV Driver-Training Certificates for drivers who successfully complete the LCV training, and 10 minutes for activities associated with the LCV Driver-Training Certificate during the hiring process.

Expiration Date: March 31, 2014.

Frequency of Response: On occasion.

Estimated Total Annual Burden: 4,397 hours. The total number of drivers who will be subjected to these requirements each year is 25,440, consisting of 940 newly-certified LCV drivers, and 24,500 currently-certified LCV drivers obtaining new employment. The total annual information collection burden is approximately 4,397 hours, consisting of 157 hours for preparation of LCV Driver-Training Certificates [940 drivers successfully completing LCV driver training × 10 minutes ÷ 60 minutes/hour] and 4,240 hours for requirements related to the hiring of LCV drivers [24,500 LCV drivers obtaining new employment × 10 minutes ÷ 60 minutes/hour].

Public Comments Invited: You are asked to comment on any aspect of this information collection, including: (1) whether the proposed collection is necessary for FMCSA's performance; (2) the accuracy of the estimated burden; (3) ways for FMCSA to enhance the quality, usefulness, and clarity of the collected information; and (4) ways that the burden could be minimized without reducing the quality of the collected information. The Agency will summarize or include your comments in the request for OMB's clearance of this information collection.

Issued under the authority of 49 CFR 1.87 on: November 20, 2013

G. Kelly Leone,

Associate Administrator, Office of Research and Information Technology, and Chief Information Officer.

[FR Doc. 2013–28809 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–EX–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

[Docket No FMCSA–2013–0457]

Motor Carrier Management Information System (MCMIS) Changes to Improve Uniformity in the Treatment of Inspection Violation Data

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Notice; request for public comment.

SUMMARY: FMCSA announces changes to its Motor Carrier Management Information System (MCMIS) to allow the Agency to upload the results of associated adjudicated State citations for roadside inspection violation data. MCMIS will be modified to accept adjudication information concerning a citation associated with a violation that was dismissed or resulted in a finding of not guilty; resulted in a conviction of a different or lesser charge; or resulted in conviction of the original charge. This action will improve roadside inspection data quality. In addition, the Agency announces new processes to provide more uniformity in the way the inspection violation data are treated in FMCSA data systems. FMCSA seeks public comments on the prospective application of the changes.

DATES: Comments must be received on or before January 2, 2014.

ADDRESSES: You may submit comments identified by docket number FMCSA–2013–0457 using any one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.*
- *Fax:* 202–493–2251.
- *Mail:* Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590–0001.
- *Hand delivery:* Same as mail address above, between 9 a.m. and 5 p.m., e.t., Monday through Friday, except Federal holidays. The telephone number is 202–366–9329.

To avoid duplication, please use only one of these four methods. See the ''Public Participation and Request for Comments'' heading under the **SUPPLEMENTARY INFORMATION** section below for instructions on submitting comments.

FOR FURTHER INFORMATION CONTACT: Ms. Courtney Stevenson, Federal Motor Carrier Safety Administration, 1200 New Jersey Avenue SE., Washington, DC 20590, telephone 202–366–5241 or by email: *courtney.stevenson@dot.gov*. FMCSA office hours are from 9 a.m. to 5 p.m., e.t., Monday through Friday, except Federal holidays. If you have questions on viewing or submitting material to the docket, call Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION:

I. Public Participation and Request for Comments

FMCSA encourages you to participate by submitting comments and related materials.

Submitting Comments

If you submit a comment, please include the docket number for this notice (FMCSA–2013–0457), indicate the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation. You may submit your comments and material online or by fax, mail, or hand delivery, but please use only one of these means. FMCSA recommends that you include your name and a mailing address, an email address, or a phone number in the body of your document so the Agency can contact you if it has questions regarding your submission.

To submit your comment online, go to *http://www.regulations.gov* and put the docket number, ''FMCSA–2013–0457'' in the ''Keyword'' box, and click ''Search.'' When the new screen appears, click on ''Comment Now!'' button and type your comment into the text box in the following screen. Choose

whether you are submitting your comment as an individual or on behalf of a third party and then submit. If you submit your comments by mail or hand delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit comments by mail and would like to know that they reached the facility, please enclose a stamped, self-addressed postcard or envelope.

FMCSA will consider all comments and material received during the comment period and may change this notice based on your comments.

Viewing Comments and Documents

To view comments, as well as documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov* and insert the docket number, ''FMCSA–2013–0457'' in the ''Keyword'' box and click ''Search.'' Next, click ''Open Docket Folder'' button and choose the document listed to review. If you do not have access to the Internet, you may view the docket online by visiting the Docket Management Facility in Room W12–140 on the ground floor of the DOT West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., e.t., Monday through Friday, except Federal holidays.

Privacy Act

All comments received will be posted without change to *http://www.regulations.gov* and will include any personal information you have provided. Anyone may search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or of the person signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on January 17, 2008 (73 FR 3316), or you may visit *http://edocket.access.gpo.gov/2008/pdf/E8-785.pdf*.

II. Executive Summary

As discussed below, States adopt and enforce motor carrier safety and hazardous materials laws and regulations as an eligibility requirement for FMCSA's Motor Carrier Safety Assistance Program (MCSAP) and report violations discovered through roadside inspections to FMCSA. Motor carriers and drivers alleging that errors have occurred may petition the States for correction. High-quality data that are complete, timely, accurate, and consistently reported enable FMCSA to continue to achieve its safety mission by identifying trends in the violation data.

One of the challenges that the Agency faces in trying to ensure the data are accurate is how best to consider violations cited during roadside inspections that are subsequently adjudicated in State and local courts. This is especially difficult when the roadside inspection results are uploaded by the State enforcement agency into FMCSA's information systems and the subsequent adjudication happens much later with no practical means for the adjudication results to be transmitted directly to FMCSA. In response to this challenge, FMCSA is modifying its MCMIS to accept adjudication information concerning a citation associated with a violation that (1) was dismissed or resulted in a finding of not guilty; (2) resulted in a conviction of a different or lesser charge; or (3) resulted in conviction of the original charge. The Agency's State partners will modify their processes and procedures to capture the State and local adjudications results associated with roadside inspection violations and upload the information to FMCSA. These changes will improve the uniformity and quality of data vital to improving safety on the Nation's roads.

III. Background

As discussed below, States enforce motor carrier safety laws under a Federal grant program and report violations discovered through roadside inspections to FMCSA. Parties alleging that errors have occurred may petition the States for correction. High-quality data that are complete, timely, accurate, and consistently reported enable FMCSA to continue to achieve its safety mission. Therefore, FMCSA announces changes to MCMIS and processes to append the results of associated adjudicated State citations to the inspection violation data. These changes improve the uniformity and quality of data vital to improving safety on the Nation's roads.

A. Definitions

For the purposes of this notice, the following definitions apply:

- *Adjudicated Citation:* A citation that has been contested and resolved through a due process proceeding in a State, local, or administrative tribunal, regardless of how the action is resolved, whether by a judge or prosecutor or as part of a plea agreement or otherwise.
- *Citation:* A notice, issued by a law enforcement officer to a commercial motor vehicle driver for a violation of State law or State-adopted Federal Motor Carrier Safety Regulation (FMCSR) or Hazardous Materials Regulation (HMR). The driver may contest the citation through a State-provided administrative or judicial system.
- *Conviction* (as defined at 49 CFR 383.5 and 390.5): An unvacated adjudication of guilt, or a determination that a person has violated or failed to comply with the law in a court of original jurisdiction or by an authorized administrative tribunal, an unvacated forfeiture of bail or collateral deposited to secure the person's appearance in court, a plea of guilty or *nolo contendere* accepted by the court, the payment of a fine or court cost, or violation of a condition of release without bail, regardless of whether or not the penalty is rebated, suspended, or probated.
- *Unvacated:* Refers to an order or judgment that has not been cancelled or rescinded.

B. Databases for Inspection Data

State law enforcement officials routinely conduct roadside inspections documenting violations of State laws or regulations that are ''compatible'' with the FMCSRs and HMRs. See 49 CFR 350.105 (which defines ''compatible or compatibility''). State officials, at their discretion, may issue State citations for the violations recorded on the roadside inspection report. States enter roadside inspection and violation data into SafetyNet, a database management system that allows entry, access, analysis, and reporting of data from driver/vehicle inspections, crashes, compliance reviews, assignments, and complaints. It is operated at State safety agencies and Federal Divisions and interfaces with roadside inspection software, SAFER,[1] MCMIS, and State systems. The MCMIS data are then used in other FMCSA data systems, including the Pre-employment Screening Program (PSP)[2] and the Safety Measurement System (SMS).[3]

Drivers and motor carriers may challenge citations associated with violations recorded during roadside inspections through State judicial or administrative systems. A citation that has been resolved through a State's judicial or administrative process,

[1] SAFER is FMCSA's Safety and Fitness Electronic Records (SAFER) system.

[2] PSP helps motor carriers make more informed hiring decisions by providing electronic access to a driver's crash and inspection history from MCMIS. See *http://www.psp.fmcsa.dot.gov/Pages/default.aspx*.

[3] SMS is an automated system that quantifies the on-road safety performance of motor carriers so that FMCSA can identify unsafe carriers, prioritize them for intervention, and monitor if a motor carrier's safety and compliance problem is improving. See *http://csa.fmcsa.dot.gov/*.

regardless of outcome, is considered to be adjudicated. Drivers, motor carriers, and members of the public may file a Request for Data Review (RDR) in FMCSA's DataQs system for acknowledgement of the adjudication in the inspection record when the State process does not result in conviction of the original charge.

C. Motor Carrier Safety Data Correction System

Pursuant to 49 CFR 350.201(s), one of the conditions for participation in the MCSAP is that a State must establish a program to ensure that accurate and timely motor carrier safety data are collected and reported, and ensure the State's participation in a national motor carrier safety data correction system prescribed by FMCSA. DataQs is that national motor carrier data correction system (49 CFR 350.211, ¶ 11).

DataQs is an online system that provides an electronic means for drivers, motor carriers, and members of the public to submit concerns about the accuracy of Federal and State crash, inspection, and violation data in FMCSA data systems. When a request for an RDR is filed, the DataQs system automatically forwards the request to the appropriate Federal or State office for processing and resolution (*https://dataqs.fmcsa.dot.gov/*).

Presently, SafetyNet and MCMIS record only inspection and violation data from the initial inspection report, and do not contain a data field that would allow the State to append the result of an adjudicated citation to the appropriate violation on the inspection report. There is some inconsistency in how States address an adjudicated citation for which an RDR is filed. The DataQs User Guide and Manual, available at: *https://dataqs.fmcsa.dot.gov/Data/Guide/DataQs_Users_Guide_and_Best_Practices_Manual.pdf*, describes standardized processes and techniques to address and resolve RDRs.

FMCSA issued guidance to State DataQs analysts in May 2011, explaining that the ''. . . DataQs guidance does NOT recommend or require blanket rejection of DataQs RDRs seeking removal of violations that have been dismissed by a court. Instead, we [FMCSA] advise that the analysts exercise discretion and good judgment by carefully reviewing the reason for the court dismissal based on any and all available information and determine whether fairness dictates removal of the violation from the State and Federal database.'' In following this guidance, some States will automatically remove a violation associated with an adjudicated citation for which there is no conviction, while others do not remove the violation unless evidence submitted to the court supports a finding that the violation did not occur. Today's notice is intended to create greater uniformity across the States.

IV. Overview of Changes

A. New Data Field for Adjudicated Citations Results

FMCSA will issue revised direction to the States to document adjudication results and supplement the initial inspection report when an RDR containing appropriate documentation is submitted. If the RDR provides adequate documentation of an adjudicated citation related to a violation or violations recorded in a roadside inspection report, the State will enter adjudication results into SafetyNet. State and Federal data systems will be modified to accept data concerning a citation associated with a violation that (1) was dismissed or resulted in a finding of not guilty; (2) resulted in a conviction of a different or lesser charge; or (3) resulted in conviction of the original charge. Those adjudications, recorded in SafetyNet, will be uploaded into MCMIS.

FMCSA is revising the MCMIS database and creating a new data field to allow inclusion of adjudicated citation results associated with violations documented during an inspection. The results of adjudicated citations recorded in MCMIS will be reflected in FMCSA's SMS and PSP.

The following table indicates how the adjudication outcomes documented in MCMIS will impact the use of the cited violation in FMCSA's SMS and PSP databases:

Result of adjudicated citation associated with a violation uploaded to MCMIS:	Violation in SMS:	Violation in PSP:
(1) Convicted of original charge	Retain violation	Retain violation.
(2) Not guilty/Dismissed	Remove violation	Remove violation.
(3) Convicted of different charge	Retain AND indicate violation as ''Resulted in conviction of a different charge'';. SMS severity weight set to lowest value in BASIC*.	Retain AND indicate violation as ''Resulted in conviction of a different charge''.

* SMS quantifies motor carrier performance in seven Behavioral Analysis Safety Improvement Categories (BASICs). The SMS methodology, including a description of severity weights used in the methodology, is provided at *http://csa.fmcsa.dot.gov/Documents/SMSMethodology.pdf.*

As required by FMCSA's MCSAP regulations (i.e., 49 CFR part 350) States must follow the Agency's regulatory definition of ''conviction'' as outlined in the definitions section in this notice and in 49 CFR 383.5 and 390.5 and address RDRs accordingly. Thus, when an RDR indicates that a State court dismissed a citation while still imposing a fine or court cost, the outcome will be recorded in SafetyNet as a conviction by the State.

Upon implementing the MCMIS policy discussed in this notice, FMCSA will update the DataQs guidance manual to reflect these changes.

B. Prospective Application of the MCMIS Changes

The primary purpose of these changes is to improve uniformity in the treatment of violation data associated with adjudicated citations. FMCSA intends that States record adjudicated citation results only for citations associated with, and issued during, a roadside inspection that occurs on or after the implementation date. This prospective approach is consistent with all of FMCSA's previous system changes designed to improve data quality.

FMCSA believes the prospective application will mitigate the potential for significantly increased numbers of RDRs, based on hundreds—potentially thousands—of past adjudicated citations, which could quickly exhaust States' DataQs capability. Such a drain on State DataQs staffs could prevent States from promptly acting on other RDR requests and/or could create a need to redirect scarce State resources from roadside enforcement to DataQs processing, adversely affecting motor carrier safety enforcement. In addition, the prospective application will (1) provide a uniform and orderly process for the States to incorporate recording adjudicated citations into their State MCSAP Commercial Vehicle Safety Plans and budgets (see 49 CFR 350.213

for description of CVSP); (2) provide an effective process that the Agency can test to ensure system effectiveness and data quality; and (3) reduce the cost of applying and implementing these changes across the Agency and the States. FMCSA seeks comments on the prospective application of the changes.

C. Prohibition on Masking Convictions

The FMCSA emphasizes the importance of accurate information concerning traffic violations in addition to roadside inspection violations. The Agency will continue its work with the States to ensure that commercial learner's permit (CLP) and commercial driver's license (CDL) holders who are found to have engaged in unsafe driving behaviors are not provided with relief from the consequences of these unsafe actions through masking of their convictions by the States. Masking convictions allows commercial drivers to accumulate multiple serious traffic safety violations without the driver's State of licensure or other States being aware of the driver's actual driving history.

FMCSA regulation at 49 CFR 384.226 prohibits States from masking convictions, deferring imposition of judgment, or allowing an individual to enter into a diversion program that would prevent a CLP or CDL holder's conviction for any violation, in any type of motor vehicle, of a State or local traffic control law (other than parking, vehicle weight, or vehicle defect violations) from appearing on the Commercial Driver's License Information System driving record, whether the driver was convicted for an offense committed in the State where the driver is licensed or another State. The Agency views the practice of State courts dismissing citations after a guilty plea has been entered or following payment of a fine or mandatory contribution to a State program as a condition of dismissal, as ''masking'' of a commercial driver's violation of State or local traffic control laws.

The changes to State and FMCSA data systems outlined in this notice will enable both the Agency and the State licensing agencies to better track and document patterns and practices that are inconsistent with 49 CFR 384.226 concerning the masking prohibition. States found to have used masking or other diversionary programs may be found in substantial noncompliance and could risk decertification of their CDL programs, which could impact grant funding.

Issued on: November 26, 2013.

Anne S. Ferro,

Administrator.

[FR Doc. 2013–28795 Filed 11–26–13; 4:15 pm]

BILLING CODE 4910–EX–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

[Docket No. FMCSA—2013–0125]

Qualification of Drivers; Application for Exemptions; Hearing

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Notice of applications for exemptions; request for comments.

SUMMARY: FMCSA announces that 10 individuals have applied for a medical exemption from the hearing requirement in the Federal Motor Carrier Safety Regulations (FMCSRs). In accordance with the statutory requirements concerning applications for exemptions, FMCSA requests public comments on these requests. The statute and implementing regulations concerning exemptions require that exemptions must provide an equivalent or greater level of safety than if they were not granted. If the Agency determines the exemptions would satisfy the statutory requirements and decides to grant theses requests after reviewing the public comments submitted in response to this notice, the exemptions would enable 10 individuals to operate CMVs in interstate commerce.

DATES: Comments must be received on or before January 2, 2014.

ADDRESSES: You may submit comments bearing the Federal Docket Management System (FDMS) Docket No. FMCSA—2013–0125 using any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov*. Follow the on-line instructions for submitting comments.
- *Mail:* Docket Management Facility; U.S. Department of Transportation, 1200 New Jersey Avenue SE., West Building Ground Floor, Room W12–140, Washington, DC 20590–0001.
- *Hand Delivery:* West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC, between 9 a.m. and 5 p.m., ET, Monday through Friday, except Federal Holidays.
- *Fax:* 1–202–493–2251.

Instructions: Each submission must include the Agency name and the docket numbers for this notice. Note that all comments received will be posted without change to *http://www.regulations.gov*, including any personal information provided. Please see the Privacy Act heading below for further information.

Docket: For access to the docket to read background documents or comments, go to *http://www.regulations.gov* at any time or Room W12–140 on the ground level of the West Building, 1200 New Jersey Avenue SE., Washington, DC, between 9 a.m. and 5 p.m., ET, Monday through Friday, except Federal holidays. The FDMS is available 24 hours each day, 365 days each year. If you want acknowledgment that we received your comments, please include a self-addressed, stamped envelope or postcard or print the acknowledgement page that appears after submitting comments on-line.

Privacy Act: Anyone may search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or of the person signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's Privacy Act Statement for the FDMS published in the **Federal Register** on January 17, 2008 (73 FR 3316), or you may visit *http://edocket.access.gpo.gov/2008/pdf/E8–785.pdf*.

FOR FURTHER INFORMATION CONTACT: Elaine M. Papp, Chief Medical Programs, (202) 366–4001, *fmcsamedical@dot.gov*, FMCSA, Department of Transportation, 1200 New Jersey Avenue, SE., Room W64–224, Washington, DC 20590–0001. Office hours are from 8:30 a.m. to 5 p.m., Monday through Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION:

Background

The Federal Motor Carrier Safety Administration has authority to grant exemptions from many of the Federal Motor Carrier Safety Regulations (FMCSRs) under 49 U.S.C. 31315 and 31136(e), as amended by Section 4007 of the Transportation Equity Act for the 21st Century (TEA—21) (Pub. L. 105–178, June 9, 1998, 112 Stat. 107, 401). FMCSA has published in 49 C.F.R. part 381, subpart C final rules implementing the statutory changes in its exemption procedures made by section 4007, 69 FR 51589 (August 20, 2004).[1] Under the

[1] This action adopted as final rules the interim final rules issued by FMCSA's predecessor in 1998 (63 FR 67600 (Dec. 8, 2008)), and adopted by FMCSA in 2001 [66 FR 49867 (Oct. 1, 2001)].

rules in part 381, subpart C, FMCSA must publish a notice of each exemption request in the **Federal Register**. The Agency must provide the public with an opportunity to inspect the information relevant to the application, including any safety analyses that have been conducted and any research reports, technical papers and other publications referenced in the application. The Agency must also provide an opportunity to submit public comment on the applications for exemption.

The Agency reviews the safety analyses and the public comments and determines whether granting the exemption would likely achieve a level of safety equivalent to or greater than the level that would be achieved without the exemption. The decision of the Agency must be published in the **Federal Register**. If the Agency denies the request, it must state the reason for doing so. If the decision is to grant the exemption, the notice must specify the person or class of persons receiving the exemption and the regulatory provision or provisions from which an exemption is granted. The notice must also specify the effective period of the exemption (up to 2 years) and explain the terms and conditions of the exemption. The exemption may be renewed.

The current provisions of the FMCSRs concerning hearing state that a person is physically qualified to drive a CMV if that person

> First perceives a forced whispered voice in the better ear at not less than 5 feet with or without the use of a hearing aid or, if tested by use of an audiometric device, does not have an average hearing loss in the better ear greater than 40 decibels at 500 Hz, 1,000 Hz, and 2,000 Hz with or without a hearing aid when the audiometric device is calibrated to American National Standard (formerly ASA Standard) Z24.5—1951.

49 CFR 391.41(b)(11). This standard was adopted in 1970, with a revision in 1971 to allow drivers to be qualified under this standard while wearing a hearing aid, 35 FR 6458, 6463 (April 22, 1970) and 36 FR 12857 (July 3, 1971).

FMCSA also issues instructions for completing the medical examination report and includes advisory criteria on the report itself to provide guidance for medical examiners in applying the hearing standard. See 49 C.F.R. 391.43(f). The current advisory criteria for the hearing standard include a reference to a report entitled ''Hearing Disorders and Commercial Motor Vehicle Drivers'' prepared for the Federal Highway Administration, FMCSA's predecessor, in 1993.[2]

FMCSA Requests Comments on the Exemption Applications

FMCSA requests comments from all interested parties on whether a driver who cannot meet the hearing standard should be permitted to operate a CMV in interstate commerce. Further, the Agency asks for comments on whether a driver who cannot meet the hearing standard should be limited to operating only certain types of vehicles in interstate commerce, for example, vehicles without air brakes. The statute and implementing regulations concerning exemptions require that the Agency request public comments on all applications for exemptions. The Agency is also required to make a determination that an exemption would likely achieve a level of safety that is equivalent to, or greater than, the level that would be *achieved absent such exemption before granting any such requests. 49 U.S.C.*

Submitting Comments

You may submit your comments and material online or by fax, mail, or hand delivery, but please use only one of these means. FMCSA recommends that you include your name and a mailing address, an email address, or a phone number in the body of your document so that FMCSA can contact you if there are questions regarding your submission.

To submit your comment online, go to *http://www.regulations.gov* and in the search box insert the docket number ''FMCSA–2013–0125'' and click the search button. When the new screen appears, click on the blue ''Comment Now!'' button on the right hand side of the page. On the new page, enter information required including the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation. If you submit your comments by mail or hand delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit comments by mail and would like to know that they reached the facility, please enclose a stamped, self-addressed postcard or envelope.

We will consider all comments and material received during the comment period and may change this proposed rule based on your comments. FMCSA may issue a final rule at any time after the close of the comment period.

Viewing Comments and Documents

To view comments, as well as any documents mentioned in this preamble, To submit your comment online, go to *http://www.regulations.gov* and in the search box insert the docket number ''FMCSA–2013–0125'' and click ''Search.'' Next, click ''Open Docket Folder'' and you will find all documents and comments related to the proposed rulemaking.

Information on Individual Applicants

Sascha Cotton

Mr. Cotton, 39, holds a Class A commercial driver's license (CDL) in Florida.

Keith C. Drown

Mr. Drown, 61, holds a Class A commercial driver's license (CDL) in Idaho.

Norman Estes

Mr. Estes, 60, holds a Class A commercial driver's license (CDL) in Alabama.

David Garland

Mr. Garland, 42, holds a Class A commercial driver's license (CDL) in Maine.

James Gooch

Mr. Gooch, 53, holds a Class A commercial driver's license (CDL) in Missouri.

Harold Johnson

Mr. Johnson, 61, holds a Class A commercial driver's license (CDL) in Pennsylvania.

Michael Paasch

Mr. Paasch, 40, holds a Class A commercial driver's license (CDL) in Nebraska.

William Symonds

Mr. Symonds, 55, holds a Class B commercial driver's license (CDL) in Illinois.

Anthony Thong

Mr. Thong, 30, holds a Class A commercial driver's license (CDL) in California.

Roger Allen Wright

Mr. Wright, 61, holds a Class A commercial driver's license (CDL) in Alabama.

Request for Comments

In accordance with 49 U.S.C. 31136(e) and 31315(b)(4), FMCSA requests public comment from all interested persons on the exemption petitions described in this notice. The Agency will consider all

[2] This report is available on the FMCSA Web site at *http://www.fmcsa.dot.gov/facts-research/research-technology/publications/medreport_archives.htm.*

comments received before the close of business January 2, 2014. Comments will be available for examination in the docket at the location listed under the **ADDRESSES** section of this notice. The Agency will file comments received after the comment closing date in the public docket, and will consider them to the extent practicable. In addition to late comments, FMCSA will also continue to file, in the public docket, relevant information that becomes available after the comment closing date. Interested persons should monitor the public docket for new material.

Issued on: November 25, 2013.

Larry W. Minor,

Associate Administrator for Policy.

[FR Doc. 2013–28804 Filed 11–29–13; 8:45 am]

BILLING CODE 4910–EX–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request on Information Collection Tools Relating to Using Omnibus Surveys.

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning an existing data-driven satisfaction surveys to understand customer opinion.

DATES: Written comments should be received on or before January 31, 2014 to be assured of consideration.

ADDRESSES: Direct all written comments to Yvette Lawrence, Internal Revenue Service, Room 6129, 1111 Constitution Avenue NW., Washington, DC 20224. Please send separate comments for each specific information collection listed below. You must reference the information collection's title, form number, reporting or record-keeping requirement number, and OMB number (if any) in your comment.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the collection tools should be directed to R. Joseph Durbala, Internal Revenue Service, Room 6129, 1111 Constitution Avenue NW., Washington, DC 20224, or at (202)622–3634, or through the Internet at *RJoseph.Durbala@irs.gov.*

SUPPLEMENTARY INFORMATION: Currently, the IRS is seeking comments concerning the following information collection tools, reporting, and record-keeping requirements:

Title: IRS Omnibus Surveys.

OMB Number: 1545–NEW. *Form Number:* N/A.

Abstract: We are requesting a three-year approval to use a data-driven approach to understanding customer opinion of the Internal Revenue Service (IRS) and its programs and services. Collecting, analyzing, and using customer opinion data is a vital component of IRS's Balanced Measures Approach, as mandated by Internal Revenue Service Reform and Restructuring Act of 1998 and Executive Order 12862.

Current Actions: This is a new request for OMB approval.

Type of Review: New collection.

Affected Public: This collection of information is necessary to enable the Agency to garner customer and stakeholder feedback in an efficient, timely manner, in accordance with our commitment to improving service delivery. The information collected from our customers and stakeholders will help ensure that users have an effective, efficient, and satisfying experience with the Agency's programs. This feedback will provide insights into customer or stakeholder perceptions, experiences and expectations, provide an early warning of issues with service, or focus attention on areas where communication, training or changes in operations might improve delivery of products or services. It will also allow feedback to contribute directly to the improvement of program management.

Estimated Number of Respondents: 90,000.

Estimated Time per Respondent: 9 min.

Estimated Total Annual Burden Hours: 4,500.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request For Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: November 15, 2013.

Yvette Lawrence,

IRS Reports Clearance Officer.

[FR Doc. 2013–28817 Filed 11–29–13; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request on Information Collection Tools Relating to Qualitative Feedback on Agency Service Delivery.

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning the collection of qualitative feedback on agency service delivery.

DATES: Written comments should be received on or before January 31, 2014 to be assured of consideration.

ADDRESSES: Direct all written comments to Yvette Lawrence, Internal Revenue Service, Room 6129, 1111 Constitution Avenue NW., Washington, DC 20224. Please send separate comments for each

specific information collection listed below. You must reference the information collection's title, form number, reporting or record-keeping requirement number, and OMB number (if any) in your comment.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the collection tools should be directed to R. Joseph Durbala, Internal Revenue Service, Room 6129, 1111 Constitution Avenue NW., Washington, DC 20224, or at (202)622–3634, or through the internet at *RJoseph.Durbala@irs.gov.*

SUPPLEMENTARY INFORMATION:

Currently, the IRS is seeking comments concerning the following information collection tools, reporting, and record-keeping requirements:

Title: Collection of Qualitative Feedback on Agency Service Delivery

OMB Number: 1545–NEW. *Form Number:* N/A.

Abstract: Executive Order 12862 directs Federal agencies to provide service to the public that matches or exceeds the best service available in the private sector. Executive Order 13571 expands on this concept to include recent developments in private sector advances in internet customer service technologies. In order to work continuously to ensure that our online products and services are effective and meet our customers' needs, The Internal Revenue Service (hereafter ''the Agency'') seeks to obtain OMB approval of a generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery. By routine customer feedback we mean information that focuses on the awareness, understanding, attitudes, preferences, or experiences of customers or other stakeholders relating to existing or future services or products, but are not statistical surveys that yield quantitative results that can be generalized to the population of study.

Current Actions: This is a new request for OMB approval.

Type of Review: New collection.

Affected Public: This collection of information is necessary to enable the Agency to garner customer and stakeholder feedback in an efficient, timely manner, in accordance with our commitment to improving service delivery. The information collected from our customers and stakeholders will help ensure that users have an effective, efficient, and satisfying experience with the Agency's programs. This feedback will provide insights into customer or stakeholder perceptions, experiences and expectations, provide an early warning of issues with service, or focus attention on areas where communication, training or changes in operations might improve delivery of products or services. It will also allow feedback to contribute directly to the improvement of program management.

Estimated Number of Respondents: 1,000,050.

Estimated Time per Respondent: 1 hr., 18 min.

Estimated Total Annual Burden Hours: 266,680.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request For Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: November 15, 2013.

Yvette Lawrence,

IRS Reports Clearance Officer.

[FR Doc. 2013–28815 Filed 11–29–13; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection: Comment Request for Regulation Project

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13(44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning TD 9540, general actuarial valuation.

DATES: Written comments should be received on or before January 31, 2014 to be assured of consideration.

ADDRESSES: Direct all written comments to Yvette Lawrence, Room 6129, 1111 Constitution Avenue NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the regulation should be directed to Katherine Dean, at *katherine.b.dean@irs.gov.*

SUPPLEMENTARY INFORMATION:

Title: Valuation Tables.

OMB Number: 1545–1343.

Regulation Project Number: TD 9540.

Abstract: This document contains final regulations relating to the use of actuarial tables in valuing annuities, interests for life or terms of years, and remainder or reversionary interests. These regulations will affect the valuation of *inter vivos* and testamentary transfers of interests dependent on one or more measuring lives. These regulations are necessary because section 7520(c)(3) directs the Secretary to update the actuarial tables to reflect the most recent mortality experience available.

Current Actions: There is no change to this existing regulation.

Type of Review: Extension of OMB approval.

Affected Public: Individuals or households.

Estimated Number of Respondents: 6,000.

Estimated Time per Respondent: 45 minutes.

Estimated Total Annual Hours: 4,500.

The following paragraph applies to all of the collections of information covered by this notice.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material

in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request For Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: October 30, 2013.

Yvette Lawrence,

OMB Reports Clearance Officer.

[FR Doc. 2013–28810 Filed 11–29–13; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery.

DATES: Written comments should be received on or before January 31, 2014 to be assured of consideration.

ADDRESSES: Direct all written comments to Yvette Lawrence, Internal Revenue Service, room 6129, 1111 Constitution Avenue NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the form and instructions should be directed to Katherine Dean, at Internal Revenue Service, room 6242, 1111 Constitution Avenue NW., Washington, DC 20224, or through the internet at *katherine.b.dean@irs.gov.*

SUPPLEMENTARY INFORMATION:

Title: Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery.

OMB Number: 1545–2208.

Abstract: Executive Order 12862 directs Federal agencies to provide service to the public that matches or exceeds the best service available in the private sector. In order to work continuously to ensure that our programs are effective and meet our customers' needs, The Internal Revenue Service (hereafter ''the Agency'') seeks to obtain OMB approval of a generic clearance to collect qualitative feedback on our service delivery. By qualitative feedback we mean information that provides useful insights on perceptions and opinions, but are not statistical surveys that yield quantitative results that can be generalized to the population of study.

Current Actions: We will be conducting different opinion surveys, focus group sessions, think-aloud interviews, and usability studies regarding cognitive research surrounding forms submission or IRS system/product development.

Type of Review: Revision of a currently approved collection.

Affected Public: Individuals and businesses or other for-profit organizations.

Estimated Number of Respondents: 150,000.

Estimated Time per Respondent: 60 minutes.

Estimated Total Annual Burden Hours: 150,000.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request For Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: October 30, 2013.

Yvette Lawrence,

IRS Reports Clearance Officer.

[FR Doc. 2013–28811 Filed 11–29–13; 8:45 am]

BILLING CODE 4830–01–P

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Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 413 and 414

Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 413 and 414

[CMS–1526–F]

RIN 0938–AR55

Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

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

ACTION: Final rule.

SUMMARY: This rule updates and makes revisions to the End-Stage Renal Disease (ESRD) prospective payment system (PPS) for calendar year (CY) 2014. This rule also sets forth requirements for the ESRD quality incentive program (QIP), including for payment year (PY) 2016 and beyond. In addition, this rule clarifies the grandfathering provision related to the 3-year minimum lifetime requirement (MLR) for Durable Medical Equipment (DME), and provides clarification of the definition of routinely purchased DME. This rule also implements budget-neutral fee schedules for splints and casts, and intraocular lenses (IOLs) inserted in a physician's office. Finally, this rule makes a few technical amendments and corrections to existing regulations related to payment for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items and services.

DATES: *Effective Date:* These regulations are effective on January 1, 2014, except for amendments to §§ 414.100, 414.102, 414.106, 414.108, 414.200, and 414.226, which are effective on April 1, 2014.

FOR FURTHER INFORMATION CONTACT: Michelle Cruse, (410) 786–7540, for issues related to the ESRD PPS.

Stephanie Frilling, (410) 786–4507, for issues related to the ESRD PPS wage index, home dialysis training, and the delay in payment for oral-only drugs under the ESRD PPS.

Heidi Oumarou, (410) 786–7942, for issues related to the ESRD bundled market basket.

Anita Segar, (410) 786–4614, for issues related to the ESRD QIP.

Sandhya Gilkerson, (410) 786–4085, for issues related to the clarification of the grandfathering provision related to the 3-year MLR for DME.

Anita Greenberg, (410) 786–4601, for issues related to the clarification of the definition of routinely purchased DME.

Christopher Molling, (410) 786–6399, for issues related to DMEPOS technical amendments and corrections.

Hafsa Vahora, (410) 786–7899, for issues related to the implementation of budget neutral fee schedules for splints and casts, and IOLs inserted in a physician's office.

SUPPLEMENTARY INFORMATION:

Electronic Access

This **Federal Register** document is also available from the **Federal Register** online database through *Federal Digital System (FDsys),* a service of the U.S. Government Printing Office. This database can be accessed via the internet at *http://www.gpo.gov/fdsys/.*

Addenda Are Only Available Through the Internet on the CMS Web Site

In the past, a majority of the Addenda referred to throughout the preamble of our proposed and final rules were available in the **Federal Register**. However, the Addenda of the annual proposed and final rules will no longer be available in the **Federal Register**. Instead, these Addenda to the annual proposed and final rules will be available only through the Internet on the CMS Web site. The Addenda to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) rules are available at: *http://www.cms.gov/ESRDPayment/PAY/list.asp.* Readers who experience any problems accessing any of the Addenda to the proposed and final rules of the ESRD PPS that are posted on the CMS Web site identified above should contact Michelle Cruse at 410–786–7540.

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Acronyms

Because of the many terms to which we refer by acronym in this final rule, we are listing the acronyms used and their corresponding meanings in alphabetical order below:

AHRQ Agency for Healthcare Research and Quality
ASP Average Sales Price
ATRA American Taxpayer Relief Act of 2012 BLS Bureau of Labor Statistics
CBSA Core Based Statistical Area
CCN CMS Certification Number
CDC Centers for Disease Control and Prevention
CKD Chronic Kidney Disease
CY Calendar Year
DFC Dialysis Facility Compare
DME Durable Medical Equipment
DMEPOS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
ESA Erythropoiesis Stimulating Agent
ESRD End-Stage Renal Disease
ESRDB End-Stage Renal Disease bundled
ESRD PPS End-Stage Renal Disease Prospective Payment System
FDA Food and Drug Administration
GEM General Equivalence Mappings
HAIs Healthcare-Acquired Infections
HCPCS Healthcare Common Procedure Coding System
HHS Department of Health and Human Services
ICD International Classification of Diseases
ICD–9–CM International Classification of Disease, 9th Revision, Clinical Modification
ICH CAHPS In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems
IGI IHS Global Insight
IOLs Intraocular Lenses
IPPS Inpatient Prospective Payment System
MAP Medicare Allowable Payment
MFP Multifactor Productivity
MLR Minimum Lifetime Requirement
NCD National Coverage Determination
NHSN National Health Safety Network
NQF National Quality Forum
OMB Office of Management and Budget
PFS Physician Fee Schedule
QIP Quality Incentive Program
SHR Standardized Hospitalization Ratio Admissions
SMR Standardized Mortality Ratio
TPS Total Performance Score
VBP Value Based Purchasing

I. Executive Summary

A. Purpose

1. End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)

This final rule updates and makes revisions to the End-Stage Renal Disease (ESRD) prospective payment system (PPS) for calendar year (CY) 2014. Section 1881(b)(14) of the Social Security Act (the Act), as added by section 153(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Public Law 110–275), and section 1881(b)(14)(F) of the Act, as added by section 153(b) of MIPPA and amended by section 3401(h) of the Affordable Care Act (Public Law 111–148), established that beginning CY 2012, and each subsequent year, the Secretary shall reduce the market basket increase factor by a productivity adjustment

described in section 1886(b)(3)(B)(xi)(II) of the Act.

In addition, section 1881(b)(14)(I) of the Act, as added by section 632(a) of the American Taxpayer Relief Act of 2012 (ATRA) (Pub. L. 112–240), requires the Secretary, by comparing per patient utilization from 2007 with such data from 2012, to reduce the single payment amount to reflect the Secretary's estimate of the change in the utilization of ESRD-related drugs and biologicals. Section 632(b) of ATRA prevents the Secretary from paying for oral-only ESRD-related drugs and biologicals under the ESRD PPS before January 1, 2016.

2. End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)

This final rule also sets forth requirements for the ESRD Quality Incentive Program (QIP), including for payment year (PY) 2016. The program is authorized under section 153(c) of MIPPA, which added section 1881(h) to the Social Security Act (the Act). The ESRD QIP is the most recent step in fostering improved patient outcomes by establishing incentives for dialysis facilities to meet performance standards established by CMS.

3. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

This final rule clarifies the definition of routinely purchased equipment covered under the DME benefit category and the scope of the 3-year minimum lifetime requirement (MLR) for DME. In addition, this final rule implements budget neutral fee schedules for splints and casts, and intraocular lenses (IOLs) inserted in a physician's office. Finally, this final rule makes a few technical amendments and corrections to existing regulations related to payment for DMEPOS items and services.

B. Summary of the Major Provisions

1. ESRD PPS

- *Update to the ESRD PPS base rate for CY 2014:* For CY 2014, the ESRD PPS base rate is $239.02. This reflects the CY 2013 ESRD PPS base rate of $240.36 adjusted by the ESRDB market basket (3.2 percent) minus productivity (0.4 percent) increase factor of 2.8 percent, the wage index budget neutrality factor of 1.000454, and the home dialysis training add-on budget neutrality adjustment factor of 0.999912 to get $247.18 ($240.36 * 1.028 * 1.000454 * 0.999912 = $247.18). We reduced this amount by the portion of the CY 2014 drug utilization adjustment that is being transitioned this year, or $8.16, to arrive at a final CY 2014 ESRD PPS base rate of $239.02 ($247.18 − $8.16 = $239.02).
- *The CY 2014 wage index and wage index floor:* We adjust wage indices on an annual basis using the most current hospital wage data to account for differing wage levels in areas in which ESRD facilities are located. We did not propose any changes to the application of the wage index adjustment factor for CY 2014, and we will continue to apply the adjustment to the ESRD PPS base rate. For CY 2014 and CY 2015, we are continuing our policy for the gradual phase-out of the wage index floor and reducing the wage index floor values to 0.45 and 0.40, respectively.
- *The outlier policy:* We are updating the outlier services fixed dollar loss amounts for adult and pediatric patients and Medicare Allowable Payments (MAPs) for adult patients for CY 2014 using 2012 claims data. Based on the use of more current data, the fixed-dollar loss amount for pediatric beneficiaries would increase from $47.32 to $54.01 and the adjusted average outlier services MAP amount would decrease from $41.39 to $40.49 as compared to CY 2013 values. For adult beneficiaries, the fixed-dollar loss amount would decrease from $110.22 to $98.67 and the adjusted average outlier services MAP amount would decrease from $59.42 to $50.25. The 1 percent target for outlier payments was not achieved in CY 2012. We believe using CY 2012 claims data to update the outlier MAP and fixed dollar loss amounts for CY 2014 will increase payments for ESRD beneficiaries requiring higher resource utilization in accordance with a 1 percent outlier policy.
- *Application of ICD–10–CM Diagnosis Codes to the comorbidity payment adjustment codes:* Effective October 1, 2014, CMS will implement the 10th revision of the ICD coding scheme. We discuss and provide a crosswalk from ICD–9–CM to ICD–10–CM for codes that are subject to the comorbidity payment adjustment. We are finalizing our proposed policy that all ICD–10–CM codes to which ICD–9–CM codes that are eligible for the comorbidity payment adjustments crosswalk will be eligible for the comorbidity payment adjustments with two exceptions.
- *The self-dialysis and home dialysis training add-on adjustment:* In response to public comments, we are finalizing an increase in the amount of the self-dialysis and home dialysis training add-on adjustment of 50 percent for both peritoneal dialysis (PD) and home hemodialysis (HHD) training treatments furnished on or after January 1, 2014. In CY 2014, the nursing time accounted for in the training add-on adjustment will increase from one hour to 1.5 hours per training treatment, resulting in an increase of $16.72, for a total training add-on adjustment of $50.16 per training treatment. We note that the increase to the training add-on adjustment will be made in a budget neutral manner in that we have applied a training add-on budget-neutrality adjustment factor of 0.999912 to the base rate.

2. ESRD QIP

This final rule implements requirements for the ESRD QIP. With respect to the PY 2016 ESRD QIP, we are continuing some of the previous ESRD QIP measures, adding new measures, and expanding the scope of some of the existing measures to cover the measure topics as follows:

- To evaluate anemia management:
  - Hemoglobin Greater Than 12 g/dL, a clinical measure
  - Anemia Management, a reporting measure †
- To evaluate dialysis adequacy:
  - A Kt/V measure for adult hemodialysis patients, a clinical measure
  - A Kt/V measure for adult peritoneal dialysis patients, a clinical measure
  - A Kt/V measure for pediatric hemodialysis patients, a clinical measure
- To determine whether patients are treated using the most beneficial type of vascular access:
  - An arteriovenous fistula measure, a clinical measure
  - A catheter measure, a clinical measure
- To address effective bone mineral metabolism management:
  - Hypercalcemia, a clinical measure*
  - Mineral Metabolism, a reporting measure †
- To address safety:
  - National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Outpatients, a clinical measure *
- To assess patient experience:
  - ICH CAHPS survey reporting measure ‡

* Denotes that this measure is new to the ESRD QIP.

† Denotes that this measure is revised in the ESRD QIP.

‡ Denotes that this measure is expanded in the ESRD QIP.

We also establish CY 2014 as the performance period for the PY 2016

ESRD QIP, establish performance standards for each measure, and adopt scoring and payment reduction methodologies that are similar to those finalized for the PY 2015 ESRD QIP.

3. DMEPOS

- *Definition of routinely purchased DME:* This final rule clarifies the definition of routinely purchased DME set forth at section § 414.220(a), as well as addresses the classification of and payment for expensive items of DME and accessories (over $150) as a capped rental items in accordance with § 414.229, if the items were not acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987.
- *Clarification of to the 3-year MLR and Related Grandfathering Policy:* This final rule provides further clarification about how we will apply the 3-year MLR set forth at § 414.202, which must be satisfied for an item or device to be considered DME.
- *Implementation of budget neutral fee schedules for splints and casts, and IOLs inserted in a physician's office:* For CY 2014, we are implementing budget neutral fee schedule amounts for splints and casts, and IOLs inserted in a physician's office. Section 1842(s) of the Act authorizes CMS to implement fee schedule amounts for these items if they are established so that they are initially budget neutral. In 2011, total allowed charges for splints and casts were $5.6 million, while total allowed charges for IOLs inserted in a physician's office were $76 thousand.

C. Summary of Costs and Benefits

In section XI. of this final rule, we set forth a detailed analysis of the impacts that the changes will have on affected entities and beneficiaries. The impacts include the following:

1. Impacts of the Final ESRD PPS

The impact chart in section XI.B.1.a. of this final rule displays the estimated change in payments to ESRD facilities in CY 2014 compared to estimated payments in CY 2013. The overall impact of the CY 2014 changes is projected to result in an average increase in payments of 0.0 percent from CY 2013 to CY 2014. Hospital-based ESRD facilities have an estimated 0.8 percent increase in payments compared with freestanding facilities with an estimated 0.0 percent increase.

We estimate that there will be no change in aggregate ESRD PPS expenditures from CY 2013 to CY 2014. This reflects a $240 million increase from the payment rate update, a $30 million increase due to the updates to the outlier threshold amounts, and a $20 million increase due to the change in the blend of payments, and a $290 million decrease in expenditures specifically related to the drug utilization adjustment. The drug utilization adjustment for CY 2014 represents 27 percent of the total drug utilization adjustment amount of $29.93. The estimated 0.0 percent overall payment change will result in a small reduction in beneficiary coinsurance compared to CY 2013 beneficiary because the CY 2014 ESRD PPS base rate is slightly less than that CY 2013 base rate, discussed in section II.C.2.a.v.

2. Impacts for ESRD QIP

The overall economic impact of the proposed ESRD QIP is an estimated $15.2 million in PY 2016. In PY 2016, we expect the total payment reductions to be approximately $15.1 million, and the costs associated with the collection of information requirements for certain measures to be approximately $39.5 thousand. For PY 2017 and future payment years, we expect the costs associated with the collection of information requirements for the expanded ICH CAHPS measure in the proposed ESRD QIP to be approximately $9.7 million.

The ESRD QIP will continue to incentivize facilities to provide higher quality care to beneficiaries. The reporting measures associated with the collection of information requirements are critical to better understanding the quality of care beneficiaries receive, particularly patients' experience of care, and will be used to incentivize improvements in the quality of care provided.

3. Impacts for DMEPOS

The overall impact of implementing fee schedules for splints and casts, and IOLs inserted in a physician's office is insignificant. The reasonable charge amounts that we convert to fee schedule amounts will be budget neutral the first year and will be updated annually thereafter based on the consumer price index for all consumers (CPI–U) for the 12-month period ending June 30 of the previous year and, reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. For the 3-year MLR, we believe that a vast majority of the categories of items that were classified as DME before January 1, 2012, did function for 3 or more years (76 FR 70289). The 3-year MLR is designed to represent a minimum threshold for determination of durability for equipment that is consistent with the statutory DME payment provisions and applies on a prospective basis, effective January 1, 2012. CMS recognizes that the healthcare industry and beneficiaries have come to rely on items that have qualified as DME on or prior to January 1, 2012, regardless of whether those items met the 3-year MLR set forth at § 414.202. We note that given that reliance and consistent with the regulation at § 414.202, CMS would not reopen those prior decisions and reclassify the equipment in light of the new 3-year standard. We believe that continuing the Medicare coverage for all the items that qualified as DME on or prior to January 1, 2012, would avoid disrupting the continuity of care for the beneficiaries that received these items for medical treatment prior to January 1, 2012, without creating a significant fiscal impact on the Medicare Program. We also do not expect any significant impact as a result of how this rule will be applied in terms of equipment that is modified. Based on our experience with the Medicare Program, items covered as DME prior to 2012 that have lifetimes of less than 3 years are well established and have been used in treating illnesses or injuries of patients for many years. The items are designed to provide treatment for the period of time generally needed for the patient and it is unlikely that devices will be modified to be less durable.

We expect that the overall impact of clarifying the definition of routinely purchased DME and finalizing our proposal to classify certain expensive items as cap rental will be a decrease in expenditures because payment on a 13-month capped rental basis rather than a lump sum purchase basis for certain, very expensive items will lower total payments for these items and because many beneficiaries would not rent the items for as long as 13 months.

II. Calendar Year (CY) 2014 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)

A. Background on the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)

On August 12, 2010, we published in the **Federal Register** a final rule (75 FR 49030 through 49214) titled, ''End-Stage Renal Disease Prospective Payment System,'' (hereinafter referred to as the CY 2011 ESRD PPS final rule). In the CY 2011 ESRD PPS final rule, we

implemented a case-mix adjusted bundled PPS for Medicare outpatient ESRD dialysis services beginning January 1, 2011, in accordance with section 1881(b)(14) of the Act, as added by section 153(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

On November 10, 2011, we published in the **Federal Register**, a final rule (76 FR 70228 through 70316) titled, ''Medicare Program; End-Stage Renal Disease Prospective Payment System and Quality Incentive Program; Ambulance Fee Schedule; Durable Medical Equipment; and Competitive Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies'' (hereinafter referred to as the CY 2012 ESRD PPS final rule). In that final rule, for the ESRD PPS, we made a number of routine updates for CY 2012, implemented the second year of the transition to the ESRD PPS, made several policy changes and clarifications, and made technical changes.

On November 9, 2012, we published in the **Federal Register**, a final rule (77 FR 67450 through 67531) titled, ''Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Bad Debt Reductions for All Medicare Providers'' (hereinafter referred to as the CY 2013 ESRD PPS final rule). In that final rule, for the ESRD PPS, we made a number of routine updates for CY 2013, implemented the third year of the transition to the ESRD PPS, and made several policy changes and reiterations. For a summary of the provisions in that final rule, we refer readers to the CY 2014 ESRD PPS proposed rule at 78 FR 40836, 40840–40841 (July 8, 2013).

B. Summary of the Proposed Provisions and Responses to Comments on the CY 2014 ESRD PPS

The proposed rule, titled ''Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies'' (78 FR 40836 through 40890), (hereinafter referred to as the CY 2014 ESRD PPS proposed rule), was published in the **Federal Register** on July 8, 2013, with a comment period that ended on August 30, 2013. In that proposed rule, for the ESRD PPS, we proposed to (1) make a number of routine updates for CY 2014, (2) implement the fourth and last year of the transition where payments are based 100 percent on the ESRD PPS, and (3) make revisions to the ESRD PPS base rate as required by statute. We received approximately 1282 public comments on the ESRD PPS proposals, including comments from ESRD facilities; national renal groups, nephrologists and patient organizations; patients; manufacturers; health care systems; and nurses.

In this final rule, we provide a summary of each proposed provision, a summary of the public comments received and our responses to them, and the policies we are finalizing for the CY 2014 ESRD PPS. Comments related to the paperwork burden are addressed in the ''Collection of Information Requirements'' section in this final rule. Comments related to the impact analysis are addressed in the ''Economic Analyses'' section in this final rule.

C. Routine Updates and Policy Changes to the CY 2014 ESRD PPS

1. Composite Rate Portion of the ESRD PPS Blended Payment

Section 1881(b)(14)(E)(i) of the Act requires a 4-year transition under the ESRD PPS. This final rule implements the fourth year of the transition for those ESRD facilities that did not elect to receive 100 percent of the payment amount under the ESRD PPS. For services furnished beginning in CY 2014, under 42 CFR 413.239(a)(4), 100 percent of the payment amount will be determined in accordance with section 1881(b)(14) of the Act. Accordingly, a blended rate will no longer be provided, all facilities will be paid 100 percent under the ESRD PPS, and there will no longer be a transition budget neutrality adjustment factor applied to these payments starting on January 1, 2014. Therefore, facilities that participate in the transition will no longer receive a portion of their payments based on the basic case-mix adjusted composite rate payment system. Because payments will no longer be based on the basic case-mix adjusted composite rate, we will not update the drug add-on or wage index values (which included a budget-neutrality adjustment factor) that comprised that rate. In this final rule, we only discuss updates and policy changes that affect the components of the ESRD PPS.

2. ESRD PPS Base Rate

In the CY 2011 ESRD PPS final rule (75 FR 49071 through 49083), we discussed the development of the ESRD PPS per treatment base rate that is codified in the Medicare regulations at § 413.220 and § 413.230. The CY 2011 ESRD PPS final rule also provides a detailed discussion of the methodology used to calculate the ESRD PPS base rate and the computation of factors used to adjust the ESRD PPS base rate for projected outlier payments and budget neutrality in accordance with sections 1881(b)(14)(D)(ii) and 1881(b)(14)(A)(ii) of the Act, respectively. Specifically, the ESRD PPS base rate was developed from CY 2007 claims (that is, the lowest per patient utilization year as required by section 1881(b)(14)(A)(ii) of the Act), updated to CY 2011, and represented the average per treatment Medicare Allowable Payment (MAP) for composite rate and separately billable services. In accordance with section 1881(b)(14)(D) of the Act and codified in regulations at § 413.230, the ESRD PPS base rate is adjusted for the patient-specific case-mix adjustments, applicable facility adjustments, geographic differences in area wage levels using an area wage index, as well as applicable outlier payments or training payments.

As discussed in section II.C.3. of this final rule, section 1881(b)(14)(F)(i) of the Act, as added by section 153(b) of MIPPA and amended by section 3401(h) of the Affordable Care Act, provides that, beginning in 2012, the ESRD PPS payment amounts are required to be annually increased by the rate of increase in the ESRD market basket, reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). Accordingly, we applied the 2.8 percent increase factor, that is the ESRDB market basket (3.2 percent) minus productivity (0.4 percent) to the CY 2013 ESRD PPS base rate of $240.36, which results in a CY 2014 ESRD PPS base rate of $247.09 ($240.36 × 1.028 = $247.09).

In addition, as discussed in section II.C.4.d. of this final rule, we apply the wage index budget-neutrality adjustment factor of 1.000454 to the CY 2014 ESRD PPS base rate (that is, $247.09), yielding a CY 2014 ESRD PPS wage-index budget-neutrality adjusted base rate of $247.20 ($247.09 × 1.000454 = $247.20). Also, as discussed in section II.D.b. of this final rule, we finalized an increase in the home dialysis training add-on in a budget-neutral manner. Because this adjustment was applied in a budget-neutral manner, we needed to adjust the CY 2014 ESRD PPS base rate after the application of the wage index budget neutrality adjustment factor to account for the increase in training payments. This application yields a CY 2014 ESRD PPS base rate of $247.18 ($247.20 × 0.999912 = $247.18). This amount is then reduced by the portion of the drug utilization adjustment that is being implemented this year, which is $8.16, which yields a final CY 2014 base rate of $239.02. The drug utilization adjustment is addressed in the following section.

a. Adjustment to the ESRD PPS Base Rate To Reflect the Change in Utilization of ESRD-Related Drugs and Biologicals

Section 1881(b)(14)(I) of the Act, as added by section 632(a) of the ATRA, requires that, for services furnished on or after January 1, 2014, the Secretary shall make reductions to the single payment for renal dialysis services to reflect the Secretary's estimate of the change in the utilization of ESRD-related drugs and biologicals (excluding oral-only ESRD-related drugs) by comparing per patient utilization data from 2007 with such data from 2012. Section 1881(b)(14)(I) further requires that in making the reductions, the Secretary take into account the most recently available data on Average Sales Prices (ASP) and changes in prices for drugs and biologicals reflected in the ESRD market basket percentage increase factor under section 1881(b)(14)(F) of the Act. Consistent with these requirements, in the CY 2014 ESRD PPS proposed rule (78 FR 40843) we proposed to apply a payment adjustment to the CY 2014 ESRD PPS base rate that reflects the change in utilization of ESRD-related drugs and biologicals from CY 2007 to CY 2012.

i. Methodology for Reducing the CY 2014 ESRD PPS Base Rate

In the CY 2014 ESRD PPS proposed rule (78 FR 40841 through 40843), we discussed the methodology used for calculating the drug utilization adjustment that will reduce the ESRD PPS base rate. Because the ESRD PPS base rate is a per treatment base rate, the adjustment is calculated on a per treatment basis. We proposed to calculate the amount of the per treatment adjustment by applying CY 2014 prices for ESRD-related drugs and biologicals to the utilization data for CY 2007 and CY 2012. We noted that the CY 2014 ESRD PPS base rate is reflective of 2007 utilization because the base rate was derived from CY 2007 data. We explained that using prices for drugs and biologicals inflated to 2014 levels allows us to appropriately measure changes that are attributable to utilization patterns as opposed to differences in pricing for drugs and biologicals in 2007 and 2012. In addition, because we proposed to make the reduction in CY 2014, we priced the ESRD-related drugs and biologicals for the year in which the adjustment applies. We explained that for purposes of this analysis, we view utilization of drugs and biologicals as units of an ESRD-related drug or biological furnished to a patient on a per treatment basis. We took the estimated amount of the per treatment difference between the estimated spending on drugs and biologicals in CY 2007 and CY 2012 and reduced this amount by the same adjustment factors that were used to calculate the ESRD PPS base rate from the CY 2007 unadjusted rate per treatment, which are the standardization, outlier, and the 98 percent budget-neutrality adjustments. A detailed explanation of these adjustment factors is provided in the CY 2011 ESRD PPS final rule (75 FR 49081 through 49082). We proposed to reduce the CY 2014 ESRD PPS base rate by the resulting amount.

ii. Determining Utilization of ESRD-Related Drugs and Biologicals

In the CY 2014 ESRD PPS proposed rule (78 FR 40841 through 40842), we explained how we determined utilization of ESRD-related drugs and biologicals. Section 1881(b)(14)(I) of the Act requires the single payment amount to be reduced by an amount that ''reflects the Secretary's estimate of the change in utilization of drugs and biologicals described in clauses (ii), (iii), and (iv) of subparagraph (B) (other than oral-only ESRD-related drugs, as such term is used in the final rule promulgated by the Secretary in the **Federal Register** on August 12, 2010 (75 FR 49030))''. As we mentioned above, for purposes of this analysis, we view utilization of drugs and biologicals as units of a drug or biological furnished to a patient per treatment. ESRD facilities report this information on claims. To calculate this adjustment, we analyzed the utilization of erythropoiesis stimulating agents (ESAs) and any oral forms of such agents furnished to individuals for the treatment of ESRD. We also analyzed the utilization of other injectable drugs and biologicals (such as iron sucrose and doxercalciferol) and any oral equivalent form of such drug or biological furnished to individuals for the treatment of ESRD that were included in the expanded bundle of services covered by the ESRD PPS. We did not include diagnostic laboratory tests or other items and services in the comparison analysis because section 1881(b)(14)(I) only refers to estimating the change in utilization of drugs and biologicals.

Section 1881(b)(14)(I) of the Act requires the Secretary to compare per patient utilization data from 2007 with per patient utilization data from 2012. For the CY 2007 utilization data for ESRD-related drugs and biologicals, we proposed to use the data analysis prepared for the CY 2011 ESRD PPS final rule. In the CY 2011 ESRD PPS final rule (75 FR 49071 through 49083), we discuss in detail the development of the ESRD PPS base rate and, as we stated above, the base rate represents the average MAP for composite rate and separately billable services, which was derived from 2007 claims data. We also explained in the CY 2011 ESRD PPS final rule that in order to comply with section 1881(b)(14)(A)(ii) of the Act, we determined that 2007 was the year with the lowest per patient utilization of renal dialysis services by Medicare ESRD beneficiaries among the years 2007, 2008, and 2009. Therefore, utilization data for ESAs and other drugs and biologicals including the oral-equivalent forms of those drugs and biologicals furnished for the treatment of ESRD was readily available for purposes of analyzing 2007 utilization.

For the CY 2012 utilization data for ESRD-related drugs and biologicals, we proposed to use the latest available claims data based on the CY 2012 ESRD facility claims. For the proposed rule, we used CY 2012 ESRD facility claims updated through December 31, 2012 (that is, claims with dates of service from January 1 through December 31, 2012, that were received, processed, paid, and passed to the National Claims History File as of December 31, 2012). We stated that we would use the CY 2012 claims file updated through June 30, 2013, (that is, claims with dates of service from January 1 through December 31, 2012, that were received, processed, paid, and passed to the National Claims History File as of June 30, 2013) to calculate 2012 utilization for the final rule. We solicited comments on the proposed use of 2007 and 2012 claims data to capture the utilization of ESRD-related drugs and biologicals in those years. The comments and our responses are set forth below.

Comment: Several commenters agreed with CMS that claims data from 2007 and 2012 are reliable sources for ESRD-related drugs and biologicals utilization.

Response: We thank the commenters for their support. For this final rule, we used the CY 2007 claims data that was used in preparation of the CY 2011 ESRD PPS final rule. In addition, we used the CY 2012 claims file updated through June 30, 2013, (that is, claims with dates of service from January 1 through December 31, 2012, that were received, processed, paid, and passed to the National Claims History File as of June 30, 2013) to calculate 2012 utilization.

In the CY 2014 ESRD PPS proposed rule (78 FR 40842), we explained that because section 1881(b)(14)(I) requires

that we compare per patient utilization of ESRD-related drugs and biologicals in 2007 with per patient utilization in 2012, we would also include utilization of drugs and biologicals furnished in ESRD facilities located in the United States Territories of Guam, American Samoa and the Northern Mariana Islands (the Pacific Rim), even though facilities in the Pacific Rim were not paid under the ESRD PPS during these years. Therefore, we proposed to use 2007 and 2012 utilization of ESRD-related drugs and biologicals (including oral equivalents) for ESRD facilities located in these territories in our analysis of the reduction required by section 1881(b)(14)(I). For the proposed rule, we did not readily have access to the 2007 utilization data for the ESRD facilities located in these areas; however, we planned to include these data in our calculation for the final rule. Because there are very few ESRD facilities in this region, we indicated that the inclusion of utilization of drugs and biologicals furnished in CY 2007 at these facilities would not have a significant impact on the amount of the adjustment.

We solicited comments on the proposal to include data on the utilization of drugs and biologicals furnished in ESRD facilities located in the Pacific Rim when comparing utilization of drugs and biologicals in CY 2007 with CY 2012. We did not receive any comments objecting to the use of data from ESRD facilities located in the Pacific Rim in the analysis. In the analysis for this final rule, we have included the drug utilization data from facilities located in the Pacific Rim.

iii. Pricing of ESRD-Related Drugs and Biologicals

In the CY 2014 ESRD PPS proposed rule (78 FR 40842 through 40843), we explained how we priced ESRD-related drugs and biologicals to CY 2014 to allow for an accurate comparison between utilization of those drugs and biologicals furnished in CY 2007 with utilization in CY 2012. In order to price ESRD-related drugs and biologicals based on CY 2014 prices, we started with CY 2011 prices as established and published in the CY 2011 ESRD PPS final rule.

In developing the CY 2011 ESRD PPS base rate, we included the MAP amounts for ESRD-related drugs and biologicals that were, prior to January 1, 2011, separately paid under Part B. We used the second quarter of 2010 ASP+6 prices (which was the most current data available at the time) and then used the Producer Price Index (PPI) to inflate the prices to CY 2011 (75 FR 49079). We also included the MAP amounts for the ESRD-related oral-equivalent drugs and biologicals that were, prior to January 1, 2011, separately paid under Part D (75 FR 49080). For setting the CY 2011 ESRD PPS base rate for these drugs, we used the growth rates for overall prescription drug prices that were used in the National Health Expenditure Projections (NHE) for updating prices for former Part D drugs to CY 2011 from CY 2007.

We proposed to inflate the prices established in the CY 2011 ESRD PPS final rule for ESRD-related drugs and biologicals and their oral equivalents to CY 2014 by applying the ESRD bundled (ESRDB) market basket, the productivity adjustment, and the wage index budget neutrality adjustment factors. Because the base rate and the ESRDB market basket account for ESRD-related drugs and biologicals and we have updated all components of the base rate annually using a market basket minus productivity with wage index budget neutrality adjustment factor, we believe that using these inflation factors is consistent with how these services are paid under the ESRD PPS. The drug component of the ESRDB market basket uses the PPI for prescription drugs as a proxy for the growth in drug prices. We believe using the ESRDB market basket to price drugs and biologicals for CY 2014 complies with the requirement in section 1881(b)(14)(I) that the Secretary take into account the changes in prices for drugs and biologicals reflected in the ESRDB market basket percentage increase factor. The ESRDB market basket minus productivity increase factors were 2.1 percent and 2.3 percent for CY 2012 and CY 2013, respectively. The proposed CY 2014 update was 2.5 percent. The wage index budget neutrality adjustment factors for the same years are 1.001520, 1.000613, and a CY 2014 proposed factor of 1.000411. Therefore, we proposed to use a total growth update factor of 7.3 percent (1.021 * 1.023 * 1.025 * 1.001520 * 1.000613 * 1.000411 = 1.073) to inflate prices for ESRD-related drugs and biologicals from CY 2011 levels to CY 2014 levels. We solicited comments on the use of the ESRDB market basket percentage increase factor to inflate prices for drugs and biologicals to CY 2014 levels. The comment and our response is set forth below.

Comment: A few commenters expressed concern that inflating the prices from 2007 levels does not capture the true cost of the drugs and biologicals for small and independent ESRD facilities and small dialysis organizations (SDOs). One commenter stated that if the price is an average number, then SDOs and mid-sized dialysis organizations (MDOs) would be at a disadvantage because their prices are far greater than the prices paid by large dialysis organizations. Therefore, the commenters did not believe that the costs incurred by SDOs and MDOs were accounted for by using 7.3 percent to inflate prices for ESRD-related drugs and biologicals from CY 2011 levels to CY 2014 levels and urged CMS to use actual drug costs reported on ESRD facility cost reports.

Response: The drug utilization adjustment is a per treatment reduction to the single ESRD PPS base rate, which is a payment amount that reflects the average cost for an ESRD facility to furnish a dialysis treatment. Because the drug utilization adjustment is a reduction to the average payment, the drug utilization analysis needs to be performed at an aggregate level, that is, across all facilities using the same sources of data regardless of ownership type. In addition, we do not believe that it would be beneficial to SDOs/MDOs to use drug costs that are reported in ESRD facility cost reports. Even if we were to use cost report drug data, the SDO/MDO costs for drugs would continue to be averaged out by that of the large dialysis organizations (LDOs), which furnish the majority of dialysis treatments. More importantly, we would only be able to consider the ESRD facility cost reports for cost reporting periods ending in 2011 and in 2012 for the drug utilization adjustment analysis, We would not have the information for cost reporting periods ending in 2013, which is when significant price increases have reportedly occurred.

For these reasons, we continue to believe using the ESRDB market basket to price drugs and biologicals for CY 2014 complies with the requirement in section 1881(b)(14)(I) that the Secretary take into account the changes in prices for drugs and biologicals reflected in the ESRDB market basket percentage increase factor and provides the most accurate way to price drugs at 2014 levels. Therefore, in this final rule we are finalizing the use of the ESRDB market basket percentage increase factor to inflate prices for drugs and biologicals to CY 2014 levels.

To determine the final growth update factor's value, we used the methodology discussed above with one modification (described below) and updated the calculation using the final CY 2014 ESRDB market basket minus the CY 2014 multifactor productivity adjustment and the final CY 2014 wage index budget neutrality adjustment factor, which are based on the most recently available data. The ESRDB

market basket minus productivity increase factors were 2.1 percent and 2.3 percent for CY 2012 and CY 2013, respectively. The final ESRDB market basket minus productivity increase factor for CY 2014 is 2.8 percent. The wage index budget neutrality adjustment factors for the same years are 1.001520, 1.000613, and a final CY 2014 factor of 1.000454.

In addition to the ESRDB market basket minus productivity increase factor and the wage index budget neutrality adjustment factor, to account for the home dialysis training add-on increase for CY 2014 we applied an additional factor of 0.999912. We made this modification so that the methodology for developing the growth update factor is consistent with the way we update the ESRD PPS base rate. For CY 2014, we are increasing the home dialysis training add-on in a budget-neutral manner, and therefore, we needed to include an adjustment that accounts for the increase. We are finalizing a total growth update factor of 7.64 percent (1.021 * 1.023 * 1.028 * 1.001520 * 1.000613 * 1.000454 * 0.999912 = 1.0764) to inflate prices for ESRD-related drugs and biologicals from CY 2011 levels to CY 2014 levels. For more information regarding the increase in the home dialysis training add-on payment, see section II.D.b. of this final rule.

In addition to proposing the use of the ESRDB market basket percentage increase factor to inflate prices for drugs and biologicals to CY 2014 levels, in the CY 2014 ESRD PPS proposed rule (78 FR 40843) we discussed an alternative method of using ASP instead of the PPI. Specifically, section 1881(b)(14)(I) requires the Secretary to ''take into account the most recently available data on average sales prices and changes in prices for drugs and biologicals reflected in the ESRDB market basket percentage increase factor'' in making the reduction to the ESRD PPS base rate to reflect the change in utilization of ESRD-related drugs and biologicals from CY 2007 to CY 2012. While we could have chosen to inflate prices for drugs and biologicals to 2014 levels with more recently available ASP data, we stated that we believed using a growth based on the ESRDB market basket is more appropriate because it reflects what Medicare is required to pay for drugs and biologicals through the ESRD PPS base rate.

In the CY 2014 ESRD PPS proposed rule (78 FR 40843), we discussed an alternative analysis using prices based on the first quarter 2013 ASP+6 percent prices and the National Drug Code (NDC) prices published on the CMS Web site located at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Outlier_Services.html* that are used for outlier calculations, and the PPI to project to CY 2014. The results were minimally different (a difference of $29.40 versus $29.52), and because we believed that the ESRDB market basket approach was a more appropriate measure of how Medicare pays for these drugs under the ESRD PPS, we proposed to use it to update drug prices. Nonetheless, we solicited comments on the potential use of ASP instead of the ESRDB market basket to inflate drug prices to 2014 levels for purposes of the drug utilization adjustment. The comments and our responses are set forth below.

Comment: An SDO expressed concern that the alternative analysis of comparing ASP to PPI is not accurate because there is an inherent problem with using ASP data. The commenter stated that ASP data does not accurately reflect the cost of epogen because the ASP data reports the combined price of epogen and procrit. The commenter further explained that procrit has a lower price than epogen but it is not a drug that ESRD facilities can purchase as an ESA to furnish to their patients because it is indicated for non-ESRD use. The commenter stated that while the average cost of procrit has diminished since 2007, the cost of epogen has risen significantly for SDOs and therefore the commenter believes that this results in a lower overall ASP amount because procrit dilutes the ASP price. A national organization for SDOs and an MDO expressed concern that due to the lag in the reporting and publishing of ASP data, the price increases that they have experienced were not fully reflected in the analysis.

Response: We thank the commenters for this information. The ASP+6 payment limits are based on actual marketplace prices submitted by manufacturers to CMS. Given that the ASP is an average price, some National Drug Codes (NDCs) in a given HCPCS code will be available at prices below the payment limit and others will be above the payment limit. The payment limits are evaluated and updated on a quarterly basis. We will initiate discussions with appropriate staff regarding the ASP for epogen to gain a better understanding of how including procrit impacts the ASP. We agree that the lag in reporting price increases in the ASP system as well as the combination of ASP data for Epoetin with that of procrit makes the use of ASP+6 prices to update the prices of drugs and biologicals to 2014 levels less desirable.

After consideration of the comments that we received on the use of ASP versus PPI, we continue to believe that using a growth based on the ESRDB market basket is more appropriate because it reflects what Medicare is required to pay for the drugs and biologicals through the ESRD PPS base rate and because, as commenters noted, ASP prices may not be accurate or up-to-date for drugs and biologicals used in the treatment of ESRD.

iv. Calculation of the Amount of the Per Treatment Reduction

In the CY 2014 ESRD PPS proposed rule (78 FR 40843), we provided detail on how the drug utilization reduction amount was calculated. We applied the 2014 prices to the CY 2007 and CY 2012 drug and biological utilization data to calculate aggregate amounts for each year. For drugs and biologicals for which we have utilization data for CY 2012, but that were not present on CY 2007 claims, we priced those drugs using the ASP+6 percent price for 2012, which is an average of the four quarter prices, and inflated it using the CY 2013 and the CY 2014 proposed ESRDB market basket, productivity, and wage index budget neutrality adjustment factors. We noted that while most of these drugs had minimal utilization, feraheme was the only significant exception. Specifically, feraheme was not available until January 2010 and once the drug was available, the use of the drug rose to the top 12th drug furnished to ESRD beneficiaries.

Next, we divided each year's estimated aggregate amount for drugs and biologicals by that year's count of treatments furnished to Medicare beneficiaries to get an average payment per treatment for the year. This resulted in a per treatment amount for drugs and biologicals of $83.76 in 2007 and a per treatment amount for drugs and biologicals of $51.42 in 2012. We then subtracted the average payment per treatment for CY 2012 from the average amount per treatment for CY 2007 to get a total of $32.34 ($83.76 − $51.42 = $32.34). We then reduced this amount by the standardization, the outlier, and the 98 percent budget neutrality adjustments to get a total of $29.52 ($32.34 × .9407 × .99 × .98 = $29.52). We applied these adjustments before reducing the base rate because the base rate was reduced by these adjustments when it was first established, and the reduction should be adjusted in the same way to make the two figures comparable. We then reduced the CY 2014 proposed base rate of $246.47 by $29.52, resulting in the CY 2014 proposed base rate of $216.95. A

reduction of $29.52 from the proposed CY 2014 ESRD PPS base rate would have amounted to a 12 percent reduction in Medicare payments. We solicited comments on the proposed methodology for the reduction to the ESRD PPS base rate to reflect the change in the utilization of ESRD-related drugs and biologicals from CY 2007 to CY 2012. The comments and our responses are set forth below.

Comment: We received comments from national organizations and a drug manufacturer that stated they were unable to determine if the methodology CMS used to calculate the reduction was proper because they did not have access to the same data that was used in the calculation.

Response: We disagree with commenters who contend that they were unable to determine whether CMS's methodology was proper because they did not have access to all of the data used to calculate the amount of the reduction. Our methodology for calculating the drug utilization adjustment required by section 1881(b)(14)(I) was described in substantial detail in the CY 2014 ESRD PPS proposed rule. As a result, we do not believe that it was necessary for commenters to have every data point used in our calculations in order to have commented meaningfully on the methodological approach to the adjustment. Nonetheless, between the information provided in the proposed rule and included in the CY 2011 ESRD PPS final rule, commenters did have data we used in calculating the drug utilization adjustment. Moreover, shortly after the CY 2014 ESRD PPS proposed rule was published we posted a table titled, ''Drug Utilization Adjustment'' onto the CMS Web site as a convenience to stakeholders following requests for the data points used in our calculation of the drug utilization adjustment amount. This table includes the data we used to perform the calculation of the reduction amount for the proposed rule and it is posted with the rule's addenda. Addendum C titled, ''Calculation of the Amount of the Per Treatment Reduction Using the End-Stage Renal Disease Bundled Market Basket'' contains updated data and the methodology used for this final rule. The Addendum can be found on the CMS Web site: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html.*

Comment: We received a comment from the Medicare Payment Advisory Commission (MedPAC) stating that they compared their own analyses of the changes in drug utilization using CMS's methods and alternative methods to check for errors in the methodology. They concluded that CMS' methods are consistent with the ATRA mandate and appear to be reasonable.

Response: We thank the MedPAC for their support.

v. Final Amount of the Drug Utilization Adjustment

Using the methodology we proposed in the 2014 ESRD PPS proposed rule, we are updating the drug utilization adjustment based on the most current claims data available, that is, CY 2012 claims with dates of service from January 1 through December 31, 2012 that were received, processed, paid, and passed to the National Claims History File as of June 30, 2013. We applied the 2014 prices to the CY 2007 and CY 2012 drug and biological utilization data to calculate aggregate amounts for each year. For drugs and biologicals for which we have utilization data for CY 2012, but that were not present on CY 2007 claims, we priced those drugs using the ASP+6 percent price for 2012, which is an average of the four quarter prices, and inflated it using the CY 2013 and the CY 2014 ESRDB market basket, productivity, and wage index budget-neutrality adjustment factors.

Next, we divided each year's estimated aggregate amount for drugs and biologicals by that year's count of treatments furnished to Medicare beneficiaries to get an average payment per treatment for the year. This resulted in a per treatment amount for drugs and biologicals of $83.96 in 2007 and a per treatment amount for drugs and biologicals of $51.17 in 2012. We then subtracted the average payment per treatment for CY 2012 from the average amount per treatment for CY 2007 to get a total of $32.79 ($83.96 − $51.17 = $32.79). We then reduced this amount by the standardization, the outlier, and the 98 percent budget neutrality adjustments to get a total of $29.93 ($32.79 × .9407 × .99 × .98 = $29.93). As in the proposed rule, we applied these adjustments because the base rate was reduced by these adjustments when it was first established, and the reduction should be adjusted in the same way to make the two figures comparable. We are finalizing the drug utilization adjustment amount of $29.93. As discussed further below, this amount will be applied to the base rate over the course of a 3- to 4-year transition.

Comment: Several national organizations representing the dialysis industry and dialysis patients believe our CY 2011 ESRD PPS base rate is incorrect and recommended that we correct the base rate prior to application of the drug utilization adjustment to account for overstated estimates of payment adjustments, especially the comorbidity case-mix adjusters, the outlier policy, and the low-volume adjuster. Because these adjustments have been paid out at a rate less than anticipated, the commenters stated that we have not met our obligation under section 1881(b)(14)(A)(ii) of the Act, which requires the Secretary to ensure that the estimated total amount of payments for 2011 for renal dialysis services equals 98 percent of the estimated total amount of payments that would have been made for services furnished in 2011 if the ESRD PPS had not been implemented. Furthermore, these commenters indicated that they were unable to receive discharge information from hospitals to document the comorbid conditions, which is necessary to seek reimbursement for the comorbidity payment adjustments. In order to the make the comorbidity adjustments more accessible, the commenters urged us to revisit the documentation requirements or remove the comorbidity adjustments entirely and return the dollars to the base rate.

Dialysis organizations also encouraged CMS to substantially reduce the percentage of the outlier pool or eliminate it entirely. One commenter is concerned that SDO and non-profit providers are disproportionately impacted by this provision because they do not have the infrastructure of larger providers and therefore are less likely to capture all of the costs for a patient. The commenter went on to state the net effect of the outlier policy is that a provision that was originally put into place to protect small providers is actually penalizing them by decreasing the base rate. This same commenter recommended that CMS either suspend or, if that is not feasible, lower the outlier withhold from 1.0 percent to 0.5 percent.

Finally, several commenters referenced the GAO report 13–287, entitled, ''End-Stage Renal Disease: CMS Should Improve Design and Strengthen Monitoring of Low-Volume Adjustment'' and published March 1, 2013, that found discrepancies in the identification of low-volume facilities. One commenter suggested that CMS delay implementation of the drug utilization adjustment until the purported problems with the underlying PPS can be resolved.

Response: In developing the final ESRD PPS base rate for 2011, in accordance with section 1881(b)(14)(A)(ii) of the Act, we standardized the rate to account for the

payment adjustments and the outlier policy. As stated in the 2011 ESRD PPS final rule (75 FR 49081), to account for the overall effects of the proposed ESRD PPS case-mix patient and facility adjustment factors and wage indexes, we had to standardize payments in order to ensure that total projected PPS payments were equal to what would otherwise have been paid had the ESRD PPS not been implemented, prior to application of the 98 percent budget-neutrality adjustment. The standardization factor was calculated by dividing total estimated payments in 2011 under the basic case-mix adjusted composite rate payment system by estimated payments under the final ESRD PPS in 2011. We do not intend to revise the standardization factor that was applied to the 2011 ESRD PPS base rate to reflect actual payments made under each of the adjustments and therefore we did not propose to re-standardize the CY 2014 ESRD PPS base rate. Rather, we used the best data available and made a good faith effort to simulate payments under the ESRD PPS to determine the standardization factor that was applied to the CY 2011 ESRD PPS base rate. The final standardization adjustment was .9407 or a reduction of 5.93 percent from the unadjusted per treatment base rate.

Since the ESRD PPS began, organizations representing LDOs have expressed concern about the comorbidity adjustments and requested that we return the 5.93 percent standardization factor to the base rate. In response to this concern, in preparation for this final rule, we performed an analysis of the composition of the standardization factor and determined that the bulk of the 5.93 percent standardization reduction to the base rate arises from factors other than the comorbidities. Age adjustments account for approximately 3.0 percent, the onset of dialysis adjustment accounts for approximately 2.4 percent, the low volume adjustment accounts for approximately 0.3 percent, the body size adjustments account for approximately 0.2 percent, and the wage adjustment accounts for approximately −0.7 percent (this was negative and partially offset the effects of the other adjustments because the average wage adjustment was less than 1.00, unlike the other adjustments). The comorbidity adjustments jointly account for approximately 0.8 percent.

Section 632(c) of ATRA requires the Secretary, by not later than January 1, 2016, to conduct an analysis of the case mix payment adjustments under section 1881(b)(14)(D)(i) of the Act and make appropriate revisions to those adjustments. Pursuant to this authority, CMS plans to conduct a regression analysis for the CY 2016 ESRD PPS rulemaking cycle to reassess the appropriateness of the patient and facility level payment adjustments. At that time, we plan to analyze the various payment adjustments under the PPS to determine whether they should continue to apply as well as whether the magnitude of the adjustments is appropriate.

In responses to the comments regarding the comorbidity adjustments, we will consider whether changes to documentation requirements are warranted with respect to qualifying for the comorbidity payment adjustment.

In regards to the outlier policy, as we explained in section II.C.6. of this final rule, section 1881(b)(14)(D)(ii) of the Act requires that the ESRD PPS include a payment adjustment for high cost outliers due to unusual variations in the type or amount of medically necessary care, including variations in the amount of erythropoiesis stimulating agents necessary for anemia management. Each year, we simulate payments under the ESRD PPS in order to set the outlier fixed dollar loss and MAP amounts for adult and pediatric patients to try to achieve the 1 percent outlier policy. We would not increase the base rate in years where outlier payments were less than 1 percent of total ESRD PPS payments, nor would we reduce the base rate if the outlier payments exceed 1 percent of total ESRD PPS payments. Rather, we would simulate payments in the following year and adjust the fixed dollar loss and MAP amounts to try to achieve outlier payments that meet the 1 percent outlier percentage. This approach to updating the outlier policy is consistent with how we update outlier policies in other Medicare prospective payment systems, for example, the prospective payment system for inpatient psychiatric facilities. We believe that the outlier policy continues to be important for patient access to ESRD-related services because it offsets the cost of high-cost patients, particularly those who receive more drugs and biologicals than the average patient. We will reassess the outlier policy along with our review of the other payment adjustments for the CY 2016 ESRD PPS. With respect to the low-volume payment adjustment, we are reviewing the GAO's findings and are considering their recommendations.

Comment: A national organization representing large dialysis organizations (LDOs) and ESRD facilities recommended that prior to making any adjustment to reduce payments to reflect changes in utilization of drugs and biologicals, CMS should take into consideration what these commenters believe to be a cross subsidization of items and services that were previously paid for under the basic case-mix adjusted composite rate payment system with payments for formerly separately billable items. The commenters believe that because the composite rate, which historically did not have annual market basket increases, was underfunded, payments for separately billable drugs, laboratory tests, and supplies offset those losses. The organization provided a report that estimates that $15–20 of costs for items and services that were previously paid for under the basic case-mix adjusted composite rate payment system are subsidized by the incorporation into the base rate of formerly separately billable drugs and biologicals, laboratory tests, and supplies. The commenters stated that CMS has the authority to take into account that Congress intended that some previously separately billable drug dollars be used to compensate for items and services formerly paid for under the purportedly underfunded basic case-mix adjusted composite rate payment system. This comment was supported by other national providers and patient organizations.

Response: Section 1881(b)(14)(I) of the Act requires that the single payment amount be reduced by an amount that reflects the Secretary's estimate of the change in utilization of drugs and biologicals. It does not provide for the reduction to account for cross-subsidization of other components of the base rate. We do not believe we would be in compliance with section 1881(b)(14)(I) if we were to eliminate most of the drug utilization reduction to reflect the purported need for cross-subsidization of the composite rate with separately billable services.

Comment: In making the reduction to the ESRD PPS base rate, national organizations representing the dialysis industry and dialysis patients recommended that we factor in the 2 percent reduction already made to the original ESRD PPS base rate in 2011 as required by section 1881(b)(14)(A)(ii), which was implemented in the form of the 98 percent budget neutrality adjustment. The comments indicated that this reduction accounts for the anticipated reduction in drug utilization and has already been built into the payment rate. The commenters stated that CMS has the authority to temper the drug utilization adjustment because section 1881(b)(14)(I) does not require a dollar-for-dollar adjustment. Rather, the statute indicates that the adjustment

should ''reflect'' the Secretary's estimate of the change in utilization of drugs and biologicals. Therefore, the commenters contended, CMS has the authority to consider the 2 percent reduction implemented in 2011 as part of the drug utilization adjustment.

Response: In the CY 2014 ESRD PPS proposed rule (78 FR 40843), we explained that once we determined the per-treatment difference in utilization of drugs and biologicals ($32.34), we reduced this amount by the standardization, the outlier, and the 98 percent budget neutrality adjustment to yield the proposed drug utilization adjustment amount of $29.52. As noted previously, for this final rule, the difference in drug utilization per treatment was computed to be $32.79 and this amount was also reduced by the standardization, the outlier, and the 98 percent budget neutrality adjustment to yield the final drug utilization adjustment amount of $29.93. Therefore, the 98 percent budget neutrality adjustment was considered in computing the drug utilization adjustment. Moreover, because the 98 percent budget neutrality adjustment and the drug utilization adjustment both apply to the ''single'' payment rate required by section 1881(b)(14)(A), we do not believe it would be appropriate to reduce the drug utilization adjustment by the amount of the 98 percent budget neutrality adjustment, absent a clear statement of congressional intent that we should do so.

Comment: Several national dialysis organizations indicated that CMS has an obligation to ensure that the single payment amount is consistent with the factors set forth in section 1881(b)(2)(B) of the Act, which provides that payment amounts for renal dialysis services be determined on a ''cost-related basis or other economical and equitable basis.'' The commenters submitted data that displayed profit margins for ESRD facilities prior to the proposed one-time reduction and then what the profit margins would look like after the one-time reduction. The comments stated that if payment rates do not reflect the cost of providing care, then they are neither economical nor equitable. Also, since section 1881(b)(14)(I) did not repeal section 1881(b)(2)(B) and the sections do not conflict with one another, both must be considered. In addition, because Congress inserted an ''and'' between section 1881(b)(2)(B) requirements and section 1881(b)(7)—the reference to the payment system in effect at the time the provision was modified—this suggests the intent to have a two-step process for setting the payment rate. Commenters claim this conjunction suggests that the Secretary must not only apply the provisions that prescribe the payment model, but also evaluate the final payment amount against the factors outlined in subsection (b)(2)(B). Using these authorities, commenters claim CMS could temper any payment reduction so the final amount remains based either upon the cost of providing services or upon economic and equitable factors. The commenters indicated that a payment amount that does not cover the cost of providing care would not be cost-related or equitable. The commenters believe use of the word ''reflect'' in section 1881(b)(14)(I) provides CMS the authority to adjust the drug utilization adjustment consistent with other provisions of section 1881. The commenters contend that this interpretation is also supported by the fact that section 1881(b)(14)(I) notes that the drug utilization adjustment applies to ''this paragraph'' (which establishes the PPS bundle) and thus, does not override or repeal other provisions of this section, including section 1881(b)(2)(B).

Response: We disagree with the commenters that section 1881(b)(2)(B) of the Act applies to the ESRD PPS. The MIPPA revisions to section 1881 of the Act did not specify that we must take section 1881(b)(2) of the Act into account in implementing the ESRD PPS. Instead, it required that we base the ESRD PPS on the lowest per patient utilization year out of 2007, 2008, and 2009 and that the system should result in payments that are 98 percent of what would otherwise have been paid. Once we established that 2007 was the lowest per patient utilization year, we used cost report and claims data to compute the base rate. Section 1881(b)(14)(I) requires the Secretary to compare per patient utilization data for 2007 with such data for 2012 and then make reductions to the ESRD PPS single payment amount to reflect the Secretary's estimate of the change in utilization of drugs and biologicals. We do not believe this very specific statutory provision gives us discretion to mitigate the amount of the reduction based on the very general authority of section 1881(b)(2)(B), which, moreover, we believe no longer applies to payment for renal dialysis services.

Other commenters pointed out that the prospective payment systems should protect beneficiary access while conserving beneficiaries' and taxpayers' resources. Accordingly, in addition to proposing a full reduction of $29.52 in CY 2014, in the CY 2014 ESRD PPS proposed rule (78 FR 40843), we noted that a one-time reduction to the ESRD PPS base rate could be a significant reduction for ESRD facilities for the year and potentially impact beneficiary access to care. Therefore, we solicited comments on a potential transition or phase-in period of the proposed 12 percent reduction and the number of years for such transition or phase-in period. The comments related to a transition and our responses are set forth below.

Comment: We received a comment from MedPAC providing the details from their March 2013 report to Congress which is one of two reports that they issue each year to advise Congress on issues affecting the Medicare program (the March 2013 report is available at the following link: *http://www.medpac.gov/documents/Mar13_entirereport.pdf*). Specifically, MedPAC noted that there is historical evidence that implementation of PPSs in Medicare has been characterized by providers quickly reducing use of services included in the payment bundle, resulting in periods of ''overpayment'' where providers benefit from the change in practice patterns and the Medicare program does not realize savings until the payment is adjusted. The MedPAC recommended that the Medicare program move expeditiously toward correcting overpayments, while also adjusting payments so that providers have time to respond in a way that does not disrupt beneficiary access. The MedPAC further recommended that CMS consider their analyses of Medicare margins, that is, the extent to which facilities are reimbursed more than their cost of furnishing services to Medicare beneficiaries, in implementing the drug utilization reduction. Based upon the available 2011 cost reports at the time of their analysis, MedPAC estimated an aggregate 2011 Medicare margin of about 4 percent for free standing ESRD facilities.

Specifically, MedPAC recommended that the Secretary take action to freeze the payment rates for 2014 at 2013 levels, consistent with their recommendation to the Congress in their March 2013 report. MedPAC explained that this method would accomplish several goals. First, it would start to move the payment system toward greater accuracy and in doing so, protect scarce Medicare resources paid for by the beneficiary and the taxpayer. Second, it would protect beneficiary access and give MedPAC the ability to report back to Congress on any developing access issues should they occur. Third, it would give ESRD facilities time to respond to payment changes by identifying efficiencies in care. Lastly, it would give CMS,

MedPAC, and the Congress time to consider policies that should be changed concurrent with further refinements, such as targeting facilities critical to beneficiary access (rather than protecting industry-wide payment rates) and improving the case-mix adjustments.

Response: We agree with the MedPAC suggestion that freezing payments could ensure access to essential ESRD services while not further perpetuating overpayments. However, we believe that section 1881(b)(14)(I) of the Act requires that, effective January 1, 2014, we ''make reductions to the single payment that would otherwise apply. . . .'' and therefore, we believe the base rate must be reduced by some portion of the drug utilization adjustment amount to be consistent with this provision. We interpreted MedPAC's recommendation of freezing payment rates at the CY 2013 level, provided in both their public comment and in their March 2013 Report to Congress, to mean that payment is adequate in CY 2013. We believe that we can be in compliance with section 1881(b)(14)(I) and follow MedPAC's recommendation by applying a portion of the drug utilization reduction to the base rate to offset the payment update, that is, the ESRDB market basket minus productivity increase factor, and other impacts (such as, changes in the outlier thresholds) to create an overall impact of zero percent for ESRD facilities from the previous year's payments in CYs 2014 and 2015. We relied on the impact chart provided in the impact analysis section of our annual rules to determine the impact of various policy changes on aggregate ESRD facility payments and took those values into consideration to determine the drug utilization adjustment for this year, and we will do the same next year.

To implement a portion of the drug utilization adjustment in CY 2014, we adjusted the CY 2013 ESRD PPS base rate by the CY 2014 ESRDB market basket minus productivity increase factor, the wage index budget-neutrality factor, and the home dialysis training add-on budget-neutrality factor. As we mentioned above, we took into consideration other impacts (provided in Table 12 presented in section XI.B.1.a. of this final rule) of the CY 2014 ESRD PPS that will cause a change in average payments to ESRD facilities in order to create and overall impact of zero percent. Specifically, for CY 2014, we are accounting for the changes to outlier payments and the movement from a 75/25 blend of PPS and pre-PPS payments to 100 percent ESRD PPS payments (for those ESRD facilities transitioning to the ESRD PPS) to create a zero percent average impact for facilities from the CY 2013 estimated payments. As indicated in Table 12, the average increase resulting from changes to the fixed dollar loss threshold and Medicare allowable payment (MAP) amounts under the ESRD PPS outlier policy is estimated to be a 0.4 percent increase over 2013 payments. For the ESRD PPS transition change to 100 percent ESRD PPS payments, the estimated average increase is 0.2 percent. These percentage increases, in addition to the ESRDB market basket minus productivity adjustment increase of 2.8 percent as discussed in section II.C.3. of this final rule, yield a drug utilization reduction for CY 2014 of 3.3 percent or $8.16 per treatment. Specifically, in Table 12, the overall impact of all of the changes for CY 2014 ESRD PPS totals 3.4 percent, however, in a multiplicative system to achieve a zero percent overall impact we had to divide 1 by 1.034 to derive a 0.967 or 3.3 percent decrease. Therefore, we are finalizing a transition of the drug utilization adjustment amount as an annual offset to payment rate updates and other impacts that would otherwise cause a change in average payments to ESRD facilities, thereby creating an overall impact of zero percent for ESRD facilities from the previous year's payments. We are finalizing this methodology for CY 2014 and CY 2015.

For CY 2016, we will evaluate how to apply the balance of the adjustment when we conduct an analysis of the case-mix adjustments required by section 632(c) of ATRA and implement the inclusion of oral-only ESRD-related drugs and biologicals consistent with section 632(b) of ATRA. At that time, this evaluation will allow us to determine if we should apply the balance of the reduction in CY 2016 or provide one additional transition year so that the entire amount of the drug utilization adjustment will have been applied to the base rate no later than CY 2017. This transition approach will make it easier for ESRD facilities to plan and budget, allow time for providers to respond to payment changes by identifying efficiencies, and allow time for CMS to consider further refinements to the ESRD PPS.

Comment: We received several comments from national organizations representing ESRD facilities stating that they were unable to provide useful or constructive comments on the nature, extent and operation of a transition until they understand how CMS intends to correct the base rate to reflect cross-subsidization of the composite rate services with separately billable services, standardization, comorbidity case-mix adjusters, the low-volume adjuster, and the outlier policy. However, the commenters stated that the transition should not be viewed as a substitute for making necessary corrections to the current payment system.

The commenters suggested that if CMS does utilize a transition to implement the drug utilization adjustment, then it should do so over a period of 2 to 4 years to minimize system disruption for beneficiaries, assess the impact on access, and correct course, as needed. The commenters further explained that a transition would allow providers to adjust to the payment reduction and engage in a more thoughtful process to evaluate and close facilities that cannot be made viable, reduce service, and change staffing. The commenters also explained that the transition would allow CMS to evaluate the impact of the payment reduction.

Response: As stated previously, we do not intend to offset the drug utilization adjustment amount to reflect purported cross-subsidization of items and services paid for under the composite rate with formerly separately billable services, nor do we intend to update the standardization and outlier reductions made to the 2011 ESRD PPS base rate to reflect actual payments of the adjustments. However, the transition approach we are adopting will spread the reduction over a 3- to 4-year period to minimize system disruption.

Comment: One national organization that represents small dialysis organizations and several independent ESRD facilities suggested that we treat small dialysis organizations differently from large dialysis organizations when implementing a transition of the reduction to the base rate because we determined in the CY 2014 ESRD PPS proposed rule (78 FR 40888) that a one-time reduction to the base rate would have a significant economic impact on a substantial number of small entities. The commenter explained that ESRD facilities that are owned by small dialysis organizations have less flexibility and working capital to withstand a substantial decrease in revenue. The commenter urged CMS to hold off on implementing the reduction for the first 6 months of CY 2014 because the rule is not likely to be finalized until November 2013 and without a 6-month delay, ESRD facilities would not have sufficient time to plan for and make adjustments in their operations. The commenter further suggested that the amount of the reduction should be transitioned over a period of 6 years after the 6-month

deferral and should not exceed 2 percent of the base rate in any given year.

Another national organization that represents not-for-profit ESRD facilities with support from several ESRD facilities recommended a transition under which the base rate is not reduced by more than $5.00 in a given year. One commenter recommended that CMS continue to provide a market basket update each year and apply the drug utilization adjustment to the base rate after the market basket update is applied. The commenter stated that CMS does not have an obligation to meet a certain overall reduction in expense over time and that it has discretion to implement a transition that does not effectively end with a lower rate than would have been in place if there were no transition. One commenter suggested that CMS implement the transition as optional, just as how the original ESRD PPS implementation allowed the option of accepting the full bundle or a 4-year transition.

Another commenter suggested that CMS create a differential payment for non-profit and SDOs. The commenter pointed out that the Regulatory Flexibility Act allows CMS to assess the impact of the regulation on small entities. A medium dialysis organization that was created as a result of a divestiture requirement imposed by the Federal Trade Commission (FTC) pointed out that the proposed drug utilization adjustment will undermine specific FTC action to preserve competition in the dialysis facility's marketplace. The commenter stated that overall the diminished competition in the marketplace will result in lower capacity, lower quality of care, and higher private payer prices in those markets.

Response: We agree with the commenters that implementing the full amount of the drug utilization adjustment in CY 2014 would have a significant impact on access to ESRD services. We believe that the transition approach we are taking, which will apply the drug utilization adjustment amount to the base rate over several years, will allow ESRD facilities an opportunity to plan for and adjust their future operations accordingly. Because facilities are currently operating efficiently under the CY 2013 payment rates and we are largely offsetting future increases to achieve an average impact of zero percent for ESRD facilities in CYs 2014 and 2015, we do not believe a 6-month grace period is necessary. We note that the dollar value of the 3.3 percent drug utilization reduction for CY 2014 is $8.16 per treatment. Although this amount is higher than the $5.00 reduction suggested by the commenters, we believe that ESRD facilities will be able to maintain their current programs and services because payments will remain close to CY 2013 levels for the next 2 years. With regard to the comment that we should provide a market basket increase prior to application of the reduction, we note that under our approach to the drug utilization adjustment we apply the ESRDB market basket minus productivity increase prior to making the drug utilization reduction.

In regards to the commenters that suggested that CMS create a different payment amount or transition scheme for non-profit ESRD facilities and SDOs, as well as for those ESRD facilities that were created due to FTC-ordered divestiture, we believe that we must provide for a single payment rate in accordance with section 1881(b)(14)(A)(i) of the Act, but that the transition will mitigate the potential negative effects of the adjustment that commenters pointed out. In addition, any other adjustments to the payment rate, such as an adjustment for non-profit facilities and SDOs would be established through regression analysis.

Comment: One patient advocacy group supported the drug utilization reduction but pointed out that the industry got the benefit of a base rate that included higher utilization of ESRD-related drugs and biologicals since CY 2011, but CMS did not make an adjustment to the payment until CY 2014 and continued to increase the base rate using the ESRDB market basket. The commenter further pointed out that prior to implementation of the ESRD PPS, annual increases to the composite rate were sporadic.

Response: We share the commenter's view that small, medium, and large dialysis facilities have benefited from an inflated base rate since CY 2011. As noted previously, there is historical evidence that implementation of PPSs has resulted in providers quickly reducing use of services included in the bundle, thereby creating periods of overpayment in which providers benefit from the change in practice patterns and the Medicare program does not realize savings until the payment is adjusted. Section 1881(b)(14)(I) of the Act provided the specific authority to reduce the base rate to reflect only the change in utilization of ESRD-related drugs and biologicals and not all renal dialysis services. We note that annual market basket increases to the ESRD PPS base rate are required by section 1881(b)(14)(F)(i)(I) of the Act, although these increases are reduced by the multifactor productivity adjustments required by section 1881(b)(14)(F)(i)(II) of the Act.

Comment: Several commenters expressed concern that with the implementation of the ESRD PPS and QIP have come a significant number of unfunded mandates that the Agency has not acknowledged in any specific way and the market basket does not address. The commenters recommended that a thorough analysis of costs should include those that have increased since the initiation of the bundle when calculating the drug utilization reduction. Notable among these are the costs of new IT requirements for participation in CROWNWeb, administration of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, participation in the National Healthcare Safety Network (NHSN), and transitioning to ICD–10–CM coding. One small dialysis organization indicated that the costs of these initiatives are as much as $5 per treatment. In addition to the costs discussed, commenters urged us to consider the reductions caused by sequestration and QIP penalties. The commenters urged us to take these costs into consideration when computing the drug utilization adjustment.

Response: We understand the commenter's concerns. Nonetheless, section 1881(b)(14)(I) of the Act requires us to make reductions to the single payment amount to reflect the Secretary's estimate of the change in utilization of drugs and biologicals from 2007 to 2012. Section 1881(b)(14)(I) does not give us authority to take into account any additional factors that may impact the cost of care, such as the sequestration, and the QIP requirements. We note that entering data in CROWNWeb is a Condition for Coverage for dialysis facilities (42 CFR § 494.180(h)), and that CROWNWeb was implemented in accordance with the 1995 Paperwork Reduction Act. In regards to the transition to ICD–10–CM coding scheme, this is a requirement that is shared by all Health Insurance Portability and Accountability Act of 1996 covered entities and is not unique to ESRD facilities.

Comment: Hundreds of comments from ESRD patients, their family members, friends and caregivers, to national organizations representing dialysis patients and facilities, to ESRD facility staff expressed grave concerns about steps facilities would take if we were to adopt the proposed drug utilization adjustment. They were concerned about facility closures, staffing cuts, cuts to hours of operation,

loss of transportation services, and their continued access to life-saving ESRD treatment. Some commenters indicated that facilities have already begun to shift costs to patients and cut back staffing and programs even though the reduction will not be applied until January 1, 2014. Patients who attend nocturnal dialysis programs stated that without these programs they would be unable to continue working. ESRD facility staff also expressed concern about the magnitude of the proposed reduction and the likelihood of facility closures and resulting job losses. One commenter pointed out that pediatric patients often require more intensive staffing; it is not uncommon for younger pediatric patients to need a staffing ratio of two nurses to one patient. The commenter stated that the drastic payment reduction proposed by CMS will challenge pediatric facilities to provide safe care for these vulnerable patients.

Commenters expressed concern about facility closures and their continued access to quality ESRD services, especially in rural and inner city areas. Many commenters noted the burden and expense of traveling long distances should their facilities close. Another commenter stated that the drug utilization adjustment threatens the networks of dialysis facilities where profitable facilities allow organizations to subsidize those facilities that operate at a loss in underserved areas. Conversely, a few comments indicated support for the proposed drug utilization adjustment, stating that facilities are primarily interested in higher profits and high corporate salaries at the expense of patient care.

One patient advocacy group expressed concern about the corporate practice by ESRD facilities of shifting the responsibility of prescribing therapy and medication from the nephrologist to the dialysis organization. Another commenter representing nephrology nurses expressed concern that the proposed reduction will cause ESRD facilities to curtail the number of nursing positions and no longer maintain staff education and competencies. Other commenters pointed out that many commercial payers use Medicare reimbursement rates as a basis for their reimbursement, limiting ESRD facilities' ability to make up the lost revenue from other sources. Several commenters expressed concern that the 12 percent payment reduction in CY 2014 may hinder the ESRD facilities' ability to participate in the Center for Medicare and Medicaid Innovation's (CMMI) Comprehensive ESRD Care model which is testing innovative models of care.

Response: We believe that the approach we have taken to transition the drug utilization reduction over a 3 to 4-year timeframe will minimize disruption in the delivery of ESRD services and will hopefully lead facilities to reverse cuts they may have already implemented in anticipation that the full amount of the drug utilization adjustment would be applied to the base rate in CY 2014. In addition, part of our rationale for the transition was to enable facilities to maintain their current programs and services. We developed a comprehensive claims-based monitoring system when we implemented the ESRD PPS in 2011 and will use that system to identify changes in practice patterns, prescribing patterns, health outcomes, and ownership that may impact the furnishing of ESRD services. We have provided sufficient information in this final rule about how we plan to transition the drug utilization adjustment so that ESRD facilities can assess whether to participate in the CMMI Comprehensive ESRD Care model.

Comment: One commenter recommended that CMS specify how it plans to ensure that access to and quality of care is not compromised by the drug utilization adjustment. They provided a list of monitoring elements including ESA and other drug utilization rates, hospital admission/readmission rates, transfusion rates, availability to patients of dietitian and social worker services, changes in numbers of shifts per facility, changes in staffing ratios or staffing composition (that is, fewer nurses), consolidation/sales of dialysis facilities in markets with limited numbers of providers, and facility closures. The commenter recommended that CMS post quarterly updates on monitored aspects of care that are feasible to report publically.

Response: We intend to monitor access through the comprehensive claims monitoring program we implemented when the ESRD PPS began in 2011. We believe that the transition approach we are adopting for implementing the drug utilization reduction will mitigate many of the unintended consequences identified by the commenters. We note that many of the suggested monitoring elements are already part of the comprehensive claims monitoring program (for example, ESA and other drug utilization rates, use of inpatient hospital services, and transfusion rates). Other elements suggested by the commenters warrant additional review by CMS to assess the burden associated with collecting the information. We currently provide a workbook that displays several key trends from CY 2011 through CY 2013 on the CMS Web site: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Spotlight.html*. This workbook is updated on a quarterly basis.

Comment: Comments from ESRD patients indicated that they believe Medicare will no longer pay for dialysis or that the cost of the reduction would be shifted to patients.

Response: We want to reassure ESRD patients, their families, and caregivers that Medicare will continue to cover dialysis services, but at a lower rate. As a result of the small reduction to the ESRD PPS base rate (that is, from the CY 2013 ESRD PPS base rate of $240.36 to CY 2014 ESRD PPS base rate of $239.02), beneficiary co-insurance will also decrease slightly. We believe the transition approach we are finalizing makes cost shifting to beneficiaries less likely.

In summary, to comply with section 1881(b)(14)(I) of the Act we have computed the drug utilization adjustment to be $29.93 as detailed in section II.C.2.a.v. above. Specifically, we used the CY 2007 claims data that was used in the preparation of the CY 2011 ESRD PPS final rule for CY 2007 utilization and included the drug utilization data from facilities located in the Pacific Rim. For CY 2012 utilization we used the CY 2012 claims file updated through June 30, 2013, (that is, claims with dates of service from January 1 through December 31, 2012, that were received, processed, paid, and passed to the National Claims History File as of June 30, 2013) to calculate 2012 utilization.

To determine the final growth update factor's value, we used the methodology discussed above resulting in a 7.64 percent growth update factor to inflate prices for ESRD-related drugs and biologicals from CY 2011 levels to CY 2014 levels. The 7.64 percent growth update factor represents the ESRDB market basket minus the multifactor productivity adjustments finalized in CYs 2012, 2013, and 2014, the wage index budget-neutrality adjustment factors finalized in CYs 2012, 2013, and 2014, and the home dialysis training add-on budget neutrality adjustment factor finalized for CY 2014. We applied the CY 2014 prices to the CY 2007 and CY 2012 drug utilization data to calculate aggregate amounts for each year. Next, we divided each year's estimated aggregate amount for drugs and biologicals by that year's count of treatments furnished to Medicare beneficiaries to get an average payment per treatment for the year. This resulted

in a per treatment amount for drugs and biologicals of $83.96 in 2007 and a per treatment amount for drugs and biologicals of $51.17 in 2012. We then subtracted the average payment per treatment for CY 2012 from the average amount per treatment for CY 2007 to get a total of $32.79 ($83.96 − $51.17 = $32.79). We then reduced this amount by the standardization, the outlier, and the 98 percent budget neutrality adjustments to get a total of $29.93 ($32.79 × .9407 × .99 × .98 = $29.93). We are finalizing $29.93 as the total drug utilization reduction.

In response to comments we are finalizing the following approach for implementing the amount of the drug utilization adjustment over a 3- to 4-year transition period. For CYs 2014 and 2015, we are implementing a transition of the drug utilization adjustment by offsetting the payment update, that is the ESRDB market basket minus productivity increase factor and other impacts (such as, changes to the outlier thresholds), by a portion of the reduction amount necessary to create an overall impact of zero percent for ESRD facilities from the previous year's payments. We relied on the impact chart provided in the impact analysis section of our annual rules to determine the impact of various policy changes on aggregate ESRD facility payments and took those values into consideration to determine the drug utilization adjustment for this year, and we will do the same for next year.

For CY 2014, this approach results in a base rate reduction of $8.16, which yields a CY 2014 ESRD PPS base rate of $239.02. This reflects the CY 2013 ESRD PPS base rate of $240.36 adjusted by the ESRDB market basket minus productivity increase factor of 2.8 percent, the wage index budget neutrality factor of 1.000454, and the home dialysis training add-on budget neutrality adjustment factor of 0.999912 to get $247.18 ($240.36*1.028*1.000454*0.999912 = $247.18). Then we reduced this amount by the portion of the drug utilization reduction that is being implemented this year—$8.16—to arrive at a final CY 2014 ESRD PPS base rate of $239.02 ($247.18 − $8.16=$239.02).

For CY 2016, we will evaluate how to apply the balance of the reduction when we conduct an analysis of the case-mix adjustments as required by section 632(c) of ATRA and implement the inclusion of oral-only ESRD-related drugs and biologicals as permitted by section 632(b) of ATRA. Following this evaluation, we will determine whether we should apply the balance of the reduction in CY 2016 or provide one additional transition year so that the full amount of the drug utilization adjustment will have been applied to the base rate over a 4-year transition period ending in CY 2017.

3. ESRD Bundled Market Basket

a. Overview and Background

In accordance with section 1881(b)(14)(F)(i) of the Act, as added by section 153(b) of MIPPA and amended by section 3401(h) of the Affordable Care Act, beginning in 2012, the ESRD payment amounts are required to be annually increased by an ESRD market basket increase factor that is reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. The application of the productivity adjustment described may result in the increase factor being less than 0.0 for a year and may result in payment rates for a year being less than the payment rates for the preceding year. The statute also provides that the market basket increase factor should reflect the changes over time in the prices of an appropriate mix of goods and services used to furnish renal dialysis services.

b. Market Basket Update Increase Factor and Labor-related Share for ESRD Facilities for CY 2014

As required under section 1881(b)(14)(F)(i) of the Act, CMS developed an all-inclusive ESRDB input price index (75 FR 49151 through 49162). Although ''market basket'' technically describes the mix of goods and services used for ESRD treatment, this term is also commonly used to denote the input price index (that is, cost categories, their respective weights, and price proxies combined) derived from a market basket. Accordingly, the term ''ESRDB market basket,'' as used in this document, refers to the ESRDB input price index.

We proposed to use the CY 2008-based ESRDB market basket described in the CY 2011 ESRD PPS final rule (75 FR 49151 through 49162) to compute the CY 2014 ESRDB market basket increase factor and labor-related share based on the best available data. Consistent with historical practice, we estimate the ESRDB market basket update based on IHS Global Insight (IGI), Inc.'s forecast using the most recently available data. IGI is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets.

Using this methodology and the IGI forecast for the first quarter of 2013 of the CY 2008-based ESRDB market basket (with historical data through the fourth quarter of 2012), and consistent with our historical practice of estimating market basket increases based on the best available data, the proposed CY 2014 ESRDB market basket increase factor was 2.9 percent.

For the CY 2014 ESRD payment update, we proposed to continue using a labor-related share of 41.737 percent for the ESRD PPS payment, which was finalized in the CY 2011 ESRD final rule (75 FR 49161).

Comment: Several commenters supported the ESRDB proposed market basket update.

Response: We appreciate the commenters support and are finalizing our update to the ESRDB market basket for CY 2014 based on the most recent forecast of the ESRDB market basket.

c. Productivity Adjustment for CY2014

Under section 1881(b)(14)(F)(i) of the Act, as amended by section 3401(h) of the Affordable Care Act, for CY 2012 and each subsequent year, the ESRD market basket percentage increase factor shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. The statute defines the productivity adjustment as equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period) (the ''MFP adjustment''). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business MFP. Please see *http://www.bls.gov/mfp* to obtain the BLS historical published MFP data.

CMS notes that the proposed and final methodology for calculating and applying the MFP adjustment to the ESRD payment update is similar to the methodology used in other payment systems, as required by section 3401 of the Affordable Care Act.

The projection of MFP is currently produced by IGI. The details regarding the methodology for forecasting MFP and how it is applied to the market basket were finalized in the CY 2012 ESRD PPS final rule (76 FR 70232 through 70234). Using this method and the IGI forecast for the first quarter of 2013 of the 10-year moving average of MFP, the proposed CY 2014 MFP factor was 0.4 percent. We did not receive any comments on this proposal.

Accordingly, are finalizing the CY 2014 MFP adjustment to the ESRDB market basket for CY 2014 based on the most recent forecast available.

d. Calculation of the Final ESRDB Market Basket Update, Adjusted for Multifactor Productivity for CY 2014

Under section 1881(b)(14)(F) of the Act, beginning in CY 2012, ESRD PPS payment amounts shall be annually increased by an ESRD market basket percentage increase factor reduced by the productivity adjustment. We proposed to use the same methodology for calculating the ESRDB market basket updates adjusted for MFP that was finalized in the CY 2012 ESRD PPS final rule (76 FR 70234) and based on the most recent forecast of the data.

It is our policy that if more recent data are available after publication of the proposed rule (for example, a more recent estimate of the market basket or MFP adjustment), we will use such data, if appropriate, to determine the CY 2014 market basket update and MFP adjustment in the CY 2014 ESRD PPS final rule. Thus, in accordance with section 1881(b)(14)(F)(i) of the Act, the final ESRDB market basket percentage increase factor for CY 2014 is based on the 3rd quarter 2013 forecast of the CY 2008-based ESRDB market basket, which is estimated to be 3.2 percent. This market basket percentage is then reduced by the MFP adjustment (the 10-year moving average of MFP for the period ending CY 2014) of 0.4 percent, which is based on IGI's 3rd quarter 2013 forecast. The resulting final MFP-adjusted ESRDB market basket update for CY 2014 is equal to 2.8 percent, or 3.2 percent less 0.4 percentage point.

4. The CY 2014 Wage Index

Section 1881(b)(14)(D)(iv)(II) of the Act provides that the ESRD PPS may include a payment adjustment by geographic wage index payment adjustment, such as the index referred to in section 1881(b)(12)(D) of the Act. In the CY 2011 ESRD PPS final rule (75 FR 49117), we finalized the use of the Office of Management and Budget's (OMB) Core-Based Statistical Areas (CBSAs)-based geographic area designations to define urban and rural areas and their corresponding wage index values. In the CY 2012 ESRD PPS final rule (76 FR 70239–70241), we finalized that, under the ESRD PPS, we will continue to utilize the ESRD PPS wage index methodology, first established under the basic case-mix adjusted composite rate payment system, for updating the wage index values using the OMB's CBSA-based geographic area designations to define urban and rural areas and corresponding wage index values; the gradual reduction of the wage index floor during the transition; and the policies for areas with no hospital data. The CBSA-based geographic area designations were originally described in OMB bulletin 03–04, issued June 6, 2003. This bulletin, as well as subsequent bulletins, are available online at *http://www.whitehouse.gov/omb/bulletins_default*.

OMB publishes bulletins regarding CBSA changes, including changes to CBSA numbers and titles. In accordance with our established methodology, we have historically adopted any CBSA changes that are published in the OMB bulletin that correspond with the IPPS hospital wage index. For CY 2014, we use the FY 2014 pre-floor, pre-reclassified hospital wage index to adjust the ESRD PPS payments. On February 28, 2013, OMB issued OMB Bulletin No. 13–01, which establishes revised delineations of statistical areas based on OMB standards published in the **Federal Register** on June 28, 2010 and 2010 Census Bureau data. Because the FY 2013 pre-floor, pre-reclassified hospital wage index was finalized prior to the issuance of this Bulletin, the FY 2013 pre-floor, pre-reclassified hospital wage index does not reflect OMB's new area delineations based on the 2010 Census. Further, as stated in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50586), because the bulletin was not issued until February 28, 2013, with supporting data not available until later, and because the changes made by the bulletin and their ramifications must be extensively reviewed and verified, we were unable to undertake such a lengthy process before publication of the FY 2014 IPPS/LTCH PPS proposed rule; therefore, the FY 2014 pre-floor, pre-reclassified hospital wage index does not reflect OMB's new area delineations based on the 2010 Census. CMS intends to propose changes to the hospital wage index based on this OMB Bulletin in the FY 2015 IPPS/LTCH PPS proposed rule. Therefore, we anticipate that the OMB Bulletin changes will be reflected in the FY 2015 hospital wage index. Because we base the ESRD PPS wage index on the hospital wage index, we anticipate that the OMB Bulletin changes would be reflected in the FY 2015 hospital wage index and, thus, in the CY 2015 ESRD PPS wage index.

For CY 2014, we will continue to use the same methodology as finalized in the CY 2011 ESRD PPS final rule (75 FR 49117), for determining the wage indices for ESRD facilities in CY 2014. Specifically, we proposed to adjust wage indices for CY 2014 to account for annually updated wage levels in areas in which ESRD facilities are located. We proposed to use the most recent, FY 2014 IPPS pre-floor, pre-reclassified hospital wage index, which, as discussed above, does not reflect OMB's new area delineations based on the 2010 Census. The ESRD PPS wage index values are calculated without regard to geographic reclassifications authorized under section 1886(d)(8) and (d)(10) of the Act and utilize pre-floor hospital data that are unadjusted for occupational mix. The CY 2014 wage index values for urban areas are listed in Addendum A (Wage Indices for Urban Areas) and the CY 2014 wage index values for rural areas are listed in Addendum B (Wage Indices for Rural Areas). Addenda A and B are located on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html*.

In the CY 2011 ESRD PPS final rule (75 FR 49117), we finalized a policy to use the labor-related share of 41.737 for the ESRD PPS portion of the payment. For the CY 2014 ESRD PPS, we did not propose any changes to the labor-related share of 41.737. However, because all providers that elected to participate in the transition are entering the fourth year of the transition and will begin being paid 100 percent under the ESRD PPS, the 53.711 labor-related share that was applied to the composite rate portion of the blended payment is no longer applicable. We discuss the methodology for the ESRD PPS labor-related share in our CY 2011 ESRD PPS final rule (75 FR 49161), where we noted that the labor-related share is typically the sum of Wages and Salaries, Benefits, Housekeeping and Operations, Professional Fees, Labor-related Services, and a portion of the Capital-related Building and Equipment expenses. For additional discussions on the labor-related share please refer to section II.C.3.b. of this final rule.

Comment: We received several comments expressing concern about applying the same labor-related share in CY 2014, as was finalized in CY 2011. Many commenters suggested that CMS review the labor-related share and update the factor to reflect 2012 cost report data. Other commenters noted that smaller providers cannot ''offset negative impacts across a national market base'' and therefore are disadvantaged by rising salary costs in labor markets that compete regionally. A few commenters suggested that CMS has erred in not updating the labor-related share for CY 2014 to appropriately reflect the decrease in pharmaceutical spending identified in ESRD facility cost reports for 2011 and 2012. One commenter noted that the current labor-related share calculation is based upon

2008 cost report data, and the decrease in pharmaceutical spending since that time has resulted in an ''understated labor-related share'' used to adjust wages when making ESRD PPS payments.

Response: The ESRD bundled labor-related share is based on the cost weights for wages and salaries, benefits, housekeeping and operation, professional fees, labor-related services and a portion of the capital-related building and equipment expenses. Because we did not propose to rebase or revise the ESRDB market basket for CY 2014, the labor-related share will remain 41.737 percent. At the time of preparing the CY 2014 ESRD PPS proposed rule we had access to cost report data through 2010. The 2011 cost report data was captured on the revised ESRD cost report form and complete data files were not available in time to estimate cost shares on the 2011 data in time for the proposed rule. In order to estimate if any major changes had occurred since 2008 (the current base years of the ESRDB market basket) we did produce ESRD market basket cost shares based on the Medicare Cost Report data for 2009 and 2010 (which were the latest, complete year of data we had available at the time) and we did not have access to the files in order to estimate the cost weights based on data from 2011 or later. We did run the cost report data for 2009 and 2010 and found that the cost share weights for the market basket and the estimated labor-related share as described in the CY 2011 ESRD PPS final rule (75 FR 49161) did not change significantly. We understand that under the bundled payment system the relative shares of wages and salaries and pharmaceuticals may change. We will be rebasing and revising the ESRD market basket for CY 2015 based on the most up-to-date and complete year of cost report data available, which will be based on data from a year after 2011. This will reflect the costs for ESRD services that were reported in a payment year under the bundled system.

a. Payment Under the ESRD PPS for Facilities Located in Guam, American Samoa, and the Northern Mariana Islands

It came to our attention after the ESRD PPS was implemented that ESRD facilities located in the United States Territories of Guam, American Samoa and the Northern Mariana Islands (collectively, the Pacific Rim) have been paid on the basis of reasonable costs and charges, rather than under the ESRD PPS. Because section 1881(b)(14)(A)(i) of the Act requires the Secretary to implement a payment system under which a single payment is made to a renal dialysis facility for renal dialysis services in lieu of any other payment for services furnished on or after January 1, 2011, and section 1881(b)(14)(E)(i) requires that the payment amounts under the ESRD PPS by fully implemented for services furnished on or after January 1, 2014, ESRD facilities located in the Pacific Rim must be paid under the ESRD PPS beginning for services furnished on or after January 1, 2014. In order to pay these facilities under the ESRD PPS, we would need to identify a wage index value for these areas to make payment adjustments for geographic wages according to § 413.231 of the regulations. We proposed to use the current value calculated under the existing methodology, that is, the pre-floor, pre-reclassified, hospital wage data that is unadjusted for occupational mix for the island of Guam of 0.9611, which is displayed in Addendum B (Wage Indices for Rural Areas), because the FY 2014 IPPS pre-floor, pre-reclassified hospital wage data does not include wage data for American Samoa and the Northern Mariana Islands. Accordingly, we proposed to apply the wage index value for Guam to facilities located in American Samoa and the Northern Mariana Islands as discussed below in section II.C.4.b. of this final rule.

Comment: We received two comments suggesting that the ESRD PPS does not sufficiently account for the unique economic circumstances faced by dialysis facilities located in the Territory of Guam. One commenter noted higher costs for shipping and warehousing of supplies, as well as significant training costs, which results from high employee turnover when military personnel and their families relocate to the mainland. Another commenter requested that Medicare continue to make payments to ESRD facilities located in Guam under reasonable costs and charges payment methodologies.

Response: We appreciate the concern expressed by commenters' regarding the payment change. However, section 1881(b)(14)(A)(i) of the Act requires the Secretary to implement a payment system under which a single payment is made to a renal dialysis facility for renal dialysis services in lieu of any other payment. In order to comply with the statute, ESRD facilities located in the Pacific Rim must be paid under the ESRD PPS and will be paid under this system for renal dialysis services furnished on or after January 1, 2014. We understand that ESRD facilities located in Guam, as well as many other geographic areas where Medicare services are furnished, have unique geographic, labor, or regulatory circumstances that have an impact on their provision of dialysis services. For example, the states of Hawaii and Alaska have similar shipping and storage considerations as Guam and these areas are paid under the ESRD PPS. Likewise, the island of Puerto Rico, (which shares the status of a United States Territory), must comply with unique staffing requirements, in that only registered nurses may furnish dialysis services to dialysis patients and these facilities are paid under the ESRD PPS. Further, many ESRD facilities are located near military bases where there is high turnover of staff and these facilities are also paid under the ESRD PPS. Nonetheless, CMS has no authority to continue to pay ESRD facilities located in the Territory of Guam or elsewhere in the Pacific Rim based on reasonable costs or any other payment methodology. Therefore, beginning January 1, 2014, in accordance with section 1881(b)(14)(A)(i) of the Act, all ESRD facilities furnishing renal dialysis services to Medicare beneficiaries will be paid 100 percent under the ESRD PPS, including ESRD facilities located in the Pacific Rim.

b. Policies for Areas With No Wage Data

In the CY 2011 ESRD PPS final (75 FR 49116 through 49117), we also discussed and finalized the methodologies we use to calculate wage index values for ESRD facilities that are located in urban and rural areas where there is no hospital data. We further explained our approach for areas with no hospital data in the CY 2012 ESRD PPS final rule (76 FR 70241). For urban areas with no hospital data, we compute the average wage index value of all urban areas within the State and use that value as the wage index. For rural areas with no hospital data, we compute the wage index using the average wage index values from all contiguous CBSAs to represent a reasonable proxy for that rural area. Therefore, we use our established methodology to compute an appropriate wage index using the average wage index values from contiguous CBSAs, to represent a reasonable proxy.

As stated previously, the FY 2014 IPPS pre-floor, pre-reclassified hospital wage data does not include wage data for American Samoa and the Northern Mariana Islands, which are rural areas with no hospital data. While we appreciate that the islands of the Pacific Rim are not actually contiguous, we believe the same principle applies here, and that Guam is a reasonable proxy for American Samoa and the Northern

Mariana Islands. We believe that Guam represents a reasonable proxy because the islands are located within the Pacific Rim and share a common status as United States Territories. We noted that if hospital data becomes available for American Samoa or the Northern Mariana Islands, we will use that data for the CBSA instead of the proxy. As discussed previously, the current wage index value for Guam using the existing methodology is 0.9611. Therefore, for CY 2014, we proposed to apply this wage index value of 0.9611 to ESRD facilities located in America Samoa and the Northern Mariana Islands and included this value in Addendum B.

For CY 2014, the only urban area without wage index data is Hinesville-Fort Stewart, GA. As we discussed in our CY 2013 ESRD PPS final rule (77 FR 67459), we will continue to use the statewide urban average based on the average of all urban areas within the state for urban areas without hospital data. Accordingly, we proposed to apply the statewide urban average wage index value for Georgia of 0.7582 to Hinesville-Fort Stewart, GA and included this value in Addendum A.

We received no public comments regarding our proposal to use the wage index value for Guam of 0.9611 as an appropriate proxy for American Samoa and the Northern Mariana Islands. Therefore, we are finalizing our proposal. For renal dialysis services furnished in American Samoa or the Northern Mariana Islands and paid under the ESRD PPS on or after January 1, 2014, a wage index value of 0.9611, as calculated for the Territory of Guam, will be applied to the ESRD PPS base rate when making Medicare payments. The wage index values for Guam, America Samoa and the Northern Mariana Islands are included in Addendum B.

We received no comments on our proposal to apply the computed statewide urban average wage index value for Georgia to the CBSA for Hinesville-Fort Stewart, GA. Therefore, we are finalizing the proposal with the following clarification. In the CY 2014 ESRD PPS proposed rule (78 FR 40845), we incorrectly stated the computed value for the statewide urban average wage index value for Georgia of 0.7582. The correct value computed for the urban average wage index value for Georgia and applied to Hinesville-Fort Stewart, GA was correctly identified in Addendum A of the CY 2014 ESRD PPS proposed rule as 0.8602. We apologize for this error. In addition, the urban wage index values have been updated with more recent data for this final rule, and therefore for CY 2014 we are finalizing a statewide urban average wage index value for Georgia of 0.8700 and will apply this value to the CBSA for Hinesville-Fort Stewart, GA and include this value in Addendum A.

c. Reduction to the ESRD Wage Index Floor

A wage index floor value has been used in lieu of the calculated wage index values below the floor in making payment for renal dialysis services under the ESRD PPS. In the CY 2011 ESRD PPS final rule (75 FR 49116 through 49117), we finalized that we would continue to reduce the wage index floor by 0.05 for each of the remaining years of the transition. In the CY 2012 ESRD PPS final rule (76 FR 70241), we finalized the 0.05 reduction to the wage index floor for CYs 2012 and 2013, resulting in a wage index floor of 0.550 and 0.500, respectively. Most recently, in the CY 2013 ESRD PPS final rule (77 FR 67459 through 67461), we discussed the elimination of the wage index floor beginning in CY 2014, noting that we would propose a new methodology in CY 2014 to address wages in rural Puerto Rico because we would no longer be applying a wage index floor.

As described above, our intention has been to provide a wage index floor only through the transition to 100 percent implementation of the ESRD PPS (75 FR 49116 through 49117; 76 FR 70240 through 70241). However, the CY 2014 wage index values for both urban and rural Puerto Rico remain below the finalized CY 2013 ESRD PPS wage index floor of 0.500 (77 FR 67459), and we believe that both rural and urban facilities in Puerto Rico would benefit from continuing the gradual reduction of the floor. We believe that continuing the wage index floor for CY 2014 and CY 2015 will allow renal dialysis facilities located in Puerto Rico the benefit afforded to other geographical areas in the fifty states, that is, a gradual and systematic elimination of the wage index floor. Therefore, for CY 2014 and for CY 2015, we proposed to continue to apply the wage index floor to areas with wage indexes below the floor. For CY 2014, Puerto Rico is the only area with a wage index value below the proposed floor; however, to the extent that other geographical areas fall below the floor in CY 2015, we believe they should have the benefit of a gradual reduction in the floor as well. Thus, for CY 2014 and CY 2015, we proposed to continue our policy of gradually reducing the wage index floor by 0.05 per year. Specifically, we proposed a wage index floor value of 0.450 for CY 2014 and a wage index floor value of 0.400 for CY 2015. We believe that continuing our policy of applying a wage index floor for an additional two years would allow Puerto Rico to benefit from the anticipated and predictable phase out of the wage index floor. While we would not expect to continue this policy past CY 2015, we will review the appropriateness of a wage index floor for CY 2016 at that time.

Comment: We received a few comments requesting that CMS review hospital wage data and consider the appropriateness of a wage index floor. For example, a commenter from Wheeling, WV, suggested that CMS consider increasing the wage index floor value, so that rural facilities with low wage index values will be able to compete with urban facilities in attracting qualified staff members. Another commenter requested that CMS modify the current wage index methodology to capture ''true'' ESRD facility wages in Puerto Rico. The current methodology relies upon hospital wage data and the commenter contended that the hospital occupational wage mix does not adequately reflect wages in ESRD facilities in Puerto Rico, where registered nurses are required to furnish dialysis care. In addition, the commenter requested that the wage index floor be frozen at 2011 levels.

Response: We thank the commenters for their comments and we appreciate their concerns regarding the impact of a wage index floor on dialysis facilities. We have committed to reviewing the appropriateness of applying a wage index floor for CY 2016. However, for CY 2014 and CY 2015, we are finalizing our proposal. We will continue our policy of gradually reducing the wage index floor by 0.05 per year. Accordingly, we are finalizing in this rule a wage index floor value of 0.450 for CY 2014, and a wage index floor value of 0.400 for CY 2015. This policy will benefit ESRD facilities located in Puerto Rico, where wage index values remain below the wage index floor values finalized in this rule. We note that if another geographic CBSA area wage index value falls below the floor in CY 2015, the facilities in that CBSA will also have the benefit of the wage index floor.

In summary, for CY 2014, we will continue to use the same wage index methodology as finalized in the CY 2011 ESRD PPS final rule (75 FR 49117). That is, we will use the most recent IPPS pre-floor, pre-reclassified hospital wage index to calculate the ESRD PPS wage index values. Thus, for CY 2014, we will use the FY 2014 IPPS pre-floor, pre-reclassified hospital wage index to

calculate the CY 2014 ESRD PPS waged index. The 2014 wage index values for urban areas, Addendum A (Wage Indices for Urban Areas) and the CY 2014 wage index values for rural areas, Addendum B (Wage Indices for Rural Areas) may be viewed at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html*.

Lastly, for CY 2014 and CY 2015, we are continuing our policy of gradually reducing the wage index floor by 0.05 per year. That is, we are finalizing a wage index floor value of 0.450 for CY 2014, and a wage index floor value of 0.400 for CY 2015.

d. Wage Index Budget-Neutrality Adjustment

Section 1881(b)(14)(D)(iv)(II) of the Act gives us broad discretion to implement payment adjustments to the ESRD PPS, including an adjustment of the ESRD PPS by a geographic index. Section 1881(b)(14)(D)(iv)(II) specifically refers to section 1881(b)(12)(D) as an example of such a geographic index, and in the CY 2011 ESRD PPS final rule, we finalized the use of the same wage index methodology that we utilized under the basic case-mix adjusted composite rate payment system (75 FR 49116). We had applied a wage index budget-neutrality adjustment factor under the basic case-mix adjusted composite payment system, and accordingly, in the CY 2012 ESRD PPS final rule, we finalized a policy for CY 2012 and future years to apply wage index budget-neutrality adjustment factors to the composite rate portion of the ESRD PPS blended payments for facilities participating in the transition as well as to the base rate for the ESRD PPS portion of the blended payment and the full ESRD PPS for those facilities that elected to receive 100 percent of their payment under that system (76 FR 70241 and 70242). We also finalized the methodology for computing the wage index budget-neutrality adjustment factors for CY 2012 and subsequent years (76 FR 70242).

For CY 2014, we did not propose any changes to the methodology, but we noted that we will no longer compute a wage index budget-neutrality adjustment factor for the composite rate portion of the ESRD PPS blended payment because all facilities will be paid 100 percent under the ESRD PPS in CY 2014. For ease of reference, we explain the methodology for computing the budget-neutrality adjustment factor here. For the CY 2014 wage index budget-neutrality adjustment factor, we use the fiscal year (FY) 2014 pre-floor, pre-reclassified, non-occupational mix-adjusted hospital data to compute the wage index values, 2012 outpatient claims (paid and processed as of June 30, 2013), and geographic location information for each facility, which may be found through Dialysis Facility Compare. Dialysis Facility Compare (DFC) can be found at the DFC Web page on the CMS Web site at *http://www.medicare.gov/dialysisfacilitycompare/*. The FY 2014 hospital wage index data for each urban and rural locale by CBSA may also be accessed on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/*. The wage index data are located in the section entitled, ''FY 2014 Final Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-Reclassified Wage Index by CBSA''.

We computed the proposed CY 2014 wage index budget-neutrality adjustment factor using treatment counts from the 2012 claims and facility-specific CY 2013 payment rates to estimate the total dollar amount that each ESRD facility would have received in CY 2013. The total of these payments became the target amount of expenditures for all ESRD facilities for CY 2014. Next, we computed the estimated dollar amount that would have been paid for the same ESRD facilities using the ESRD wage index for CY 2014. The total of these payments becomes the new CY 2014 amount of wage-adjusted expenditures for all ESRD facilities.

The wage index budget-neutrality factor is calculated as the target amount divided by the new CY 2014 amount. When we multiplied the wage index budget-neutrality factor by the applicable CY 2014 estimated payments, aggregate payments to ESRD facilities would remain budget neutral when compared to the target amount of expenditures. That is, the wage index budget-neutrality adjustment factor ensures that wage index adjustments do not increase or decrease aggregate Medicare payments with respect to changes in wage index updates. Therefore, we proposed a wage index budget-neutrality adjustment factor of 1.000411, which would be computed in ESRD PPS base rate payment methodology when making payment for renal dialysis services in CY 2014.

We received no public comments on this proposal, and therefore, we are finalizing the proposed CY 2014 wage index budget-neutrality adjustment factor as updated with the most recently available data. In the proposed rule, the CY 2014 wage index budget-neutrality adjustment factor was computed at 1.000411. This calculation was based upon the use of the FY 2014 pre-floor, pre-reclassified, non-occupational mix-adjusted hospital data computed for wage index values and the CY 2012 Medicare outpatient claims data file as of December 31, 2012. For CY 2014, we are finalizing a wage index budget-neutrality adjustment factor of 1.000454. This final calculation reflects the most recent Medicare claims data available, which is the FY 2014 pre-floor, pre-reclassified, non-occupational mix-adjusted hospital data computed for wage index values and the CY 2012 Medicare outpatient claims data file (that is, claims with dates of service from January 1, through December 31, 2012, that were received, processed, paid, and passed to the National Claims History file as of June 30, 2013).

5. Application of the International Classification of Diseases (ICD), Tenth Revision, to the Comorbidity Payment Adjustment Codes

In the CY 2011 ESRD PPS final rule (75 FR 49094), we explained that section 1881(b)(14)(D)(i) of the Act, as added by section 153(b) of MIPPA, requires that the ESRD PPS include a payment adjustment based on case-mix that may take into account, among other things, patient comorbidities. Comorbidities are specific patient conditions that coexist with the patient's principal diagnosis that necessitates dialysis. The comorbidity payment adjustments recognize the increased costs associated with comorbidities and provide additional payment for certain conditions that occur concurrently with the need for dialysis.

To develop the comorbidity payment adjustments, we used a stepwise regression model to analyze comorbidity data and found that certain comorbidities are predictors of variation in payments for ESRD patients. Details on the development of the comorbidity categories eligible for a comorbidity payment adjustment, including an explanation of the stepwise regression model that we used to analyze comorbidity data, is discussed in the CY 2011 ESRD PPS final rule (75 FR 49094 through 49108). We analyzed the comorbidity categories and excluded those categories from the comorbidity payment adjustments that met any of three exclusion criteria (75 FR 49095 through 49100): (1) Inability to create accurate clinical definitions; (2) potential for adverse incentives regarding care; and (3) potential for

ESRD facilities to directly influence the prevalence of the comorbidity either by altering dialysis care, changing diagnostic testing patterns, or liberalizing the diagnostic criteria.

We finalized six comorbidity categories that are eligible for a comorbidity payment adjustment, each with associated International Classification of Disease, 9th Revision, Clinical Modification (ICD–9–CM) diagnosis codes (75 FR 49100). Among these categories are three acute, short-term diagnostic categories (pericarditis, bacterial pneumonia, and gastrointestinal tract bleeding with hemorrhage) and three chronic diagnostic categories (hereditary hemolytic anemia with sickle cell anemia, myelodysplastic syndrome, and monoclonal gammopathy). The comorbidity categories eligible for an adjustment and their associated ICD–9–CM codes were published in the Appendix of the CY 2011 ESRD PPS final rule as Table E: ICD–9–CM Codes Recognized for a Comorbidity Payment Adjustment (75 FR 49211).

In the CY 2012 ESRD PPS final rule (76 FR 70252), we clarified that the ICD–9–CM codes eligible for a comorbidity payment adjustment are subject to the annual ICD–9–CM coding updates that occur in the hospital IPPS final rule and are effective October 1st of every year. We explained that any updates to the ICD–9–CM codes that affect the categories of comorbidities and the diagnoses within the comorbidity categories that are eligible for a comorbidity payment adjustment would be communicated to ESRD facilities through sub-regulatory guidance. Accordingly, Change Request (CR) 7476, Transmittal 2255, entitled, ''Quarterly Update to the End-Stage Renal Disease Prospective Payment System,'' was issued on July 15, 2011 to update the ICD–9–CM codes eligible for a comorbidity payment adjustment in accordance with the annual ICD–9–CM update effective October 1, 2011. This CR can be found on the CMS Web site at the following link: *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2255CP.pdf*. There have not been updates to the ICD–9–CM codes eligible for a comorbidity payment adjustment since October 1, 2011.

Effective October 1, 2014, CMS will implement the 10th revision of the ICD coding scheme—ICD–10–CM. Because the transition to ICD–10–CM coding will occur during CY 2014, we discuss here the crosswalk from ICD–9–CM to ICD–10–CM codes for the purpose of determining eligibility for a comorbidity payment adjustment.

We crosswalked the ICD–9–CM codes that are eligible for a comorbidity payment adjustment to ICD–10–CM codes using the General Equivalence Mappings (GEM) tool, which is the authoritative source for crosswalking developed by the National Center for Health Statistics and CMS. The crosswalk from ICD–9–CM to ICD–10–CM diagnosis codes resulted in three scenarios: one ICD–9–CM code crosswalked to one ICD–10–CM code; one ICD–9–CM code crosswalked to multiple ICD–10–CM codes; or multiple ICD–9–CM codes crosswalked to one ICD–10–CM code. We applied the three exclusion criteria listed above to each of the ICD–10–CM codes to which the ICD–9–CM codes crosswalked.

In our clinical evaluation, we found the ICD–9–CM codes generally crosswalked to one ICD–10–CM code that codes for the same diagnosis, has the same code descriptor, and does not meet any of our exclusion criteria. Accordingly, with the exceptions noted below, we proposed that ICD–10–CM codes will be eligible for a comorbidity payment adjustment where they crosswalk from ICD–9–CM codes that are eligible for a comorbidity payment adjustment. There are, however, two instances where ICD–9–CM codes crosswalk to ICD–10–CM codes that we believe meet one or more of the exclusion criteria described above, and we proposed to exclude these codes from eligibility for a comorbidity payment adjustment.

a. One ICD–9–CM Code Crosswalks to One ICD–10–CM Code

Table 1 lists all the instances in which one ICD–9–CM code crosswalks to one ICD–10–CM code. We proposed that all of those ICD–10–CM codes would receive a comorbidity payment adjustment with the exception of K52.81 Eosinophilic gastritis or gastroenteritis. Currently, 535.71 Eosinophilic gastritis with hemorrhage is one of 40 ICD–9–CM diagnosis codes under the acute comorbidity category of Gastrointestinal (GI) Bleeding. The descriptor of K52.81, the ICD–10–CM code to which this ICD–9–CM code crosswalks, does not include the word ''hemorrhage.'' In the CY 2011 ESRD PPS final rule (75 FR 49097), we specifically limited the GI bleeding category for the comorbidity payment adjustment to GI bleed with hemorrhage because we believed that the gastrointestinal tract bleeding category met our first exclusion criterion—inability to create accurate clinical definitions—because it was overly broad. We also believed that use of this diagnosis category could lead to gaming consistent with the second and third exclusion criteria listed above. For these reasons, we limited the gastrointestinal tract bleeding diagnosis category to gastrointestinal tract bleeding with hemorrhage, which we believe creates accurate clinical definitions and mitigates the potential for adverse incentives in ESRD care. Accordingly, we proposed to exclude ICD–10–CM code K52.81 Eosinophilic gastritis or gastroenteritis from eligibility for the comorbidity payment adjustment because the code descriptor does not indicate the diagnosis of a hemorrhage. We proposed that all of the other ICD–10–CM codes listed in the Table 1 below would be eligible for a comorbidity payment adjustment.

TABLE 1—ONE ICD–9–CM CODE CROSSWALKS TO ONE ICD–10–CM CODE

GASTROINTESTINAL BLEEDING			
ICD–9	Descriptor	ICD–10	Descriptor
530.21	Ulcer of esophagus with bleeding	K22.11	Ulcer of esophagus with bleeding
535.71	Eosinophilic gastritis, with hemorrhage	K52.81	Eosinophilic gastritis or gastroenteritis
537.83	Angiodysplasia of stomach and duodenum with hemorrhage	K31.811	Angiodysplasia of stomach and duodenum with bleeding
569.85	Angiodysplasia of intestine with hemorrhage	K55.21	Angiodysplasia of colon with hemorrhage
BACTERIAL PNEUMONIA			
ICD–9	Descriptor	ICD–10	Descriptor
003.22	Salmonella pneumonia	A02.22	Salmonella pneumonia

TABLE 1—ONE ICD–9–CM CODE CROSSWALKS TO ONE ICD–10–CM CODE—Continued

482.0	Pneumonia due to Klebsiella pneumonia	J15.0	Pneumonia due to Klebsiella pneumoniae
482.1	Pneumonia due to Pseudomonas	J15.1	Pneumonia due to Pseudomonas
482.2	Pneumonia due to Hemophilus influenzae [H. influenzae]	J14	Pneumonia due to Hemophilus influenzae
482.32	Pneumonia due to Streptococcus, group B	J15.3	Pneumonia due to streptococcus, group B
482.40	Pneumonia due to Staphylococcus, unspecified	J15.20	Pneumonia due to staphylococcus, unspecified
482.41	Methicillin susceptible pneumonia due to Staphylococcus aureus	J15.211	Pneumonia due to Methicillin susceptible Staphylococcus aureus
482.42	Methicillin resistant pneumonia due to Staphylococcus aureus	J15.212	Pneumonia due to Methicillin resistant Staphylococcus aureus
482.49	Other Staphylococcus pneumonia	J15.29	Pneumonia due to other staphylococcus
482.82	Pneumonia due to escherichia coli [E. coli]	J15.5	Pneumonia due to Escherichia coli
482.83	Pneumonia due to other gram-negative bacteria	J15.6	Pneumonia due to other aerobic Gram-negative bacteria
482.84	Pneumonia due to Legionnaires' disease	A48.1	Legionnaires' disease
507.0	Pneumonitis due to inhalation of food or vomitus	J69.0	Pneumonitis due to inhalation of food and vomit
507.8	Pneumonitis due to other solids and liquids	J69.8	Pneumonitis due to inhalation of other solids and liquids
510.0	Empyema with fistula	J86.0	Pyothorax with fistula
510.9	Empyema without mention of fistula	J86.9	Pyothorax without fistula
PERICARDITIS			
ICD–9	Descriptor	ICD–10	Descriptor
420.91	Acute idiopathic pericarditis	I30.0	Acute nonspecific idiopathic pericarditis
HEREDITARY HEMOLYTIC AND SICKLE CELL ANEMIA			
ICD–9	Descriptor	ICD–10	Descriptor
282.0	Hereditary spherocytosis	D58.0	Hereditary spherocytosis
282.1	Hereditary elliptocytosis	D58.1	Hereditary elliptocytosis
282.41	Sickle-cell thalassemia without crisis	D57.40	Sickle-cell thalassemia without crisis
282.43	Alpha thalassemia	D56.0	Alpha thalassemia
282.44	Beta thalassemia	D56.1	Beta thalassemia
282.45	Delta-beta thalassemia	D56.2	Delta-beta thalassemia
282.46	Thalassemia minor	D56.3	Thalassemia minor
282.47	Hemoglobin E-beta thalassemia	D56.5	Hemoglobin E-beta thalassemia
282.49	Other thalassemia	D56.8	Other thalassemias
282.61	Hb-SS disease without crisis	D57.1	Sickle-cell disease without crisis
282.63	Sickle-cell/Hb-C disease without crisis	D57.20	Sickle-cell/Hb-C disease without crisis
282.68	Other sickle-cell disease without crisis	D57.80	Other sickle-cell disorders without crisis
MYELODYSPLASTIC SYNDROME			
ICD–9	Descriptor	ICD–10	Descriptor
238.7	Essential thrombocythemia	D47.3	Essential (hemorrhagic) thrombocythemia
238.73	High grade myelodysplastic syndrome lesions	D46.22	Refractory anemia with excess of blasts 2
238.74	Myelodysplastic syndrome with 5q deletion	D46.C	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality
238.76	Myelofibrosis with myeloid metaplasia	D47.1	Chronic myeloproliferative disease

b. One ICD–9–CM Code Crosswalks to Multiple ICD–10–CM Codes

Table 2 lists all of the instances in which one ICD–9–CM code crosswalks to multiple ICD–10–CM codes. In those instances, we proposed that all the crosswalked ICD–10–CM codes would receive a comorbidity payment adjustment, with the exception of D89.2 Hypergammaglobulinemia, unspecified. ICD–9–CM code 273.1 Monoclonal paraproteinemia is the only ICD–9–CM code eligible for the comorbidity payment adjustment under the chronic comorbidity category of Monoclonal gammopathy. ICD–9–CM code 273.1 Monoclonal paraproteinemia crosswalks to two ICD–10–CM codes: D47.2 Monoclonal gammopathy and D89.2 Hypergammaglobulinemia, unspecified. We analyzed both of these ICD–10–CM codes and determined that D47.2 Monoclonal gammopathy should be eligible for the comorbidity payment adjustment because, like ICD–9–CM code 273.1 Monoclonal paraproteinemia, it indicates that there is an excessive amount of a single monoclonal gammaglobulin. When we analyzed the comorbidity category for the CY 2011 ESRD PPS final rule, single monoclonal gammaglobulin was shown to have an association with higher ESA usage, thereby resulting in higher costs to dialysis facilities. After clinical evaluation of D89.2 Hypergammaglobulinemia, unspecified, however, we determined that this ICD–10–CM code should not be eligible for the comorbidity payment adjustment because D89.2 Hypergammaglobulinemia, unspecified indicates only that 1 or more immunoglobulins are elevated, but does not identify which immunoglobulin(s) are elevated. We believe that the lack of specificity of this particular code results in an inability to create an accurate clinical definition, which is the first of the three exclusion criteria. Accordingly, we proposed that D89.2 Hypergammaglobulinemia, unspecified would not be eligible for the comorbidity payment adjustment. We proposed that all of the other ICD–10–CM codes listed in Table 2 below would be eligible for the comorbidity payment adjustment.

TABLE 2—ONE ICD–9–CM CODE CROSSWALKS TO MULTIPLE ICD–10–CM CODES

GASTROINTESTINAL BLEEDING			
ICD–9	Descriptor	ICD–10	Descriptor
562	Diverticulosis of small intestine with hemorrhage	K57.11	Diverticulosis of small intestine without perforation or abscess with bleeding
		K57.51	Diverticulosis of both small and large intestine without perforation or abscess with bleeding
562.03	Diverticulitis of small intestine with hemorrhage	K57.01	Diverticulitis of small intestine with perforation and abscess with bleeding
		K57.13	Diverticulitis of small intestine without perforation or abscess with bleeding
		K57.41	Diverticulitis of both small and large intestine with perforation and abscess with bleeding
		K57.53	Diverticulitis of both small and large intestine without perforation or abscess with bleeding
562.12	Diverticulosis of colon with hemorrhage	K57.31	Diverticulosis of large intestine without perforation or abscess with bleeding
		K57.91	Diverticulosis of intestine, part unspecified, without perforation or abscess with bleeding
		K57.51	Diverticulosis of both small and large intestine without perforation or abscess with bleeding
562.13	Diverticulitis of colon with hemorrhage	K57.21	Diverticulitis of large intestine with perforation and abscess with bleeding
		K57.33	Diverticulitis of large intestine without perforation or abscess with bleeding
		K57.41	Diverticulitis of both small and large intestine with perforation and abscess with bleeding
		K57.53	Diverticulitis of both small and large intestine without perforation or abscess with bleeding
BACTERIAL PNEUMONIA			
ICD–9	Descriptor	ICD–10	Descriptor
513.0	Abscess of lung	J85.0	Gangrene and necrosis of lung
		J85.1	Abscess of lung with pneumonia
		J85.2	Abscess of lung without pneumonia
PERICARDITIS			
ICD–9	Descriptor	ICD–10	Descriptor
420.0	Acute pericarditis in diseases classified elsewhere	A18.84	Tuberculosis of heart
		I32	Pericarditis in diseases classified elsewhere
		M32.12	Pericarditis in systemic lupus erythematosus
420.90	Acute pericarditis, unspecified	130.1	Infective pericarditis
		I30.9	Acute pericarditis, unspecified
420.99	Other acute pericarditis	I30.8	Other forms of acute pericarditis
		I30.9	Acute pericarditis, unspecified
HEREDITARY HEMOLYTIC AND SICKLE CELL ANEMIA			
ICD–9	Descriptor	ICD–10	Descriptor
282.2	Anemias due to disorders of glutathione metabolism	D55.0	Anemia due to glucose-6-phosphate dehydrogenase [G6PD] deficiency
		D55.1	Anemia due to other disorders of glutathione metabolism
282.3	Other hemolytic anemias due to enzyme deficiency	D55.2	Anemia due to disorders of glycolytic enzymes
		D55.3	Anemia due to disorders of nucleotide metabolism
		D55.8	Other anemias due to enzyme disorders
		D55.9	Anemia due to enzyme disorder, unspecified
282.42	Sickle-cell thalassemia with crisis	D57.411	Sickle-cell thalassemia with acute chest syndrome
		D57.412	Sickle-cell thalassemia with splenic sequestration
		D57.419	Sickle-cell thalassemia with crisis, unspecified
282.62	Hb-SS disease with crisis	D57.00	Hb-SS disease with crisis, unspecified
		D57.01	Hb-SS disease with acute chest syndrome
		D57.02	Hb-SS disease with splenic sequestration
282.64	Sickle-cell/Hb-C disease with crisis	D57.211	Sickle-cell/Hb-C disease with acute chest syndrome
		D57.212	Sickle-cell/Hb-C disease with splenic sequestration
		D57.219	Sickle-cell/Hb-C disease with crisis, unspecified
282.69	Other sickle-cell disease with crisis	D57.811	Other sickle-cell disorders with acute chest syndrome
		D57.812	Other sickle-cell disorders with splenic sequestration
		D57.819	Other sickle-cell disorders with crisis, unspecified

TABLE 2—ONE ICD–9–CM CODE CROSSWALKS TO MULTIPLE ICD–10–CM CODES—Continued

MONOCLONAL GAMMOPATHY			
ICD–9	Descriptor	ICD–10	Descriptor
273.1	Monoclonal paraproteinemia	D47.2	Monoclonal gammopathy
		D89.2	Hypergammaglobulinemia, unspecified
MYELODYSPLASTIC SYNDROME			
ICD–9	Descriptor	ICD–10	Descriptor
238.72	Low grade myelodysplastic syndrome lesions	D46.0	Refractory anemia without ring sideroblasts, so stated
		D46.1	Refractory anemia with ring sideroblasts
		D46.20	Refractory anemia with excess of blasts, unspecified
		D46.21	Refractory anemia with excess of blasts 1
		D46.4	Refractory anemia, unspecified
		D46.A	Refractory cytopenia with multilineage dysplasia
		D46.B	Refractory cytopenia with multilineage dysplasia and ring sideroblasts
238.75	Myelodysplastic syndrome, unspecified	D46.9	Myelodysplastic syndrome, unspecified
		D46.Z	Other myelodysplastic syndromes

c. Multiple ICD–9–CM Codes Crosswalk to One ICD–10–CM Code

Table 3 displays the crosswalk where multiple ICD–9–CM codes crosswalk to one ICD–10–CM code. For the reasons explained above, we propose that all of the crosswalked ICD–10–CM codes listed below would be eligible for a comorbidity payment adjustment.

TABLE 3—MULTIPLE ICD–9–CM CODES CROSSWALK TO ONE ICD–10–CM CODE

GASTROINTESTINAL BLEEDING			
ICD–9	Descriptor	ICD–10	Descriptor
533.20	Acute peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction	K27.2	Acute peptic ulcer, site unspecified, with both hemorrhage and perforation
533.21	Acute peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction		
533.40	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, without mention of obstruction	K27.4	Chronic or unspecified peptic ulcer, site unspecified, with hemorrhage
533.41	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, with obstruction		
533.60	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction	K27.6	Chronic or unspecified peptic ulcer, site unspecified, with both hemorrhage and perforation
533.61	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction		
534.00	Acute gastrojejunal ulcer with hemorrhage, without mention of obstruction	K28.0	Acute gastrojejunal ulcer with hemorrhage
534.01	Acute gastrojejunal ulcer, with hemorrhage, with obstruction		
534.20	Acute gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction	K28.2	Acute gastrojejunal ulcer with both hemorrhage and perforation
534.21	Acute gastrojejunal ulcer with hemorrhage and perforation, with obstruction		
534.40	Chronic or unspecified gastrojejunal ulcer with hemorrhage, without mention of obstruction	K28.4	Chronic or unspecified gastrojejunal ulcer with hemorrhage
534.41	Chronic or unspecified gastrojejunal ulcer, with hemorrhage, with obstruction		
534.60	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction	K28.6	Chronic or unspecified gastrojejunal ulcer with both hemorrhage and perforation
534.61	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, with obstruction		
BACTERIAL PNEUMONIA			
ICD–9	Descriptor	ICD–10	Descriptor
482.30	Pneumonia due to Streptococcus, unspecified	J15.4	Pneumonia due to other streptococci
482.31	Pneumonia due to Streptococcus, group A		
482.39	Pneumonia due to other Streptococcus		
482.81	Pneumonia due to anaerobes	J15.8	Pneumonia due to other specified bacteria
482.89	Pneumonia due to other specified bacteria		

In summary, based on our clinical evaluation of the ICD–10–CM codes to which the eligible ICD–9–CM codes crosswalk, we proposed that both D89.2 Hypergammaglobulinemia, unspecified and K52.81 Eosinophilic gastritis or gastroenteritis would not be eligible for the comorbidity payment adjustment. We proposed that all other ICD–10–CM codes to which eligible ICD–9–CM codes crosswalk that are listed in the Tables above would be eligible for a comorbidity payment adjustment effective October 1, 2014. We solicited comment on the ICD–10–CM codes that we proposed to exclude and those that we proposed would be eligible for a comorbidity adjustment. The comments that we received and our responses are set forth below.

Comment: We received a few comments that acknowledged the implementation of the ICD–10–CM coding scheme. Two commenters supported our proposal to exclude D89.2 Hypergammaglobulinemia, unspecified and K52.81 Eosinophilic gastritis or gastroenteritis from eligibility for a comorbidity payment adjustment.

Response: We thank commenters for their support. We are finalizing our proposal that the ICD–10–CM codes listed in the Tables above are eligible for a comorbidity payment adjustment, and that ICD–10–CM codes D89.2 Hypergammaglobulinemia, unspecified and K52.81 Eosinophilic gastritis or gastroenteritis are excluded from eligibility for a comorbidity payment adjustment.

Comment: One commenter questioned why CMS includes monoclonal gammopathy but excludes multiple myeloma and plasma cell leukemia. The commenter encouraged CMS to determine methods for proper disease identification as myeloma is the most common malignancy leading to ESRD.

Response: In the CY 2011 ESRD PPS final rule (75 FR 49099), we discuss the exclusion of the cancer comorbidity diagnostic category from eligibility for a comorbidity payment adjustment. We explained that providing a payment adjustment for the cancer comorbidity category could overstate costs for some patients whose dialysis treatment is no longer affected by their history of cancer and could understate the costs of patients whose current cancer diagnosis and treatment affect their dialysis treatments. Until we are able to differentiate the cost between the two groups, we are unable to accurately reflect the ESRD resources being used to determine a comorbidity payment adjustment for patients with multiple myeloma and leukemia.

Comment: We received two comments stating that implementing ICD–10–CM in 2014 will be another unfunded mandate and small dialysis organizations will suffer the most.

Response: We understand that the transition from ICD–9–CM to ICD–10–CM may present a challenge for some ESRD facilities; however, the compliance date for implementation of ICD–10–CM is October 1, 2014 for all Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities, regardless of their size.

6. Revisions to the Outlier Policy

Section 1881(b)(14)(D)(ii) of the Act requires that the ESRD PPS include a payment adjustment for high cost outliers due to unusual variations in the type or amount of medically necessary care, including variability in the amount of erythropoiesis stimulating agents (ESAs) necessary for anemia management. Our regulations at 42 CFR § 413.237(a)(1) provide that ESRD outlier services are the following items and services that are included in the ESRD PPS bundle: (i) ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B; (ii) ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B; (iii) medical/surgical supplies, including syringes, used to administer ESRD-related drugs, that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B; and (iv) renal dialysis service drugs that were or would have been, prior to January 1, 2011, covered under Medicare Part D, excluding ESRD-related oral-only drugs.

In the CY 2011 ESRD PPS final rule (75 FR 49142), we stated that for purposes of determining whether an ESRD facility would be eligible for an outlier payment, it would be necessary for the facility to identify the actual ESRD outlier services furnished to the patient by line item on the monthly claim. The ESRD-related drugs, laboratory tests, and medical/surgical supplies that we would recognize as outlier services were specified in Attachment 3 of Change Request 7064, Transmittal 2033 issued August 20, 2010, rescinded and replaced by Transmittal 2094, dated November 17, 2010. With respect to the outlier policy, Transmittal 2094 identified additional drugs and laboratory tests that may be eligible for ESRD outlier payment. Transmittal 2094 was rescinded and replaced by Transmittal 2134, dated January 14, 2011, which was issued to correct the subject on the Transmittal page and made no other changes.

In the CY 2012 ESRD PPS final rule (76 FR 70246), we eliminated the issuance of a specific list of eligible outlier service drugs which were or would have been separately billable under Medicare Part B prior to January 1, 2011. However, we use separate guidance to continue to identify renal dialysis service drugs which were or would have been covered under Part D for outlier eligibility purposes in order to provide unit prices for calculating imputed outlier services. We also can identify, through our monitoring efforts, items and services that are incorrectly being identified as eligible outlier services in the claims data. Any updates to the list of renal dialysis items and services that qualify as outlier services are made through administrative issuances.

Our regulations at 42 CFR § 413.237 specify the methodology used to calculate outlier payments. An ESRD facility is eligible for an outlier payment if its actual or imputed Medicare Allowable Payment (MAP) amount per treatment for ESRD outlier services exceeds a threshold. The MAP amount represents the average incurred amount per treatment for services that were or would have been considered separately billable services prior to January 1, 2011. The threshold is equal to the ESRD facility's predicted ESRD outlier services MAP amount per treatment (which is case-mix adjusted) plus the fixed dollar loss amount. In accordance with § 413.237(c) of the regulations, facilities are paid 80 percent of the per treatment amount by which the imputed MAP amount for outlier services (that is, the actual incurred amount) exceeds this threshold. ESRD facilities are eligible to receive outlier payments for treating both adult and pediatric dialysis patients.

In the CY 2011 ESRD PPS final rule, using 2007 data, we established the outlier percentage at 1.0 percent of total payments (75 FR 49142 through 49143). We also established the fixed dollar loss amounts that are added to the predicted outlier services MAP amounts. The outlier services MAP amounts and fixed dollar loss amounts are different for adult and pediatric patients due to differences in the utilization of separately billable services among adult and pediatric patients (75 FR 49140).

As we explained in the CY 2011 ESRD PPS final rule (75 FR 49138 and 49139), the predicted outlier services MAP amounts for a patient are determined by multiplying the adjusted average outlier services MAP amount by the product of the applicable patient-specific case-mix

adjusters using the outlier services payment multipliers developed from the regression analysis to compute the payment adjustments. The average outlier services MAP amount per treatment for CY 2011 was based on payment amounts reported on 2007 claims and adjusted to reflect projected prices for 2011. For CY 2012, the outlier services MAP amounts and fixed dollar loss amounts were based on 2010 data (76 FR 70250). Thus, for CYs 2011 and 2012, the MAP and fixed dollar loss amounts were computed based on pre-ESRD PPS claims data and utilization. For CY 2013, the outlier services MAP amounts and fixed dollar loss amounts were based on 2011 data (77 FR 67464). Therefore, the outlier thresholds for CY 2013 were based on utilization of ESRD-related items and services furnished under the ESRD PPS. Because of the lower utilization of erythropoietin stimulating agents (ESA) and other outlier services in CY 2011, we lowered the MAP amounts and fixed dollar loss amounts for both adult and pediatric patients for CY 2013 to allow for an increase in payments for ESRD beneficiaries requiring higher resources.

a. Impact of Changes to the Outlier Policy

In the CY 2014 ESRD PPS proposed rule (78 FR 40850 through 40852), we did not propose any changes to the methodology used to compute the MAP or fixed dollar loss amounts. Rather, we proposed to update the outlier services MAP amounts and fixed dollar loss amounts to reflect the utilization of outlier services reported on the 2012 claims using the December 2012 claims file (that is, claims with dates of service January 1 through December 31, 2012, that were received, processed, paid, and passed to the National Claims History File as of December 31, 2012). In this final rule, for CY 2014, we used the June 2013 update of the CY 2012 National Claims History File to update the outlier services MAP amounts and fixed dollar loss amounts. The impact of this update is shown in Table 4 below, which compares the outlier services MAP amounts and fixed dollar loss amounts used for the outlier policy in CY 2013 with the updated estimates for CY 2014. The estimates for the CY 2014 outlier policy, which are included in Column II of Table 4, were inflation adjusted to reflect projected 2014 prices for outlier services.

TABLE 4—OUTLIER POLICY: IMPACT OF USING UPDATED DATA TO DEFINE THE OUTLIER POLICY

	Column I Final outlier policy for CY2013 (based on 2011 data price inflated to 2013)*		Column II Final outlier policy for CY2014 (based on 2012 data price inflated to 2014)*	
	Age < 18	Age >= 18	Age < 18	Age >= 18
Average outlier services MAP amount per treatment [1]	$38.65	$61.38	$37.29	$51.97
Adjustments:				
Standardization for outlier services [2]	1.0927	0.9878	1.1079	0.9866
MIPPA reduction	0.98	0.98	0.98	0.98
Adjusted average outlier services MAP amount [3]	$41.39	$59.42	$40.49	$50.25
Fixed dollar loss amount that is added to the predicted MAP to determine the outlier threshold [4]	$47.32	$110.22	$54.01	$98.67
Patient months qualifying for outlier payment	7.6%	5.1%	6.7%	5.3%

* The outlier services MAP amounts and fixed dollar loss amounts were inflation adjusted to reflect updated prices for outlier services (that is, 2013 prices in Column I and projected 2014 prices in Column II).

[1] Excludes patients for whom not all data were available to calculate projected payments under an expanded bundle. The outlier services MAP amounts are based on 2012 data. The medically unbelievable edits of 400,000 units for Epoetin and 1,200 mcg for aranesp that are in place under the ESA claims monitoring policy were applied.

[2] Applied to the average outlier MAP per treatment. Standardization for outlier services is based on existing case mix adjusters for adult and pediatric patient groups.

[3] This is the amount to which the separately billable (SB) payment multipliers are applied to calculate the predicted outlier services MAP for each patient.

[4] The fixed dollar loss amounts were calculated using 2012 data to yield total outlier payments that represent 1 percent of total projected payments for the ESRD PPS.

As shown in Table 4, the estimated fixed dollar loss amount that determines the 2014 outlier threshold amount for adults (Column II) is lower than that used for the 2013 outlier policy (Column I). The estimated fixed dollar loss amount that determines the 2014 outlier threshold amount for pediatric patients (Column II) is higher than that used for the 2013 outlier policy (Column I). The main reason for the reduction for adult patients is that the lower utilization of ESA and other outlier services continued to decline during the second year of the PPS. This can be seen by comparing the outlier service MAP amount per treatment for adult patients in Column I ($61.38, which is based on 2011 data) with that amount in Column II ($51.97, which is based on 2012 data).

For pediatric patients, the overall average outlier service MAP amount per treatment decreased from $38.65 in 2011 to $37.29 in 2012. In addition, there was a greater tendency in 2012 for a relatively small percentage of pediatric patients to account for a disproportionate share of the total outlier service MAP amounts. The one percent target for outlier payments is therefore expected to be achieved based on a smaller percentage of pediatric outlier cases using 2012 data compared to 2011 data (6.7 percent of pediatric patient months are expected to qualify for outlier payments rather than 7.6 percent). These patterns led to the estimated fixed dollar loss amount for pediatric patients being higher for the outlier policy for CY 2014 compared to the outlier policy for CY 2013. Generally, there is a relatively higher likelihood for pediatric patients that the outlier threshold may be adjusted to reflect changes in the distribution of outlier service MAP amounts. This is due to the much smaller overall number of pediatric patients compared to adult patients, and to the fact that the outlier threshold for pediatric patients is calculated based on data for a much smaller number of pediatric patients compared to adult patients.

For this final rule, based on the use of the most recently available data, we are updating the fixed dollar loss amounts that are added to the predicted MAP amounts per treatment to

determine the outlier thresholds for CY 2014 from $110.22 to $98.67 for adult patients and from $47.32 to $54.01 for pediatric patients compared with CY 2013 amounts. We are also updating the adjusted average outlier services MAP amounts for CY 2014 from $59.42 to $50.25 for adult patients and from $41.39 to $40.49 for pediatric patients compared with CY 2013 amounts.

We estimate that the percentage of patient months qualifying for outlier payments under the current policy will be 5.3 percent and 6.7 percent for adult and pediatric patients, respectively, based on the 2012 data. The pediatric outlier MAP and fixed dollar loss amounts continue to be lower for pediatric patients than adults due to the continued lower use of outlier services (primarily reflecting lower use of ESAs and other injectable drugs).

b. Outlier Policy Percentage

42 CFR 413.220(b)(4) stipulates that the per treatment base rate is reduced by 1 percent to account for the proportion of the estimated total payments under the ESRD PPS that are outlier payments. For this final rule, based on analysis of the June 2013 update of the CY 2012 National Claims History File, outlier payments represented approximately 0.2 percent of total payments, again falling short of the 1 percent target due to the continuing decline in use of ESAs and other outlier services. Use of 2012 data to recalibrate the thresholds, which reflect lower utilization of ESAs and other outlier services, is expected to result in aggregate outlier payments close to the 1 percent target in CY 2014 and result in increased payments for ESRD beneficiaries requiring higher resource utilization.

We note that recalibration of the fixed dollar loss amounts for CY 2014 outlier payments results in no change in payments to ESRD facilities for beneficiaries with renal dialysis items and services that are not eligible for outlier payments, but increases payments to providers for beneficiaries with renal dialysis items and services that are eligible for outlier payments. Therefore, beneficiary co-insurance obligations increase for renal dialysis services eligible for outlier payments.

We received the following comments on this proposal:

Comment: Commenters generally supported CMS's proposal to use CY 2012 claims data to update and recalibrate the outlier policy with the most recent data available for adult and pediatric patients for CY 2014.

Response: We thank the commenters for their support of our CY 2014 proposal to update the ESRD PPS outlier payment policy for adult and pediatric patients with the most recent data available. As stated previously, for this final rule, we used the June 2013 update of the 2012 National Claims History File. This data file represents the most recent available data of CY 2012 paid Medicare claims.

Comment: A few commenters urged CMS to ensure with a ''high level of probability'' that the full one percent outlier holdback will be expended in CY 2014. One commenter contended that updating the outlier policy with recent data does not address the ongoing problem of ''overstating the outlier'' and ''artificially'' reducing the base rate. Some commenters suggested that the ''chronic underpayment of the outlier pool'' suggests that an outlier policy is unnecessary. Other commenters urged CMS to avoid future ''underpayment'' of the outlier policy by lowering or eliminating the threshold for CY 2014. A few commenters requested that CMS ''consider giving back'' the amounts not paid in CY 2012 by increasing the CY 2014 base rate to include outlier monies held back but not paid out in CY 2012.

Response: We are unable to assure the commenters that the one percent outlier holdback will fully be expended in CY 2014. The total amount of outlier payments are dependent upon patient utilization of high cost outlier-eligible services (most significantly ESAs), that are furnished to Medicare beneficiaries in a given payment year. Using the most recent claims and utilization data, we simulated 2014 Medicare payments and established the MAP and fixed dollar loss amounts to achieve one percent of the total ESRD PPS payments for CY 2014. Given the continued decline in utilization of ESAs and other outlier services from CY 2011 to CY 2013, it is possible that the one percent outlier may not be fully paid out in CY 2014. At the same time, since the MAP and fixed dollar loss amounts have been reduced, it is also possible that the outlier payments could exceed the 1 percent of payments that are held back. Either outcome is possible because we cannot predict with certainty the utilization of outlier services in a future year. However, we make a good faith effort to estimate future use of outlier services by simulating payment using the most current data available. To the extent that actual 2014 outlier payment do not reach that level, we will update the MAP and fixed dollar loss amounts for CY 2015.

We disagree with the commenter who contended that CMS is overstating the outlier and artificially reducing the base. We remind the commenter that updating the outlier payment policy for CY 2014 does not change payments for dialysis items and services that are not eligible for outlier payments. Rather, the outlier payment is a per treatment payment increase, available to ESRD facilities when they furnish Medicare beneficiaries with high cost dialysis items and services that are eligible for outlier payments. If the ESRD facilities are not furnishing high cost, outlier-eligible, dialysis items and services to the patient then we believe that the base rate, and applicable adjustments, is an appropriate payment. Nonetheless, we continue to believe that use of the most recent data available to update the outlier payment policy should result in appropriate outlier payments. We disagree with the commenters who contended that CMS outlier payment policy has resulted in ''chronic underpayment of the outlier,'' and we continue to believe that the one percent outlier policy has not been fully realized under the ESRD PPS because of the continued decline in ESA utilization, rather than an inherent flaw in the outlier payment methodology. We also disagree with commenters who suggest that CMS has the authority to eliminate the outlier policy for CY 2014 or at some point in the future, as the statute at section 1881(b)(14)(D)(ii) clearly states that the ESRD PPS ''shall include a payment adjustment for high cost outliers due to unusual variations in the type or amount of medically necessary care, including variations in the amount of erythropoiesis stimulating agents necessary for anemia management.''

We also disagree that with commenters that we should ''give back'' outlier monies to account for not achieving the 1 percent outlier threshold. As we explained in the CY 2013 ESRD PPS final rule (77 FR 67450, 67465), ''[t]he 1 percent outlier policy is a prospective payment mechanism in which thresholds are established and adjusted on a yearly basis based on historical data. In the FY 1997 Inpatient Prospective Payment System (IPPS) final rule (61 FR 46229 and 46230), we explained that we believe our outlier policies are consistent with the statute and the goals of the prospective payment system. Many of the factors used to set prospective payment amounts for a given year are estimates. These factors include not only the outlier thresholds, but also the market basket rate of increase, the update factors, and the required budget-neutrality provisions. We do not believe that Congress intended that the standardized amounts should be adjusted (upward or downward) to reflect differences between projected or

actual outlier payments for a given year. Moreover, retroactive adjustments would be extremely difficult or impracticable (if not impossible) to administer. We further explained that the thresholds for a given year reflect certain levels of costs, so that if costs are held down, fewer cases qualify for outlier payments and outlier payments are lower than expected. We believe that the same explanation applies to the ESRD PPS.'' Finally, we plan to review the outlier policy as a whole when we refine the system in the future.

D. The Self-Dialysis and Home Dialysis Training Add-On Payment

a. Medicare Policy for Self-Dialysis Training, Home Dialysis Training, and Retraining

The existing Medicare policy for furnishing self-dialysis training, home dialysis training, and retraining was finalized in our CY 2011 ESRD PPS final rule (75 FR 49062 through 49064) and further discussed in the Medicare Benefits Policy Manual, (Publication 100–02, Chapter 11, Section 30). Self-dialysis or home dialysis can only be performed after an ESRD patient has completed an appropriate course of training. The scope of training services that a certified ESRD home dialysis training facility must furnish to ESRD patients as a condition of coverage are described at 42 CFR 494.100(a). For instance, 42 CFR 494.100(a)(2) states that the training must be conducted by a registered nurse who meets the requirements of 42 CFR 494.140(b)(2). For additional information on the requirements for ESRD facilities in furnishing dialysis training, see 42 CFR Part 494, and for additional information regarding home dialysis training certification, see the State Operations Manual, which may be viewed on the Medicare Web site at the following link: *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Dialysis.html.*

Our regulation at 42 CFR 494.70 (Condition: Patients' rights) requires that facilities inform patients (or their representatives) of their rights and responsibilities when they begin their treatment and protect and provide for the exercise of those rights. Our regulation at 42 CFR 494.70(a)(7) requires a facility to inform patients about all treatment modalities and settings, including but not limited to transplantation, home dialysis modalities, and in-facility hemodialysis. This includes the patient's right to receive resource materials for dialysis modalities not offered by the facility. We expect that all ESRD facilities comply with this regulation and furnish resource information on home dialysis, even if the home modality is not offered by the facility. When ESRD facilities are certified for home dialysis training, we expect the facility to provide training throughout the self-dialysis or home dialysis experience (42 CFR 494.100). Self-dialysis or home dialysis training services and supplies may include but are not limited to personnel services, dialysis supplies, written training manuals and materials, and ESRD-related items and services.

We discuss Medicare's training policies in Table 5 (Medicare's Self or Home Training by Modality) for the following dialysis modalities:

- Home Hemodialysis Training
- Intermittent Peritoneal Dialysis Training
- Continuous Ambulatory Peritoneal Dialysis Training
- Continuous Cycling Peritoneal Dialysis Training

We would expect that patients who elect self-dialysis or home dialysis training will be good candidates for these modalities and that they will be successful in completing the training. We also expect facilities to comply with the patient assessment Condition of Participation including the requirement in 42 CFR 494.80(a)(9) to include in the assessment: ''Evaluation of the patient's abilities, interests, preferences, and goals, including the desired level of participation in the dialysis care process; the preferred modality (hemodialysis or peritoneal dialysis), and setting (for example, home dialysis), and the patient's expectations of care outcomes.''

TABLE 5—MEDICARE'S SELF OR HOME TRAINING BY MODALITY

Home Hemodialysis (HHD) Training.	HHD training is generally furnished in 4 weeks. Medicare will pay the ESRD facility for up to 25 HHD training sessions. In some HHD programs, the dialysis caregiver is trained to perform the dialysis treatment in its entirety and the patient plays a secondary role. In other programs, the patient performs most of the treatment and is only aided by a helper.
Intermittent Peritoneal Dialysis (IPD) Training.	IPD training is generally furnished in 4 weeks. Medicare will pay the ESRD facility for up to 15 PD training sessions. In the IPD program, the patient's caregiver is usually trained to carry out the dialysis care. The patient plays a minimal role, as most are unable to perform self-care dialysis because of other debilitating conditions.
Continuous Ambulatory Peritoneal Dialysis (CAPD) Training.	CAPD training is generally furnished in 2 weeks. Medicare will pay the ESRD facility for up to 15 PD training sessions. In CAPD programs both the patient and the caregiver are trained.
Continuous Cycling Peritoneal Dialysis (CCPD) Training.	CCPD training is generally furnished in 2 weeks. Medicare will pay the ESRD facility for up to 15 PD training sessions. In CCPD programs both the patient and the caregiver are trained.

b. Payment Methodology

In our CY 2011 ESRD PPS final rule (75 FR 49062 through 49064), we included training costs in computing the ESRD PPS base rate, but stated that the ESRD PPS base rate alone does not account for the staffing costs associated with training treatments furnished by a registered nurse. Thus, we finalized the training add-on payment, to be an additional payment made under the ESRD PPS, when one-on-one self or home dialysis training is furnished by a nurse working for a Medicare-certified training facility to a Medicare beneficiary for either hemodialysis or the peritoneal dialysis training modalities listed in Table 5. Likewise, we noted in our CY 2012 ESRD PPS final rule (76 FR 70252), that ''ESRD facilities receive a per-treatment payment that accounts for case-mix, geographic location, low-volume, and outlier payment regardless [of whether] the patient receives dialysis at home or in the facility, plus the training add-on[,]'' if applicable.

We discuss our policies for retraining sessions in the Medicare Benefit Policy Manual, Publication 100–02, Chapter 11, Section 30.2.E. The add-on payment is also applied for retraining sessions after a patient or caregiver has completed the initial training program and if the patient continues to be an appropriate candidate for self or home dialysis modalities. We would expect that most Medicare beneficiaries receive

retraining sessions when they receive new equipment, have a change in caregiver, or a change in modality. The ESRD facility may not bill Medicare for retraining services when they install home dialysis equipment or furnish monitoring services. For example, an ESRD facility nurse may not bill for retraining sessions when they update a home dialysis patient's treatment record, order monthly supplies, or instruct the patient on the use of a new medication for the treatment of infection. When retraining sessions are furnished to a patient or caregiver, there is an expectation that the patient or caregiver is already knowledgeable of the elements of home dialysis, and if additional training is being done for a change of equipment or a change in modality, fewer sessions would be necessary because of the transferability of certain basic skills for home dialysis.

If a Medicare beneficiary exceeds the maximum amount of training sessions based upon their modality, and, if they continue to be a good candidate for home modalities, additional training sessions or retraining sessions may be paid by Medicare with medical justification. In such cases, the ESRD facility must indicate the medical justification with the claim for the training or retraining session submitted for payment. Because the requirement of medical justification is specific to the patient's training needs, circumstances (such as a change in caregiver), or condition (change in modality), we would not expect that an ESRD facility would routinely bill Medicare for training or retraining sessions on any patient.

In CY 2011, we finalized the amount for the training add-on adjustment at $33.44 per treatment, and noted that this amount would be added to the ESRD PPS payment when a training treatment is furnished by the ESRD facility to a Medicare beneficiary. In addition, we noted that because the training add-on payment is directly related to nursing salaries, and that nursing salaries differ greatly based on geographic location, we would adjust the training add-on payment by the geographic area wage index applicable to the ESRD facility. (For further discussions on wage indices, please see section II.C.4. of this final rule.) To summarize, when home dialysis training sessions are furnished to a Medicare beneficiary by a Medicare-certified home dialysis training facility, Medicare will make the ESRD PPS computed base rate payment with all applicable adjustments, and then the separate add-on payment for self or home dialysis training.

In the CY 2013 ESRD PPS final rule (77 FR 67468 through 67469), we addressed comments on Medicare's self and home dialysis training policies under the ESRD PPS. In that final rule, we stated that commenters were concerned that the payment for home dialysis training is insufficient and does not reflect the true costs of training and that they indicated various ranges of time required for home training in terms of time per day and number of training sessions. At that time, we responded to those comments by confirming that CMS will continue to monitor and analyze trends in home dialysis training, but that we believe our payment methodology is adequate for ESRD facilities furnishing training services.

In the CY 2014 ESRD PPS proposed rule, we sought public comments on the costs associated with furnishing self or home dialysis training (78 FR 40854). We requested comments on the elements of PD vs. HHD training sessions, specifically the costs of furnishing such training, the appropriate number of training sessions, and the duration of the training sessions. Lastly, we sought comments on a ''holdback'' payment methodology, which we discussed in the CY 2011 ESRD PPS final rule (75 FR 49063). Under this methodology, a portion of the training payments would be withheld from the ESRD facility until the ESRD patient demonstrates that they have successfully transitioned to a home modality. Specifically, in the CY 2014 proposed rule (78 FR 40854), we sought comments on the costs associated with furnishing self or home dialysis training, the training elements of PD and HHD training, and the number of training sessions.

Although we did not specifically propose to increase the training add-on payment amount in the CY 2014 ESRD PPS proposed rule (78 FR 40852 through 40854), we received several hundred comments from Medicare beneficiaries, dialysis patients, caregivers, friends and family members, industry stakeholders and other interested parties in response to our request for comments that overwhelmingly encouraged us to evaluate the training add-on adjustment and to increase the training add-on payment amount in this final rule. Commenters generally noted the substantial patient benefits of utilizing home dialysis modalities, including improved quality of life; continued employment; and the ability to travel and live a ''normal life.'' In addition, commenters identified many significant training elements that were not contemplated in the original training add-on adjustment payment methodology, such as self cannualation and certain aspects of operating a HHD machine.

After a review of the considerable number of compelling public comments and MedPAC's ''Report to Congress'' of March 2013, ''Considering alternative dialysis treatment options: Use of more frequent hemodialysis and home dialysis'' that advocates for greater use of home dialysis modalities among Medicare beneficiaries, we are finalizing a 50 percent increase to the home dialysis training add-on adjustment payment amount beginning in CY 2014. We are persuaded to finalize this increase because we agree with commenters that access to home modalities is limited, and that the current home dialysis training add-on payment amount per treatment, which represents 1 hour of nursing time, does not adequately represent the staff time required to ensure that a patient is able to perform home dialysis safely.

Therefore, beginning January 1, 2014, the payment add-on will be computed based upon 1.5 hours of nursing time per training treatment, which amounts to a payment increase of $16.72 per training treatment. The training add-on adjustment payment amount for CY 2014 and future years will be $50.16 and will continue to be adjusted by the facility's wage index. We believe increasing the training time is an appropriate change because commenters largely contended that the number of allowable training sessions is adequate, but that the payment amount is insufficient.

We also note that the finalized per training treatment add-on payment amount of $50.16 is in line with the costs reported on the 2010 ESRD facility cost reports, which indicates an average facility training cost of $53.00 per training treatment. In addition to the home dialysis training add-on payment, the base rate also compensates facilities for the cost of providing home dialysis training.

We received the following comments:

Comment: The majority of commenters recognized the importance of dialysis training services and modality choice for a beneficiary's well-being. Many patient comments included personal stories about their ability to lead fulfilling lives after they transferred to HHD, including being able to return to work, travel, and participate in family activities. The commenters confirmed that the training elements for HHD are significant and require additional face-to-face nursing time. Commenters identified such elements as setting up

and orienting the patient to the HHD unit; explaining safety alarms; troubleshooting alarms; and teaching the patient self cannualation as training elements that they do not believe were adequately paid for by the base rate and the training add-on payment.

Some commenters noted that a single training add-on payment amount for both PD and HHD training services disincentives HHD training. The commenters contend that the training add-on payment amount is sufficient for PD training services, but that higher training costs are incurred by the facility when they furnish HHD training services. A few commenters urged CMS to ''fix'' this bias in the training payment so that more patients have access to the modality of HHD services. One commenter pointed out that Medicare's existing regulations require that dialysis patients be informed of all dialysis options, however, the modality of HHD is not available to many patients because facilities will not invest in home dialysis training programs under the current payment methodology.

Response: Again, we thank the patients for their willingness to share their home dialysis training experiences with CMS, and in particular, to patients for commenting on the importance of modality choice in returning to work and participating fully in their lives. While we did not propose to increase the home dialysis training add-on payment amount, we found the comments very compelling. In particular, we agree with commenters that the current home dialysis training add-on payment amount, together with the base rate, does not sufficiently cover the costs of providing the critical HHD training elements that commenters identified. We also agree with commenters that the single home dialysis training add-on payment could disincentivize training in HHD, as opposed to PD, as the cost of HHD training is higher than the cost of PD training. As we noted in the CY 2013 ESRD PPS final rule (77 FR 67468), we do not intend to encourage the use of one type of home dialysis modality over another; rather we believe that decisions regarding the appropriate home dialysis modality should be made by beneficiaries in consultation with their physicians. Where a beneficiary and his or her physician decide that HHD is the appropriate home dialysis modality, we do not want the amount of the home dialysis training add-on payment to discourage the use of that modality.

We appreciate the comments detailing face-to-face nursing time and the training provided during that time. These comments noted significant face-to-face training time for the training elements of self cannualation, effective machine set-up, explaining warning alarms, troubleshooting alarms, and what the patient and caregiver should do in case of an emergency. We agree with the commenters that these training elements are significant to a patient's ability to safely and effectively dialyze in the home, and that these training elements are unique to HHD training services. HHD training elements were not included in the original training add-on payment adjustment because prior to the PPS, home training services furnished to Medicare beneficiaries were largely based upon training elements for the modality of PD, with few patients receiving HHD services at home. We agree with commenters that self cannualation and troubleshooting alarms are critical training elements for HHD, and that they require additional training time. For all of these reasons, we are increasing the per-treatment home dialysis training treatment payment to account for 1.5 hours of nursing time per training session furnished on or after January 1, 2014, instead of 1 hour per training session.

We expect all ESRD facilities to comply with our regulation at 42 CFR 494.70(a)(7) and inform beneficiaries of the availability of HHD, even if this modality is not offered by the facility. Although we believe increasing the amount of the home dialysis training add-on payment adjustment in this final rule will further enable patients to dialyze at home, we also believe that the ESRD PPS, along with Medicare Conditions for Coverage requirements set forth in 42 CFR § 494.100(a), contributed to the increase in utilization rates for home modalities. In the CY 2011 ESRD PPS final rule, we stated that the ESRD PPS monitoring program would assess the effect of the expanded bundled payment on home dialysis utilization rates (75 FR 49058). We continue to monitor Medicare submitted and paid claims to assess home modality utilization rates. This data is available on the ESRD PPS Spotlight and may be viewed at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Spotlight.html*.

Comment: Commenters applauded CMS for seeking industry feedback for refinements to self and home dialysis training policies. In general, commenters requested that CMS increase the payment amount for dialysis training services to more accurately reflect the actual costs incurred by facilities when they furnish self or home dialysis training services to a Medicare beneficiary. Many commenters noted that the training add-on payment, equal to 1 hour of registered nursing time, $33.44, is ''inadequate'' to cover the training costs incurred by the facility when they furnish a home dialysis training treatment. Numerous commenters urged CMS to increase the training add-on payment amount to ''appropriately recognize'' a facility's costs when furnishing home dialysis training services and specifically noted the higher cost incurred by the facility when they furnish HHD training services.

Response: We thank the facility commenters who shared detailed analysis regarding their training costs. A few commenters furnished CMS with an ''Updated Home Hemodialysis Cost Study: 2010 Medicare Cost Report Analysis.'' The analysis shows that current Medicare policies to reimburse for home dialysis training fall short of the average costs facilities incur when they furnish training treatments. As stated above, we noted in our CY 2011 ESRD PPS final rule (75 FR 49062 through 49064), that the ESRD PPS base rate alone does not account for the staffing costs associated with training treatments furnished by a registered nurse and that the training add-on payment is an additional payment made under the ESRD PPS to acknowledge the one-on-one self or home dialysis training furnished by a nurse. We clarified this policy again in the CY 2013 ESRD PPS final rule (77 FR 67468) where we stated, ''Training costs are included in the ESRD PPS base rate, however, we also provide an add-on adjustment for each training treatment furnished by a Medicare-certified home dialysis training facility.'' As such, it is not the intent of the add-on treatment to reimburse a facility for all of the training costs furnished during training treatments. Rather, the single ESRD PPS base rate, all applicable case-mix and facility level adjustments, as well as the add-on payment should be considered the Medicare payment for each training treatment and not the training add-on payment alone. Nonetheless, we agree with commenters that the home dialysis add-on payment, together with the base rate, does not account for all of the training elements commenters identified.

We note that patient and caregiver commenters indicated a training time for home dialysis training of 2 to 6 weeks in length, with face-to-face nursing time of 2 to 6 hours per training day. Commenters also acknowledged that many of the training days took place in the training facility, in a group setting, and not in the patient's home.

In addition, some commenters reported that nursing staff were not present for the final week of training, as the patient had achieved total independent self-care. While we understand that training for home dialysis is specific to the patients' needs and that several factors, including a patient's health status and emotional and mental state, are considerations for the length and number of training services furnished, we are concerned about the wide-ranging variance in training times and the duration of training sessions indicated in the comments. While believe that an increase in the amount of the home dialysis training add-on payment is appropriate, we note that, based on the comments we received, training services furnished to Medicare beneficiaries appear inconsistent across training facilities. We will continue to monitor training services furnished to Medicare beneficiaries in the future.

Comment: A few commenters urged CMS to increase the training add-on payment amount without making a reduction to the base rate to maintain budget neutrality. One commenter noted that, ''we believe that CMS has the discretion to independently make this change without adjustments for budget neutrality.'' A few commenters urged CMS to make no change to the training add-on payment amount that would further reduce the base rate for CY 2014.

Response: We appreciate commenters concern for protecting the ESRD PPS base rate. However, we are not changing the payment methodology used to compute the training add-on adjustment and the training add-on payment will continue to be budget neutral, which means the base rate will be affected. We believe that an additional half hour per training session better reflects the costs facilities incurred when furnishing training services to Medicare beneficiaries. The training add-on payment increase will be budget neutral for CY 2014 in that we will reduce the base rate by $0.02 to account for the cost of the increase.

We computed the final CY 2014 home dialysis training add-on budget-neutrality adjustment factor using treatment counts from the 2012 claims and facility-specific CY 2014 payment rates to estimate the total dollar amount that each ESRD facility would have received in CY 2014 with no adjustment to the training add-on factor. The total of these payments became the target amount of expenditures for all ESRD facilities for CY 2014. Next, we computed the estimated dollar amount that would have been paid for the same ESRD facilities using the final adjusted home dialysis training add-on of $50.16 for CY 2014. The total of these payments becomes the new CY 2014 amount of expenditures for all ESRD facilities.

The training add-on budget-neutrality factor is calculated as the target amount divided by the new CY 2014 amount. When we multiplied the training add-on budget-neutrality factor by the applicable CY 2014 estimated payments, aggregate payments to ESRD facilities would remain budget-neutral when compared to the target amount of expenditures. The training add-on budget-neutrality factor ensures that training add-on adjustments do not affect aggregate Medicare payments. Therefore, we are finalizing a training add-on budget-neutrality adjustment factor of .999912, which will be applied directly to the CY 2014 ESRD PPS base rate.

Comment: A few commenters noted that the training add-on payment is a ''fixed'' payment and does not adjust from year to year for inflation or wages. One commenter noted that the training add-on payment is not included in the annual market basket used to update the ESRD PPS and that CMS should address this inconsistency.

Response: We agree with comments that the training add-on payment adjustment is a fixed payment amount and is not updated by the annual wage data from the Bureau of Labor and Statistics. However, we also note that although the training add-on payments are not adjusted by the ESRD PPS market basket, the payment is adjusted by the geographic wage index values. This geographic adjustment allows Medicare payments to appropriately reflect the local wage of a registered nurse in the geographic areas where the training services are furnished. We appreciate commenters' suggestions for updating the training add-on payment amount with a market basket or other inflation indicator such as the most recent wage data. We will take these comments into account in considering future refinements to the home dialysis training add-on payment adjustment.

Comment: Several commenters discouraged CMS from considering a holdback payment methodology for making training add-on payments. One commenter expressed serious concerns regarding a holdback policy for home dialysis training, stating that the policy would ''penalize facilities'' for unsuccessful training. Another commenter contended that providers should not be held responsible for patients who decide that they are not able to adequately perform home dialysis.

Response: We thank the commenters for their comments and note that CMS did not receive a single comment that endorsed the holdback payment methodology. We agree with commenters that a holdback payment methodology penalizes the facilities for patients who decide that they are not able to perform self or home dialysis and that this decision may not be a reflection of the quality of the training the patient received.

In summary, in response to comments, CMS will finalize a payment increase of 50 percent for both PD and HD training treatments. Beginning January 1, 2014, the payment add-on will be computed based upon 1.5 hours of nursing time per training treatment, which amounts to a payment increase of $16.72 per training treatment. The training add-on adjustment payment amount for CY 2014 and future years will be $50.16 and will continue to be adjusted by the facility's wage index. ESRD facilities may continue to bill a maximum of 25 training sessions per patient for HHD training and 15 sessions for CCPD and CAPD. For all home modalities, we will pay for additional training sessions when medical necessity is documented. We believe increasing the training time is an appropriate policy refinement, as CMS evaluated the training elements reported to be furnished during training treatments and determined that self-cannualation, equipment preparation and alarm management were significant training elements that require additional time per training treatment and that payment of an additional half hour per treatment would appropriately recognize the costs incurred by facilities when they furnish training treatments. We will reduce the base rate by $0.02 to account for the increase in the amount of the home dialysis training add-on payment adjustment.

E. Delay of Payment for Oral-Only Drugs Under the ESRD PPS

Section 1881(b)(14)(A)(i) of the Act, as added by section 153(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), requires the Secretary to implement a payment system under which a single payment is made to a provider of services or a renal dialysis facility for ''renal dialysis services'' in lieu of any other payment. Section 1881(b)(14)(B) of the Act defines renal dialysis services, and subclause (iii) of that section states that these services include ''other drugs and biologicals that are furnished to individuals for the treatment of ESRD and for which payment was (before the application of this paragraph) made separately under this title, and any oral equivalent form of such drug or

biological[.]'' We interpreted this provision as including not only injectable drugs and biologicals used for the treatment of ESRD (other than ESAs, which are included under clause (ii)), but also all non-injectable drugs used for the treatment of ESRD furnished under Title XVIII. We also concluded that, to the extent ESRD-related oral-only drugs do not fall within clause (iii) of the statutory definition of renal dialysis services, such drugs would fall under clause (iv), and constitute other items and services used for the treatment of ESRD that are not described in clause (i). Accordingly, we defined ''renal dialysis services'' at 42 CFR 413.174 as including, among other things, ''[o]ther items and services that are furnished to individuals for the treatment of ESRD and for which payment was (prior to January 1, 2011) made separately under title XVIII of the Act (including drugs and biologicals with only an oral form).'' Although oral-only drugs are included in the definition of renal dialysis services, in the CY 2011 ESRD PPS final rule we also finalized a policy to delay payment for these drugs under the PPS until January 1, 2014 (75 FR 49044). We stated that there were certain advantages to delaying the implementation of payment for oral-only drugs, including allowing ESRD facilities additional time to make operational changes and logistical arrangements in order to furnish oral-only ESRD-related drugs and biologicals to their patients. Accordingly, 42 CFR 413.174(f)(6) provides that payment to an ESRD facility for renal dialysis service drugs and biologicals with only an oral form is incorporated into the PPS payment rates effective January 1, 2014.

On January 3, 2013, the Congress enacted ATRA. Section 632(b) of ATRA states that the Secretary ''may not implement the policy under section 413.176(f)(6) of title 42, Code of Federal Regulations (relating to oral-only ESRD-related drugs in the ESRD prospective payment system), prior to January 1, 2016.'' Accordingly, payment for oral-only drugs will not be made under the ESRD PPS before January 1, 2016, instead of on January 1, 2014, which is the date originally finalized for payment of ESRD-related oral-only drugs under the ESRD PPS (75 FR 49044). We proposed to pay for oral-only drugs consistent with section 632(b) of ATRA and implement this delay by revising the effective date for providing payment for oral-only ESRD-related drugs under the ESRD PPS at 42 CFR 413.174(f)(6) from January 1, 2014 to January 1, 2016.

Because we proposed that oral-only drugs will be included in the ESRD PPS starting in CY 2016, we also proposed to change the reference to January 1, 2014 for the outlier policy described in 42 CFR 413.237(a)(1)(iv) to January 1, 2016. In the CY 2011 ESRD PPS final rule (75 FR 49138), we defined outlier services as including oral-only drugs effective January 1, 2014. In addition to modifying the date on which oral-only drugs will be eligible for outlier payments, we also proposed to clarify our regulation at 42 CFR 413.237(a)(1)(iv) by changing the word ''excluding'' to ''including'' to make clear that oral-only drugs are ESRD outlier services for purposes of the outlier policy effective January 1, 2016, consistent with the policy we established in the CY 2011 final rule (75 FR 49138).

We received the following comments on this proposal:

Comment: A few comments supported our amended regulations codifying the delay of oral-only drugs paid under the ESRD PPS payment bundle until January 1, 2016. One commenter suggested that CMS use this 2-year delay to ''gather stakeholder input and conduct careful assessment'' of the costs facilities will incur when furnishing oral-only drugs to dialysis patients. Another commenter cautioned CMS not to ''negatively impact'' Medicare beneficiaries by taking away patient protections, such as comprehensive drug utilization reviews, currently enjoyed under Medicare Part D plans. The commenter contends that phosphate binders and calcimimetics have significant drug interactions with commonly prescribed ESRD medications and could result in significant drug safety issues for patients if effective mechanisms for identifying drug-drug interactions are not available.

Response: We thank the commenters for their support in implementing section 632(b) of ATRA. We appreciate the commenters' suggestion on how CMS should best use the 2-year delay. In addition, we appreciate the commenters' concern for patient safety and beneficiary protections that are available under Medicare Part D. In anticipation of the inclusion of oral-only ESRD-related drugs in the payment bundle beginning in CY 2016, we intend to consider appropriate patient protections.

After consideration of the public comments we received, we are finalizing the proposed revisions to 42 CFR 413.174 and 413.237 without modification. We will delay the effective date for providing payment for oral-only ESRD-related drugs under the ESRD PPS at 42 CFR 413.174(f)(6) until January 1, 2016. Likewise, 42 CFR 413.237(a)(1)(iv) is revised to make clear that oral-only drugs are ESRD outlier services for purposes of the outlier policy effective January 1, 2016.

F. Miscellaneous Comments

We received many comments from Medicare beneficiaries, family members, ESRD facilities, nurses, physicians, professional organizations, renal organizations, and manufacturers related to issues that were not specifically addressed in the CY 2014 ESRD PPS proposed rule. Some of these comments are discussed below.

Comment: A few commenters requested that CMS amend the ESRD facility cost report and eliminate the cap on medical director fees. One commenter noted that the limitation for reporting medical director fees on Medicare cost reports is $165,000 annually, and that this amount reflects the wage of a physician of internal medicine and not a board-certified nephrologist. The commenter requested that CMS evaluate wages for nephrologists and adjust the reasonable compensation equivalent (RCE) on ESRD facility cost reports. Other commenters requested that CMS recognize the cost of supporting the ESRD networks. One commenter suggested that CMS include the $0.50 per treatment network fee as a cost, or an offset to revenue, on ESRD cost reports.

Response: We thank commenters for their suggestions. We will consider these comments for future refinements. We note that CMS has already implemented several updates and enhancements to the ESRD facility Medicare cost report. For example, the addition of cost report ''Worksheet C'' allows facilities to report a computation of the average cost per treatment by modality furnished under the ESRD PPS payment bundle.

Comment: Several commenters expressed confusion regarding eligibility requirements for the Low Volume Payment Adjustment (LVPA) available under the ESRD PPS. A few commenters requested clarification on the identification of free-standing and hospital-based low-volume facilities, while other commenters noted the Government Accountability Office (GAO) report 13–287 (End-Stage Renal Disease: CMS Should Improve Design and Strengthen Monitoring of Low-Volume Adjustment) and urged CMS to expeditiously refine this significant payment adjustment for deserving facilities as outlined in the report.

Response: We agree with commenters that the LVPA is an important and

significant payment adjustment for eligible facilities under the ESRD PPS. CMS discussed the eligibility requirements for the LVPA payment adjustment in the CY 2011 ESRD PPS final rule (75 FR 49117 through 49125), and codified the adjustment in our regulations at 42 CFR § 413.232. For specific inquiries regarding LVPA eligibility, we suggest that facilities contact their Medicare Administrative Contractor (MAC) directly. As part of potential future refinements, we plan to evaluate our current policies for the LVPA to ensure that we are effectively targeting low-volume facilities, in order to support access to dialysis services.

Comment: Some commenters requested that CMS consider payment implications outside of the ESRD PPS payment methodology for dialysis services. For example, a few commenters cautioned CMS that a static payment policy may ''dampen'' incentives to develop innovations and new technologies in the treatment of ESRD and urged CMS to establish a new technology adjustment.

Response: We thank the commenters and appreciate the suggestion that we consider different payment mechanisms that would encourage innovation for ESRD treatments and ensure quality patient care.

Comment: A few commenters requested that CMS consider a ''case-mix adjustor to address racial and ethnic disparities in ESRD treatment,'' and noted that some patient sub-groups require higher utilization of ESAs and other pharmaceuticals in furnishing quality patient care.

Response: We thank the commenters for expressing their concern regarding possible racial and ethnic disparities in the treatment of ESRD, and note that we discuss our analysis of a potential race case-mix adjustor in our CY 2011 ESRD PPS final rule (75 FR 49108 through 49115). In that rule, we noted that while section 1881(b)(14)(D)(i) of the Act allows CMS to consider the implementation of race/ethnicity payment adjustments, we believed that other patient characteristics such as ''body-size and co-morbidities,'' and not a patient's race contribute to higher treatment costs. We stated that ''[i]n particular, we are not convinced that race or ethnicity adjustments are necessary to ensure beneficiary access to ESRD services. That is, we believe that there may be race-neutral biological factors that have not yet been identified in the ESRD PPS modeling that could explain the increased cost associated with providing renal dialysis services to members of certain racial or ethnic groups.'' (75 FR 49109.) We will continue to monitor the health outcomes for all Medicare ESRD beneficiaries, and assess the underlying clinical conditions that incur higher treatment costs for future analysis.

Comment: A few facility commenters noted a geographic effect on ''payer mix trends'' for facilities located in inner city areas with nearly exclusive Medicare and Medicaid patients. Other commenters encouraged CMS to consider a payment mechanism that appropriately recognize the ''higher costs'' incurred by facilities when furnishing ESRD treatments to inner city patients, as these demographics have more minority patients, ''a large number of whom are African American, who have shown to require a higher volume of pharmaceutical products.''

Response: We thank the commenters for sharing the economic perspective of inner city ESRD facilities and we agree that inner city communities may have unique economic or demographic factors to manage in furnishing ESRD services. However, we disagree that the ESRD PPS payment methodology does not appropriately recognize these unique circumstances when making payments for dialysis services. For example, the outlier policy is a payment mechanism specifically designed to recognize higher cost patients in terms of drug, laboratory services, and supply utilization. In addition, we provide a wage index adjustment to reflect geographic differences in wages. Likewise, patient case-mix (that is, body size and comorbidities) and the LVPA facility adjustments recognize patient and facility characteristics that contribute to higher costs of care. And lastly, ESRD facilities are allowed to recover a portion of uncollected beneficiary coinsurance as outlined in 42 CFR § 413.89. While we continue to believe that the ESRD PPS payment methodology appropriately recognizes high cost patients and high cost geographic areas, we will continue to monitor patient utilization for all Medicare beneficiaries and will consider these comments in future refinements.

Comment: One commenter noted that historical and future Medicare bad debt policies do not allow for the full recovery of a facility's bad debt and estimates a payment shortfall of approximately $4 to $5 per treatment in uncompensated care. Other commenters pointed out that inner city facilities provide services in a ''fragile economic environment'' where they are unable to collect beneficiary co-payments.

Response: We thank the commenter for sharing their concerns regarding Medicare bad debt policies. CMS finalized the self-implementing statutory provision for the reduction in bad debt in the CY 2013 ESRD PPS final rule (77 FR 67518).

Comment: An organization that represents kidney health professionals urged CMS to publicize ways for ESRD patients, their families, and care providers to alert CMS to changes in care delivery that raise concern about negative effects on the quality of care provided as a result of the drug utilization reduction. They suggested such mechanisms could include, but are not limited to; the Medicare 1–800 number system; the ESRD Network complaint and quality of care reporting system; and a dedicated CMS email address.

Response: We appreciate the commenters' concern regarding ensuring quality care; however, because the implementation strategy for the drug utilization reduction will be transitioned over time, we believe that ESRD facilities should be able to maintain their current programs and services. We do not expect that the drug utilization reduction will negatively impact the quality of service a facility provides; therefore, we believe that our current methods (the 1–800 number system and the ESRD Network complaint and quality of care reporting system, as opposed to a dedicated email address) for beneficiaries, their families, and providers to communicate with CMS are adequate at this time.

Comment: Several commenters expressed concern regarding data transparency in rate setting, and requested that CMS release a CY 2014 data rate setting file.

Response: We agree with the commenters that a rate setting file would enhance transparency, and therefore, we are working to make such a file available in the future.

Comment: A few national organizations representing dialysis facilities expressed concern that a change to the census process in the Consolidated Renal Operations in a Web-Enabled Network (CROWNWeb) has resulted in a delay in the date of first dialysis reconciliation and verification. The commenters noted that, as a result, facilities are unable to obtain, or there is a delay in receiving, the onset of dialysis payment adjustment.

Response: We appreciate the commenters bringing the on-set payment adjustment issues to our attention. We will consider these comments and work with agency staff to ensure that the on-set payment adjustment is applied appropriately in the future.

Comment: One commenter pointed out the significant payment difference in dialysis treatments furnished and paid through the hospital outpatient prospective payment system (OPPS) versus those paid under the ESRD PPS.

Response: We agree with the commenter that the payment difference for emergency or unscheduled dialysis services and maintenance renal dialysis services is significant, and note that the OPPS payment amount is based upon hospital claims data and reflects a significantly higher level of effort and resources to treat the patient in the hospital.

Comment: A commenter representing teaching hospitals expressed concern that the proposed drug utilization reduction would have a serious impact on teaching hospitals and the patients they treat. The commenter recommended that the regulatory impact analysis display the impact for hospital-based facilities according to teaching status for CY 2014.

Response: We appreciate the commenter's recommendation. While we are unable to include this information for the CY 2014 impact analysis, we will consider modifying the impact table to identify hospital-based ESRD facilities that are part of teaching hospitals in the future.

III. End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)

A. Background

For more than 30 years, monitoring the quality of care provided to patients with end-stage renal disease (ESRD) by dialysis facilities has been an important component of the Medicare ESRD payment system. The ESRD quality incentive program (QIP) is the most recent step in fostering improved patient outcomes by establishing incentives for dialysis facilities to meet or exceed performance standards established by CMS. The ESRD QIP is authorized by section 1881(h) of the Social Security Act (the Act), which was added by section 153(c) of Medicare Improvements for Patients and Providers Act (MIPPA). CMS established the ESRD QIP for payment year (PY) 2012, the initial year of the program in which payment reductions were applied, in two rules published in the **Federal Register** on August 12, 2010, and January 5, 2011 (75 FR 49030 and 76 FR 628, respectively). Subsequently, on November 10, 2011, CMS published a rule in the **Federal Register** outlining the PY 2013 and PY 2014 ESRD QIP requirements (76 FR 70228). On November 9, 2012, CMS published a rule in the **Federal Register** outlining the ESRD QIP requirements for PY 2015 and future payment years (77 FR 67450).

Section 1881(h) of the Act requires the Secretary to establish an ESRD QIP by (i) selecting measures; (ii) establishing the performance standards that apply to the individual measures; (iii) specifying a performance period with respect to a year; (iv) developing a methodology for assessing the total performance of each facility based on the performance standards with respect to the measures for a performance period; and (v) applying an appropriate payment reduction to facilities that do not meet or exceed the established Total Performance Score (TPS). This final rule discusses each of these elements and the policies we are finalizing for their application to PY 2016 and future payment years of the ESRD QIP. As of January 1, 2014, ESRD facilities located in Guam, American Samoa, and the Northern Marina Islands will be paid under the ESRD PPS. Under section 1881(h)(1)(A) of the Act, these facilities will receive a reduction to their ESRD PPS payments, beginning with January 1, 2014 dates of service, if they do not meet the requirements of the ESRD QIP.

B. Summary of the Proposed Provisions and Responses to Comments on the ESRD QIP for PY 2016

The proposed rule, entitled ''Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies'' (78 FR 40836), hereinafter referred to as the CY 2014 ESRD PPS proposed rule, appeared in the **Federal Register** on July 8, 2013, with a comment period that ended on August 30, 2013. In that proposed rule, we made proposals for the ESRD QIP, including introducing, expanding, and revising measures; refining the scoring methodology; modifying the program's public reporting requirements; and continuing the data validation pilot program. We received approximately 55 public comments on these proposals from many interested parties, including dialysis facilities, organizations representing dialysis facilities, nephrologists, nurses, dietitians, home health advocacy groups, pharmaceutical manufacturers, patients, patient advocacy groups, and the Medicare Payment Advisory Commission (MedPAC).

In this final rule, we provide a summary of each proposed provision, a summary of the public comments received and our responses to them, and the policies we are finalizing for the ESRD QIP. Comments related to the paperwork burden are addressed in the ''Collection of Information Requirements'' section in this final rule.

C. Considerations in Updating and Expanding Quality Measures Under the ESRD QIP for PY 2016 and Subsequent PYs

1. Value-Based Purchasing (VBP) Overview

Throughout the past decade, Medicare has been transitioning from a program that pays for healthcare based on particular services furnished to a beneficiary to a program that ties payments to providers and suppliers based on the quality of services they deliver. By paying for the quality of care rather than quantity of care, we believe we are strengthening the healthcare system by focusing on better care and lower costs through improvement, prevention and population health, expanded healthcare coverage, and enterprise excellence—while also advancing the National Strategy for Quality Improvement in Health Care (National Quality Strategy). CMS is currently working to update a set of domains and specific measures of quality for our VBP programs, and to link the aims of the National Quality Strategy with our payment policies on a national scale. We are working in partnership with beneficiaries, providers, advocacy groups, the National Quality Forum (NQF), the Measures Application Partnership, operating divisions within the Department of Health and Human Services (HHS), and other stakeholders to develop new measures where gaps exist, refine measures requiring adjustment, and remove measures when appropriate. We are also collaborating with stakeholders to ensure that the ESRD QIP serves the needs of our beneficiaries and also advances the goals of the National Quality Strategy to coordinate healthcare delivery, reduce healthcare costs, enhance patient satisfaction, promote healthy communities, and increase patient safety.[1]

We believe that the development of an ESRD QIP that is successful in supporting the delivery of high-quality healthcare services in dialysis facilities is paramount. We seek to adopt measures for the ESRD QIP that promote better, safer, and more-efficient care. Our measure development and selection activities for the ESRD QIP take into account national priorities such as those

[1] 2012 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care, *http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.pdf.*

established by the National Priorities Partnership (*http://www.nationalprioritiespartnership.org/*), HHS Strategic Plan (*http://www.hhs.gov/secretary/about/priorities/priorities.html*), the National Strategy for Quality Improvement in Healthcare (*http://www.healthcare.gov/center/reports/quality03212011a.html*), and the HHS National Action Plan to Prevent Healthcare Associated Infections (HAIs) (*http://www.hhs.gov/ash/initiatives/hai/esrd.html*). To the extent feasible and practicable, we have sought to adopt measures that have been endorsed by a national consensus organization, are recommended by multi-stakeholder organizations, and developed with the input of providers, beneficiaries, and other stakeholders.

2. Brief Overview of Proposed PY 2016 Measures

For the PY 2016 ESRD QIP and future payment years, we proposed a total of 14 measures. We believe that the PY 2016 ESRD QIP proposed measures promote high-quality care for patients with ESRD, and also strengthen the goals of the National Quality Strategy. We proposed to adopt the following measures to evaluate facilities on the clinical quality of care:

- To evaluate anemia management:
  - Hemoglobin Greater Than 12 g/dL, a clinical measure
  - Patient Informed Consent for Anemia Treatment, a clinical measure*
  - Pediatric Iron Therapy, a reporting measure*
  - Anemia Management, a reporting measure (revised)
- To evaluate dialysis adequacy:
  - A Kt/V measure for adult hemodialysis patients, a clinical measure
  - A Kt/V measure for adult peritoneal dialysis patients, a clinical measure
  - A Kt/V measure for pediatric hemodialysis patients, a clinical measure
- To determine whether patients are treated using the most beneficial type of vascular access:
  - An arterial venous (AV) fistula measure, a clinical measure
  - A catheter measure, a clinical measure
- To address effective bone mineral metabolism management:
  - Hypercalcemia, a clinical measure*
  - Mineral Metabolism, a reporting measure (revised)
- To address patient safety:
  - National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Outpatients, a clinical measure*
- To address patient-centered experience:
  - In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS), a reporting measure**
- To gather data regarding comorbidities:
  - Comorbidity, a reporting measure*

* Indicates that the proposed measure would be new to the ESRD QIP.

** Indicates that the proposed measure is newly expanded in the ESRD QIP.

At that time, we did not propose to adopt measures that address care coordination, efficiency, population and community health, or cost of care. However, we solicited comments on potential measures that would cover these areas. Our responses to these comments are discussed in section III.C.4 below.

3. Measures Application Partnership Review

Section 1890A(a)(1) of the Act, as added by section 3014(b) of the Affordable Care Act, requires the entity with a contract (currently the NQF) under section 1890(a) of the Act to convene multi-stakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures for use in certain programs. Section 1890A(a)(2) of the Act requires the Secretary to make available to the public (not later than December 1 of each year) a list of quality and efficiency measures that are under consideration for use in certain programs. Section 1890A(a)(3) of the Act requires the entity with a contract under section 1890(a) of the Act to transmit the input of the multi-stakeholder groups to the Secretary not later than February 1 of each year, beginning in 2012. Section 1890A(a)(4) of the Act requires the Secretary to take into consideration the input of the multi-stakeholder groups in selecting quality and efficiency measures. The Measures Application Partnership is the public/private partnership comprised of multi-stakeholder groups convened by NQF for the primary purpose of providing input on measures as required by sections 1890A(a)(1) and (3) of the Act. The Measures Application Partnership's input on the quality and efficiency measures under consideration for adoption in CY 2013 was transmitted to the Secretary on February 1, 2013, and is available at (*http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Final_Reports.aspx*). As required by section 1890A(a)(4) of the Act, we considered these recommendations in selecting quality and efficiency measures for the ESRD QIP.

We publicly made available a number of measures in accordance with section 1890A(a)(2) of the Act, and these measures were reviewed by the Measures Application Partnership. Of these measures, a subset is related to a number of proposed new measures for the PY 2016 ESRD QIP (one each for anemia management, hypercalcemia, infection monitoring, comorbidity reporting, and ESA usage). The Measures Application Partnership supported the following:

- NQF-endorsed measure NQF #1454: Proportion of patients with hypercalcemia
- NQF-endorsed measure NQF #1433: Use of Iron Therapy for Pediatric Patients (which forms the basis for the proposed Pediatric Iron Therapy reporting measure)
- NQF-endorsed measure NQF #1460: National Healthcare Safety Network (NHSN) Bloodstream Infection Measure (which forms the basis for the proposed Bloodstream Infection in Hemodialysis Outpatients clinical measure)
- NQF-endorsed measure NQF #0369: Dialysis Facility Risk-adjusted Standardized Mortality Ratio (the proposed Comorbidity reporting measure may assist in calculating performance on this measure, should we propose to adopt it in the future)

The Measures Application Partnership supported the direction of the following measures:

- NQF-endorsed measure NQF #1463: Standardized Hospitalization Ratio for Admissions (the proposed Comorbidity reporting measure may assist in calculating performance on this measure, should we propose to adopt it in the future)
- M2774: Blood Transfusion Appropriateness (which forms the basis for the Patient Informed Consent for Anemia Treatment clinical measure)

We have taken comments from the Measures Application Partnership and the NQF into consideration for the PY 2016 ESRD QIP. In addition, we received several other comments on the Measures Application Partnership, and the measures development process in general. These comments and our responses are set forth below.

Comment: Several commenters noted that four of the five new measures proposed for the PY 2016 ESRD QIP are not endorsed by the NQF. These commenters were also concerned that there are NQF-endorsed versions of some of these measures, and that the

MAP reviewed the NQF-endorsed versions during its pre-rulemaking activities. The commenters believe that by proposing to adopt measures that the MAP did not actually review, CMS has not acted in accordance with the pre-rulemaking process set forth at section 1890A(a) of the Act. Commenters also believe that measures ''based on'' NQF-endorsed measures lack credibility. Some commenters recommended adopting the NQF-endorsed versions of the measures instead of the versions that we proposed to adopt in the proposed rule. Other commenters recommended that if CMS makes modifications to NQF-endorsed measures, CMS should resubmit the modified measures to the NQF for endorsement before proposing to adopt them for the ESRD QIP.

Response: We agree that consensus-building is an essential part of measure development and implementation, but we disagree that the new measures proposed for the PY 2016 program circumvented the MAP pre-rulemaking review process. We note that one of the five newly proposed clinical measures, Hypercalcemia, has been NQF-endorsed (NQF #1454). Another one of the newly proposed clinical measures, NHSN Bloodstream Infection in Hemodialysis Outpatients, is not substantively different than NQF-endorsed measure #1460. As described in more detail below, the only differences between the NQF-endorsed NHSN measure and the proposed NHSN measure involve programmatic implementation (i.e., the requirement to complete the NHSN Dialysis Event Protocol and the requirement to submit 12 months of data to NHSN).

As explained more fully below, we have decided not to finalize the Comorbidity reporting measure due to concerns raised in public comments submitted in response to the PY 2016 ESRD QIP proposed rule. However, we note that the measure would have required facilities to report data that could be incorporated into two NQF-endorsed measures that were reviewed by the MAP.

A fourth measure, the Patient Informed Consent for Anemia Treatment clinical measure, is not being finalized due to concerns raised in public comments submitted in response to the proposed rule (explained in more detail below). Nevertheless, this measure did receive feedback from the MAP in February 2013, which voted to support the direction of the measure, pending further measure development.

The proposed Pediatric Iron Therapy reporting measure is also not being finalized in this final rule in response to comments received on the proposed rule (explained in more detail below). This measure, however, would have been based on NQF #1433, which received a time-limited endorsement from NQF and was supported by the MAP.

Comment: Several commenters disapproved of the current processes used for measure development because (1) the current process is neither transparent nor consensus based; and (2) it was impossible to provide meaningful comment on the future measures described in the proposed rule because the preamble did not provide sufficient information to understand what CMS was proposing to do in the future. These commenters urged CMS to establish a systematic, phased-in process for incorporating new measures into the ESRD QIP, and to work with the community to identify a few domains that can be appropriately and explicitly prioritized.

Response: We currently develop measures using the Measures Management System Blueprint (Blueprint), which is described in detail at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MeasuresManagementSystemBlueprint.html.* This process was used to develop some of the quality measures for use in the ESRD QIP. The development process we use is designed to be transparent and result in consensus-based measures that are appropriate for inclusion in our quality reporting and pay-for-performance programs. For example, we conduct extensive environmental scans and research other relevant evidence as part of measure development. We also seek advice from Technical Expert Panels (TEPs), which provide independent guidance on measures under development, and from the public through a comment solicitation process. We also ask the NQF to endorse many of the measures we develop, which gives the public another opportunity to provide input into the measures we are considering for our programs. When we consider adopting measures that we did not develop, we routinely consider measures that are NQF-endorsed because the NQF endorsement process ensures that measure specifications and testing remain transparent to the public. The NQF also provides the public with an opportunity to provide input and feedback prior to measure endorsement.

We recognize that our list of potential future measures does not typically contain detailed information about measures that we are considering for future use. However, we nonetheless believe that the list further makes transparent our future policy goals. We also note that before we can adopt any measure on that list, we must complete the measure development process outlined above. We are always interested in hearing from the community regarding what measures should be prioritized for development and implementation and encourage a continued dialog.

Comment: Several commenters recommended that nephrology nurses should be part of every TEP because, compared with physicians, they have a better understanding of the practical aspects of collecting and entering data.

Response: We make an effort to include in our measure development process input from a variety of stakeholders, including nephrology nurses, who provide care to the ESRD population. We plan to continue this approach as we continue our measure development activities.

D. Measures for the PY 2016 ESRD QIP and Subsequent PYs of the ESRD QIP

We previously finalized ten measures in the CY 2013 ESRD PPS final rule for the PY 2015 ESRD QIP and future PYs (77 FR 67471), and these measures are summarized in Table 6 below. We proposed to continue to use nine of the ten measures for the PY 2016 ESRD QIP and future payment years, modifying three of the measures as follows:

- ICH CAHPS (reporting measure): Expand
- Mineral Metabolism (reporting measure): Revise
- Anemia Management (reporting measure): Revise

For the PY 2016 ESRD QIP and future payment years, we proposed to add three new clinical measures (Patient Informed Consent for Anemia Treatment, Hypercalcemia, and NHSN Bloodstream Infection in Hemodialysis Outpatients) and two new reporting measures (Pediatric Iron Therapy, and Comorbidity). (See Table 7.) We believe that, collectively, these measures will continue to promote improvement in dialysis care in the PY 2016 ESRD QIP and in future payment years.

TABLE 6—MEASURES ADOPTED FOR THE PY 2015 ESRD QIP AND FUTURE PAYMENT YEARS

NQF #	Measure title and description
N/A	Anemia Management: Hgb >12. Percentage of Medicare patients with a mean hemoglobin value greater than 12 g/dL.
0249	Hemodialysis Adequacy: Minimum delivered hemodialysis dose. Percent of hemodialysis patient-months with spKt/V greater than or equal to 1.2.
0318	Peritoneal Dialysis Adequacy: Delivered dose above minimum. Percent of peritoneal dialysis patient-months with spKt/V greater than or equal to 1.7 (dialytic + residual) during the four month study period.
1423	Pediatric Hemodialysis Adequacy: Minimum spKt/V. Percent of pediatric in-center hemodialysis patient-months with spKt/V greater than or equal to 1.2.
0257	Vascular Access Type: Arterial Venous (AV) Fistula. Percentage of patient-months on hemodialysis during the last hemodialysis treatment of the month using an autogenous AV fistula with two needles.
0256	Vascular Access Type: Catheter >= 90 days. Percentage of patient-months for patients on hemodialysis during the last hemodialysis treatment of month with a catheter continuously for 90 days or longer prior to the last hemodialysis session.
N/A [1]	National Healthcare Safety Network (NHSN) Dialysis Event Reporting. Number of months for which facility reports NHSN Dialysis Event data to the Centers for Disease Control and Prevention (CDC).
N/A [2]	In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey Administration [+]. Attestation that facility administered survey in accordance with specifications.
N/A [3]	Mineral Metabolism Reporting [+]. Number of months for which facility reports uncorrected serum calcium and phosphorus for each Medicare patient.
N/A	Anemia Management Reporting [+]. Number of months for which facility reports ESA dosage (as applicable) and hemoglobin/hematocrit for each Medicare patient.

[1] We note that an NQF-endorsed bloodstream infection measure (NQF#1460) exists.
[2] We note that a related measure utilizing the results of this survey has been NQF-endorsed (#0258). It is our intention to use this measure in future years of the ESRD QIP. We believe that a reporting measure is a necessary step in reaching our goal to implement NQF#0258.
[3] We note that this measure is based upon a current NQF-endorsed serum phosphorus measure (#0255), and a calcium monitoring measure that NQF had previously endorsed (#0261).
[+] Indicates a measure we are proposing to revise for PY 2016 and future years of the ESRD QIP.

TABLE 7—NEW MEASURES PROPOSED FOR THE PY 2016 ESRD QIP AND FUTURE PAYMENT YEARS

NQF #	Measure title
N/A	Anemia of chronic kidney disease: Patient Informed Consent for Anemia Treatment.
N/A [1]	Use of Iron Therapy for Pediatric Patients Reporting.
1454	Proportion of Patients with Hypercalcemia.
N/A [2]	NHSN Bloodstream Infection in Hemodialysis Outpatients.
N/A [3]	Comorbidity Reporting.

[1] We note that the NQF has previously endorsed a pediatric iron therapy measure (#1433) upon which this measure is based.
[2] We note that the NQF has previously endorsed a National Healthcare Safety Network (NHSN) bloodstream infection measure (#1460) upon which this measure is based.
[3] We note that the NQF has previously endorsed risk-adjusted hospitalization and mortality measures (#1463 and #0369). The proposed Comorbidity reporting measure may assist in calculating performance on these measures, should we propose to adopt them in the future.

We received several comments on proposed measures for the PY 2016 ESRD QIP and future payment years. The comments and our responses are set forth below.

Comment: One commenter urged CMS to find a way to incentivize quality attainment and improvement rather than solely focusing on penalizing facilities.

Response: We do not have the statutory authority to award bonus payments to facilities for high performance under the ESRD QIP. Furthermore, we continue to believe that the structure of the ESRD QIP appropriately incentivizes improvements in the quality of care for patients with ESRD.

Comment: Several commenters stated that the ESRD QIP should have consistent exclusions for all measures unless there is a specific clinical or operational reason to do otherwise. These commenters recommended the following exclusions for PY 2014, PY 2015, and subsequent years: (i) beneficiaries who are regularly treated at the facility and who fit into one of these categories: (a) beneficiaries who die within the applicable month, (b) in-center hemodialysis patients who receive fewer than 7 treatments in a month (or home peritoneal dialysis patients with fewer than 14 days of treatment) because it is difficult to affect outcomes with fewer treatments or less treatment time, as patients may miss draws, and it is difficult to predict a hospitalization, and (c) beneficiaries receiving home dialysis therapy who miss their in-center appointments when there is a documented, good-faith effort to have them participate in such a visit during the applicable month because it may be difficult for facilities to procure adherence, but the good-faith exception ensures that facilities will attempt to ensure proper patient education and compliance; (ii) transient dialysis patients; (iii) pediatric patients (unless the measure is specific to this population); and (iv) kidney transplant recipients with a functioning graft. These commenters stated that their recommended exclusions are ''consistent with CMS' own measures that were NQF-endorsed in 2007, CROWNWeb, and the URR reporting specifications.'' Additionally, these commenters believe that their recommended exclusions would hold facilities accountable only for those patients to whom they regularly furnish care.

Response: We thank the commenters for their recommendations regarding the uniform application of exclusion criteria to the ESRD QIP. We interpret the commenter's statement about CMS measures that were NQF-endorsed in 2007 to mean the Hemodialysis Adequacy (NQF #0249), Peritoneal Adequacy (NQF #0318), Vascular Access Type: Fistula (NQF #0257) and Vascular Access Type: Catheter (NQF #0256) measures. While we generally agree that exclusion criteria should be consistent where feasible, we also believe that exclusions should take into account the population to which a given measure applies. In addition, we believe that exclusions should take into account the settings (for example, in-center hemodialysis as opposed to home hemodialysis) for which the measures were developed. We will continue to look for ways to align exclusion criteria for measures in the ESRD QIP in future payment years as long as there is evidence to support such consistency.

Comment: Several commenters expressed concerns that the ESRD QIP is adopting too many measures. These commenters noted that as more measures are adopted, the importance of any single measure to a facility's payment is reduced. The commenters also noted that CMS established criteria for retiring an ESRD QIP measure in the PY 2015 ESRD QIP, and the commenter is concerned that CMS has yet to propose the removal or retirement of any ESRD QIP measure while simultaneously continuing to propose the inclusion of new measures with little relative impact on patient outcomes (that is, patient informed consent of anemia treatment and reporting of comorbidities).

Response: We recognize that as more measures are added to the ESRD QIP, the significance of a facility's score on any single measure in relation to the overall TPS is reduced. In the CY 2013 ESRD PPS final rule (77 FR 67475), we finalized a list of criteria we will use to make determinations about whether to remove or replace a measure: ''(1) measure performance among the majority of ESRD facilities is so high and unvarying that meaningful distinctions in improvements or performance can no longer be made; (2) performance or improvement on a measure does not result in better or the intended patient outcomes; (3) a measure no longer aligns with current clinical guidelines or practice; (4) a more broadly applicable (across settings, populations, or conditions) measure for the topic becomes available; (5) a measure that is more proximal in time to desired patient outcomes for the particular topic becomes available; (6) a measure that is more strongly associated with desired patient outcomes for the particular topic becomes available; or (7) collection or public reporting of a measure leads to negative unintended consequences.'' We are currently in the process of evaluating all of our ESRD QIP measures against these criteria, and based on our findings, we will consider removing or replacing one or more measures next year.

Comment: One commenter expressed concerns that laboratory measures continue to be proposed for the ESRD QIP without reference to the sources, magnitude, and implications of unavoidable analytical variation. This commenter believes that between-laboratory variation renders laboratory-based clinical performance measures poor candidates for inclusion in a quality incentive program. The commenter recommended that the results of the same-sample, between-laboratory analysis should be shared with any TEP considering a laboratory-based performance measure.

Response: In April 2013, CMS convened a mineral bone disease TEP that reached conclusions similar to those pointed out by this commenter, and recommended that CMS convene an additional TEP for the purpose of addressing the issue of variability in all laboratory-based measures. We are continuing to consider how this issue might best be addressed through future measure development.

1. PY 2015 Measures Continuing in PY 2016 and Future Payment Years

We are continuing using six measures adopted in the CY 2013 ESRD PPS final rule for the PY 2016 ESRD QIP and future payment years of the program. We are also continuing to use two measure topics adopted. Our policies regarding the scoring of these measures are discussed in sections III.C.5 through III.C.11 and III.C.13. For the reasons stated in the CY 2012 ESRD PPS final rule (76 FR 70262, 70264 through 70265, 70269) and in the CY 2013 ESRD PPS final rule (77 FR 67478 through 67480, 67487 through 67490), we will continue using:

- The Hemoglobin Greater than 12 g/dL measure.

The Dialysis Adequacy measure topic, which is comprised of

- Hemodialysis Adequacy Clinical Performance Measure III: Hemodialysis Adequacy—HD Adequacy—Minimum Delivered Hemodialysis Dose (NQF # 0249),
- Peritoneal Dialysis Adequacy Clinical Performance Measure III—Delivered Dose of Peritoneal Dialysis Above Minimum (NQF #0318);
- Minimum spKt/V for Pediatric Hemodialysis Patients (NQF #423); and

The Vascular Access Type measure topic, which is comprised of

- Vascular Access Type: Arterial Venous (AV) Fistula (NQF #0257); and
- Vascular Access Type: Catheter >= 90 days (NQF #0256).

The technical specifications for these measures can be found at: *http://www.dialysisreports.org/ESRDMeasures.aspx.*

We received the following comments on measures continuing in the PY 2016 ESRD QIP:

Comment: One commenter noted that measures appropriate for in-center hemodialysis are not necessarily appropriate for peritoneal dialysis or home hemodialysis. The commenter recommended accounting more fully for these distinctions in existing measure specifications, as well as the adoption of quality measures that focus on home hemodialysis.

Response: We agree that the needs of patients receiving dialysis through different modalities must be considered while implementing quality measures, and we seek to take these issues into account through TEP feedback during measure development and maintenance, as well as via public feedback. We continue to pursue additional quality measures that will support quality assessment and improvement for all modalities.

Comment: Many commenters expressed concerns that the ESRD QIP includes catheter and fistula measures without including a graft measure. These commenters stated that this creates a disincentive for using a clinically appropriate access (that is, a graft) even when it is in the best interest of a patient.

Response: We are aware of the concern relating to the lack of a graft measure in the ESRD QIP measure set. We are in the process of determining whether to propose to revise the current Vascular Access Type measures, and/or whether it is feasible to develop and propose to adopt an independent graft measure.

Comment: One commenter expressed concerns that the low performance standard and benchmark for the hemoglobin greater than 12 g/dL measure places facilities with large numbers of home peritoneal dialysis patients at a disadvantage. The commenter stated that home peritoneal dialysis patients are more likely than in-center hemodialysis patients to have hemoglobin levels greater than 12 g/dL, so facilities with large numbers of home

peritoneal dialysis patients are disproportionately likely to have more than 1.2 percent of their patients with a hemoglobin level greater than 12 g/dL.

Response: We disagree that the apparent difference in average hemoglobin levels for in-center hemodialysis and home peritoneal dialysis patients warrants a revision to the measure specifications for the Hemoglobin Greater Than 12 g/dL measure. First, the FDA-approved labeling for ESAs does not differentiate appropriate hemoglobin levels based on dialysis modality. In addition, we are not aware of evidence-based support for the assertion that it is acceptable for a greater proportion of ESA-treated peritoneal dialysis patients to achieve hemoglobin levels greater than 12 g/dL. For these reasons, we continue to believe that the Hemoglobin Greater Than 12 g/dL measure does not place certain types of facilities at a disadvantage.

Comment: One commenter supported the continuation of the hemoglobin greater than 12 g/dL measure because of the potential problems stemming from the over-prescription of ESAs. However, the commenter stated that fewer ESRD QIP measures may be more effective in accurately and efficiently monitoring the quality of care delivered by dialysis facilities, and that CMS should focus more on a Hemoglobin Less Than 10g/dL measure as a means to monitor anemia management.

Response: We agree that quality measurement and assessment should contribute to the ESRD QIP as parsimoniously as is feasible while capturing quality for the complex treatment of dialysis patients. We will continue to take this into consideration in future rulemaking. Our rationale for removing the Hemoglobin Less Than 10 g/dL measure was published in the CY 2012 ESRD PPS proposed rule (76 FR 40519), and we believe those concerns remain sufficiently valid to merit not reintroducing the measure to the ESRD QIP at this time.

Comment: Several commenters recommended retiring the Hemoglobin Greater Than 12 g/dL measure. These commenters noted that the benchmark for the measure is 0 percent and the performance standard is 1.2 percent. The commenters believe that such a condensed performance range means the measure is incapable of distinguishing performance between facilities. The commenters also stated that the measure is no longer needed because facilities no longer have an incentive to overuse ESAs under the PPS.

Response: We recognize that facility performance for the Hemoglobin Greater Than 12 g/dL measure is very high overall, and that this is likely a consequence of including ESAs in the ESRD PPS bundled payment. We decided to continue using the measure in the PY 2016 program because we continue to believe that over-prescription of ESA constitutes a significant risk for patients with ESRD, and we continue to believe that the Hemoglobin Greater than 12 g/dL measure helps ensure that patients are not over-prescribed ESAs.

2. Expansion of One PY 2015 Measure and Revision of Two PY 2015 Measures for PY 2016 and Subsequent Payment Years

As stated earlier, we believe it is important to continue using measures from one payment year to the next payment year of the program to encourage continued improvements in patient care. Therefore, we proposed to expand and revise the measures discussed below that we finalized in the CY 2013 ESRD PPS final rule. For all measures except for the ICH CAHPS reporting measure, these proposed requirements would apply to the measures for PY 2016 and future payment years. For the ICH CAHPS measure, certain proposed expanded requirements would apply to PY 2016, and some additional proposed requirements would apply to PY 2017 and future payment years.

a. Expanded ICH CAHPS Reporting Measure

Patient-centered experience is an important measure of the quality of patient care. It is a component of the National Quality Strategy. The NQF endorses and the Measures Application Partnership supports a clinical measure on this topic, NQF #0258 [2] CAHPS In-Center Hemodialysis Survey, which is based on how facilities perform on the ICH CAHPS survey. In PY 2015, we continued to use a reporting measure related to the ICH CAHPS survey, requiring that facilities attest they had administered the survey according to the specifications set by the Agency for Healthcare Research and Quality (AHRQ), but not requiring the submission of survey data. We required that facilities attest by January 31, 2014, to administering the ICH CAHPS survey during the performance period (77 FR 67480 through 67481).

We are taking several steps to develop the baseline data necessary to propose and implement NQF #0258 as a clinical measure in the PY 2018 ESRD QIP. We expect to be able to certify ICH CAHPS survey vendors beginning in early CY 2014. We are also building the capacity to accept survey data; developing detailed specifications for administering the ICH–CAHPS survey in light of questions vendors asked about previous procedures; and developing specifications for submitting data to CMS, such as file specifications, structure and instructions that the survey vendors will use. We have taken these steps in order to make it possible for facilities to contract with third-party vendors to transfer survey data results to CMS, so that we might collect the baseline data necessary to propose and implement NQF #0258.

For PY 2016, we proposed that each facility arrange by July 2014 for a CMS-approved vendor to conduct the ICH CAHPS survey according to CMS (rather than AHRQ) specifications, available at the ICH CAHPS Web site (*https://ichcahps.org*). Facilities will need to register on the *https://ichcahps.org* Web site in order to authorize the CMS-approved vendor to administer the survey and submit data on their behalf. Each facility must administer (via its vendor) the survey once during the performance period and, by 11:59 ET on January 28, 2015, report the survey data to CMS using the specifications on the ICH CAHPS Web site.

For PY 2017 and subsequent payment years, we proposed similar requirements except that each facility must arrange to have the survey administered twice during each performance period and must report the data (via its CMS-approved vendor) to CMS by the date specified on the ICH CAHPS Web site.

Although we have required that other types of providers, including home health agencies and acute care hospitals, administer and submit CAHPS survey data on a monthly, continuous basis, we recognize that there are generally low rates of turnover in dialysis-facility patient populations. For this reason, we do not see the same need to require facilities to administer the survey as frequently and, as proposed above, we would require facilities to administer the survey once during the performance period for PY 2016 (in order to allow facilities enough time to select a vendor) and twice for subsequent payment years. We believe that this frequency of survey administration will enable us to gather sufficient data to adopt in future rulemaking a clinical version of this

[2] Please note that the proposed rule initially included a typographical error, such that the measure was referred to as NQF #0285 instead of NQF #0258. We have revised the text here in response to a public comment, which is discussed below.

measure without unduly burdening facilities. The technical specifications for this proposed measure are located at *http://www.dialysisreports.org/pdf/esrd/public-measures/ICHCAHPS–2016NPRM.pdf.*

We requested comments on this proposal. The comments we received on these proposals and our responses are set forth below.

Comment: Many commenters supported monitoring patients' experiences. However, these commenters stated that the ICH CAHPS survey is too burdensome and lengthy for patients to complete. Commenters suggested that the ICH CAHPS survey be divided into three parts, with each patient receiving one of these parts and a group of core questions.

Response: We do not agree that the ICH CAHPS survey is overly burdensome and we clarify that only 38 core survey questions are applicable to all respondents, plus 21 questions in the ''About You'' section. To be considered as complete, 19 of the 38 core questions must be answered. As we noted in the CY 2012 ESRD PPS final rule (76 FR 70269 through 70270) and the CY 2013 ESRD PPS final rule (77 FR 67480), we continue to believe that assessing the experiences of patients is vital to quality care. Patient surveys can, and should, draw a facility's attention to issues that can only be raised by those receiving care. Although commenters may consider the survey to be burdensome to patients, the ICH CAHPS tool went through extensive testing during development including focus groups and one-on-one patient sessions which assessed this burden and created specifications accordingly. Furthermore, we believe that concerns about patient burden can be at least partially mitigated without decreasing the number of questions on the survey or how the survey is administered. For example, as the specifications indicate, patients may take a break during the administration of the survey or take the survey in multiple sittings if they feel that the number of questions is too great to answer at one time.

Additionally, there are no plans to change the measure specifications used in the AHRQ version, which received NQF endorsement in 2007. The ICH CAHPS survey underwent rigorous testing when it was being developed, and the testing refers to the survey in its entirety. The suggestion to parse the survey into three parts would make implementation too complex. In addition, the survey is designed to address many aspects of a patient's experience with in-center hemodialysis. Breaking the survey up into three separate components would mean that any single patient would not be asked about the full range of their experience.

Comment: One commenter sought clarification on the measure specifications for the ICH CAHPS measure. The commenter asked if the case minimum for the measure pertains to total patients, eligible patients, or respondents to the survey. Another commenter requested clarification on the 30-case minimum for the ICH CAHPS measure. One commenter wanted to know the period of time used to determine numbers of eligible patients treated (for example, between January and the end of April).

Response: The case minimum pertains to patients who are eligible for the survey, and patients over the age of eighteen with at least 3 months of experience on hemodialysis at their current facility are eligible. We further clarify that the performance period (for example, January through December 2014 for PY 2016) is the period of time that should be used to determine numbers of eligible patients.

Comment: One commenter did not agree that the target number of completed ICH CAHPS surveys should be 200. The commenter stated this target number makes no sense, regardless of clinic size, and should be removed.

Response: We selected 200 as the target number of completed surveys because we found that this was the number needed to reach a confidence interval of +/−0.07—a range that we believe ensures that facility scores will be accurate and comparable between facilities. We recognize that it will be difficult for smaller facilities to reach this target. We clarify that there are no penalties if a facility submits less than 200 complete surveys.

Comment: A few commenters raised concerns about the inclusion of homeless persons and nursing home patients with respect to eligibility for the ICH CAHPS survey because these patients may be difficult to contact for purposes of administering the survey.

Response: We are aware that it might be difficult to contact homeless and nursing home patients for any survey. However, these subgroups are important groups of people who may have different concerns than other dialysis patients. Although we have identified 200 completed surveys as a target response rate, there is no required minimum number of surveys that a facility must submit in order to satisfy the reporting requirements for the measure.

Comment: Several commenters stated that facilities should not be held accountable, leading to a penalty, for low response rates from such populations for which CMS's contact information may be inaccurate and/or out-of-date or based on the number of responses in the survey. Some commenters stated that facilities have no way to ensure that patients' contact information is as accurate and up-to-date as possible because the survey is administered by a third-party vendor. Other commenters did not support the ICH CAHPS measure specifications that require each patient to fill out at least half of the survey for the survey to count as complete. Commenters were also concerned because patients often skip or refuse to answer survey questions, and the commenters do not believe that facilities should be penalized for this.

Response: Facilities do not face any penalties for low-response rates. Survey vendors will receive contact information for patients sampled from a facility directly from CMS and its contractor, which will extract addresses and telephone numbers from CROWNWeb.

There are only 38 core survey questions that are applicable to all respondents, plus 21 questions in the ''About You'' section. To be considered as complete, 19 of the 38 core questions must be answered. Answering the survey is voluntary, and respondents may refuse to answer specific questions. With pre-notification by the vendor of the importance of their input, we hope that sampled patients will be willing to participate. Nevertheless, we clarify that facilities will not be penalized if they submit incomplete surveys.

Comment: Several commenters sought clarity on the ICH CAHPS measure specifications, which read that ''survey responses will not be shared with individual facilities, even if the respondent were to provide permission to do so.'' These commenters recommended that the specifications should clearly state that aggregate responses will be provided, but individual survey responses will not be shared.

Response: In an effort to protect the confidentiality of responses to the survey among this highly vulnerable population, in-center hemodialysis facilities must hire a third-party vendor to administer the survey. In addition, CMS will not allow vendors to share the responses of individual patients with in-center hemodialysis facilities. Vendors may provide aggregate results to facilities, but these results cannot include demographic data or other information that could be used to match patients and their survey responses. These measure specifications are consistent with the AHRQ specifications

for fielding the survey and handling the survey responses.

Comment: Several commenters did not support the proposal to adopt the ICH CAHPS measure because it is not appropriate to publicly publish scores that aggregate survey results when facilities have no means to impact responses to some of the questions. For example, cuts to the ESRD PPS payment rates may result in physicians spending less time with patients, and patients are also asked in the survey to comment on physicians that are not associated with the facility. Some commenters recommended including the physician component of the ICH CAHPS measure in the Physician Quality Reporting System instead of in the ESRD QIP.

Response: We believe that the survey results, in the aggregate, will be sufficient to promote quality improvement and, as we explain above, also believe that the interest in protecting patient anonymity and confidentiality outweighs the cost of making public individual survey responses. We also note that ICH CAHPS has been in the public domain since 2007, and dialysis facilities are already using the survey (with the ARHQ specifications) to meet the requirements for the PY 2014 ESRD QIP.

Questions about physicians are only one component of the ICH CAHPS survey, but we believe that the experience patients have with their physicians is critical to understanding and measuring their experience at the facility overall. We continue to believe that facilities can impact their performance on the physician component of the survey by encouraging physicians who see the facilities' patients to improve the quality of care they provide.

Comment: Many commenters discussed the impact of facility size on survey administration. Some commenters stated that small facilities would likely have low response rates that could skew results. Other commenters did not support the proposal to exclude facilities with fewer than 30 eligible patients from ICH CAHPS survey. These commenters stated that in CY 2011, nearly 20 percent of all in-center dialysis facilities would have been excluded from the measure; that CMS should evaluate patient experience of care in small facilities; and that CMS should develop further methodologies to collect reliable data from small facilities. Commenters also did not support the measure specifications for the ICH CAHPS measure. Specifically, these commenters noted that while the measure specifications require facilities with more than 200 patients to minimize overlap between the random sample of patients who receive each semi-annual survey, it will be difficult for facilities with close to 200 patients to minimize sampling overlap because many patients will likely be sampled in both of the bi-annual surveys.

Response: For our survey measures, we want to ensure that we are measuring true performance. In any measurement system there is a mixture of signal (true performance) and noise (random error). By using a case minimum of 30, we can increase reliability of the ICH CAHPS measure and the likelihood that it is measuring signal and not noise. Facilities with fewer than 30 eligible cases are excluded from the ICH CAHPS survey because results from these facilities might not be reliable. We recognize that when facilities have close to 200 patients, most of these patients will receive both of the semi-annual surveys in PY 2017 and future payment years. Nevertheless, these facilities should attempt to minimize overlapping patients by removing patients from the second survey if they were sampled in the first survey, and most facilities serve 99 or fewer unique patients per year.

Comment: Many commenters did not support the proposal to require facilities to administer the ICH CAHPS survey twice annually, starting in PY 2017, particularly in light of the proposed cuts to the ESRD PPS. Some of these commenters stated that it makes sense for hospitals to conduct the survey regularly because they generally do not treat the same patients more than once; however, dialysis facilities see the same patients over the course of the year, so there is no need to conduct a second survey. Commenters also stated that there are no data demonstrating that semi-annual surveys improve the validity of survey results. Additionally, many commenters did not support the proposal to administer the ICH CAHPS survey twice annually because doing so will lead to ''survey fatigue'' by decreasing the response rates to the ICH CAHPS survey, and other surveys administered by dialysis facilities, including the Kidney Disease Quality of Life-36 survey, which commenter states are required by the ESRD Conditions for Coverage (CfC) regulations. These commenters recommended fielding the survey once annually.

Response: We decided to require semi-annual administration of the survey in order to collect data about patients' experiences with dialysis care at different points in the calendar year, to ensure that patients could accurately recall their experience of care, and to ensure that survey responses were collected in timely fashion. Conducting the survey on an annual basis increases the likelihood of collecting outdated or inaccurate information, while making it more difficult to solicit information that accurately reflects the experiences of patients. Although we recognize that the requirement to conduct a second, semi-annual ICH CAHPS survey may decrease response rates to other surveys that facilities are required to complete (such as the Kidney Disease Quality of Life-36 survey), we believe that the drawbacks associated with the possibility of survey fatigue are outweighed by improvements in the reliability of the data collected through the ICH CAHPS survey.

Comment: Several commenters disagreed with the proposal to adopt the expanded ICH CAHPS measure because the survey is too expensive to administer.

Response: Although we acknowledge that there is a cost to administer the ICH CAHPS survey, we suggest that dialysis facilities compare several vendors before deciding on a vendor. We strongly believe that the information facilities gain from the ICH CAHPS survey outweighs the costs to administer the survey, because facilities can use this information to improve the care provided to patients with ESRD. Furthermore, as stated in the CY 2013 ESRD PPS final rule (77 FR 67481), ''Facilities may report allowable operating expenses in their Medicare cost reports. We believe that it is consistent with this payment policy for facilities to include the ICH CAHPS costs on their cost reports because they are allowable operating expenses.''

Comment: Some commenters suggested that CMS redesign the survey to account for special populations (for example, low literacy, hearing and vision impaired, elderly, and physically handicapped). Other commenters stated that the ICH CAHPS survey should not be administered in languages other than English and Spanish, as proper translation of surveys requires a complicated forward and backward translation process, and it is unlikely that surveys conducted in other languages can be properly compared to surveys conducted in English and Spanish because of the complexity of the translation process.

Response: The survey administration procedures take into account the needs of special populations such as low literacy, hearing and vision impaired, elderly, and physically handicapped. Patients can get assistance in answering the survey as long as they, and not the assistor, actually answer the questions.

In addition, for telephone as well as in-person interviews, the interviewer will be instructed to permit respondents to take breaks as needed and to call back at another time if a respondent becomes fatigued. Finally, participation in the survey is completely voluntary on the part of the patients. They may refuse to participate or refuse to answer any questions they do not wish to answer. Facilities are not required to administer the survey in languages other than English and Spanish. However, CMS-approved vendors may use other approved translations that are authorized and developed by CMS.

Comment: A few commenters raised concerns about the administration of the survey and ways to ensure that sampled patients would/could complete the survey, especially those who may have lost their mail version of the survey or those with cognitive and/or language barriers.

Response: Responsiveness might vary by survey mode, language barriers, cognitive issues, literacy, and health issues. We believe that the ICH CAHPS measure is designed to maximize patient response rates while retaining its voluntary nature. Every sampled patient will receive a pre-notification letter from CMS (on its letterhead) prior to receipt of the mail survey or initial telephone call. This letter will describe the survey and the patient's role in providing feedback to improve the quality of care at the facility. The survey methodology also allows for assistance for patients who might have difficulty completing the survey.

The measure specifications suggest that survey vendors use current best practices to enhance response rates by (1) standardizing the survey materials; (2) improving readability; (3) allowing multiple contacts (up to 5) for follow-up in the telephone or mixed-mode; (4) offering call back times that are best suited for the sample patient; and/or (5) breaking up the survey over multiple calls.

In all three modes of administration (mail-only, telephone-only, and mixed modes), a pre-notification letter will include both email addresses and telephone numbers to call CMS or its ICH CAHPS contractor if the respondent has questions or problems with the survey. For the mail-only sample patients, cover letters will include the contact information of the CMS-approved survey vendors, who can replace lost surveys. Lost surveys should not be an issue for the telephone-only mode. For the other modes, sample patients will receive multiple surveys during the follow-up period or may contact the vendor for replacements.

Comment: A few commenters suggested making the survey available for patients online.

Response: We are aware that online surveys are popular, but this capability does not currently exist. We will continue to investigate new modes of administration, and in the meantime will continue with more traditional efforts to reach patients.

Comment: Many commenters expressed concerns that the ICH CAHPS survey only covers in-center hemodialysis patients. Many of these commenters recommended that CMS assess the experience of home dialysis patients and peritoneal dialysis patients as well.

Response: We thank commenters for their feedback. Eighty-nine percent of all ESRD patients receive in-center hemodialysis. Even those receiving peritoneal or home dialysis, have their initial care at an in-center hemodialysis facility. Therefore, this survey was specifically designed to capture the experience of in-center hemodialysis patients. Surveys for peritoneal and home dialysis patients may be considered for future development.

Comment: One commenter stated that there is a discrepancy between the proposed rule and the measure specifications for the ICH CAHPS measure. Specifically, the measure specifications establishes the survey periodicity for CY 2014 as ''twice annually,'' yet the proposed rule establishes the survey periodicity for CY 2014 as annually.

Response: We proposed that facilities would only have to administer the ICH CAHPS survey once in CY 2014. This is consistent with the measure specifications that appear at *https://ichcahps.org/Portals/0/ICH_DifferencesBtwAHRQandICHCAHPSSurveySpecs.pdf*.

Comment: One commenter noted that on page 40857, second column, subsection a, there is a typographical error. NQF #285 should be NQF #258.

Response: We thank the commenter for pointing out this typographical error. We have corrected it above.

Comment: Several commenters requested clarification about whether each facility will need to register on the *www.ichcahps.org* Web site, or if umbrella organizations that include a number of facilities will be able to authorize a selected vendor to administer the survey and submit data on behalf of each its facilities. These commenters stated that the contracting for this process will be centralized, and it would be inefficient for individual facilities to complete these steps when they could be done on an organization-wide basis. Concerns were also raised about having time to meet the system requirements for submitting ICH CAHPS data to CMS.

Response: Dialysis organizations may hire and authorize a single vendor to conduct the survey and submit data for all facilities under the corporate umbrella of the organization, but the corporate umbrella must report facility-level data to ensure that results can be attributed to individual facilities. The vendor may batch data from several facilities into a single zip file for submission.

Because third-party vendors are already conducting ICH CAHPS surveys on behalf of multi-facility organizations, we believe that the facilities will be able to timely meet the system requirements for administering the survey.

Comment: One commenter did not support the proposal to change the measure specifications for the ICH CAHPS measure from the AHRQ version to the CMS version. This commenter stated that doing so will make it hard to compare results between the two versions of the survey, and also cause confusion for facilities.

Response: Changes to the AHRQ measure specifications, which received NQF endorsement in 2007, are not substantive. Rather, the CMS measure specifications provide more details about the field operations and data submission in order to standardize the procedures used by third-party vendors. These non-substantive changes to the measure specifications were made in response to requests for this standardization. We have found that it is easier for vendors to administer the survey when they have detailed specifications, and we believe that this standardization helps ensure that the data will be comparable across all facilities.

For these reasons, we are finalizing the expanded ICH CAHPS reporting measure as proposed for the PY 2016 ESRD QIP and for future payment years. The technical specifications for this finalized measure can be found at *http://www.dialysisreports.org/pdf/esrd/public-measures/ICHCAHPS-2016FR.pdf*.

b. Revised Mineral Metabolism Reporting Measure

Adequate management of bone mineral metabolism and disease in patients with ESRD continues to be a high priority because it can cause severe consequences such as osteoporosis, osteomalacia, and hyperparathyroidism. The PY 2015 ESRD QIP has a reporting

measure focused on mineral metabolism (77 FR 67484 through 67487). We proposed two changes for PY 2016 and future payment years. First, when we finalized the measure in the CY 2013 ESRD PPS final rule, we inadvertently excluded home peritoneal dialysis patients from the measure specifications. For PY 2016 and future payment years, we proposed to include home peritoneal dialysis patients in the Mineral Metabolism reporting measure. Therefore, we proposed that a qualifying case for this measure will be defined as (i) an in-center Medicare patient who had been treated at least seven times by the facility; and (ii) a home dialysis Medicare patient for whom the facility submitted a claim at least once per month.

Second, if the proposed Hypercalcemia clinical measure (described below) is finalized based on public comment, then we believe it would be redundant, and unduly burdensome, for facilities to also continue reporting serum calcium levels as part of the Mineral Metabolism reporting measure. Accordingly, in light of our proposal to adopt the Hypercalcemia measure, we proposed to change the specifications for the Mineral Metabolism measure such that it no longer requires facilities to report serum calcium levels. We solicited comments on this proposal, and in particular on whether we should retain the reporting of serum calcium levels as part of the Mineral Metabolism reporting measure if the proposed Hypercalcemia measure was not finalized.

As described in more detail below (Proposed Minimum Data for Scoring Measures), we also proposed to eliminate the 11-case minimum for this measure, which was finalized in the CY 2013 ESRD PPS final rule (77 FR 67486). Because of the proposed revised case minimum, and because there are circumstances that might make it challenging for a facility to draw a sample from certain patients, such as those who are admitted to hospital during the month, we proposed that, in order to receive full points on this measure, facilities that treat 11 or more qualifying cases over the entire performance period will have to report at the lesser of the 50th percentile of facilities in CY 2013 or 97 percent per month, on a monthly basis, for each month of the performance period. We further proposed that facilities that treat fewer than 11 qualifying cases during the performance period will have to report on a monthly basis the specified levels for all but one qualifying case. If a facility only has one qualifying case during the entire performance period, a facility will have to attest to that fact in CROWNWeb by January 31 of the year following the performance period in order to avoid being scored on the measure. We made this proposal because we seek to ensure the highest quality of care regardless of facility size, and because we seek to mitigate cherry-picking by ensuring that one patient does not skew a facility's score (77 FR 67474).

The comments we received on these proposals and our responses are set forth below.

Comment: Several commenters supported the proposal to include home peritoneal dialysis patients in the Mineral Metabolism reporting measure.

Response: We thank the commenters for their support.

Comment: Many commenters supported removing calcium from the reporting requirements of the Mineral Metabolism reporting measure if the Hypercalcemia measure is finalized, and retaining calcium in the Mineral Metabolism measure if the Hypercalcemia measure is not finalized.

Response: We thank the commenters for their support.

Comment: One commenter supported the proposal to modify the Mineral Metabolism measure and asked whether the revised Mineral Metabolism reporting measure would also include home hemodialysis patients.

Response: We thank the commenter for the support. We clarify that the measure includes home hemodialysis patients, as well as home peritoneal dialysis patients.

Comment: Some commenters stated the Mineral Metabolism reporting measure should include an exclusion for patients not on chronic dialysis to make the measure consistent with the anemia management reporting measure.

Response: We clarify that patients not on chronic dialysis have always been excluded from the Mineral Metabolism reporting measure, which is appropriate because the measure was designed for patients on chronic dialysis. We have updated the measure specifications to state this explicitly.

Comment: Several commenters noted that there is an inconsistency between the proposed rule and the measure specifications for the Mineral Metabolism reporting measure. The proposed rule states that ''if a facility only has 1 qualifying case during the entire performance period, a facility will have to attest to that fact in CROWNWeb by January 31 of the year following the performance period in order to avoid being scored on the measure.'' By contrast, the measure specifications state that ''fewer than 1 patient during the performance period who are (i) in-center Medicare patients who have been treated at least 7 times by the facility during the reporting month; or (ii) home dialysis Medicare patients for whom the facility submits a claim during the reporting month must attest to this fact in CROWNWeb to not be scored on this measure.''

Response: We thank commenters for identifying this discrepancy. We have changed the measure specifications to state that the case minimum is one eligible patient. Facilities with two or more eligible patients will be scored on the measure, and facilities with one eligible patient will be scored on the measure unless they attest to this fact in CROWNWeb. We made this proposal to enable us to gather data on patients in small facilities.

Comment: One commenter recommended that the Mineral Metabolism reporting measure specifications be modified to indicate that plasma and serum should both be acceptable blood samples for the measurement of calcium. The commenter stated that plasma testing is more stable and requires less manipulation, has been used since 2006, has been validated for most clinical chemistry analyzers, and has been deemed acceptable and equivalent by analyzer manufacturers.

Response: We disagree that the measure specification should be modified to include plasma calcium measurements. This issue was discussed at length during the April 2013 mineral bone disease TEP (*http://www.cms.gov/Medicare/End-Stage-Renal-Disease/CPMProject/index.html*). Overall, TEP members determined that there is a lack of strong evidence supporting the acceptance of measurements of serum phosphorus on plasma (vs. serum). Published literature indicates that the difference in phosphorus levels measured on plasma vs. serum are not trivial and may be as high as 10 percent.[3] Based on these observations, TEP members voted and unanimously recommended to keep the measure unchanged, such that facilities are required to report serum levels.

Comment: One commenter stated that the Mineral Metabolism measure will not improve patient care because it does not measure outcomes. The commenter recommended adopting an outcomes-based phosphorus measure in future payment years.

Response: As stated in the CY 2013 ESRD PPS final rule (77 FR 67486), we

[3] Carothers, JE et. al. Clinical Chemistry, volume 22, Issue 11, 1976 (Table 3).

continue to believe that the Mineral Metabolism reporting measure will help improve patient outcomes. Kidney Disease Improving Global Outcomes (KDIGO) recommends monthly measurements and emphasizes the importance of following trends versus single measurements, thus supporting relatively frequent measurements (for example, monthly).[4] There is evidence that extreme phosphorus levels may be associated with poor clinical outcomes. Monthly measurements will identify elevated levels of serum phosphorus and trigger therapeutic interventions, thus contributing to high-quality care.

Comment: Many commenters supported the inclusion of home dialysis patients in the Mineral Metabolism reporting measure. However, these commenters expressed concern that the inclusion of these patients will discourage home hemodialysis, force home dialysis patients to visit a facility too frequently or otherwise present greater challenges for regular blood draws, and cause difficulties for small facilities that only treat home dialysis patients.

Response: We disagree that the inclusion of home peritoneal dialysis patients in the Mineral Metabolism measure will force the patients to visit their dialysis facility too frequently, or otherwise discourage patients from receiving dialysis at home. Between May 2012 and March 2013, a large percentage of patients had blood testing performed each month. The percentage of patients with monthly testing varied by modality and specific blood test, but all populations provided data for between 72 percent and 89 percent of qualifying patients. Furthermore, the ESRD CfCs, implemented in October 2008, require monthly testing for some labs (for example, Albumin, Hemoglobin/Hematocrit at § 494.90(a)(2) and § 494.90(a)(4), respectively) and require that all patients (including home dialysis patients) see a practitioner (for example, a physician, physician's assistant, or nurse practitioner) at least monthly as specified at § 494.90(b)(4). Therefore, we do not believe that requiring monthly measurements of serum phosphorus will discourage patients from receiving dialysis at home, since the vast majority of home dialysis patients already receive monthly blood tests, and facilities are already required under the CfCs to conduct some other lab tests on a monthly basis.

Comment: One commenter stated that the language used to finalize the Mineral Metabolism reporting measure in the CY 2013 ESRD PPS was unclear about what was meant by ''monthly basis.'' The commenter asked whether this means the percent of complete months in which 96 percent of eligible patients were tested, or if this means the percent of eligible patients for that facility who had monthly testing in excess of 96 percent. The commenter also sought clarification with respect to the equation used to calculate scores on the Mineral Metabolism measure.

Response: By ''monthly basis,'' we mean meeting the reporting threshold for each month during the performance period. Facilities are scored on the measure based on the number of months in which the facility successfully meets this reporting threshold. Measure scores are not determined by the percent of months in which the facility meets this reporting threshold, but rather according to the equation below, which appears in the CY 2013 ESRD PPS final rule (77 FR 67506). We also affirm that this methodology will be used to calculate scores on the Mineral Metabolism measure in the PY 2015 and PY 2016 programs, as well as future payment years.

$$\frac{\text{Number of Months Facility Successfully Reports}}{\text{Number of Months in the Performance Period Facility has CCN}} \times 12 - 2$$

For the reasons stated above, and the reasons stated in section III.C.10 below, we are finalizing the Mineral Metabolism reporting measure for the PY 2016 ESRD QIP and for future payment years. Additionally, because we are finalizing the Hypercalcemia clinical measure (see Section III.C.3.b below), we are also finalizing the proposal to change the specifications for the Mineral Metabolism measure such that the measure no longer requires facilities to report serum calcium levels. Technical specifications for the revised Mineral Metabolism reporting measure can be found at: *http://www.dialysisreports.org/pdf/esrd/public-measures/MineralMetabolism-Reporting-2016FR.pdf.*

c. Revised Anemia Management Reporting Measure

Section 1881(h)(2)(A)(i) requires ''measures on anemia management that reflect the labeling approved by the Food and Drug Administration for such management.'' In the CY 2013 ESRD PPS final rule, we finalized an Anemia Management reporting measure for the reasons stated in that final rule (77 FR 67491 through 67495). However, we inadvertently excluded home peritoneal patients from the measure specifications. For PY 2016 and future payment years, we proposed to include home peritoneal patients in the Anemia Management reporting measure. Therefore, we proposed that a qualifying case for this measure will be defined as (i) an in-center Medicare patient who had been treated at least seven times by the facility; and (ii) a home dialysis Medicare patient for whom the facility submitted a claim at least once per month.

We believe that there are circumstances that might make it challenging to draw a sample from certain patients. Therefore we proposed that, in order to receive full points on this measure, facilities that treat 11 or more qualifying cases over the entire performance period must report at the lesser of the 50th percentile of facilities in CY 2013 or 99 percent per month, on a monthly basis for each month of the performance period. In addition, we proposed that, in order to receive full points on this measure, facilities that treat fewer than 11 qualifying cases during the performance period must report on a monthly basis the specified levels for all but one qualifying case. If

[4] KDIGO recommends measurement of serum phosphorus every 1–3 months in Chapter 3, KDIGO Clinical Practice Guideline for the Diagnosis, Evaluation, Prevention, and Treatment of Chronic Kidney Disease-Mineral and Bone Disorders (CKD–MBD) Kidney International vol 76, supplement 113, August 2009.

a facility only has one qualifying case during the entire performance period, a facility will have to attest to that fact in CROWNWeb by January 31 of the year following the performance period in order to avoid being scored on the measure. We made this proposal because we seek to ensure the highest quality of care regardless of facility size, and because we seek to mitigate cherry-picking by ensuring that one patient does not skew a facility's score (77 FR 67474).

The comments we received on these proposals and our responses are set forth below.

Comment: Many commenters supported the proposal to include home peritoneal dialysis patients in the Anemia Management reporting measure.

Response: We thank the commenters for their support.

Comment: Several commenters supported the inclusion of home peritoneal dialysis patients in the Anemia Management reporting measure. However, these commenters expressed some concern that the inclusion of these patients will discourage home hemodialysis, force home dialysis patients to visit a facility too frequently, and cause difficulties for small facilities that only treat home dialysis patients.

Response: We disagree that the inclusion of home peritoneal dialysis patients in the Anemia Management reporting measure will force the patients to visit their dialysis facility too frequently, or otherwise discourage patients from receiving dialysis at home. Most home dialysis patients, including peritoneal dialysis patients, receive blood testing on a monthly basis. Furthermore, the CfCs require monthly testing for some labs (for example, Albumin, Hemoglobin/Hematocrit at § 494.90(a)(2) and § 494.90(a)(4), respectively) and require that all patients (including home dialysis patients) see a practitioner (for example, a physician, physician's assistant, nurse practitioner) at least monthly as specified at § 494.90(b)(4). Therefore, we do not believe the inclusion of home peritoneal dialysis patients will discourage home dialysis, because most home dialysis patients already visit dialysis facilities for monthly blood tests, and because facilities are already required to conduct monthly hemoglobin/hematocrit tests for all dialysis patients.

Comment: Several commenters noted that there is an inconsistency between the proposed rule and the measure specifications for the Anemia Management reporting measure. The proposed rule states that ''if a facility only has 1 qualifying case during the entire performance period, a facility will have to attest to that fact in CROWNWeb by January 31 of the year following the performance period in order to avoid being scored on the measure.'' By contrast, the measure specifications state that ''fewer than 1 patient during the performance period who are (i) in-center Medicare patients who have been treated at least 7 times by the facility during the reporting month; or (ii) home dialysis Medicare patients for whom the facility submits a claim during the reporting month, must attest to this fact in CROWNWeb to not be scored on this measure.''

Response: We thank commenters for identifying this discrepancy. We have changed the measure specifications to state that the case minimum is one eligible patient. Facilities with two or more eligible patients will be scored on the measure, and facilities with one eligible patient will be scored on the measure until they attest to this in CROWNWeb. We made this proposal to enable us to gather data on patients in small facilities.

For these reasons, and the reasons stated in section III.C.10 below, we are finalizing the Anemia Management reporting measure as proposed for the PY 2016 ESRD QIP and for future payment years. Technical specifications for this proposed measure can be found at *http://www.dialysisreports.org/pdf/esrd/public-measures/AnemiaManagement-Reporting-2016FR.pdf*.

3. New Measures for PY 2016 and Subsequent Payment Years of the ESRD QIP

As the program evolves, we believe it is important to continue to evaluate and expand the measures selected for the ESRD QIP. Therefore, for the PY 2016 ESRD QIP and future payment years, we proposed to adopt five new measures. The proposed new measures include two measures on anemia management, one measure on mineral metabolism, one measure on bloodstream infection monitoring, and one measure on comorbidities.

a. Anemia Management Clinical Measure Topic and Measures

Section 1881(h)(2)(A)(i) of the Act states that the measures specified for the ESRD QIP are required to include measures on ''anemia management that reflect the labeling approved by the Food and Drug Administration for such management.'' For PY 2016 and future payment years, we proposed to create a new anemia management clinical measure topic, which consists of one measure initially finalized in the PY 2012 ESRD QIP final rule and most recently finalized for PY 2015 and future PYs in the CY 2013 ESRD PPS final rule, and one new proposed measure, described below. We note that, like other measure topics, we proposed that the Anemia Management clinical measure topic consist only of clinical and not reporting measures.

i. Anemia Management: Hgb > 12

For the PY 2016 ESRD QIP and future payment years of the program, we proposed to include the current Hgb > 12 measure in a new Anemia Management Clinical measure topic. In the event that the Patient Informed Consent for Anemia Treatment measure described below is not finalized, we proposed to retain the Hgb > 12 measure as an independent measure. We solicited comments on this proposal.

We did not receive any comments on these proposals.

ii. Anemia of Chronic Kidney Disease: Patient Informed Consent for Anemia Treatment

This is a measure of the proportion of dialysis patients for whom a facility attests that risks, potential benefits, and alternative treatment options for anemia were evaluated, and that the patient participated in the decision-making regarding an anemia treatment strategy. We believe that this measure is consistent with recent changes to the FDA-approved labeling [5] for ESAs and Kidney Disease: Improving Global Outcomes (KDIGO) Anemia Management Guidelines [6] that highlight the evolving understanding of risks associated with ESA therapy, as required in section 1881(h)(2)(A)(i) of the Act. We believe it is appropriate for facilities and physicians to ensure that steps are taken to make patients aware of those potential risks within the context of treatment for anemia. For these reasons, we proposed to adopt this measure (Anemia of Chronic Kidney Disease: Patient Informed Consent for Anemia Treatment) for the ESRD QIP in PY 2016 and future payment years of the program. In order to meet the requirements of this proposed measure, facilities must attest in CROWNWeb for each qualifying patient, on an annual basis, that informed consent was obtained from that patient, or that patient's legally authorized representative, during the performance period. We proposed that qualifying

[5] *http://www.fda.gov/Drugs/DrugSafety/ucm259639.htm.*

[6] Kidney Disease: Improving Global Outcomes (KDIGO) Anemia Work Group. KDIGO Clinical Practice Guideline for Anemia in Chronic Kidney Disease. Kidney inter., Suppl. 2012 (2): 279–335.

cases for this measure would be defined as patients who received dialysis in the facility for 30 days or more. The proposed deadline for reporting these attestations for the PY 2016 ESRD QIP would be January 31, 2015, or, if that is not a regular business day, the first business day thereafter. Missing attestation data for a patient would be interpreted as failure to obtain informed consent from that patient.

We requested comments on these proposals. The comments we received on these proposals and our responses are set forth below.

Comment: Many commenters expressed a variety of concerns about the proposed Patient Informed Consent of Anemia Treatment clinical measure and did not support its adoption for the ESRD QIP. Some commenters stated that obtaining informed patient consent is already a standard of clinical care, and that the measure would therefore not promote quality care, but would instead add more, unnecessary recordkeeping. Other commenters stated that the informed consent measure would be duplicative and possibly inconsistent with the FDA's Risk Evaluation and Mitigation Strategy (REMS) for ESAs, which already requires physicians to discuss with patients the risks of ESA therapy. Other commenters expressed conflicting opinions about the proposed measure. One group of commenters stated that nephrologists, not dialysis facilities, prescribe ESAs, so it would be unreasonable to expect facilities to obtain informed consent from patients. A different group of commenters noted that obtaining informed patient consent is already an ESRD CfC for dialysis facilities, so it would be unnecessary for the ESRD QIP to adopt a measure on the topic.

Response: We appreciate the commenters' concerns. We continue to believe that this measure is a useful complement to the other anemia management measures currently used in the ESRD QIP, as those measures focus exclusively on hemoglobin levels and not the patient's knowledge of the risks and benefits of anemia treatment. We also believe that it is essential to provide patients with this information, in light of the lack of scientific evidence regarding ESAs and ideal hemoglobin levels in this patient population. Additionally, we disagree that this measures and the FDA REMS accomplish the same goal. The FDA REMS program is focused on ensuring that patients are aware of the risks associated with aspects of ESA use in overall anemia management, particularly in the setting of cancer chemotherapy. The informed consent measure, by contrast, would require facilities to provide a balanced discussion of both the risks and the potential benefits of a contemplated treatment.

However, we agree with commenters who noted that providing informed consent is already a standard of care that is at least partially regulated through the ESRD CfCs. We do not want to create additional recordkeeping requirements for facilities when there is already an existing standard that facilities are required to meet. For this reason, we are not finalizing the Patient Informed Consent for Anemia Treatment clinical measure at this time. Because we are not finalizing this measure, we are also not finalizing the proposed Anemia Management Clinical measure topic. Instead, the Hemoglobin Greater Than 12 g/dL clinical measure will remain an independent clinical measure, unassociated with a clinical measure topic, as it has in previous payment years. Technical specifications for the Hemoglobin Greater Than 12 g/dL measure can be found at *http://www.dialysisreports.org/pdf/esrd/public-measures/AnemiaManagement-HGB-2016FR.pdf*.

b. Hypercalcemia

Section 1881(h)(2)(A)(iii)(II) of the Act states that the measures specified for the ESRD QIP shall include other measures as the Secretary specifies, including, to the extent feasible, measures of bone mineral metabolism. Abnormalities of bone mineral metabolism are exceedingly common, and contribute significantly to morbidity and mortality in patients with advanced Chronic Kidney Disease (CKD). Many studies have associated disorders of mineral metabolism with mortality, fractures, cardiovascular disease, and other morbidities. Therefore, we believe it is critical to adopt a clinical measure that encourages adequate management of bone mineral metabolism and disease in patients with ESRD.

Elevated serum calcium level (or hypercalcemia) has been shown to be significantly associated with increased all-cause mortality in patients with advanced CKD. Both KDIGO Clinical Practice Guideline for the Diagnosis, Evaluation, Prevention, and Treatment of Chronic Kidney Disease–Mineral and Bone Disorder (CKD–MBD) and the National Kidney Foundation's Kidney Disease Outcomes Quality Initiative (KDOQI) support maintaining serum calcium levels within reference ranges. Hypercalcemia is also a proxy for vascular and/or valvular calcification [7] [8] and subsequent risk for cardiovascular deaths. We previously proposed a hypercalcemia clinical measure for the PY 2015 ESRD QIP (77 FR 40973 through 40974), but decided not to finalize the measure because we lacked baseline data that could be used to calculate performance standards, achievement thresholds, and benchmarks (77 FR 67490 through 67491). We now possess enough baseline data to calculate these values. Therefore, we proposed to adopt the NQF-endorsed measure NQF #1454: Proportion of Patients with Hypercalcemia, for PY 2016 and future payment years of the ESRD QIP.

The proposed Hypercalcemia measure assesses the number of patients with uncorrected serum calcium greater than 10.2 mg/dL for a 3-month rolling average. (''Uncorrected'' means not corrected for serum albumin concentration.) In order to enable us to calculate this measure, each facility will be required to enter in CROWNWeb, on a monthly basis, an uncorrected calcium level for each in-center and home dialysis patient over the age of eighteen.

Performance on this measure is expressed as a proportion of patient-months for which the 3-month rolling average exceeds 10.2 mg/dL. The numerator is the total number of eligible patient-months where the 3-month rolling average is greater than 10.2 mg/dL, and the denominator is the total number of eligible patient-months. We proposed that facilities would begin to submit data on this measure based on January 2014 uncorrected serum calcium levels but that we would calculate the first 3-month rolling average for each eligible patient in March 2014 using January, February, and March 2014 data. We would then calculate a new 3-month rolling average each successive eligible patient-month (April through December measure calculations) by dropping the oldest month's data and using instead the newest month's data in the 3-month period. The facility's performance will be determined by calculating the proportion of the 3-month averages calculated monthly (March through December, each time using the latest 3

[7] Wang A, Woo J, Law C, et al. Cardiac Valve Calcification as an Important Predictor for All-Cause Mortality and Cardiovascular Mortality in Long-Term Peritoneal Dialysis Patients: A Prospective Study. J Am. S. Nephrology 2011 (14/1): 159–168.

[8] Wang A, Ho S, Wang M, et al. Cardiac Valvular Calcification as a Marker of Atherosclerosis and Arterial Calcification in End-stage Renal Disease. JAMA 2005 (165/3): 327–332.

months of data) for all eligible patients that was greater than 10.2 mg/dL.

Because we proposed to adopt this measure not only for PY 2016, but also for subsequent payment years, we also proposed that, beginning with the PY 2017 program, we would measure hypercalcemia beginning in January of the applicable performance period. This will allow us to have a 3-month rolling average for all months in the performance period. We proposed that the 3-month rolling average rate for January would be calculated using the rates from November and December of the previous year, as well as January of that year. Likewise, we proposed that the rate for February would be calculated using the rates from December, January, and February to calculate the 3-month rolling average, and so on.

We requested comments on these proposals. The comments we received on these proposals and our responses are set forth below.

Comment: One commenter supported the proposal to adopt the hypercalcemia measure because ''this measure represents an incentive for maintaining this important standard of care and protecting patients'' in light of the ''intention to include oral drugs, such as phosphorus binders, in the PPS in 2016.'' The commenter also stated that there is no clinical rationale for needing a full year of baseline data for improvement and achievement scoring.

Response: We thank the commenter for the support.

Comment: Several commenters strongly supported the inclusion of mineral metabolism measures in the ESRD QIP, including the proposal to adopt the hypercalcemia measure. These commenters also supported the adoption of other mineral metabolism measures (for example, PTH and phosphorus), in future payment years because oral drugs used to regulate mineral metabolism are moving from Medicare Part D to the ESRD PPS bundled payment in CY 2016.

Response: We thank the commenters for their support. Additionally, we agree that we should explore other measures to assess mineral metabolism for future payment years. We are currently developing such measures, and will continue to do so.

Comment: Many commenters supported the proposal to adopt the hypercalcemia measure. However, some of these commenters stated that patients who present with other non-ESRD conditions that may cause hypercalcemia should be excluded from the 3-month rolling average. Commenters also stated that patients treated fewer than seven times by a facility should be excluded from the measure. Additionally, one commenter noted that the 10.2 mg/dL threshold used to evaluate the hypercalcemia measure is higher than the KDOQI and KDIGO guidelines, which recommend a threshold of 9.5 mg/dL. This commenter prefers the 9.5 threshold, but supports the adoption of the hypercalcemia measure because having an upper target for calcium is a valuable addition to the ESRD QIP.

Response: We thank the commenters for the support. While we acknowledge that calcium levels in dialysis patients might be impacted by conditions unrelated to ESRD, we also believe it is appropriate to monitor and minimize the prevalence of hypercalcemia in all patients with ESRD, since mineral and bone disorder are highly prevalent in this population, and because some dialysis-related treatments impact serum calcium levels.

We further note that patients are included in the denominator only if they are on dialysis for at least 90 days as of the first day of the most recent month of the ''measurement period'' (that is, the 3-month period used to calculate the rolling average for the measure) and are in the facility for at least 30 days as of the last day of the most recent month of the measurement period. These NQF-endorsed exclusion criteria will exclude the vast majority of in-center patients who are treated fewer than seven times by a facility. However, the NQF-endorsed exclusion criteria are broad enough to include home dialysis patients. We believe that the NQF-endorsed exclusion criteria are more appropriate because they will not exclude home dialysis patients, who are rarely treated at a facility seven or more times in a month.

Finally, the 10.2 threshold is consistent with KDIGO guideline 4.1.2 [2009] ''In patients with CKD stages 3–5D, we suggest maintaining serum calcium in the normal range,'' since 10.2 mg/dL is considered the upper limit of the normal range in the majority of clinical laboratories. This threshold is also consistent with the value discussed and supported by the 2006 TEP. The hypercalcemia measure using the 10.2 threshold was developed by the 2010 TEP as summarized in the final TEP report posted by CMS at *http://www.cms.gov/Medicare/End-Stage-Renal-Disease/CPMProject/index.html*.

Comment: Several commenters did not support the proposal to adopt the hypercalcemia measure. These commenters stated that this metric is not the best measure in the mineral metabolism domain to impact patient outcomes, in the absence of clinical metrics for other related mineral disturbances, such as phosphorus and PTH. Some of these commenters recommended adopting the hypercalcemia measure as a reporting measure.

Response: We believe that the hypercalcemia measure is the best measure supported by current evidence available for implementation in the ESRD QIP at this time. CMS has convened three discrete TEPs since 2006 charged with developing quality measures related to management of bone and mineral disorders in chronic dialysis patients. The 3-month rolling average hypercalcemia measure is the first outcome measure developed in this topic area that has received NQF endorsement. The measure is important because it addresses a potential healthcare-associated condition, hypercalcemia, that may result from treatments chosen by dialysis providers to treat CKD-related bone disease. However, we are currently exploring the feasibility of adopting in the future additional measures to address PTH monitoring to ensure that dialysis patients' bone and mineral disease laboratory outcomes are monitored at a frequency consistent with clinical consensus guidelines.

Comment: Some commenters did not support the proposal to adopt the hypercalcemia measure because there is no consensus that the measure is appropriate. These commenters also stated that the measure should only apply to Medicare patients because CMS should not collect data on patients who are not enrolled in Medicare. Commenters recommended that calcium and phosphorus data continue to be collected via the mineral metabolism reporting measure.

Response: The Hypercalcemia measure (NQF# 1454) has been endorsed by the NQF, and we believe that this endorsement reflects broad consensus that the measure is appropriate for assessing hypercalcemia within the ESRD population. In addition, the collection of all-patient data on this measure allows us to assess the quality of care provided to Medicare patients with ESRD, in part, by analyzing how that care compares to the quality of care provided to the ESRD population overall. Because we are finalizing the adoption of the Hypercalcemia measure for the ESRD QIP, facilities will not be required to submit calcium data for the Mineral Metabolism reporting measure.

Comment: One commenter did not support the proposal to adopt the hypercalcemia measure because there is

no evidence that facilities are not adequately managing hypercalcemia, and because there is no agreement on how calcium should be adjusted (if at all) for albumin levels.

Response: The published literature indicates that large numbers of patients with ESRD are affected by hypercalcemia.[9] [10] [11] [12] [13] In addition, patient-level analysis of CROWNWeb data collected for July 2012 shows that of 441,681 patients, 81.9 percent had uncorrected serum calcium reported during the month, 59.8 percent met the denominator for this proposed measure, and 3.0 percent had hypercalcemia based on a rolling-average from May 2012 through July 2012. We agree that there is lack of agreement on the need to correct serum calcium for serum albumin concentration. Furthermore, there is lack of agreement on the accuracy of different available methods for correction of serum calcium for albumin concentration. We are therefore using uncorrected calcium to score the Hypercalcemia clinical measure, instead of scoring the measure on the basis of corrected calcium.

Comment: Several commenters did not support the proposal to adopt the hypercalcemia measure because it may lead to unintended consequences (for example, sudden cardiac death) and because it will incentivize facilities to decrease calcium levels in patients with serum calcium levels near 10.2 mg/dL.

Response: Although patients with serum calcium concentrations below the lower limit of normal may be at increased risk for cardiac arrhythmias, the available literature reviewed by KDIGO suggests that the risk of hypocalcemia occurs below 8.4 mg/dl calcium concentration, if at all. While facilities are incentivized to prevent patients from developing extremely high levels of calcium, we believe the threshold is sufficiently high that it is unlikely to incentivize facilities to cause hypocalcemia in patients. Therefore we do not anticipate an increased risk for sudden death, provided that clinicians properly monitor calcium levels.

Comment: One commenter did not support the proposal to adopt the Hypercalcemia measure for a number of reasons: (1) The measure should exclude patients not on dialysis for at least 90 days to ensure that the 3-month rolling average is calculated using a consistent methodology; (2) the measure should provide a method for calculating a 3-month rolling average when data is only reported for months 1 and 3; and (3) the measure should specify that values were obtained during the current dialysis facility admission, and that samples must be obtained before hemodialysis treatment. The commenter recommends retaining the Mineral Metabolism reporting measure (to include reporting of serum calcium) until these issues are addressed.

Response: We will respond to each issue in turn.

First, the measure excludes patients not on dialysis for less than 90 days, as described in the proposed measure specifications. Patients are included in the denominator if they are 18 years or older as of the first day of the most recent month of the measurement period, are on dialysis for at least 90 days as of the first day of the most recent month of the measurement period, are in the facility for at least 30 days as of the last day of the most recent month of the measurement period, and have at least one serum calcium measurement within the measurement period.

Second, the patient must have at least one serum calcium measurement in the three month period. If the patient only had one serum calcium measurement in the three month period, then the average serum calcium would be that value. If the patient only had serum calcium measurement for months 1 and 3 within the three month period, then the average would only use these two values.

Third, the measure specifies that only patients who have been at the facility for at least 30 days should be included. In addition, this measure uses serum calcium concentrations reported in CROWNWeb. CROWNWeb data dictionary directions specify reporting of pre-dialysis serum calcium only. While not stated in the measure specifications, it is well understood that the vast majority of blood samples for serum calcium testing are drawn before the patient receives hemodialysis treatment on a particular treatment day.

Comment: Several commenters did not support the proposal to adopt the Hypercalcemia measure. Commenters stated that CMS has not collected a full year of data that would support the performance standards, achievement thresholds, and benchmarks for the measure. These commenters stated that having at least one year of reporting data is a core criterion for moving structural reporting measures to clinical measures. Some of the commenters recommended adopting the Hypercalcemia measure as a reporting measure.

Response: As stated in the CY 2013 ESRD PPS final rule (77 FR 67488), we believe that achievement thresholds, benchmarks, and performance standards should be based on a full year of data whenever possible. However, we also believe that in certain circumstances it is not practical or necessary to use a full year of baseline data. In this case, we only have data for the Hypercalcemia measure starting in May 2012 because that was when CROWNWeb was rolled out nationally. In this case, we believe that it is appropriate to use 7 months of baseline data because serum calcium levels are not subject to seasonal variations, and because the 7-month time window offers a consistent representation of national facility performance. Based on CROWNWeb data, monthly patient-level uncorrected serum calcium averages were stable during May 2012 through March 2013, with averages ranging from 8.99 mg/dL to 9.06 mg/dL.

Comment: One commenter did not support the proposal to adopt the Hypercalcemia measure because manually reporting calcium values is overly burdensome.

Response: We do not agree that entering patients' calcium phosphorus levels into CROWNWeb on a monthly basis is overly burdensome. The Mineral Metabolism measure finalized in the CY 2012 ESRD PPS final rule (76 FR 70271) required facilities to enter this information, so the Hypercalcemia measure does not impose any additional burden for facilities.

Comment: One commenter expressed concerns that CROWNWeb will not be able to accurately capture data needed to calculate the Hypercalcemia measure because it cannot handle situations when a patient switches modalities in the middle of a month, and because CROWNWeb is lacking data for roughly 10 percent of patients.

Response: We recognize that CROWNWeb is currently experiencing issues if a patient switches modalities during a clinical month and the facility attempts to indicate this through the submission of batch data. This is a

[9] National Kidney Foundation: K/DOQI Clinical Practice Guidelines for Bone Metabolism and Disease in Chronic Kidney Disease. American Journal of Kidney Disease 2003 42:S1–S202 (suppl 3).

[10] Kidney Disease: Improving Global Outcomes (KDIGO) CKD–MBD Work Group: KDIGO Clinical Practice Guideline for the Diagnosis, Evaluation, Prevention, and Treatment of Chronic Kidney Disease-Mineral and Bone Disorder (CKD–MBD). Kidney International 2009 76 (Suppl 113): S1–S130.

[11] Block GA, Klassen PS, Lazarus JM, et al. Mineral metabolism, mortality, and morbidity in maintenance hemodialysis. Journal of the American Society of Nephrology: JASN 2004 15:2208–18.

[12] Young EW, Albert JM, Satayathum S, et al. Predictors and consequences of altered mineral metabolism: the Dialysis Outcomes and Practice Patterns Study. Kidney international 2005 67:1179–87.

[13] Kalantar-Zadeh K, Kuwae N, Regidor DL, et al. Survival predictability of time-varying indicators of bone disease in maintenance hemodialysis patients. Kidney international 2006 70:771–80.

serious concern, and we are working to address it. However, this issue does not affect patient data when facilities manually enter the data. We therefore recommend that facilities manually enter patient data when patients switch modalities during a clinical month. Furthermore, we are currently conducting an analysis to determine what percentage of patient data are missing data in CROWNWeb. We recognize that CROWNWeb should not lack data for a high percentage of patients. Nevertheless, we continue to believe that CROWNWeb possesses valid data for the vast majority of patients, and we continue to affirm that facilities are responsible for ensuring that patient data are accurately reflected in CROWNWeb. For these reasons, we believe it is appropriate to use CROWNWeb as the primary data source for the Hypercalcemia clinical measure.

For these reasons, we are finalizing the Hypercalcemia clinical measure (NQF #1454) as proposed for the PY 2016 ESRD QIP and for future payment years. Technical specifications for this measure can be found at *http://www.dialysisreports.org/pdf/esrd/public-measures/MineralMetabolism-Hypercalcemia-2016FR.pdf*

c. Use of Iron Therapy for Pediatric Patients Reporting Measure

Section 1881(h)(2)(A)(i) states that the ESRD QIP must include measures on ''anemia management that reflect the labeling approved by the Food and Drug Administration for such management.'' Appropriate anemia management requires the presence of sufficient stores of iron.[14] Iron deficiency is a leading cause of non-response to ESA therapy, and several studies suggest that providing oral or IV iron is effective in correcting iron deficiency in the pediatric population.[15] [16] Pediatric patients have previously been excluded from all anemia management measures, limiting the participation of dialysis facilities with substantial numbers of pediatric patients in the ESRD QIP. In an effort to address this issue, and account for the quality of care dialysis facilities provide to pediatric patients, we proposed to adopt a pediatric iron therapy measure for the ESRD QIP in PY 2016 and future payment years of the program.

We considered proposing an NQF-endorsed clinical measure on the use of iron therapy for pediatric patients as part of the proposed Anemia Management clinical measure topic (NQF #1433: Use of Iron Therapy for Pediatric Patients). This measure is an assessment of the percentage of all pediatric hemodialysis and peritoneal dialysis patients who received IV iron or were prescribed oral iron within three months of attaining the following conditions: (i) Patient had hemoglobin less than 11.0 g/dL; (ii) patient had simultaneous values of serum ferritin concentration less than 11.0; and (iii) patient's transferrin saturation (TSAT) was less than 20 percent. Upon investigation, we discovered that there were not enough patients who would qualify for this measure to establish reliable baseline data that would allow us to propose to adopt this measure as a clinical measure for PY 2016. We also note that the clinical measure currently presents other issues related to the minimum number of cases that would need to be reported for scoring, and we are considering the use of an adjuster that could be applied where the sample size is small. While we continue to consider these and other issues related to the adoption of a pediatric iron therapy clinical measure, we proposed a related reporting measure for PY 2016 and future payment years in order to acquire a sufficient amount of baseline data for the development of a clinical measure in the future.

For PY 2016 and future payment years, we proposed that facilities must enter in CROWNWeb on a quarterly basis, for each qualifying case (defined in the next sentence): (i) Patient admit/discharge date; (ii) hemoglobin levels; (iii) serum ferritin levels; (iv) TSAT percentages; (v) the dates that the lab measurements were taken for items (ii)–(iv); (vi) intravenous IV iron received or oral iron prescribed (if applicable); and (vii) the date that the IV iron was received or oral iron was prescribed (if applicable). We proposed that qualifying cases for this measure would be defined as in-center and home dialysis patients under the age of eighteen.

We proposed that each facility must report data on the Use of Iron Therapy for Pediatric Patients measure if it treats one or more qualifying cases during the performance period. Because this reporting measure requires that a facility enter data in CROWNWeb only once per quarter for each patient, we believe that the burden is appropriate and will not unduly impact small facilities, since it is proportionate to the number of patients that facilities treat. However, for the same reasons stated in the final description of the PY 2014 ESRD QIP Mineral Metabolism measure (which had a one patient minimum) (77 FR 67472 through 67474), we proposed that, in order to receive full points on this measure, facilities that treat 11 or more qualifying cases over the performance period will have to report at the lesser of the 50th percentile of facilities in CY 2013 or 97 percent per quarter, for each quarter of the performance period. We proposed that facilities that treat fewer than 11 qualifying cases during the performance period will have to report on a quarterly basis the specified data elements for all but one qualifying case. If a facility only has one qualifying case during the entire performance period, a facility will have to attest to that fact in CROWNWeb by January 31 of the year following the performance period in order to avoid being scored on the measure.

We requested comments on these proposals. The comments we received on these proposals and our responses are set forth below.

Comment: Several commenters expressed concerns about the proposal to adopt the pediatric iron therapy reporting measure. Some commenters recommended that facilities should only be required to report that they prescribed oral iron therapy or administered IV iron, since patients typically take over-the-counter iron supplements and the facility would not be able to verify that patients obtained non-prescription medications. Other commenters stated that the measure would unduly burden pediatric facilities, which are typically small and do not use batch data submissions.

Response: We thank commenters for raising these concerns. We will consider alternate implementation of quality reporting for pediatric patients and facilities relating to iron therapy through future rulemaking. Independent of these concerns, we conducted an analysis of the scope and impact of the proposed pediatric iron therapy measure. Over the course of the analysis, we determined that fewer than 100 patients would be eligible for this measure if it was adopted as a clinical measure. We also determined that facilities would not be required to report data for many of these patients because the proposed measure specifications for the reporting measure excluded facilities with one or fewer eligible patients. The purpose of adopting the reporting measure would have been to collect the baseline data needed to adopt a clinical measure in future

[14] Seeherunvong W, Rubio L, Abitbol CL, et al. Identification of poor responders to erythropoietin among children undergoing hemodialysis. J Pediatr 2001 (138/5):710–714.

[15] Warady BA, Zobrist RH, Wu J, Finan E. Sodium ferric gluconate complex therapy in anemic children on hemodialysis. Pediatr Nephrol 20: 1320–7, 2005.

[16] Frankenfield DL, Neu AM, Warady BA, et al. Anemia in pediatric hemodialysis patients: results from the 2001 Clinical Performance Measures Project. Kidney International 64:1120–4, 2003.

payment years, but our analysis suggests that this would not be feasible. These data were not available through CROWNWeb at the time the measure was proposed. Accordingly, we are not finalizing this measure for the ESRD QIP.

Comment: Several commenters supported the proposal to adopt the Pediatric Iron Therapy reporting measure because it is important for measures in the ESRD QIP to cover pediatric patients.

Response: We appreciate the commenters' support. However, we have concluded that it is not feasible to adopt the measure because very few patients would be eligible for the measure.

For the reasons noted above, we are not finalizing the Pediatric Iron Therapy reporting measure at this time. However, we will continue to investigate measures on anemia management for pediatric patients, and we intend to adopt a measure on this topic in future payment years.

d. NHSN Bloodstream Infection in Hemodialysis Outpatients Clinical Measure

Healthcare-acquired infections (HAI) are a leading cause of preventable mortality and morbidity across different settings in the healthcare sector, including dialysis facilities. Bloodstream infections are a pressing concern in a population where individuals are frequently immunocompromised and depend on regular vascular access to facilitate dialysis therapy. In a national effort to reduce infection rates, CMS has partnered with the CDC to encourage facilities to report to the NHSN as a way to track and facilitate action intended to reduce HAIs. The NHSN is a secure, internet-based surveillance system that is managed by the Division of Healthcare Quality Promotion at the CDC. NHSN has been operational since 2006, and tracks data from acute care hospitals, long-term care hospitals, psychiatric hospitals, rehabilitation hospitals, outpatient dialysis centers, ambulatory surgery centers, and long-term care facilities. We continue to believe that accurately reporting dialysis events to the NHSN by these facilities supports national goals for patient safety, particularly goals for the reduction of HAIs. In addition, we believe that undertaking other activities designed to reduce the number of HAIs supports national goals for patient safety. For further information regarding the NHSN's dialysis event reporting protocols, please see *http://www.cdc.gov/nhsn/dialysis/index.html.*

We have worked during the past 2 years to help dialysis facilities become familiar with the NHSN system through the adoption of an NHSN Dialysis Event reporting measure. We now believe that facilities are sufficiently versed in reporting this measure to the NHSN. In light of the importance of monitoring and preventing infections in the ESRD population, and because a clinical measure would have a greater impact on clinical practice by holding facilities accountable for their actual performance, we proposed to replace the NHSN Dialysis Event reporting measure that we adopted in the CY 2013 ESRD PPS final rule (77 FR 67481 through 67484) with a new clinical measure for PY 2016 and future payment years. This proposed measure, NHSN Bloodstream Infection in Hemodialysis Outpatients, is based closely on NQF #1460 in that it evaluates the number of hemodialysis outpatients with positive blood cultures per 100 hemodialysis patient-months.

We proposed that facilities must submit 12 months of accurately reported dialysis event data (defined in the next sentence) to NHSN on a quarterly basis. In order to ensure that a facility submits data that can be used to identify the source of bloodstream infections, to preserve the internal validity of bloodstream infection data, and to help prevent future bloodstream infections, we proposed to define ''accurately reported dialysis event data'' as data reported by facilities that follow the NHSN enrollment and training guidelines specified by the CDC (available at *http://www.cdc.gov/nhsn/dialysis/enroll.html* and *http://www.cdc.gov/nhsn/Training/dialysis/index.html*), according to the reporting requirements specified within the NHSN Dialysis Event Protocol. (This protocol, which facilities are already using to meet the requirements of the NHSN Dialysis Event reporting measure, includes information about IV antimicrobial starts and evidence of vascular access site infection, as well as information about the presence of a bloodstream infection.)

Additionally, we proposed that each quarter's data would be due 3 months after the end of that quarter. For example, data from January 1 through March 31, 2014 would need to be entered by June 30, 2014; data from April 1 through June 30, 2014 would need to be submitted by September 30, 2014; data from July 1 through September 30, 2014 would need to be submitted by December 31, 2014; and data from October 1 through December 31, 2014, would need to be submitted by March 31, 2015. If facilities do not report 12 months of these data according to the requirements and the deadlines specified above, we proposed that they would receive a score of zero on the measure. We also proposed that facilities with a CCN open date after January 1, 2014 will be excluded from the measure. We note that in previous payment years we have awarded partial credit to facilities that submitted less than 12 months of data to encourage them to enroll in and report data in the NHSN system. However, we proposed to require 12 months of data on this clinical measure because infection rates vary through different seasons of the year.

We note that this proposed measure only applies to facilities treating in-center hemodialysis patients (both adult and pediatric). We will determine whether a facility treats in-center patients by referencing the facility's information in the Standard Information Management System and CROWNWeb.

We recognize that the CDC has published Core Interventions for BSI Prevention in Dialysis, which are listed at *http://www.cdc.gov/dialysis/prevention-tools/core-interventions.html.* We encourage facilities to adopt the nine listed interventions in order to help prevent infections, but did not propose to require facilities to adopt any of these interventions at this time.

We requested comments on this proposal, and in particular on the issue of whether it is appropriate at this time to convert the current NHSN Dialysis Event Reporting measure into a clinical measure. The comments we received on these proposals and our responses are set forth below.

Comment: Several commenters supported the proposal to adopt the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure. These commenters stated that the monitoring of bloodstream infections and the adoption of CDC's core prevention interventions will reduce healthcare acquired infections in the ESRD patient population.

Response: We thank the commenters for their support.

Comment: Several commenters did not support the proposal to adopt the NHSN clinical measure because they believe that the measure does not reflect actual patient-exposure time each month. Specifically, these commenters stated that using a monthly census on the first two working days of the month ignores patient hospitalization during the month, and can be adversely impacted by an influx of new patients after the first two working days of the month.

Response: CDC has conducted pilot validation work with a group of dialysis facilities and found that the census on the first two working days of the month was an accurate predictor of the entire month's census. The alternative of counting denominator data on a daily basis has been required in inpatient settings, but was determined by CDC to be unacceptably burdensome for the dialysis facility setting because this setting has a relatively stable patient population. Although patients with ESRD may be hospitalized at various times during a month, we have no reason to believe this would systematically be more likely to occur at a certain time relative to the first two working days of the month. Similarly, we are unaware of admission or transfer patterns whereby there is an increased likelihood of patient influx after the first two working days of the month.

Comment: Many commenters expressed concerns that the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure will misattribute infections to a dialysis facility. Some of these commenters stated that the measurement of positive blood cultures is not specific enough to detect HAIs contracted at another facility, and may include blood cultures associated with another site or contaminated samples. Commenters also raised concerns that these types of issues will result in an overestimate of the number of dialysis-related bloodstream infections, limit the capacity to develop reliable benchmark data, and may increase the possibility that facilities will be improperly penalized.

Other commenters stated that elderly, newly diagnosed dialysis patients with other chronic conditions and wounds are particularly likely to have infections that are unrelated to vascular access. Some commenters worried that infections in these patients will be inappropriately attributed to dialysis facilities because the NHSN measure does not focus on access-related bloodstream infections. Commenters also expressed concerns that the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure does not risk adjust for common comorbidities in the ESRD patient population.

Another commenter stated that the rate of positive blood cultures should be interpreted in the context of the facility's rate of empiric antibiotic treatment, also recorded by NHSN, since some physicians and facilities may treat empirically rather than on the basis of culture results.

Several commenters stated that culture results needed to designate the event as a bloodstream infection for NHSN reporting purposes are frequently not available to facilities. Therefore, between-facility differences in NHSN-reported BSI rates currently reflect differences not in infection rates, but rather in the availability and capture of blood culture results. Given this, the commenters believe that the measure will incentivize under-reporting of blood culture results, thereby undoing the great benefit that the current NHSN reporting metric has afforded dialysis facilities.

One commenter stated that sufficient knowledge and infrastructure does not exist to determine the type of vascular access to which the infection was related. This commenter further stated that the TEP that reviewed the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure concluded that the ''vascular access infection CPMs should not be used for reimbursement purposes.''

Commenters provided several recommendations in light of these perceived issues. Some commenters recommended retaining the NHSN reporting measure until these technical issues are resolved. Other commenters stated that it would be inappropriate to adopt the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure under any circumstances. Another commenter recommended adopting, in a staggered manner, three alternative HAI measures: Local access site infection, access-related bloodstream infection, and vascular access infection.

Response: We do not believe that misattribution is a significant enough issue to warrant a delay in the adoption of the NHSN clinical measure. The NHSH Bloodstream Infection in Hemodialysis Outpatients clinical measure tracks infection events that present real dangers to patients. We believe that tracking these infection events and rewarding facilities for minimizing these events is of critical importance to protecting patient safety and improving the quality of care provided to patients with ESRD.

First, NQF endorsed a bloodstream infection measure (NQF #1460, the measure upon which the proposed NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure is based) because bloodstream infections can be objectively identified. By contrast, NQF raised concerns about an access-related bloodstream infection measure because determining the source of infections (for example, determining whether an infection was related to vascular access) requires subjective assessments. The NHSH Bloodstream Infection in Hemodialysis Outpatients clinical measure avoids this subjectivity by including all positive blood cultures. This makes it simpler and more reliable than an access-related bloodstream infection measure. While we recognize that the NHSH Bloodstream Infection in Hemodialysis Outpatients clinical measure may occasionally misattribute bloodstream infections to dialysis facilities, we believe that the measure's objectivity, simplicity, and reliability make it the most appropriate measure for assessing facility performance. NHSN relies upon use of standard definitions to ensure that infection events are reported in the same manner across facilities. The vast majority of reported bloodstream infection events represent true, HAIs that are not the result of misclassification or misattribution. Therefore, considering the benefits to patients associated with strong incentives to reduce bloodstream infections, we believe that these technical issues are not significant enough to warrant a delay in adopting the NHSH Bloodstream Infection in Hemodialysis Outpatients clinical measure. CDC will continue to assess the possibility that certain facility-related factors could systematically overestimate infection rates, and it will consider risk-adjusting the measure to take these factors into account.

Second, our goal is to eliminate all preventable HAIs, including those in elderly patients and patients with certain comorbidities. Therefore, we do not believe it is appropriate to risk-adjust the measure to account for those patient characteristics.

Third, regardless of whether antibiotics are started before culture results become available, facilities are required to report positive blood culture results to NHSN. We recognize that additional information reported to NHSN, including antibiotic starts, provide useful contextual information to help interpret rates and facilitate prevention efforts. We believe that this information is important for identifying strategies to reduce bloodstream infections.

Fourth, with respect to concerns about between-facility differences in NHSN-reported BSI rates, we are legitimately concerned about this issue of differential capture rate and the potential impact it could have on valid inter-facility comparisons. Facilities are expected to follow the NHSN reporting protocol, which includes reporting all positive blood cultures drawn from their patients in the outpatient setting or within one calendar day after a hospital admission. In both of these scenarios, facilities should have access to blood

culture results to properly diagnose and treat patients under their care, and to include in the patient's medical record. Although results of blood cultures that were drawn outside of the dialysis center can sometimes be challenging to retrieve, facilities should be working to develop systems to enable complete capture of all positive blood cultures that meet reporting criteria.

Fifth, we agree with the commenters' concerns about determining the type of vascular access to which the infection was related, and we reiterate that NQF endorsed a bloodstream infection measure and not an access-related bloodstream infection measure. The NQF endorsement process includes an expert review assessing the feasibility of implementing of the measure. The NQF determined that the infrastructure and clinical expertise needed to determine the source of bloodstream infections do exist in the dialysis-facility setting. Therefore, the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure only requires facilities to report positive blood culture results. It does not involve a clinical diagnosis of infection, nor does it rely upon a determination of vascular access-relatedness or identification of the access to which the infection is related. When an event is reported to NHSN, all vascular accesses the patient has in place at the time of the event are reported. The user is not asked to attribute the event to a particular access. This is consistent with the recommendations of the TEP that the commenter cited.

Finally, we appreciate the commenters' recommendations. In light of the responses detailed above, and the urgent need to provide facilities with strong incentives to improve patient safety, we believe that the technical issues raised by commenters are not significant enough to warrant a delay in the adoption of the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure.

Comment: Many commenters expressed concerns about the methodology used to score the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure. Some commenters did not support the proposal to use CY 2014 as the performance period for the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure. These commenters stated that under the proposed timeline, a facility will not be able to determine whether it is meeting the goals of the measures or still need to improve. Other commenters urged CMS to wait to penalize facilities until there are established performance standards, until facilities have a chance to adopt practices that demonstrably reduce infection rates, and until CMS has collected the data needed to calculate improvement scores. Other commenters did not support the proposal to use CY 2014 as the performance period and the baseline period for the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure, and to define the performance standard as the 50th percentile of facility performance in CY 2014. These commenters stated that this methodology guarantees a 50-percent ''failure rate,'' which is inconsistent with quality improvement approaches to medicine. In light of these concerns, some commenters recommended postponing the adoption of the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure until CMS has collected one year of baseline data.

Response: We appreciate the commenters' concerns about penalizing facilities for their performance on the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure before we have collected the data needed to establish both the achievement and improvement performance standards. We also recognize that, in so doing, we are deviating somewhat from the scoring methodology used in the PY 2014 and PY 2015 programs. However, as stated in the PY 2016 proposed rule (78 FR 40863), we believe it is important to begin assessing facilities on the number of these events as soon as possible, rather than on merely whether they report these events, because of the abnormally large impact HAIs have upon patients and the healthcare industry.

Furthermore, when calculating the minimum TPS facilities need to achieve in order to avoid a payment reduction, we set the number low enough that a facility can meet the minimum TPS even if it receives zero achievement points on the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure, as long as it meets or exceeds the performance standard for each of the other finalized clinical measures and scores 5 points on each of the finalized reporting measures. We did this to balance our policy goal to provide facilities with strong incentives to improve patient safety as soon as possible against our recognition that we will not initially have enough data to award improvement points to facilities. In some circumstances, a facility may score zero points on the NHSN Bloodstream Infection in Hemodialysis Outpatients and receive a payment reduction. Nevertheless, the payment reduction a facility would receive in these circumstances (using the scoring methodology we are finalizing for the measure) would necessarily be no more than the payment reduction it would have received if the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure was not included in the minimum TPS calculations. Therefore, we strongly believe that these considerations should alleviate concerns associated with the atypical scoring methodology.

Comment: One commenter approved of CMS's support of CDC's core prevention interventions, but stated that CMS should require facilities to follow core interventions 7 and 8 (that is (i) the use of alcohol-based chlorhexidine >0.5 percent, the first line skin antiseptic for central line insertions and dressing changes, and (ii) reducing risk of intraluminal biofilm by ''scrubbing hubs'' prior to accession or disconnection).

Response: We thank the commenter for the support. We continue to encourage facilities to adopt all of CDC's core prevention interventions. However, they are not required under the ESRD QIP because we do not believe it is feasible at this time to design a performance measure that would accurately evaluate facility compliance.

Comment: One commenter raised concerns that the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure, as proposed, will unduly penalize small facilities because these facilities will be disproportionately impacted by a small number of infections. Instead, the commenter recommends using the Standardized Infection Rate risk-adjustment method, along with the development of a publicized data validation process for NHSN data.

Response: As stated in the proposed measure specifications, the measure will be calculated using a Standardized Infection Ratio with adjustment for volume of exposure to address this issue. We also agree with the need for a publicized data validation process for the NHSN data. As stated in the PY 2016 ESRD QIP proposed rule (78 FR 40872), we are considering a feasibility study for validating NHSN data, and we will publicize the data validation process after the conclusion of the feasibility study.

Comment: Several commenters did not support the proposal that facilities must submit 12 months of data or receive a score of 0 on the NHSN measure. These commenters stated that facilities cannot improve in such an all-or-nothing environment.

Response: We disagree that the requirement to report 12 months of NHSN data is an unreasonable expectation. Facilities began reporting NHSN data for the PY 2014 program during CY 2012, so they will have had two years of experience at the beginning of the performance period for the PY 2016 program. We strongly believe that two years is a sufficient amount of time for facilities to become acclimated to the NHSN system. We also note that it would be inappropriate to score facilities on less than 12 months of data because HAIs are subject to seasonal variability. Furthermore, given the critical importance of reducing HAIs and the NHSN system's capacity to address this pressing issue, we believe that it is appropriate to provide facilities with the strongest possible incentives to report NHSN data.

Comment: One commenter did not support the proposal to adopt the NHSN clinical measure because NHSN was intended to be a surveillance system, not for scoring facilities on the ESRD QIP.

Response: We believe that the NHSN system can be used for the purposes of incentivizing quality improvement. HAIs are implicated in significant clinical problems for patients, and they are an important source of increased medical costs. Given the importance of HAIs for patients and providers, we strongly believe that reducing HAIs is a central pillar in efforts to improve the quality of healthcare offered in the dialysis setting, and we continue to believe that facilities have the strongest incentive to improve when their performance is linked to payment. Furthermore, we note that facilities are scored based on their performance on NHSN infection measures in the Hospital Value Based Purchasing Program.

Comment: One commenter recommends aligning the Vascular Access Type measure topic and census requirement for the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure to reduce administrative burden. Commenter notes that the Vascular Access Type measure topic is based on the last treatment of the month, while the NHSN census is based on the ESRD facility's first two working days of the month.

Response: We appreciate the comment, and will further investigate whether the divergent dates for the two measures increases the reporting burden for facilities.

Comment: One commenter did not agree with CMS's position that the urgency of reducing bloodstream infections warrants the adoption of the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure before two years of baseline data are available to calculate achievement and improvement scores. The commenter stated that central venous catheters present the greatest risk for bloodstream infections in the ESRD patient population, and that the ESRD QIP already has a measure that addresses this issue (Vascular Access Type—Catheter greater than 90 Days).

Response: According to the 2012 Annual Data Report of the United States Renal Data System, hemodialysis patients experienced an adjusted hospitalization rate of 103 per 1,000 due to vascular access infection in 2010. We recognize that these rates have declined since 2005, but we believe they are still unacceptably high. Additionally, rates of adjusted hospitalizations due to bacteremia/sepsis in hemodialysis patients have increased significantly since 2000, rising to 116 per 1,000 in 2010.[17] These and other indicators have led to the inclusion of ESRD facilities in the Assistant Secretary for Health's National Action Plan to Prevent Health Care-Associated Infections, and the inclusion of dialysis facilities in this report reflects the urgency of reducing HAIs in patients with ESRD. We agree with the commenter's observation that central venous catheters present the greatest risk for bloodstream infections in the ESRD patient population. However, considering that these rates increased at same time as the Fistula First Breakthrough Initiative sought to reduce the use of catheters, we do not believe that the Vascular Access Type measure topic is sufficient to reduce rates of HAIs. Additionally, for the reasons stated above, we believe the significance of HAIs warrants adopting a clinical measure before we have collected the baseline data needed to calculate achievement and improvement scores. Therefore, we strongly believe that Vascular Access Type measure topic and the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure are complimentary, not duplicative, because they address infections in different and equally valid ways.

Comment: Some commenters did not support the proposal to adopt the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure because the measure is dependent upon voluntary reporting of data that is often subjective. These commenters stated that the identification of positive bloodstream infections often relies upon subjective assessments of whether a bacteremia is access-related. The commenters believed that facilities will be less likely to identify and report positive bloodstream infections if they will be financially penalized for doing so.

Response: The NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure is an objective measure based solely on the presence of a positive blood culture. Although NHSN collects information on access-relatedness to provide additional information that is of use for prevention purposes, the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure does not rely upon assessments of whether the bloodstream infection was access-related. There may still be perceived disincentives to conduct thorough surveillance to identify all positive blood cultures that meet the bloodstream infection definitional criteria. For this reason, it is important that the data be validated in a rigorous manner, and we are in the process of evaluating the feasibility of launching a pilot program to validate NHSN data.

For these reasons, we are finalizing the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure for the PY 2016 ESRD QIP and for future payment years. The technical specifications for this measure are located at *http://www.dialysisreports.org/pdf/esrd/public-measures/NHSNBloodstreamInfection-2016FR.pdf*.

e. Comorbidity Reporting Measure

The NQF endorsed a clinical measure for Dialysis Facility Risk-Adjusted Standardized Mortality Ratio (#0369) in 2008, and a clinical measure for Standardized Hospitalization Ratio for Admissions (#1463) in 2011. We have long been interested in adding a Standardized Mortality Ratio (SMR) measure and a Standardized Hospitalization Ratio (SHR) measure to the ESRD QIP. As articulated in the CY 2013 ESRD PPS final rule, ''We believe that dialysis facilities own partial responsibility for the rate at which their patients are hospitalized, in particular when that rate is substantially higher than at other peer facilities and may not be explained by variation in the illness of patients'' (77 FR 67496). Similarly, we continue to believe that the ''SMR may help distinguish the quality of care offered by dialysis facilities as determined by mortality, a key health care outcome used to assess quality of

[17] United States Renal Data System, 2012 USRDS Annual Data Report, Volume 2: Atlas of End-Stage Renal Disease in the United States, pg. 240.

care in other settings, such as hospitals'' (77 FR 67497).

Although we believe that SHR and SMR capture important indicators of morbidity and mortality, we are considering whether and how we might be able to adopt them through future rulemaking in a way that properly takes into account the effect that comorbidities have on hospitalization and mortality rates for the ESRD population. We also acknowledge concerns raised by commenters in the past that the NQF-endorsed SMR and SHR measures are not adequately risk-adjusted (77 FR 67496). Currently, information about patient comorbidities is collected by CMS via the Medical Evidence Reporting Form 2728, which is typically only submitted by facilities to CMS when a new patient first begins to receive dialysis treatment. We also use Form 2728 to capture the date of first dialysis in order to help determine patient exclusions for all of the clinical measures finalized in the PY 2013 ESRD PPS final rule. However, facilities are not required to update this form, which makes it difficult to capture information about comorbidities that develop after the initiation of dialysis treatment. We acknowledge the concerns of commenters who stated that ''there is currently no mechanism either for correcting or updating patient comorbidity data on CMS' Medical Evidence Reporting Form 2728, and these comorbidities affect the calculation of the measure'' (76 FR 70267).

We proposed to adopt a Comorbidity reporting measure for the PY 2016 ESRD QIP and future payment years of the ESRD QIP. The purpose of this measure is two-fold. First, the proposed reporting measure offers a mechanism for collecting annual information about patient comorbidities, thereby providing a reliable source of data that we can use to develop a risk-adjustment methodology for the SHR and SMR clinical measures, should we propose to adopt such measures in the future. Second, the reporting measure will make it possible to improve our understanding of the risk factors that contribute to morbidity and mortality in the ESRD patient population. The data we gather will enable us to develop risk-adjustment methodologies for possible use in calculating the SHR and SMR measures, should we propose to adopt those measures in the future, and therefore more reliably calculate expected hospitalization and mortality rates in future payment years of the ESRD QIP. When we examine updated data on comorbidities, we will determine the appropriateness of including that data as additional risk-adjustment factors for the SMR and SHR measures by considering the extent to which each comorbidity may be influenced by the quality of dialysis facility care, as opposed to factors outside of a facility's control.

Section 1881(h)(2)(B)(i) of the Act requires that, unless the exception set forth in section 1881(h)(2)(B)(ii) of the Act applies, the measures specified for the ESRD QIP under section 1881(h)(2)(A)(iii) of the Act must have been endorsed by the entity with a contract under section 1890(a) of the Act (which is currently NQF). Under the exception set forth in section 1881(h)(2)(B)(ii) of the Act, in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed, so long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

NQF has not endorsed a measure for updating comorbidity information for patients with ESRD. We have given due consideration to endorsed measures, as well as those adopted by a consensus organization, and we are proposing this measure under the authority of 1881(h)(2)(B)(ii) of the Act. We believe that the proposed measure's potential to improve clinical understanding and practice outweighs the minimal burden it would impose upon facilities. Additionally, we believe that this measure will provide data that is currently unavailable through Form 2728 because the measure accounts for the most recent information about patient risk factors, which may change over time as a patient continues receiving dialysis.

For this proposed reporting measure, we proposed each facility will annually update in CROWNWeb up to 24 comorbidities, or indicate ''none of the above,'' for each qualifying case. For the purposes of this measure, we proposed to define a ''qualifying case'' as a hemodialysis or peritoneal dialysis patient being treated at the facility as of December 31 of the performance period, according to admit and discharge dates entered into CROWNWeb. In fulfilling this reporting requirement, facilities would select one or more of the following for each qualifying case.

• Congestive heart failure	• Diabetes, on oral medications	• Drug dependence
• Atherosclerotic heart disease (ASHD)	• Diabetes, without medications	• Inability to ambulate
• Other cardiac disease	• Diabetic retinopathy	• Inability to transfer
• Cerebrovascular disease (CVA, TIA)	• Chronic obstructive pulmonary disease	• Needs assistance with daily activities
• Peripheral vascular disease	• Tobacco use (current smoker)	• Institutionalization—Assisted Living
• History of hypertension	• Malignant neoplasm, Cancer	• Institutionalization—Nursing Home
• Amputation	• Toxic nephropathy	• Institutionalization—Other Institution
• Diabetes, currently on insulin	• Alcohol dependence	• Non-renal congenital abnormality
• None of the above		

Therefore, to receive full points on this measure, we proposed that facilities would be required to provide the updates in CROWNWeb by January 31, 2015, or, if that is not a regular business day, the first business day thereafter. While we proposed to require facilities to report a single annual update per patient, we encourage facilities to update this information more frequently in order to more closely monitor their patients' risk factors, and to improve the quality of the data.

We requested comments on these proposals. The comments we received on these proposals and our responses are set forth below.

Comment: While several commenters supported the proposal to adopt the Comorbidity reporting measure and the decision to collect more information before adopting the SMR and SHR measures, many commenters did not support the proposal. Several commenters stated that they did not think the Comorbidity reporting measure was a quality measure and expressed a concern that it had never been developed nor endorsed by a consensus-based organization or reviewed by the MAP. Commenters also stated that CMS should either use the ESRD CfCs or revise Form 2728 to accomplish this data collection, rather

than using the ESRD QIP for this purpose.

Response: We appreciate the many comments we received on the Comorbidity reporting measure. As a result of the significant concerns expressed about the measure, we have decided not to finalize the measure at this time. We will consider whether there is a better way to update this important comorbidity information, including the suggestion to collect comorbidity data under the CfCs, in the future.

For these reasons, we are not finalizing the Comorbidity reporting measure as proposed for the PY 2016 ESRD QIP and for future payment years.

4. Other Measures Under Development

As part of our effort to continuously improve the ESRD QIP, we continue to work on developing additional robust measures that provide valid assessments of the quality of care furnished by facilities to patients with ESRD. We are considering the feasibility of developing quality measures in other topic areas (for example, blood transfusions, kidney transplantation, quality of life, and health information technology) for quality improvement at the point of care as well as for the electronic exchange of information in support of care coordination across providers and settings. Additional areas of potential interest include residual renal function, complications associated with ESRD, and frequently comorbid conditions (for example, diabetes and heart disease).

We requested comments on these potential areas of future measurement, and welcomed suggestions on other topics for measure development. The comments we received on these proposals and our responses are set forth below.

Comment: Many commenters provided recommendations on potential areas of future measurement. Some commenters urged CMS to adopt measures on patient education (covering, for example, renal replacement therapies, diet, and access placements), health information technology, kidney transplants, fluid management, blood transfusions, quality of life, care coordination, symptom management, clinical depression, pain screening, dyspnea, advanced care planning, emergency department use, 30-day hospital readmissions, use of home dialysis, hospitalization rates, and mortality rates. Other commenters urged CMS to not adopt measures on blood transfusions, hospitalization rates, mortality rates, 30-day hospitalization readmissions, quality of life, kidney transplants, and care coordination.

Response: We thank the commenters for their recommendations and will consider them as we develop our policies for future years of the ESRD QIP.

Comment: Many commenters urged CMS to adopt a hemoglobin measure that establishes a minimum safe hemoglobin level for patients. These commenters stated that the use of the Hemoglobin Greater Than 12 g/dL measure has led to an increase in transfusions, which are not covered in the ESRD PPS bundled payment but remain an expense for Medicare. Some commenters believe that there is a consensus in the field that keeping hemoglobin levels above 10 g/dL yields optimal patient outcomes.

Response: Using a Hemoglobin Less Than 10 g/dL measure without a corresponding measure that targeted high hemoglobin levels might place patients at increased risk for complications of aggressive ESA therapy. Furthermore, we note that randomized, controlled trials targeting patients to higher, rather than lower hemoglobin levels, or comparing the effect of ESAs against a placebo have indicated an increased risk of myocardial infarction, stroke, venous thromboembolism, thrombosis of vascular access, and overall mortality, and in patients with a history of cancer, tumor progression or recurrence. Because we cannot yet identify which patients would be included in this subset (and accordingly exclude them from the specifications of a Hemoglobin Less Than 10g/dL measure) we have concluded that it is not appropriate at this time to include such a measure in the ESRD QIP. Finally, we note that our rationale for removing the Hemoglobin Less Than 10 g/dL was published in the PY 2013 ESRD QIP proposed rule (76 FR 40519), and we believe those concerns remain sufficiently valid to merit not reintroducing the measure to the ESRD QIP at this time.

5. Scoring for the PY 2016 ESRD QIP and Future Payment Years

Section 1881(h)(3)(A)(i) of the Act requires the Secretary to develop a methodology for assessing the total performance of each facility based on the performance standards established with respect to the measures selected for the performance period. We believe that the methodology set forth in the CY 2013 ESRD PPS final rule incentivizes facilities to meet the goals of the ESRD QIP; therefore, with the exception of the proposed changes further discussed in the applicable section below, we proposed to adopt a scoring methodology for the PY 2016 ESRD QIP and future payment years that is nearly identical to the one finalized in the CY 2013 ESRD PPS final rule. To the extent that the scoring methodology differs, those differences are discussed below.

Comment: Many commenters recommended adding a provision to the rule to exempt facilities forced to close temporarily due to natural disaster or other extenuating circumstances from the requirements of all of the clinical and reporting measures (and the NHSN measure in particular). These commenters stated that such a provision exists in the Hospital Inpatient Quality Reporting Program. The commenters stated that adopting a similar policy for the ESRD QIP would allow facilities to avoid payment reductions due to circumstances they cannot control.

Response: We agree that there are times when facilities are unable to submit required quality data due to extraordinary circumstances that are not within their control, and we do not wish to penalize facilities for such circumstances or unduly increase their burden during these times. We are developing a disaster/extraordinary circumstances exception process, and we intend to propose to adopt such a process in future rulemaking.

6. Performance Period for the PY 2016 ESRD QIP

Section 1881(h)(4)(D) of the Act requires the Secretary to establish the performance period with respect to a year, and that the performance period occur prior to the beginning of such year. In the CY 2013 ESRD PPS final rule, we finalized a performance period of CY 2013. We stated our belief that, for most measures, a 12-month performance period is the most appropriate for the program because this period accounts for any potential seasonal variations that might affect a facility's score on some of the measures, and also provides adequate incentive and feedback for facilities and Medicare beneficiaries. For the reasons outlined in the CY 2013 ESRD PPS final rule (77 FR 67500), we have determined for PY 2016 that CY 2014 is the latest period of time during which we can collect a full 12 months of data and still implement the payment reductions beginning with renal dialysis services furnished on January 1, 2016. Therefore, for the PY 2016 ESRD QIP, we proposed to establish CY 2014 as the performance period for all of the measures.

We requested comment on this proposal. We did not receive any comments on this proposal. We will, therefore, finalize that CY 2014 is the performance period for the PY 2016 ESRD QIP.

7. Performance Standards for the PY 2016 ESRD QIP and Future Payment Years

We proposed to adopt performance standards for the PY 2016 ESRD QIP measures that are similar to what we finalized in the CY 2013 ESRD PPS final rule. Section 1881(h)(4)(A) provides that ''the Secretary shall establish performance standards with respect to measures selected . . . for a performance period with respect to a year.'' Section 1881(h)(4)(B) of the Act further provides that the ''performance standards . . . shall include levels of achievement and improvement, as determined appropriate by the Secretary.'' We use the performance standards to establish the minimum score a facility must achieve to avoid a Medicare payment reduction.

We received several comments on performance standards for the PY 2016 ESRD QIP and future payment years. The comments and our responses are set forth below.

Comment: Many commenters registered their concern with CMS's reliance on CROWNWeb data to establish performance benchmarks for achievement and improvement, particularly for the Hypercalcemia measure. These commenters stated that CROWNWeb is unreliable because (1) frequent changes to the business requirements have resulted in an inconsistent set of rules under which data are collected, making the data collected unreliable for setting performance standards and benchmarks; (2) CROWNWeb collects less than 100% of facility data, and a facility could be found not to meet the ESRD QIP performance standard because the CROWNWeb system ''kicks out'' a particular patient and/or data for a particular patient; (3) CROWNWeb defects open the possibility of ''gaming the system'' by manually and preferentially excluding the data for patients who fail to meet a particular goal; and (4) there is still a problem with accurate reconciliation with dialysis census data and the patient counts in CROWNWeb, which could result in the misattribution of patients to facilities. The commenters recommended that CROWNWeb should not be relied upon for setting performance standards and benchmarks or to collect individual patient-level data until (1) facility and CROWNWeb patient attribution lists are identical; (2) only 1 percent of the data are ''kicked out'' by CROWNWeb; and (3) clear business rules remain in place for at least one year to allow for the consistent collection data before the data are used for the ESRD QIP. Commenters also recommended that (1) CMS establish a CROWNWeb Help Desk to assist them in real time to resolve roster data discrepancies; (2) new data definitions be shared with the provider community for comment well in advance of including them in CROWNWeb; (3) CMS initiate a formal quality assessment and process improvement program that would field-test each CROWNWeb update before it is scheduled for general release; and (4) current CROWNWeb data not be shared for the purpose of measure development with CMS TEPs until and unless the recorded data have been carefully evaluated for completeness, accuracy, and reliability.

Response: We appreciate commenters' concerns about CROWNWeb and we welcome the opportunity to respond. We will address each issue in turn.

First, CROWNWeb has been updated six times since the national rollout in June 2012. We recognize that facilities received revised information for entering data with every release of CROWNWeb. Nevertheless, we note that the clinical fields in the single user interface and batch submissions have stayed the same. We believe that this continuity in the clinical fields has minimized data inconsistencies resulting from changes to the business requirements, and we will continue to correct and standardize the business requirements for data submission, collection, and reporting.

Second, CROWNWeb does not ''kick out'' patients or data once the patients have been entered into the CROWNWeb. Rather, patient data (such as, demographic information, clinical values, and information about vascular access) may not be allowed into CROWNWeb via the batch submission process if CROWNWeb determines that the data are inconsistent or invalid. Facilities entering data manually do not experience such issues, and we note that electronic data interchange (EDI) users are able to view and correct data that do not pass validations testing. We have already implemented two successful patches to alleviate CROWNWeb systems barriers to EDI, and we will continue to release patches to address additional areas of concern. Nevertheless, we affirm that facilities are responsible for ensuring that their patient censuses and patient clinical data in CROWNWeb is complete and accurate.

Third, we understand there are concerns about ''gaming the system,'' possibly due to the fact that facilities are not required to enter clinical data elements in order to proceed in the CROWNWeb system. We do not believe this is a system defect; in certain instances, it might not be appropriate to enter such data, and the system is not designed to make these determinations. Additionally, we are not aware of any defects that allow facilities to preferentially exclude patients. If facilities and submission organizations are aware of other defects, we encourage them to report this to the QualityNet Helpdesk or on EDI Data Discrepancy Support calls. If we receive such reports, we will investigate them immediately and prioritize patches for the next available CROWNWeb patch release.

Fourth, we are aware that CROWNWeb is currently experiencing some issues related to the attribution of patients to facilities. We are in the process of implementing new business requirements that should address this known defect. We continue to encourage facilities to ensure that their patient censuses are accurately reflected in CROWNWeb.

With respect to commenters' recommendations for improving the accuracy of CROWNWeb data, we agree that facility attribution lists should match patient censuses in CROWNWeb. As stated above, we are actively working to resolve this issue, and we encourage facilities to review their patient censuses in CROWNWeb to ensure that they match their attribution lists. Additionally, we agree that CROWNWeb should minimize the amount of accurate data that does not pass validation testing while ensuring that inaccurate data is not used to calculate scores on ESRD QIP clinical performance measures. As stated above, we affirm that facilities are responsible for ensuring that patient data is accurately reflected in CROWNWeb while we continue to improve the EDI submission process. Furthermore, we do not agree that business rules need to remain in place for one year before the data can be used to calculate scores on ESRD QIP clinical performance measures, as long as changes to the business rules are not significant enough to render data from the baseline period incomparable with data from the performance period. Finally, we note that facilities are able to report concerns about roster-data discrepancies to the QualityNet helpdesk. We note that new data definitions are regularly provided to the ESRD community.

We appreciate the recommendation to not share CROWNWeb data with any CMS TEPs due to concerns about completeness, accuracy, and reliability. We will consider these concerns before sharing CROWNWeb data with CMS TEPs in the future. We also appreciate

the recommendation to field-test CROWNWeb updates before they are scheduled for general release, and we are working on a process that would allow users and ''beta testers'' to test system functionalities in real-world settings.

Comment: One commenter did not support the addition of other measures to the ESRD QIP until concerns about the program's complexity and the reliability of CROWNWeb are alleviated.

Response: We appreciate the commenter's concerns about the complexity of the ESRD QIP and the reliability of CROWNWeb. We make every effort (e.g., through National Provider Calls, CROWN Memos, and other educational programs) to ensure that facilities receive the information they need to understand the ESRD QIP. We also work diligently to make reporting requirements and measurement methodologies as simple as possible. Additionally, we appreciate the commenter's concerns about the reliability of CROWNWeb, and we are working to address related concerns that have been raised by the ESRD community. However, given the fact that facilities are able to ensure that their data is accurately represented in CROWNWeb at any time, as well as the fact that CMS and its contractors check the validity of CROWNWeb data when calculating measure scores, we believe that there are processes in place to ensure that technical issues with CROWNWeb do not impact the measure scores that facilities receive. We therefore do not believe it is appropriate or necessary to postpone programmatic developments until these technical issues are completely resolved.

Comment: Several commenters asked CMS to provide sufficient data and explanation to allow the kidney care community to understand the methodology underlying the models used to estimate ESRD QIP payment adjustments and the minimum TPS. These commenters stated that without this data, it is difficult to know the assumptions CMS uses in its modeling and to offer meaningful comments on the proposed rule.

Response: We appreciate commenters' request. We will make publicly available facility-level data that is used to estimate ESRD QIP payment adjustments and the minimum TPS. Information used to estimate these values in the CY 2014 ESRD PPS proposed rule will be released by December 31, 2013. Information used to estimate these values in proposed rules for future payment years will be released within two weeks of the publication of the applicable proposed rule. However, since this data is preliminary, individual facility identifiers will be removed before the data is released so that it will not be possible to connect estimated measure scores to individual facilities. Additionally, final data used to determine finalized ESRD QIP payment adjustments and the finalized minimum TPS will continue to be posted on a CMS Web site every year in December.

Comment: Some commenters noted that many of the measure specifications list SIMS as a data source. These commenters sought clarity on this, as SIMS has been decommissioned.

Response: We thank commenters for noting this discrepancy. When the proposed rule was published, it was not clear that SIMS would be decommissioned. We have updated the final measure specifications to reflect the fact that SIMS has been decommissioned.

a. Clinical Measure Performance Standards

For the same reasons stated in the CY 2013 ESRD PPS final rule (77 FR 67500 through 76502), we proposed for PY 2016 to set the performance standards (both achievement and improvement) based on the national performance rate (that is, the 50th percentile) of facility performance in CY 2012, except as specified below.

With respect to the proposed NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure, we proposed to begin data collection beginning with CY 2014 events. We do not have data prior to CY 2014 for purposes of setting a performance standard based on the national performance rate of facility performance in CY 2012. For that reason, we proposed that the performance standard for the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure for PY 2016 be the 50th percentile of the national performance rate on the measure during CY 2014. Because we lack the baseline data needed to calculate an improvement score, we also proposed that, for PY 2016, facilities be scored only on achievement for this measure, and not on the basis of improvement. Although we recognize that with other measures that lacked baseline data we instituted a reporting measure to ensure that both an achievement and improvement score could be assessed, we believe that it is appropriate, in this case, to adopt a clinical measure without the baseline data necessary for an improvement score. Hospital Acquired Infections (HAIs) are a leading cause of preventable mortality and morbidity across different settings in the healthcare sector, including dialysis facilities, costing patient lives and billions of dollars. CMS has recognized that reducing HAIs is critically important to the Agency's three main goals of improving healthcare, improving health, and reducing healthcare costs. Because of the abnormally great impact HAIs have upon patients and the healthcare industry, we believe it is important to begin assessing facilities on the number of these events as soon as possible, rather than on merely whether they report these events. Additionally, the NHSN measure has been a reporting measure since PY 2014, which will give facilities 2 years to report data before they are scored on the data results. Thus, although we do not yet have complete baseline data to give improvement scores in PY 2016, we believe it is appropriate to implement this measure using only achievement scores because of the urgency in reducing these events and the time facilities have had to prepare themselves for such a measure. Finally, we proposed that facilities would receive a score of zero on the NHSN clinical measure if they do not submit 12 months of data, as defined in Section III.C.3.d above, and by the deadlines specified in Section III.C.3.d above.

For the proposed Patient Informed Consent for Anemia Treatment, we stated that we believed that facilities should meet the standard 100 percent of the time. However, we recognized that unexpected events might make a 100 percent standard difficult to meet, so we proposed that facilities should be allowed to meet the standard for less than 100 percent of their patients. Because prior data are unavailable for the establishment of a performance standard, benchmark, and achievement threshold, we developed a methodology to determine appropriate achievement standards. As described in Section III.C.10 of the proposed rule, we proposed that a small facility adjuster would be applied to facilities with between 11 and 25 qualifying patients. Since facilities with between 11 and 25 patients would be subject to the favorable scoring modifications applied by the small-facility adjuster, these facilities would have an easier time achieving the proposed achievement standards. Therefore, the minimum number of cases a facility may have and not benefit from a small-facility adjuster would be 26. We calculated that if a facility with 26 cases failed to obtain consent for two qualifying cases, it would have obtained consent 92 percent

of the time (rounded). If the facility failed to obtain consent for one case, it would have obtained consent 96 percent of the time (rounded). We believed that these values (92 and 96 percent) encourage a high consistency of care for patients with ESRD that is reasonably attainable by all facilities, while accounting for the possibility that facilities would be unable to obtain informed consent for reasons beyond their control. Therefore, we proposed that the achievement threshold be defined as obtaining informed consent for 92 percent of qualifying cases during the performance period, and that the benchmark would be defined as obtaining informed consent for 96 percent of such cases. Furthermore, we proposed to calculate the proposed performance standard using the average of the benchmark and achievement threshold, which is 94 percent. We sought comments on this performance standard.

Because we lack the baseline data needed to calculate improvement scores for the Patient Informed Consent for Anemia Treatment measure, we also proposed that for PY 2016, facilities be scored only on achievement for this measure, and not on the basis of improvement. We recognized that with other measures where we lacked baseline data, we adopted a reporting measure to ensure that both an achievement and improvement score could be assessed. However, we stated that we believe that it is appropriate, in this case, to adopt a clinical measure without the baseline data necessary for an improvement score. Anemia management is a topic highlighted in the ESRD QIP authorizing statute, requiring measures that reflect labeling approved by the Food and Drug Administration. (See section 1881(h)(2)(A) of the Act.) The inclusion of the topic in statue highlights its importance to CMS and to dialysis patients. ESA labeling has changed over time as additional safety information has become available, and the informed consent process is designed to ensure that the most current safety information is communicated to patients before ESAs are administered. In addition, obtaining informed consent for anemia treatment is a standard of practice that should already be in place at dialysis facilities, so facilities should already have procedures in place to support the measure. Thus, although we did not yet have complete baseline data to give improvement scores in PY 2016, we stated that we believed it would be appropriate to implement this measure using only achievement scores because of the importance of providing patients with current information about the risks and benefits of anemia therapy, and because this is already a standard clinical practice.

For the proposed Hypercalcemia measure, the first month that we can use to establish the baseline is May 2012. This is because the Hypercalcemia measure relies on CROWNWeb as its data source, CROWNWeb was first rolled out nationally in May 2012, and data submitted to CROWNWeb before that time is considered test or pilot data. For that reason, we proposed to set the performance standard as the 50th percentile of national performance from May 2012 through November 2012.

We requested comments on these proposals. The comments we received on these proposals and our responses are set forth below.

Comment: Several commenters stated that measures should have at least one year of reporting data available using consistent, well-defined data elements before being adopted as clinical measures.

Response: As stated in the CY 2013 ESRD PPS final rule (77 FR 67488), we believe that achievement thresholds, benchmarks, and performance standards should be based on a full year of data whenever possible. However, we also believe that, in certain circumstances, it not practical or necessary to use a full year of baseline data. For example, as stated in the proposed rule, we believe the clinical importance of reducing HAIs warrants the adoption of the NHSN clinical measure without a full year of baseline data. Similarly, we believe that it is appropriate to use seven months of baseline data for the Hypercalcemia measure because serum calcium levels are not subject to seasonal variations, and because the seven-month time window offers a reliable representation of national facility performance.

Comment: Several commenters stated that measures that lack the baseline data to calculate achievement and improvement scores should not be part of the ESRD QIP.

Response: Although we believe that achievement and improvement scores should generally be based on two years of baseline data, we also believe that other considerations may warrant the adoption of clinical measures before this baseline data is available. In particular, we believe that the urgency of addressing substantial gaps in the quality of clinical care may outweigh the benefits associated with using two years of baseline data if these gaps present safety concerns for patients. Given the significant increases in healthcare acquired infections in dialysis patients discussed above, we believe the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure meets this criterion. As we explained above, we have taken steps to minimize the financial impact on facilities associated with adopting this measure in the PY 2016 ESRD QIP, and we will propose to award both achievement and improvement points to facilities on this measure as soon as the baseline data is available. We also note that the ESRD QIP has used reporting measures since the PY 2014 program. These measures are not scored on the basis of achievement and improvement. Rather, they exist in order to help facilities become familiar with different reporting mechanisms, ensure that facilities capture data that can improve the quality of care they provide, and collect the baseline data needed to calculate achievement and improvement scores.

Comment: One commenter approved of the ESRD QIP overall. However, the commenter urged CMS to use measures that have been tested for reliability and validity, and that all clinical data should be retrieved from a single source.

Response: We thank the commenter and affirm that all the measures in the ESRD QIP have been tested for reliability and validity. With respect to the suggestion that we limit clinical data to a single data collection source, it is infeasible at this time to collect all ESRD QIP data from a single source. Although we are mindful of the reporting burden for facilities, we strive to make use of existing data collection systems, and we consider the benefits and drawbacks of collecting data in different reporting systems.

After consideration of the comments, we are finalizing the following performance standards for all of the PY 2016 clinical measures, except the Patient Informed Consent for Anemia Management clinical measure. We are not finalizing a performance standard for the Patient Informed Consent for Anemia Management clinical measure because we are not adopting that measure for the ESRD QIP.

b. Performance Standards for Clinical Measures

TABLE 8—FINALIZED NUMERICAL VALUES FOR THE PERFORMANCE STANDARDS FOR THE PY 2016 ESRD QIP CLINICAL MEASURES USING THE MOST RECENTLY AVAILABLE DATA [18]

Measure	Performance Standard
Vascular Access Type:	
%Fistula	62.3%
%Catheter	10.6%
Kt/V:	
Adult Hemodialysis.	93.4%
Adult Peritoneal Dialysis.	85.7%
Pediatric Hemodialysis.	93% [1]
Hemoglobin > 12 g/dL	0%
Hypercalcemia	1.7%
NHSN Bloodstream Infection in Hemodialysis Outpatients.	50th percentile of eligible facilities' performance during the performance period.

[1] According to the most recent data available, the performance standard for the Kt/V Pediatric Hemodialysis Adequacy measure is 91.9%. Because this is lower than the performance standard of 93% from the PY 2015 ESRD QIP, we are finalizing a performance standard of 93%.

If the final numerical values for the PY 2016 performance standards are worse than PY 2015 for a measure, then we proposed to substitute the PY 2015 performance standard for that measure. We stated our belief that the ESRD QIP should not have lower standards than in previous years.

We requested comment on this proposal. We did not receive any comments on this proposal. Using the most recent available data, we determined that the performance standard for the Kt/V Pediatric Hemodialysis Adequacy measure is 91.9%. Because this is lower than the performance standard of 93 percent from the PY 2015 ESRD QIP, we are finalizing a performance standard of 93 percent for the PY 2016 ESRD QIP. The finalized performance standards for the PY 2016 ESRD QIP clinical measures are set forth above in Table 8.

[18] Medicare claims data from 2012 were used to calculate the performance standard for the Hemoglobin > 12 g/dL, Dialysis Adequacy, and Vascular Access Type clinical measures. CROWNWeb data from May 2012 through December 2012 were used to estimate the performance standard for the Hypercalcemia clinical measure.

c. Performance Standards for Reporting Measures

For the proposed ICH CAHPS reporting measure, we proposed to set the performance standard for PY 2016 as the facility's successful submission, by January 28, 2015, of ICH CAHPS survey data collected during the performance period in accordance with the measure CMS specifications at *https://ichcahps.org*. For PY 2017 and future payment years, we proposed that the PY 2016 performance standard continue except that, in each performance period, facilities are required to submit data from the two surveys conducted during the performance period, rather than one, and that the survey data must be submitted by the dates specified by CMS at *https://ichcahps.org*.

For the proposed Mineral Metabolism reporting measure, we proposed to set the performance standard as successfully reporting the measure for the number of qualifying cases specified in Section III.C.2.b for each month of the 12-month duration of the performance period.

For the proposed Anemia Management reporting measure, we proposed to set the performance standard as successfully reporting the measure for the number of qualifying cases specified in Section III.C.2.c for each month of the 12-month duration of the performance period.

For the proposed Anemia Management: Pediatric Iron Therapy reporting measure, we proposed to set the performance standard as successfully reporting for each qualifying case each quarter the following: (i) patient admit/discharge date; (ii) hemoglobin levels; (iii) serum ferritin levels; (iv) TSAT percentages; (v) the dates that the lab measurements were taken for items (ii)–(iv); (vi) intravenous IV iron prescribed or oral iron prescribed (if applicable); and (vii) the date that the IV iron or oral iron was prescribed (if applicable).

For the proposed Comorbidity reporting measure, we proposed to set the performance standard as successfully updating in CROWNWeb at least once during the performance period for each qualifying case, the patient's comorbidities. We also proposed that the update be entered into CROWNWeb by the January 31 following the conclusion of the performance period or, if that is not a regular business day, the first business day thereafter.

We requested comment on these proposals. We did not receive any comments on these proposals. We will therefore finalize the reporting measure performance standards as proposed except for the Anemia Management: Pediatric Iron Therapy and the Comorbidity reporting measures, which we are not finalizing for adoption in the ESRD QIP.

8. Scoring for the PY 2016 ESRD QIP Measures

In order to assess whether a facility has met the performance standards, we finalized a methodology for the PY 2014 ESRD QIP under which we separately score each clinical and reporting measure. We score facilities based on an achievement and improvement scoring methodology for the purposes of assessing their performance on the clinical measures (76 FR 70272 through 70273). We proposed to use a similar methodology for the purposes of scoring facility performance on each of the clinical measures for the PY 2016 ESRD QIP and future payment years, except that we proposed that there will only be an achievement score for the NHSN Bloodstream Infection in Hemodialysis Outpatients and Patient Informed Consent for Anemia Treatment clinical measures, because data are not available to calculate an improvement score.

In determining a facility's achievement score for the PY 2016 program and future payment years, we proposed to continue using the current methodology described above, under which facilities would receive points along an achievement range based on their performance during the proposed performance period for each measure, which we define as a scale between the achievement threshold and the benchmark explained below. We proposed to define the achievement threshold for each of the proposed clinical measures as the 15th percentile of the national performance rate during CY 2012, except as otherwise specified below for the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure, the Patient Informed Consent for Anemia Treatment clinical measure, and the Hypercalcemia clinical measure. We believe that this achievement threshold will provide an incentive for facilities to continuously improve their performance, while not reducing incentives to facilities that score at or above the national performance rate for the clinical measures (77 FR 67503). We proposed to define the benchmark as the 90th percentile of the national performance rate during CY 2012, except as proposed below for the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure and the Patient Informed Consent for Anemia Treatment clinical measure, because it represents a

demonstrably high but achievable standard of quality that the high performing facilities reached.

For the proposed NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure, we proposed that the achievement threshold and benchmark be the 15th and 90th percentiles, respectively, of national performance during CY 2014.

For the proposed Patient Informed Consent for Anemia Treatment clinical measure, and for the reasons described in Section III.C.7.a, we proposed that the achievement threshold be defined as obtaining informed consent for 92 percent of qualifying cases during the performance period, and that the benchmark be defined as obtaining informed consent for 96 percent of such cases.

For the reasons described above, the first month that we can use to establish the baseline for the proposed Hypercalcemia measure is May 2012. Therefore, we proposed to set the achievement threshold as the 15th percentile of national performance and the benchmark as the 90th percentile of national performance from May 2012 through November 2012.

With the exception of the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure and the Patient Informed Consent Anemia Treatment clinical measure, we proposed that facilities receive points along an improvement range, defined as a scale running between the improvement threshold and the benchmark. We proposed to define the improvement threshold as the facility's performance on the measure during CY 2013. The facility's improvement score would be calculated by comparing its performance on the measure during CY 2014 (the proposed performance period) to its performance rate on the measure during CY 2013. Because we lack the baseline data needed to calculate improvement scores for the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure and the Patient Informed Consent for Anemia Treatment clinical measure, we proposed that facilities will not receive improvement scores for these measures for PY 2016.

We requested comments on these proposals. The comments we received on these proposals and our responses are set forth below.

Comment: Several commenters supported the achievement/improvement scoring methodology that is carried over from the PY 2015 program.

Response: We thank the commenters for their support.

Comment: Several commenters believed that the achievement/improvement scoring methodology is inappropriate for measures with compressed performance ranges. These commenters stated that in such cases, noncompliance for a single patient can easily result in a facility receiving 0 points instead of 10, resulting in a standard of perfection that is impossible to meet. In such cases, the commenters recommended giving a facility a pass for one noncompliant patient or otherwise altering the scoring methodology to award higher scores to facilities with very few noncompliant patients..

Response: We recognize that measures with compressed performance scores, such as the Hemoglobin Greater Than 12 g/dL measure, present special challenges for the achievement/improvement methodology finalized in the CY 2013 ESRD PPS final rule. We will consider the commenters' suggestion as we work to address these challenges in future payment years.

Comment: One commenter recommended that new facilities should be scored the first year they are open on all of the clinical and reporting measures, and that their scores should be publicly reported, but that they should not be eligible to receive a payment reduction. The commenter stated that this is a fair way to handle new facilities, because they will have to post a Performance Score Certificate, but they would not experience adverse financial consequences.

Response: We appreciate the commenter's concerns about the difficulties new facilities face when meeting the requirements of the ESRD QIP. It is because of these concerns that facilities with CCN open dates after July 1 of the performance period are excluded from the reporting measures and are therefore not eligible to receive a TPS. However, we disagree that it is unfair for a facility to be eligible for a payment reduction if it has a CCN open date before July 1 of the performance period because we believe that 6 months is enough time to become familiarized with the ESRD QIP requirements, and because we believe that financial incentives provide the strongest enticement to improve the quality of care provided to patients with ESRD.

Comment: One commenter recommended that facilities be given a monthly report that previews the facility's performance rate on each of the measures in the ESRD QIP. The commenter believes this would provide facilities with a better opportunity to monitor and improve performance.

Response: We appreciate the commenter's request for CMS to provide timely information about facilities' performance on the ESRD QIP. However, we believe that offering a monthly preview of a facility's performance rate may not provide an accurate estimate of a facility's actual score during the performance period. Most clinical measures require at least four months of data, and a monthly preview may not include enough data for the first several months. Additionally, case minimums for the clinical and reporting measures are based on numbers of patients treated during the performance period, so it would not be possible to determine if a facility were eligible to receive a score on each of the measures until the conclusion of the performance period. Furthermore, attestations through CROWNWeb are due by January 31 of the year following the performance period, and this information could not be incorporated into the monthly reporting.

After consideration of the comments, we are finalizing the achievement thresholds, benchmarks, and improvement thresholds for the PY 2016 ESRD QIP clinical measures that are listed below. We are not finalizing achievement thresholds, benchmarks, and improvement thresholds for the Informed Consent for Anemia Management clinical measure because we are not adopting that measure for the ESRD QIP. We have calculated the numerical values for the achievement threshold and benchmarks based on data from the dates described above; we will calculate the numerical values for the improvement thresholds (where applicable) based on individual facilities' data from CY 2013. The numerical values for the achievement thresholds and benchmarks for the PY 2016 ESRD QIP clinical measures are set forth below in Table 9.

TABLE 9—FINALIZED ACHIEVEMENT THRESHOLDS AND BENCHMARKS FOR THE PY 2016 ESRD QIP CLINICAL MEASURES USING THE MOST RECENTLY AVAILABLE DATA [19]

Measure	Achievement threshold	Benchmark
%Fistula	49.9%	77.0%
%Catheter	19.9%	2.8%
Kt/V:		
Adult Hemodialysis	86%[1]	97.4%
Adult, Peritoneal Dialysis	67.8%	94.8%
Pediatric Hemodialysis	83%[2]	97.1%
Hemoglobin > 12 g/dL	1.2%	0%
Hypercalcemia	5.4%	0%
NHSN Bloodstream Infection in Hemodialysis Outpatients.	15th percentile of eligible facilities' performance during the performance period.	90th percentile of eligible facilities' performance during the performance period.

[1] According to the most recent data available, the achievement threshold for the Adult Hemodialysis Adequacy measure is 85.6%. Because this is lower than the achievement threshold of 86% from the PY 2015 ESRD QIP, we are finalizing an achievement threshold of 86%.

[2] According to the most recent data available, the achievement threshold for the Pediatric Hemodialysis Adequacy measure is 71.3%. Because this is lower than the achievement threshold of 83% from the PY 2015 ESRD QIP, we are finalizing an achievement threshold of 83%.

We proposed that if the final PY 2016 numerical values for the achievement thresholds and benchmarks are worse than PY 2015 for a given measure, we will substitute the PY 2015 achievement thresholds and benchmarks for that measure. We stated our belief that the ESRD QIP should not have lower standards than previous years.

We requested comments on this proposal. We did not receive any comments on this proposal. Using the most recent available data, we determined that the achievement threshold for the Kt/V Adult Hemodialysis Adequacy measure is 85.6 percent. Because this is lower than the achievement threshold of 86 percent from the PY 2015 ESRD QIP, we are finalizing an achievement threshold of 86 percent for the PY 2016 ESRD QIP. Using the most recent available data, we determined that the achievement threshold for the Kt/V Pediatric Hemodialysis Adequacy measure is 71.3 percent. Because this is lower than the achievement threshold of 83 percent from the PY 2015 ESRD QIP, we are finalizing an achievement threshold of 83 percent for the PY 2016 ESRD QIP. We will, therefore, finalize the achievement thresholds and benchmarks set forth above in Table 9 for the PY 2016 ESRD QIP clinical measures.

a. Scoring Facility Performance on Clinical Measures Based on Achievement

Using the same methodology we finalized in the CY 2013 ESRD PPS final rule, we proposed to award between 0 and 10 points for each of the proposed clinical measures (77 FR 67504). As noted, we proposed that the score for each of these clinical measures will be based upon the higher of an achievement or improvement score on each of the clinical measures, except for the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure and the Patient Informed Consent for Anemia Treatment clinical measure, which we proposed to score on achievement alone. For purposes of calculating achievement scores for the clinical measures, we proposed to base the score on where a facility's performance rate falls relative to the achievement threshold and the benchmark for that measure. (Performance standards do not enter into the calculation of improvement or achievement scores.) Identical to what we finalized in the CY 2013 ESRD PPS final rule, we proposed that if a facility's performance rate during the performance period is:

- Equal to or greater than the benchmark, then the facility would receive 10 points for achievement;
- Less than the achievement threshold, then the facility would receive 0 points for achievement; or
- Equal to or greater than the achievement threshold, but below the benchmark, then the following formula would be used to derive the achievement score:

[9 * ((Facility's performance period rate—achievement threshold)/(benchmark—achievement threshold))] + .5, with all scores rounded to the nearest integer, with half rounded up.

Using this formula, a facility would receive a score of 1 to 9 points for a clinical measure based on a linear scale distributing all points proportionately between the achievement threshold and the benchmark, so that the interval in the performance between the score for a given number of achievement points and one additional achievement point is the same throughout the range of performance from the achievement threshold to the benchmark.

We did not receive any comments on this proposal. Therefore, we are finalizing the achievement scoring methodology for the PY 2016 ESRD QIP and future payment years, with the exception of the Informed Consent for Anemia Management clinical measure, because we are not adopting that measure for the ESRD QIP.

b. Scoring Facility Performance on Clinical Measures Based on Improvement

Using the same methodology we have previously finalized for the ESRD QIP, we proposed that facilities would earn between 0 and 9 points for each of the clinical measures that will have an improvement score (that is, all clinical measures except the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure and the Patient Informed Consent for Anemia Treatment), based on how much their performance on the measure during CY 2014 improved from their performance on the measure during CY 2013 (77 FR 67504). A specific improvement range for each measure would be established for each facility. We proposed that if a facility's performance rate on a measure during the performance period is:

- Less than the improvement threshold, then the facility would receive 0 points for improvement; or
- Equal to or greater than the improvement threshold, but below the benchmark, then the following formula would be used to derive the improvement score:

[10 * ((Facility performance period rate—Improvement threshold)/(Benchmark—Improvement

[19] Medicare claims data from 2012 were used to calculate the achievement threshold and benchmark for the Hemoglobin > 12 g/dL, Dialysis Adequacy, and Vascular Access Type clinical measures. CROWNWeb data from May 2012 through December 2012 were used to estimate the percentiles for the Hypercalcemia clinical measure.

threshold))]—.5, with all scores rounded to the nearest integer, with half rounded up.

Note that if the facility score is equal to or greater than the benchmark, then it would receive 10 points on the measure based on the achievement score methodology discussed above.

We did not receive any comments on this proposal. We will therefore finalize the improvement scoring methodology for the PY 2016 ESRD QIP and future payment years with the exception of the Informed Consent for Anemia Management clinical measure, because we are not adopting that measure for the ESRD QIP.

c. Calculating Facility Performance on Reporting Measures

As noted above, reporting measures differ from clinical measures in that they are not scored based on clinical values; rather, they are scored based on whether facilities are successful in achieving the reporting requirements associated with each of these proposed measures. The criteria that we proposed would apply to each reporting measure are discussed below.

With respect to the proposed Anemia Management reporting measure and the proposed Mineral Metabolism reporting measure, we proposed to award points to facilities using the same formula that we finalized in the CY 2013 ESRD PPS final rule for Mineral Metabolism and Anemia Management (77 FR 67506):

$$\left(\frac{\textit{Number of Months Facility Successfully Reports}}{\textit{Number of Months in the Performance Period Facility has CCN}}\ x\ 12\right) - 2$$

With respect to the proposed Use of Iron Therapy for Pediatric Patients reporting measure, we proposed to award points to facilities using the following formula:

$$\frac{\textit{Number of Quarters Facility Successfully Reports}}{\textit{Number of Quarters in the Performance Period Facility has CCN}}\ x\ 10$$

We proposed to score the Pediatric Iron Therapy measure differently than the proposed Anemia Management reporting measure and the proposed Mineral Metabolism reporting measure because it requires quarterly rather than monthly reporting; therefore, scoring based on monthly reporting rates is not feasible.

With respect to the proposed ICH CAHPS reporting measure and Comorbidity reporting measure, we proposed that a facility receive a score of 10 points if it satisfies the performance standard for the measure, and 0 points if it does not. We proposed to score these reporting measures differently than the other reporting measures because these measures require annual or biannual reporting, and therefore scoring based on monthly or quarterly reporting rates is not feasible.

We requested comments on the proposed methodology for scoring the PY 2016 ESRD QIP reporting measures. We did not receive any comments on this proposal. We will, therefore, finalize the scoring methodology for the reporting measures as proposed, with the exception of the Pediatric Iron Therapy and Comorbidity reporting measures, because we are not adopting those measures for the ESRD QIP.

9. Weighting the PY 2016 ESRD QIP Measures and Calculating the PY 2016 ESRD QIP Total Performance Score

Section 1881(h)(3)(A)(iii) of the Act provides that the methodology for calculating the facility TPS shall include a process to weight the performance scores with respect to individual measures to reflect priorities for quality improvement, such as weighting scores to ensure that facilities have strong incentives to meet or exceed anemia management and dialysis adequacy performance standards, as determined appropriate by the Secretary. In determining how to appropriately weight the PY 2016 ESRD QIP measures for purposes of calculating the TPS, we considered two criteria: (1) the number of measures we proposed to include in the PY 2016 ESRD QIP; and (2) the National Quality Strategy priorities.

a. Weighting Individual Measures To Compute Measure Topic Scores for the Kt/V Dialysis Adequacy Measure Topic, the Vascular Access Type Measure Topic, and the Anemia Management Clinical Measure Topic

In the CY 2013 ESRD PPS final rule, we established a methodology for deriving the overall scores for measure topics (77 FR 67507). For the reasons described in the CY 2013 ESRD PPS final rule, we proposed to use the same methodology in PY 2016 and future payment years to calculate the scores for the three measure topics. After calculating the individual measure scores within a measure topic, we proposed to calculate a measure topic score using the following steps: (i) Dividing the number of patients in the denominator of each measure by the sum of the number of patients in each denominator for all of the applicable measures in the measure topic; (ii) multiplying that figure by the facility's score on the measure; (iii) summing the results achieved for each measure; and (iv) rounding this sum (with half rounded up). We proposed that if a facility does not have enough patients to receive a score on one of the measures in the measure topic (as discussed below), then that measure would not be included in the measure topic score for that facility. Only one measure within the measure topic needs to have enough cases to be scored in order for the measure topic to be scored and included in the calculation of the TPS. We also proposed that the measure topic score would be equal to one clinical measure in the calculation of the TPS. For an additional explanation, see the examples provided at 77 FR 67507.

We did not receive any comments on this proposal. We will therefore finalize this methodology of weighting individual measure scores to derive a measure topic score for the PY 2016 ESRD QIP and future payment years with the exception of the Anemia Management Clinical measure topic, because we are not adopting that measure topic for the ESRD QIP.

b. Weighting the Total Performance Score

We continue to believe that weighting the clinical measures/measure topics equally will incentivize facilities to improve and achieve high levels of

performance across all of these measures, resulting in overall improvement in the quality of care provided to patients with ESRD. We also continue to believe that, while the reporting measures are valuable, the clinical measures evaluate actual patient outcomes and therefore justify a higher combined weight (77 FR 67506 through 67508). For the reasons outlined in the CY 2013 ESRD PPS final rule, we proposed to continue weighting clinical measures as 75 percent and reporting measures as 25 percent of the TPS. We requested comments on this proposed methodology for weighting the clinical and reporting measures.

We have also considered the issue of awarding a TPS to facilities that do not report data on the proposed minimum number of cases with respect to one or more of the measures or measure topics. For the reasons stated in the CY 2013 ESRD PPS final rule, for PY 2016 and future payment years, we proposed to continue to require a facility to have at least one clinical and one reporting measure score to receive a TPS (77 FR 67508). We requested comments on our proposals to require a facility to be eligible for a score on at least one reporting and one clinical measure in order to receive a TPS.

Finally, we proposed that the TPSs be rounded to the nearest integer, with half of an integer being rounded up. We requested comments on this proposal. For further examples regarding measure and TPS calculations, we refer readers to the figures below.

We requested comments on these proposals. The comments we received on these proposals and our responses are set forth below.

Comment: Several commenters supported the proposed methodology for weighting measures in the TPS.

Response: We thank the commenters for their support.

Comment: One commenter did not support the adoption of the Hypercalcemia measure because hypercalcemia might not be an important clinical indicator, and the measure would dilute the effectiveness of the ESRD QIP by reducing the weight of other clinical measures. Other commenters did not support the adoption of the Hypercalcemia measure but recommended weighting it at 10 percent of the TPS if the measure was adopted.

Response: Given commenters' concerns about the clinical significance of the Hypercalcemia measure (see Section III.C.3.b above), particularly because the measure does not incorporate other indicators of mineral metabolism, we agree with the recommendation to decrease the measure's weight in the TPS. We note that if the Hypercalcemia measure were weighted at 10 percent of the TPS, and the clinical measures continued to comprise 75 percent of the TPS overall, then the weight of the Hypercalcemia measure would be receive roughly two-thirds the weight of the four other clinical measures. We believe that decreasing the Hypercalcemia measure's weight by one-third appropriately reflects the fact that in the absence of other information about mineral management, the Hypercalcemia measure is less clinically significant than the other clinical measures.

Therefore, for PY 2016 and future payment years, we are finalizing that the Hypercalcemia measure will weighted at two-thirds the weight of the other clinical measures, and that the clinical measures will continue to constitute 75 percent of the TPS. If a facility is not eligible for one or more of the clinical measures, we are finalizing that the Hypercalcemia measure will still be weighted at two-thirds the weight of the other clinical measures, and that the other measures will be equally weighted, such that the clinical measures comprise 75 percent of the TPS.

Comment: Several commenters did not support either the proposal to equally weight all clinical measures or the proposal to equally weight all reporting measures. These commenters expressed concerns that this methodology over-weights new measures and may not place enough emphasis on measures that have the most clinical importance. The commenters recommended establishing a set of weighting principles that take into account (1) how long the measure has been included in the ESRD QIP; (2) whether room for improvement exists; (3) the measure's clinical significance; and (4) the number of patients affected by the measure. The commenters also recommended that CMS should collaborate with the MAP to determine measure weights.

Response: We agree that it is not appropriate to equally weight all of the clinical measures if their clinical significance is not equal. That is why we are reducing the weight of the Hypercalcemia clinical measure, as explained above. Using this criterion, we do not agree that the reporting measures should be weighted differently because the reporting measures have similar clinical significance.

Furthermore, we appreciate the recommended principles for weighting the measures' contribution to the TPS. We will consider these recommendations in future rulemaking except for the recommendation to collaborate with the MAP on measure weighting.

Although the MAP provides input on measures under consideration, its statutorily authorized function does not include commenting on Medicare quality incentive program implementation policy.

Comment: One commenter recommended that the clinical measures should constitute 90 percent of the TPS and the reporting measures should constitute 10 percent. The commenter stated that the ESRD QIP should evaluate providers' performance rather than their ability to track and report information, and that a 90 percent/10 percent weighting methodology would accomplish that.

Response: We agree that it is important to weight the clinical measures significantly more than the reporting measures because the clinical measures evaluate provider's clinical performance, rather than their ability to track and report information. However, we also believe that the reporting measures should carry enough weight to provide facilities with an incentive to report data to CMS. We are finalizing 5 clinical measures/measure topics and 3 reporting measures. Since this ratio is not significantly different than our proposal to adopt 6 clinical measures/measure topics and 5 reporting measures we continue to believe that the 75 percent/25 percent distribution appropriately balances the need to incentivize performance with the need to incentive the reporting of data.

For these reasons, we are finalizing that the clinical measures will be weighted at 75 percent of the TPS and that the reporting measures will be weighted at 25 percent of the TPS. We are also finalizing that the Hypercalcemia clinical measure will be weighted at two-thirds the weight of the other clinical measures, and that the reporting measures will be weighted equally.

c. Examples of the PY 2016 ESRD QIP Scoring Methodology

In this section, we provide examples to illustrate the scoring methodology for PY 2016. Figures 1–3 illustrate the scoring for the Vascular Access Type—Fistula measure. Figure 1 shows Facility A's performance on the measure. Note that for this example, the facility has performed very well. The example benchmark (the 90th percentile of performance nationally in CY 2012) calculated for this clinical measure is 77 percent, and the example achievement threshold (which is the 15th percentile

of performance nationally in CY 2012) is 50 percent. Therefore, Facility A's performance of 86 percent on the clinical measure during the performance period exceeds the benchmark of 77 percent, so Facility A would earn 10 points (the maximum) for achievement for this measure. (Because, in this example, Facility A has earned the maximum number of points possible for this measure, its improvement score is irrelevant.)

Figure 1

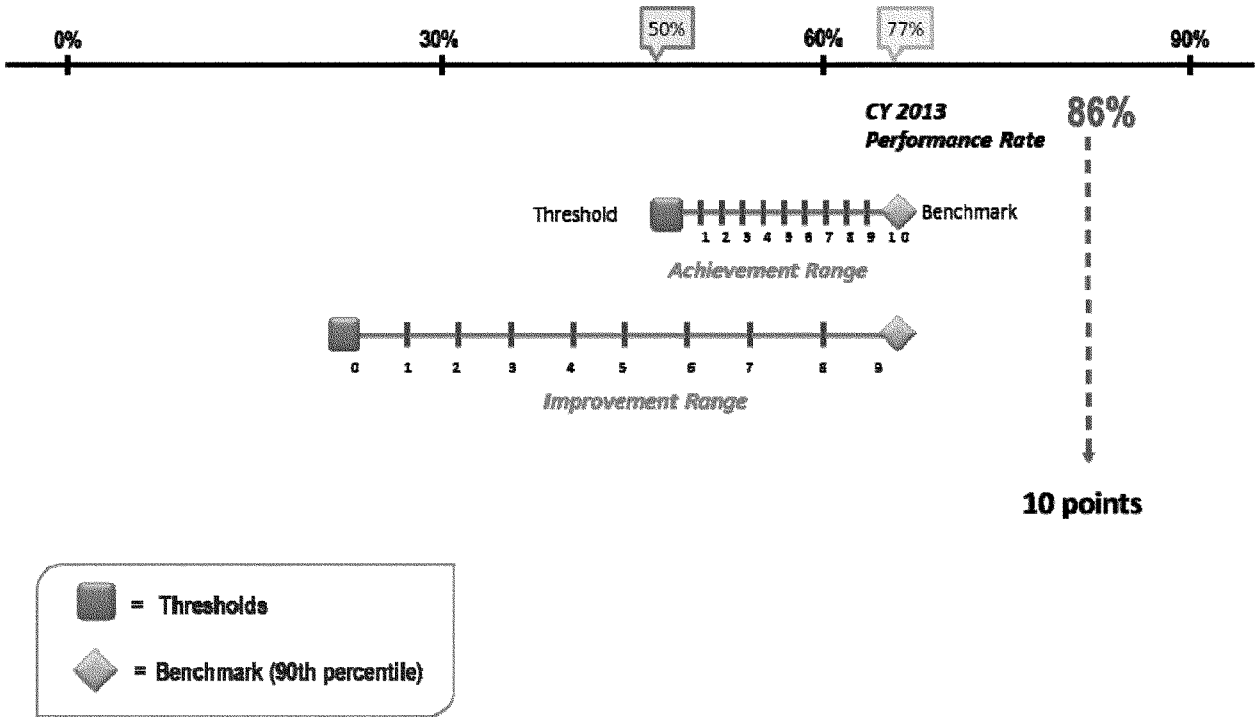


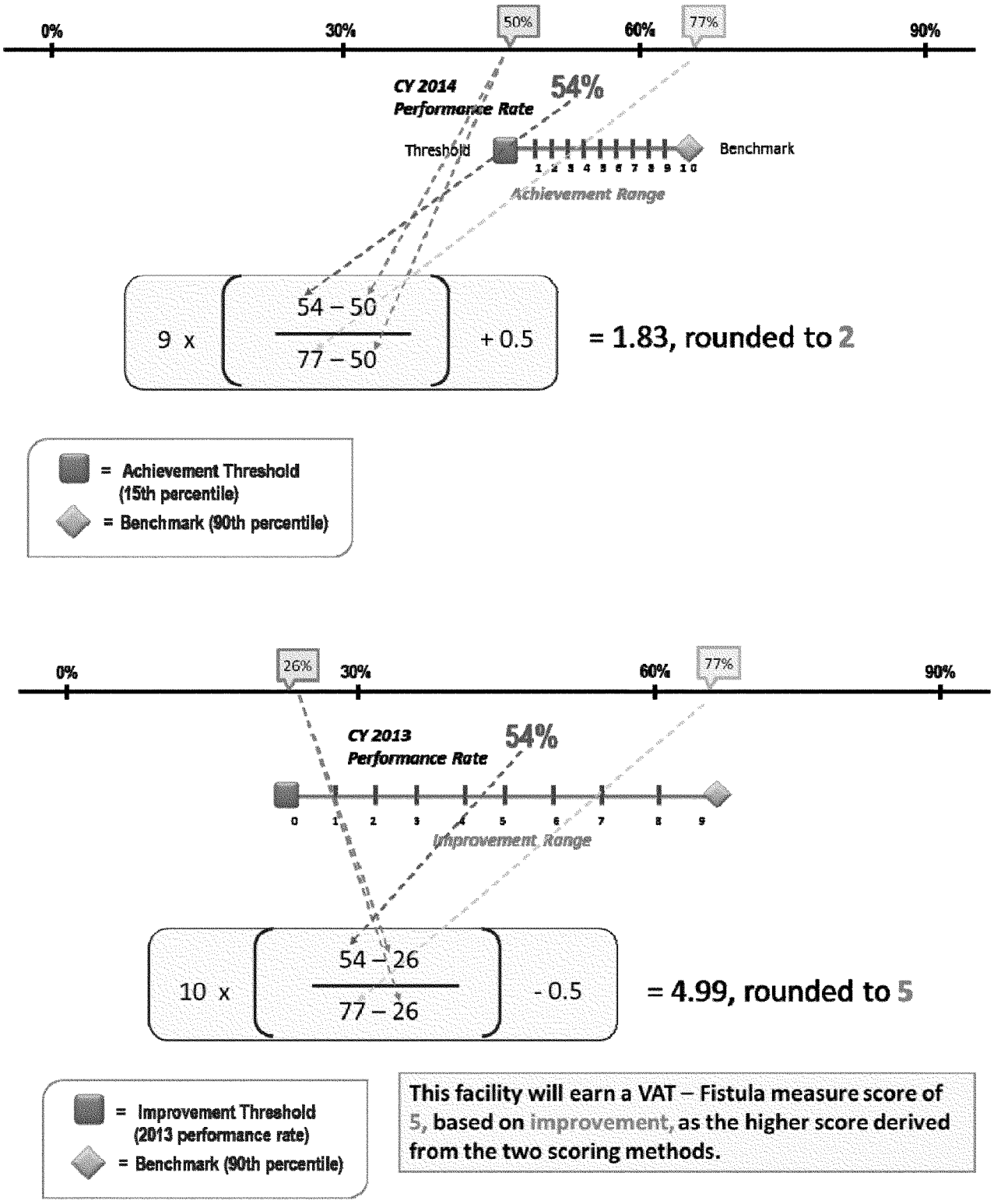
Figure 2 shows an example of scoring for another facility, Facility B. As illustrated below, the facility's performance on the Vascular Access Type—Fistula measure improved from 26 percent in CY 2013 to 54 percent during the performance period. The achievement threshold is 50 percent and the achievement benchmark is 77 percent. Because the facility's performance during the performance period is within the achievement range and the improvement range, we must calculate the improvement and achievement scores to determine the Vascular Access Type—Fistula measure.

To calculate the achievement score, we would apply the formula discussed above. The result of this formula for this example is [9 * ((54—50)/(77—50))] + .5, which equals 1.83, and we round to the nearest integer, which is 2.

Likewise, to calculate the improvement score, we apply the improvement formula discussed above. The result of this formula for this is example is [10 * ((54—26)/(77—26))]—.5, which equals 4.99 and we round to the nearest integer, which is 5.

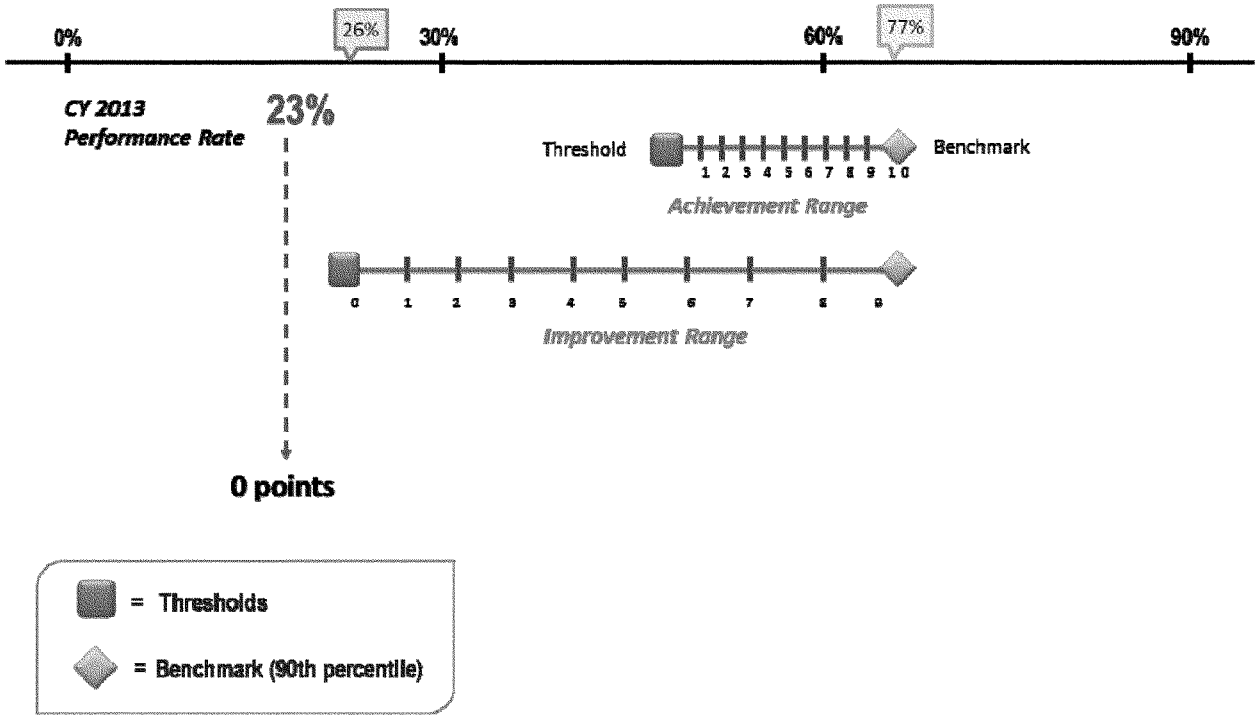
Therefore, for the Vascular Access Type—Fistula measure, Facility B's achievement score is 3, and its improvement score is 5. We award Facility B the higher of the two scores for this clinical measure. Thus, Facility B's score on this measure is 5.

Figure 2



In Figure 3, Facility C's performance on the Vascular Access Type—Fistula measure drops from 26 percent in CY 2013 to 23 percent during the performance period, a decline of 3 percent. Because Facility C's performance during the performance period falls below the achievement threshold of 26 percent, it receives 0 points for achievement. Facility C also receives 0 points for improvement, because its performance during the performance period was lower than its performance during CY 2013. Therefore, in this example, Facility C would receive 0 points for the Vascular Access Type—Fistula measure.

Figure 3



The methods illustrated above would be applied to each clinical measure in order to obtain a score for each measure. (Scores for reporting measures are calculated based upon their individual criteria, as discussed earlier.)

After calculating the scores for each measure, we would calculate the TPS. As an example, by applying the weighting criteria to a facility that receives a score on all finalized measures, we would calculate the facility's TPS using the following formula:

Total Performance Score = [(.161 * Vascular Access Type Measure Topic) + (.161 * Kt/V Dialysis Adequacy Measure Topic) + (.161 * Hemoglobin Greater Than 12 g/dL) + (.107 * Hypercalcemia Measure) + (.161 * NHSN Bloodstream Infection in Hemodialysis Outpatients) + (.083 * ICH CAHPS Survey Reporting Measure) + (.083 * Mineral Metabolism Reporting Measure) + (.083 * Anemia Management Reporting Measure)] * 10.

The TPS would be rounded to the nearest integer (and any individual measure values ending in .5 would be rounded to the next higher integer).

The formula changes in the event that a facility does not receive a score on a particular measure. If, for example, a facility did not receive a score (that is, did not have enough qualifying cases) on the NHSN Bloodstream Infection in Hemodialysis Outpatients clinical measure, then the facility's TPS would be calculated as follows:

Total Performance Score = [(.205 * Vascular Access Type Measure Topic) + (.205 * Kt/V Dialysis Adequacy Measure Topic) + (.205 * Hemoglobin Greater Than 12 g/dL) + (.137 * Hypercalcemia) + (.083 * ICH CAHPS Survey Reporting Measure) + (.083 * Mineral Metabolism Reporting Measure) + (.083 * Anemia Management Reporting Measure)] * 10.

Again, the TPS would be rounded to the nearest integer (and any individual measure values ending in .5 would be rounded to the next higher integer).

If, for example, a facility did not receive a score (that is, did not have enough qualifying cases) on the Hypercalcemia clinical measure, then the facility's TPS would be calculated as follows:

Total Performance Score = [(.188 * Vascular Access Type Measure Topic) + (.188 * Kt/V Dialysis Adequacy Measure Topic) + (.188 * Hemoglobin Greater Than 12 g/dL) + (.188 * NHSN Bloodstream Infection in Hemodialysis Outpatients) + (.083 * ICH CAHPS Survey Reporting Measure) + (.083 * Mineral Metabolism Reporting Measure) + (.083 * Anemia Management Reporting Measure)] * 10.

If a facility is eligible for only two of the reporting measures, then the facility's TPS would be calculated as follows:

Total Performance Score = [(.161 * Vascular Access Type Measure Topic) + (.161 * Kt/V Dialysis Adequacy Measure Topic) + (.161 * Hemoglobin Greater Than 12 g/dL) + (.107 * Hypercalcemia Measure) + (.161 * NHSN Bloodstream Infection in Hemodialysis Outpatients) + (.125 * ICH CAHPS Survey Reporting Measure) + (.125 * Anemia Management Reporting Measure)] * 10.

Again, the TPS would be rounded to the nearest integer (and any individual measure values ending in .5 would be rounded to the next higher integer).

10. Minimum Data for Scoring Measures for the PY 2016 ESRD QIP and Future Payment Years

For the same reasons described in the CY 2013 ESRD PPS final rule (77 FR 67510 through 67512), for PY 2016 and future payment years, we proposed to only score facilities on clinical and reporting measures for which they have a minimum number of qualifying cases during the performance period. For PY 2016 and future payment years, we proposed that a facility must have a threshold of at least 11 qualifying cases for the entire performance period in order to be scored on a clinical measure. We proposed that reporting measures other than ICH CAHPS will have a threshold of one qualifying case during the performance period. The 11-qualifying case minimum was intended to reduce burden on facilities with

limited qualifying cases for earlier reporting measures (77 FR 67480, 67483, 67486 and 67493). We proposed to set the reporting measure case minimums at one because we plan to use data to permit future implementation of clinical measures. If patients in small facilities are systematically excluded, then we will not be able to gather the robust data we need to support the performance standard, benchmark, and achievement threshold calculations in future payment years. For those reasons, we proposed that the case minimum for all reporting measures except for ICH CAHPS be one.

For the proposed expanded ICH CAHPS reporting measure, we proposed that facilities with fewer than 30 qualifying cases during the performance period not be scored on the measure. In the CY 2013 ESRD PPS final rule, we excluded facilities with 10 or fewer adult in-center hemodialysis patients from the ICH CAHPS measure because we recognized that, for many small dialysis facilities, hiring a third-party administrator to fulfill the ICH CAHPS survey requirements would have been impractical or prohibitively costly (77 FR 67480). As we move toward developing a clinical measure, we have determined that the survey results are more reliable if there are at least 30 surveys submitted per facility. Therefore, we proposed that for PY 2016 and future payment years, facilities that treat fewer than 30 qualifying cases (defined as adult in-center hemodialysis patients) during the performance period will be excluded from this measure. We further proposed that we will consider a facility to have met the 30-patient threshold unless it affirmatively attests in CROWNWeb by January 31 of the year prior to the year in which payment reductions will be made (for example, January 31, 2015, for the PY 2016 ESRD QIP) that it treated 29 or fewer adult in-center hemodialysis patients during the performance period.

For the same reasons described in the CY 2013 ESRD PPS final rule (77 FR 67510 through 67512), for PY 2016 and future payment years, we proposed to apply to each clinical measure score for which a facility has between 11 and 25 qualifying cases the same adjustment factor we finalized in the CY 2013 ESRD PPS final rule (77 FR 67511). We solicited public comment on these proposals.

For the PY 2016 ESRD QIP and future payment years, we also proposed to continue to begin counting the number of months or quarters, as applicable, for which a facility is open on the first day of the month after the facility's CCN open date. With the exception of the ICH CAHPS expanded reporting measure, we proposed that only facilities with a CCN open date before July 1, 2014, be scored on the proposed reporting measures. Under the specifications for the proposed ICH CAHPS reporting measure, facilities would need to administer the survey (via a CMS-approved, third-party vendor) during the performance period. Because arranging such an agreement takes time, we proposed that only facilities with a CCN open date before January 1 of the performance period to be scored on this measure. Additionally, we proposed that facilities with CCN open dates after January 1, 2014 will not be scored on the NHSN. We note that in previous payment years we have awarded partial credit to facilities that submitted less than 12 months of data to encourage them to enroll in and report data in the NHSN system. However, we proposed to collect 12 months of data on this clinical measure because infection rates vary through different seasons of the year.

As discussed above, we proposed that a facility will not receive a TPS unless it receives a score on at least one clinical and one reporting measure. We noted that finalizing this proposal would result in facilities not being eligible for a payment reduction for the PY 2016 ESRD QIP and future payment years if they have a CCN open date on or after July 1 of the performance period (CY 2014 for the PY 2016 ESRD QIP).

We requested comments on these proposals. The comments we received on these proposals and our responses are set forth below.

Comment: Several commenters supported the proposed performance standards for the reporting measures, including the 30-case minimum for the ICH CAHPS reporting measure.

Response: We thank the commenters for their support.

Comment: Several commenters did not support the proposed reporting threshold of 97 and 99 percent for the Mineral Metabolism and Anemia Management reporting measures. These commenters stated that the threshold will unduly penalize small facilities. The commenters did not believe that that this possibility is mitigated by the alternative threshold of the 50th percentile of facility reporting in CY 2013, or by the requirement for facilities with fewer than 11 patients to report for all but one patient.

Response: We disagree that the proposed reporting threshold for the mineral metabolism and anemia management reporting measures unduly penalizes small facilities. In proposing that facilities with between 10 and 2 eligible patients must report monthly serum phosphorus and hemoglobin/hematocrit levels for all but one patient, we effectively created a reporting threshold of 90 percent for facilities with 10 patients, and a reporting threshold of less than 90 percent for facilities with 9 or fewer patients. Because facilities with fewer than 11 patients must meet lower reporting thresholds than facilities with more than 11 patients, we believe that this provision adequately addresses the possibility that a small facility will not be able to report data for certain patients for reasons that are beyond the facility's control.

Comment: Several commenters recommended applying a consistent case minimum (of either 11 or 26) to all ESRD QIP measures.

Response: We disagree that it is appropriate to establish a consistent case minimum for all of the ESRD QIP measures. As stated in the CY 2014 ESRD PPS proposed rule (78 FR 40871), we proposed to ''set the reporting measure case minimums at one because we plan to use data to permit future implementation of clinical measures. If patients in small facilities are systematically excluded, then we will not be able to gather the robust data we need to support the performance standard, benchmark, and achievement threshold calculations in future payment years.'' Additionally, due to the considerations about the reliability of ICH CAHPS data discussed above, we decided that 30 was the appropriate case minimum for the ICH CAHPS reporting measure. We therefore do not believe that an 11- or 26-case minimum is appropriate for any of the reporting measures.

As stated in the CY 2013 ESRD PPS final rule (77 FR 67510 through 67511), we adopted an 11-case minimum for the clinical measures based on the minimum number of cases needed to protect patient privacy, which could be compromised by the public reporting of data for small facilities. Given our goal to encourage quality improvement, we want to ensure the full participation of as many facilities as possible in the program. We therefore do not believe that a 26 case minimum is appropriate for the clinical measures.

Comment: One commenter expressed concerns that the 11-case minimum for the clinical measures excludes virtually all of the pediatric dialysis facilities from participation in the ESRD QIP. The commenter recognizes the this case minimum is important for the purposes of protecting patient confidentiality, but the commenter remained concerned that

pediatric facilities will not have an opportunity to use the ESRD QIP to improve performance.

Response: We are cognizant of the issues relating to inclusion of pediatric dialysis facilities in the ESRD QIP and continue to consider pathways to ensure that they are not excluded from participation. We appreciate the commenter's concerns and will continue to consider new pathways for incorporating pediatric dialysis facilities in the ESRD QIP.

Comment: Some commenters did not support the proposal to use the small-facility adjuster for facilities with 11 to 26 patients. These commenters stated that (1) the volatility associated with small sample sizes may create unintended and harmful consequences for facilities; (2) the methodology to adjust results for small samples sizes is complex and opaque; and (3) very small differences in both sample size and SE (x_i) can cause the achievement score to ''jump'' from 10 to 0 points (or vice versa).

Response: We do not agree that the small-facility adjuster will create harmful consequences for facilities, or that small differences in sample size and SE (x_i) can result in significant disparities in measure scores. While we recognize that the adjustment methodology is complex, we disagree that it is opaque. First, as illustrated below, the proposed small facility adjuster could only improve a facility's individual component score and will not create unintended and harmful consequences for small facilities (or facilities of any size). Second, the adjuster is transparent and straightforward, in that the adjustment explicitly depends on a facility's size (number of patients eligible for the measure), the unadjusted measure rate, and the standard error for that measure at the facility, which quantifies the amount of uncertainty in the unadjusted measure rate. Thirdly, even with small differences in both sample size and SE (x_i), the adjustment will still be applied in favor of the facility, and it is impossible for a facility's measure score to be reduced as a result of the application of the adjuster. The following example illustrates how the small facility adjustment impacts the achievement score for the AV fistula measure.

Facility B (% AVF Fistula)

- Unadjusted Measure (x_B) = 55%
- Achievement Threshold = 50%
- Benchmark = 77%
- Patients (n_B) = 12
- Standard Error ($SE(x_B)$) = 25%
- C = 26

Unadjusted Achievement Score:

$$9 * \frac{\textbf{Performance Rate} - \textbf{Achievement Threshold}}{\textbf{Benchmark} - \textbf{Achievement Threshold}} + 0.5 = 9 * \frac{55 - 50}{77 - 50} + 0.5 = 2.17, \text{ rounds to } \mathbf{2}.$$

Small facility adjustment:

- Calculation steps:
  - Weight $w_B = 1 - \frac{n_B}{C} = 1 - \frac{12}{26} = 0.54$
  - Adjusted Measure $t_B = x_B + w_B * SE(x_B)$

$$= 55\% + 0.54 * 25\%$$
$$= 55\% + 13.5\%$$
$$= 68.5\%, \textbf{ rounds to } \mathbf{69\%}$$

Adjusted Achievement Score:

$$9 * \frac{69 - 50}{77 - 50} + 0.5 = 6.8, \text{ rounds to } \mathbf{7}.$$

In the example above, the small-facility adjustment increased the AV fistula performance rate from 55 percent to 69 percent and the achievement score from 2 to 7.

For these reasons, we are finalizing as proposed the minimum data requirements for scoring measures for the PY 2016 ESRD QIP and future payment years.

11. Payment Reductions for the PY 2016 ESRD QIP and Future Payment Years

Section 1881(h)(3)(A)(ii) of the Act requires the Secretary to ensure that the application of the scoring methodology results in an appropriate distribution of payment reductions across facilities,

such that facilities achieving the lowest TPSs receive the largest payment reductions. For PY 2016, we proposed that a facility would not receive a payment reduction if it achieves a minimum TPS that is equal to or greater than the total of the points it would have received if: (i) it performed at the performance standard for each clinical measure; (ii) it received zero points for each clinical measure that did not have a numerical value for the performance standard published with the PY 2016 final rule; and (iii) it received five points for each reporting measure. We requested comments on these proposals.

Section 1881(h)(3)(A)(ii) of the Act requires that facilities achieving the lowest TPSs receive the largest payment reductions. For PY 2016 and future payment years, we proposed that the payment reduction scale be the same as the PY 2015 ESRD QIP (77 FR 67514 through 67516). We proposed that, for every 10 points a facility falls below the minimum TPS, the facility would receive an additional 0.5 percent reduction on its ESRD PPS payments for PY 2016 and future payment years, with a maximum reduction of 2.0 percent. As we stated in the CY 2012 ESRD PPS final rule, we believe that such a sliding scale will incentivize facilities to meet the performance standards established and continue to improve their performance; even if a facility fails to achieve the minimum TPS, such a facility will still be incentivized to strive for and attain better performance rates in order to reduce the percentage of its payment reduction (76 FR 70281).

We requested comments on these proposals. The comments we received on these proposals and our responses are set forth below.

Comment: Several commenters supported the payment reduction scale. However, these commenters remained concerned that ''when a facility has a small number of patients, its TPS can be quickly reduced, causing financial harm to the facility.''

Response: We are aware that small facilities are more susceptible to the effects of outliers, due to their small sample sizes, and that this creates a real potential for them to be unfairly scored on measures in the ESRD QIP. It is for this reason that the ESRD QIP includes a small facility adjustment on the clinical measures for facilities that treat between 11 and 25 patients. We continue to believe that this adjustment provides a fairer and more precise way to account for the effects of outliers that could otherwise impact a small facility's TPS.

For the reasons stated above, we are finalizing our proposals for calculating payment reductions for PY 2016 and future payment years. Based on this approach, the minimum TPS for PY 2016 is 54 points. Facilities failing to meet this minimum will receive payment reductions in the amounts indicated in Table 10 below.

TABLE 10—FINALIZED PAYMENT REDUCTION SCALE FOR PY 2016 BASED ON THE MOST RECENTLY AVAILABLE DATA [20]

Total performance score	Reduction (percent)
100–54	0
53–44	0.5
43–34	1.0
33–24	1.5
23–0	2.0

12. Data Validation

One of the critical elements of the ESRD QIP's success is ensuring that the data submitted to calculate measure scores and TPSs are accurate. We began a pilot data-validation program in CY 2013 for the ESRD QIP, and we are now in the process of procuring the services of a data-validation contractor, who will be tasked with validating a national sample of facilities' records as they report CY 2013 data to CROWNWeb. The first priority will be to develop a methodology for validating data submitted to CROWNWeb under the pilot data-validation program; once this methodology has been developed, CMS will publicize it through a CROWN Memo and solicit public comment. As part of the CY 2013 ESRD QIP PPS final rule (77 FR 67522 through 67523), we finalized a requirement to sample approximately 10 records from 750 randomly selected facilities; these facilities will have 60 days to comply once they receive requests for records. We proposed to extend this pilot data-validation program to include analysis of data submitted to CROWNWeb during CY 2014. For the PY 2016 ESRD QIP, sampled facilities will be reimbursed by our validation contractor for the costs associated with copying and mailing the requested records. Additionally, we proposed to reduce the annual random sample size from 750 to 300. We believe that this smaller sample size will still yield a sufficiently precise estimate of ESRD QIP reliability while imposing a smaller burden on ESRD QIP-eligible facilities and CMS alike. We proposed to extend our policy that no facility will receive a payment reduction resulting from the validation process for CY 2014 during PY 2016. Once we have gathered additional information based on these initial validation efforts, we will propose further procedures for validating data submitted in future years of the ESRD QIP. These procedures may include a method for scoring facilities based on the accuracy of the data they submit to CROWNWeb, and a method to assign penalties for submitting inaccurate data. We solicited comments on these proposals.

We are also considering a feasibility study for validating data reported to CDC's NHSN Dialysis Event Module. Although this is still in the early stages of development, we anticipate that this study may incorporate the methodology used by CMS's Hospital Inpatient Quality Reporting Program (77 FR 53539 through 53553), as well as additional input from CDC. The feasibility study will likely: (i) Estimate the burden and associated costs to ESRD QIP-eligible facilities for participating in an NHSN validation program; (ii) assess the costs to CMS to implement an NHSN validation program on a statistically relevant scale; and (iii) develop and test a protocol to validate NHSN data in nine ESRD QIP-eligible facilities. Facilities would be selected on a voluntary basis. Based on the results of this study, we intend to propose more detailed requirements for validating NHSN data used in the ESRD QIP in the future.

We requested comments on these proposals. The comments we received on these proposals and our responses are set forth below.

Comment: Several commenters urged CMS to validate NHSN data and to publish the processes that will be used for data validation.

Response: As noted above, we are considering a feasibility study for validating NHSN data submitted by facilities. If we proceed with the study, then we will publish the process used to validate NHSN data before the study is conducted.

Comment: Several commenters supported the proposal to extend the data-validation pilot, to reduce the sample size from 750 to 300 facilities, and to not penalize facilities for submitting invalid data (particularly until CROWNWeb is fully functional). These commenters also appreciated the opportunity to comment on future validations methodologies. However, some commenters urged CMS to reimburse facilities for staff time, as

[20] Medicare claims data from 2012 were used to calculate the achievement threshold, benchmark, and performance standard for the Hemoglobin > 12 g/dL, Dialysis Adequacy, and Vascular Access Type clinical measures. CROWNWeb data from May 2012 through December 2012 were used to estimate the percentiles for the Hypercalcemia clinical measure.

well as for costs associated with copying and mailing patient records.

Response: We thank the commenter for the support. Additionally, we note that CMS has not historically reimbursed provider staff or contractors for staff time spent in connection with copying and mailing patient records, and we believe these costs are minimal in comparison with the value of validating data used in the ESRD QIP.

For the reasons stated above, we are finalizing our proposal to extend the data validation pilot as proposed, and we will post the methodology, procedures and results of the PY 2016 pilot on *http://www.dialysisreports.org.*

13. Scoring Facilities Whose Ownership Has Changed

During PY 2012 (our first implementation year for the ESRD QIP), facilities requested guidance regarding how a change in ownership affects any applicable ESRD QIP payment reductions. Starting with the implementation of the PY 2015 ESRD QIP (the performance period of which is CY 2013), the application of an ESRD QIP payment reduction depended on whether the facility retained its CCN after the ownership transfer. If the facility's CCN remained the same after the facility was transferred, then we considered the facility to be the same facility (despite the change in ownership) for the purposes of the ESRD QIP, and we applied any ESRD QIP payment reductions that would have applied to the transferor to the transferee. Likewise, as long as the facility retained the same CCN, we calculated the measure scores using the data submitted during the applicable period, regardless of whether the ownership changed during one of these periods. If, however, a facility received a new CCN as a result of a change in ownership, then we treated the facility as a new facility for purposes of the ESRD QIP based on the new facility's CCN open date. We believe that these policies are the most operationally efficient, and will allow facilities the greatest amount of certainty when they change ownership. We proposed to continue applying these rules during the PY 2016 ESRD QIP and future years of the program, and we requested public comments on this proposal.

We did not receive any comments on this proposal. Therefore, we are finalizing our proposals for scoring facilities whose ownership has changed for the PY 2016 ESRD QIP and for future payment years.

14. Public Reporting Requirements

Section 1881(h)(6)(A) of the Act requires the Secretary to establish procedures for making information available to the public about facility performance under the ESRD QIP, including information on the TPS (along with appropriate comparisons of facilities to the national average with respect to such scores) and scores for individual measures achieved by each facility. Section 1881(h)(6)(B) of the Act further requires that a facility have an opportunity to review the information to be made public with respect to that facility prior to publication. In addition, section 1881(h)(6)(C) of the Act requires the Secretary to provide each facility with a certificate containing its TPS to post in patient areas within the facility. Finally, section 1881(h)(6)(D) of the Act requires the Secretary to post a list of facilities and performance-score data on a CMS Web site.

In the PY 2012 ESRD QIP final rule, we adopted uniform requirements based on sections 1881(h)(6)(A) through 1881(h)(6)(D) of the Act, thereby establishing procedures for facilities to review the information to be made public and for informing the public through facility-posted certificates. We proposed to maintain the public reporting requirements as finalized in the CY 2013 ESRD PPS final rule, except regarding the timing of when facilities must post their certificates.

For PYs prior to PY 2014, we required facilities to post certificates within 5 business days of us making these certificates available for download from *dialysisreports.org* in accordance with section 1881(h)(6)(C) of the Act. (77 FR 67516 and 76 FR 637) In the CY 2013 ESRD PPS final rule, we noted that many individuals responsible for posting the certificates were away on holiday during the December time period when certificates typically become available, and finalized that, beginning in PY 2014, a facility must post copies of its certificates by the first business day after January 1 of the payment year. (77 FR 67517) We also noted that certificates are typically available for download on or around December 15 of each year, and stated that we believe that this two week time period is enough to allow facilities to post them.

Since the CY 2013 ESRD PPS final rule was finalized, we have noted that a posting deadline of the first business day after January 1 could create difficulties for facilities if it were ever the case that certificates were not available for download in the typical timeframe. We want to ensure that facilities have adequate time to post certificates as required in this circumstance, and that the required timing accommodates the December holidays. Therefore, we proposed that, beginning in CY 2014, facilities must post certificates within fifteen business days of CMS making these certificates available for download from *dialysisreports.org* in accordance with section 1881(h)(6)(C) of the Act.

The comments we received on these proposals and our response are set forth below.

Comment: Several commenters supported the public-reporting proposal to require facilities to post performance score certificates fifteen business days after they are made available.

Response: We thank the commenters for the support.

For this reason, we are finalizing the public reporting requirements as proposed for the PY 2016 ESRD QIP and for future payment years.

IV. Clarification of the Definition of Routinely Purchased Durable Medical Equipment (DME)

A. Background

1. Background for DME

Title XVIII of the Social Security Act (the Act) governs the administration of the Medicare program. The statute provides coverage for broad categories of benefits, including, but not limited to, inpatient and outpatient hospital care, skilled nursing facility care, home health care, physician services, and DME. ''Medical and other health services,'' which is defined under section 1861(s)(6) of the Act to include DME, is a separate Medicare Part B benefit for which payment is authorized by section 1832 of the Act. In accordance with section 1861(n) of the Act, the term ''durable medical equipment'' includes iron lungs, oxygen tents, hospital beds, and wheelchairs used in the beneficiary's home, including an institution used as his or her home other than an institution that meets the requirements of section 1861(e)(1) or section 1819(a)(1) of the Act.

Section 1834(a) of the Act, as added by section 4062 of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), Public Law 100–203, sets forth the payment rules for DME furnished on or after January 1, 1989. The Medicare payment amount for a DME item is generally equal to 80 percent of the lesser of the actual charge or the fee schedule amount for the item, less any unmet Part B deductible. The beneficiary's coinsurance for such items is generally equal to 20 percent of the

lesser of the actual charge or the fee schedule amount for the item once the deductible is met. The fee schedule amounts are generally calculated using average allowed charges from a base period and then increased by annual update factors. Sections 1834(a)(2) through (a)(7) of the Act set forth separate classes of DME and separate payment rules for each class. The six classes of items are: inexpensive and other routinely purchased DME; items requiring frequent and substantial servicing; customized items; oxygen and oxygen equipment; other covered items (other than DME); and other items of DME, also referred to as capped rental items. The class for inexpensive and other routinely purchased DME also includes accessories used in conjunction with nebulizers, aspirators, continuous positive airway pressure devices and respiratory assist devices. Items of DME fall under the class for other items of DME (capped rental items) if they do not meet the definitions established in the statute and regulations for the other classes of DME.

2. Medicare Guidance and Rulemaking Regarding Definition of Routinely Purchased DME

On July 14, 1988, CMS issued a program memorandum containing guidance for carriers to follow in developing a data base that would be used in identifying other routinely purchased DME for the purpose of implementing section 1834(a)(2)(A)(ii) of the Act. For the purpose of identifying routinely purchased items, the carriers were instructed via the program memorandum to ''compute the unduplicated count of beneficiaries who purchased the item, by Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) code (now the Healthcare Common Procedure Coding System), and a count of those who only rented the item during the 7/1/86–6/30/87 period.'' The carriers were instructed to include purchase of new and used items and beneficiaries who purchased an item that was initially rented in the count of beneficiaries who purchased the item. The carriers made determinations regarding whether DME furnished during this period would be rented (non-capped) or purchased based on which payment method was more economical.

In November 1988, CMS revised Part 3 (Claims Process) of the Medicare Carriers Manual (HCFA Pub. 14–3) via transmittal number 1279, by adding section 5102 and detailed instructions for implementation of the fee schedules and payment classes for DME mandated by section 4062 of OBRA 87. The new implementing instructions were effective for services furnished on or after January 1, 1989. Section 5102.1.A.2 indicated that carriers would be provided with a listing of the equipment in the routinely purchased DME category. The initial classifications were implemented on January 1, 1989, in accordance with the program instructions, and included a listing of HCPCS codes for base equipment such as canes and walkers, as well as HCPCS codes for replacement accessories such as cane tips, walker leg extensions, and power wheelchair batteries for use with medically necessary, patient-owned base equipment (canes, walkers, and power wheelchairs). In the case of expensive accessories that were not routinely purchased during July 1986 through June 1987, such as a wheelchair attachment to convert any wheelchair to one arm drive, these items fell under the listing of HCPCS codes for capped rental items. Medicare payment for DME extends to payment for replacement of essential accessories used with patient-owned equipment or accessories, attachments, or options that modify base equipment, such as the addition of elevating leg rests to a manual wheelchair.

The Medicare definition of routinely purchased equipment under 42 CFR § 414.220(a)(2) specifies that routinely purchased equipment means ''equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. This definition was promulgated via an interim final rule (IFC) on December 7, 1992 (57 FR 57675), remaining consistent with Medicare program guidance in effect beginning in 1988 and discussed above, and finalized on July 10, 1995 (60 FR 35492). In the preamble of the 1992 IFC (57 FR 57679), we discussed how items were classified as routinely purchased DME based on data from July 1986 through June 1987, ''in the absence of a statutory directive that defines the period for determining which items are routinely purchased.'' CMS indicated that it ''selected the period July 1, 1986 through June 30, 1987, because it is the same 12-month period required by section 1834(a)(2)(B)(i) of the Act for calculating the base fee schedule amount for routinely purchased equipment.'' (57 FR 57679) This period was therefore established as the period from which data was used for identifying the items that had been acquired on a purchase basis 75 percent of the time or more under the Medicare rent/purchase program.

3. Payment for Inexpensive or Routinely Purchased Items and Capped Rental Items

Under § 414.220(b), payment for inexpensive or routinely purchased DME is made on a purchase or rental basis, with total payments being limited to the purchase fee schedule amount for the item. If an item is initially rented and then purchased, the allowed purchase charge is based on the lower of the actual charge or fee schedule amount for purchase of the item minus the cumulative allowed charge for previously paid rental claims. Under § 414.229(f), payment for capped rental items is made on a monthly rental basis for up to 13 months of continuous use. The supplier must transfer title to the equipment to the beneficiary on the first day following the 13th month of continuous use.

B. Current Issues

Concerns have been raised about the application of the definition of and payment for routinely purchased DME, as it applies to expensive DME accessories. For example, recently one manufacturer of a new, expensive wheelchair accessory, included under a HCPCS code that would result in a corresponding Medicare fee schedule amount of approximately $3,000, if purchased, questioned why the HCPCS code describing their product was classified as capped rental DME. They pointed out that codes added to the HCPCS in recent years for other similar and more expensive wheelchair accessories costing $4,000 to $10,000 were classified as routinely purchased DME even though the items were not purchased under Medicare during the period specified in § 414.220(b). As a result, we began a review of expensive items that have been classified as routinely purchased equipment since 1989, that is, new codes added to the HCPCS after 1989 for items costing more than $150, to address this apparent inconsistency.

As a result of this review, we found some codes that are not classified consistent with the regulatory definition of routinely purchased equipment at section § 414.220(a)(2). We found that HCPCS codes added after 1989 for expensive, durable accessories used with base equipment, such as wheelchairs, have been classified as routinely purchased equipment. While section 1834(a)(2)(A)(iii) of the Act and 42 CFR § 414.220(a)(3) of the regulations allow payment for the purchase of accessories used in conjunction with

nebulizers, aspirators, continuous positive airway pressure devices (CPAP), other items covered under the DME benefit, including DME other than nebulizers, aspirators, CPAP devices, respiratory assist devices and accessories used in conjunction with those items, are paid for in accordance with the rules at section 1834(a) of the Act and are classified under sections 1834(a)(3) thru (7) of the Act as inexpensive and other routinely purchased DME, items requiring frequent and substantial servicing, certain customized items, oxygen and oxygen equipment, other covered items other than DME, or other covered items of DME.

Additionally, we found that in some cases, expensive items of DME were classified as routinely purchased based on information suggesting that payers other than Medicare were routinely making payment for the items on a purchase basis. We believe that classifying an item as routinely purchased equipment based on data and information from other payers for the purposes of implementing § 414.220(b) is inappropriate because other payers do not operate under the same payment rules as Medicare. Other payers may decide to purchase expensive items for reasons other than achieving a more economical alternative to rental, the basis Medicare contractors used in deciding whether to purchase items during July 1986 through June 1987. In other cases, expensive items of DME were classified as routinely purchased equipment based on requests from manufacturers of equipment primarily used by Medicaid beneficiaries. We do not believe we should classify an item as routinely purchased equipment for the purposes of implementing § 414.220(b) of the Medicare regulations based on how this might affect other payers such as Medicaid state agencies because such classifications are not consistent with the regulations. After reviewing this issue, we do not think the regulation supports the classification of expensive DME as routinely purchased equipment based on whether other payers routinely pay for the item on a purchase basis or how manufacturers would prefer that other payers pay for the item. The classification of HCPCS codes for expensive equipment added after 1989 as routinely purchased equipment based on this kind of information does not comply with the Medicare definition of routinely purchased equipment and defeats a fundamental purpose of the capped rental payment methodology to avoid paying the full purchase price of costly equipment when used only a short time.

DME and accessories used in conjunction with DME are paid for under the DME benefit and in accordance with the rules at section 1834(a) of the Act. In the proposed rule (78 FR 40874), we proposed to clarify the existing definition of routinely purchased equipment at § 414.220(a)(2) and provide notice that certain HCPCS codes for DME and DME accessories added to the HCPCS after 1989 that are currently classified as routinely purchased equipment would be reclassified as capped rental items (see Table 11 below). Under our proposal, this would apply to all expensive items for which Medicare claims data from July 1986 through June 1987 does not exist or does not indicate that the item was acquired by purchase on a national basis at least 75 percent of the time. In the case of expensive accessories that are furnished for use with complex rehabilitative power wheelchairs, we proposed that the purchase option for complex rehabilitative power wheelchairs at section 1834(a)(7)(A)(iii) of the Act would also apply to these accessories. For any wheelchair accessory classified as a capped rental item and furnished for use with a complex rehabilitative power wheelchair (that is, furnished to be used as part of the complex rehabilitative power wheelchair), the supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished. These items would be considered as part of the complex rehabilitative power wheelchair and associated purchase option set forth at § 414.229(a)(5).

We also solicited comments on the effective date(s) for reclassifying items previously classified as routinely purchased equipment to the capped rental payment class in order to be in compliance with current regulations. (78 FR 40874) Given that some items (HCPCS codes) may be included in the Round 2 and/or Round 1 Recompete phases of the competitive bidding program (CBP), we indicated we do not believe we could change the classification for items furnished under these programs until the contracts awarded based on these competitions expire on July 1, 2016, and January 1, 2017, respectively, regardless of whether the item is provided in an area subject to competitive bidding or not. We proposed that the reclassification of items previously classified as routinely purchased equipment to the capped rental payment class be effective January 1, 2014, for all items that are not included in either a Round 2 or Round 1 Recompete CBP established in accordance with § 414.400. For any item currently under a Round 2 CBP, instead of a January 1, 2014, effective date we proposed July 1, 2016, for these reclassifications, which would apply to all items furnished in all areas of the country, with the exception of items furnished in a Round 1 Recompete CBP. For items furnished in a Round 1 Recompete CBP, we proposed an effective date of January 1, 2017, which would only apply to items furnished in the nine Round 1 Recompete areas. Therefore, we proposed to generally base the effective dates on when the CBPs end. To summarize, the proposed effective dates for the reclassifications of these items from the routinely purchased DME class to the capped rental DME class would be:

- January 1, 2014, for items furnished in all areas of the country if the item is not included in Round 2 or Round 1 Recompete CBP;
- July 1, 2016, for items furnished in all areas of the country if the item is included in a Round 2 CBP and not a Round 1 Recompete CBP and for items included in a Round 1 Recompete CBP but furnished in an area other than one of the 9 Round 1 Recompete areas; and
- January 1, 2017, for items included in a Round 1 Recompete CBP and furnished in one of the nine Round 1 Recompete areas.

We noted that this implementation strategy would allow the item to be moved to the payment class for capped rental items at the same time in all areas of the country without disrupting CBPs currently underway. For Round 1 Recompete items furnished in nine areas of the country for the six-month period from July 1, 2016, thru December 31, 2016, Medicare payment would be on a capped rental basis in all parts of the country other than these nine areas.

Alternatively, we noted the effective date for the reclassifications could be January 1, 2014, for all items paid under the fee schedule (78 FR 40875). In other words, the reclassification would not affect payments for items furnished under the Round 2 or Round 1 Recompete CBPs in the respective competitive bidding areas (CBAs) until the contract entered into under these programs expire on July 1, 2016, and January 1, 2017, respectively. However, such an alternative would result in an extensive two and a half year period from January 2014 through June 2016, where Medicare payment would be on a capped rental basis for the items in half of the country (non-CBAs) and on a purchase basis in the other half of the country (109 Round 2 and/or Round 1 Recompete CBAs). We believed that this

bifurcation in payment classifications would create confusion and would be difficult to implement, but we solicited comments on this alternative implementation strategy.

For this final rule, we have identified 78 HCPCS codes that will require reclassification from the inexpensive or routinely purchased DME payment class to the capped rental DME payment class (78 FR 40875 through 40876). The codes are shown in Table 11 below. As shown in Table 11, Column A of the table shows the type of DME, Columns B and C indicate the HCPCS level II codes and the short descriptor. The long descriptor for each code is available at *http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html*.

As shown in Column A, the majority of codes relate to manual wheelchairs and wheelchair accessories. In the case of accessories used with complex rehabilitative power wheelchairs, the purchase option for complex rehabilitative power wheelchairs applies to these accessories because they are part of the complex rehabilitative power wheelchair.

TABLE 11—ROUTINELY PURCHASED ITEMS RECLASSIFIED TO CAPPED RENTAL

Group category	HCPCS	Descriptor
Automatic External Defibrillator	K0607	Repl battery for AED.
Canes/Crutches	E0117	Underarm spring assist crutch.
Glucose Monitor	E0620	Capillary blood skin piercing device laser.
High Frequency Chest Wall Oscillation Device (HFCWO)	A7025	Replace chest compress vest.
Hospital Beds/Accessories	E0300	Enclosed ped crib hosp grade.
Misc. DMEPOS	A4639	Infrared ht sys replacement pad.
	E0762	Trans elec jt stim dev sys.
	E1700	Jaw motion rehab system.
Nebulizers & Related Drugs	K0730	Ctrl dose inh drug deliv system.
* * *	*	* * *
Other Neuromuscular Stimulators	E0740	Incontinence treatment system.
	E0764	Functional neuromuscular stimulation.
Pneumatic Compression Device	E0656	Segmental pneumatic trunk.
	E0657	Segmental pneumatic chest.
Power Operated Vehicles (POV)	E0984	Add pwr tiller.
* * *	*	* * *
Speech Generating Devices	E2500	SGD digitized pre-rec <= 8 min.
	E2502	SGD prerec msg >8 min <= 20 min.
	E2504	SGD prerec msg >20 min <= 40 min.
	E2506	SGD prerec msg > 40 min.
	E2508	SGD spelling phys contact.
	E2510	SGD w multi methods messg/access.
Support Surfaces	E0197 *	Air pressure pad for mattress.
	E0198	Water pressure pad for mattress.
Traction Equipment	E0849	Cervical pneum traction equip.
	E0855	Cervical traction equipment.
	E0856	Cervical collar w air bladder.
Walkers	E0140 *	Walker w trunk support.
	E0144	Enclosed walker w rear seat.
	E0149 *	Heavy duty wheeled walker.
Wheelchairs Manual	E1161	Manual adult wc w tiltinspac.
	E1232	Folding ped wc tilt-in-space.
	E1233	Rig ped wc tltnspc w/o seat.
	E1234	Fld ped wc tltnspc w/o seat.
	E1235	Rigid ped wc adjustable.
	E1236	Folding ped wc adjustable.
	E1237	Rgd ped wc adjstabl w/o seat.
	E1238	Fld ped wc adjstabl w/o seat.
Wheelchairs Options/Accessories		
	E0985 *	W/c seat lift mechanism.
	E0986	Man w/c push-rim pow assist.
	E1002 ∧	Pwr seat tilt.
	E1003 ∧	Pwr seat recline.
	E1004 ∧	Pwr seat recline mech.
	E1005 ∧	Pwr seat recline pwr.
	E1006 ∧	Pwr seat combo w/o shear.
	E1007 ∧	Pwr seat combo w/shear.
	E1008 ∧	Pwr seat combo pwr shear.
	E1010 ∧	Add pwr leg elevation.
	E1014	Reclining back add ped w/c.
	E1020 *	Residual limb support system.
	E1028 *	W/c manual swingaway.
	E1029	W/c vent tray fixed.
	E1030 ∧	W/c vent tray gimbaled.
	E2227	Gear reduction drive wheel.
	E2228 *	Mwc acc, wheelchair brake.
	E2310 ∧	Electro connect btw control.
	E2311 ∧	Electro connect btw 2 sys.

TABLE 11—ROUTINELY PURCHASED ITEMS RECLASSIFIED TO CAPPED RENTAL—Continued

Group category	HCPCS	Descriptor
	E2312 ∧	Mini-prop remote joystick.
	E2313 ∧	PWC harness, expand control.
	E2321 ∧	Hand interface joystick.
	E2322 ∧	Mult mech switches.
	E2325 ∧	Sip and puff interface.
	E2326 ∧	Breath tube kit.
	E2327 ∧	Head control interface mech.
	E2328 ∧	Head/extremity control interface.
	E2329 ∧	Head control interface nonproportional.
	E2330 ∧	Head control proximity switch.
	E2351 ∧	Electronic SGD interface.
	E2368 *	Pwr wc drivewheel motor replace.
	E2369 *	Pwr wc drivewheel gear box replace.
	E2370 *	Pwr wc dr wh motor/gear comb.
	E2373 ∧	Hand/chin ctrl spec joystick.
	E2374 ∧	Hand/chin ctrl std joystick.
	E2375 *	Non-expandable controller.
	E2376 ∧	Expandable controller, replace.
	E2377 ∧	Expandable controller, initial.
	E2378	Pw actuator replacement.
	K0015 *	Detach non-adjus hght armrst.
	K0070 *	Rear whl complete pneum tire.
Wheelchairs Seating	E0955 *	Cushioned headrest.

* Effective July 1, 2016. If the item is furnished in CBAs in accordance with contracts entered into as part of the Round 1 Recompete of DMEPOS CBP, then effective January 1, 2017.
∧ Item billable with Complex Rehabilitative Power Wheelchair codes K0835—K0864.
** Code E0760 not included in final list based on comments received on proposed list.
*** Code E0457 not included in final list as code has been made invalid for Medicare effective January 1, 2014.

In summary, we provided notice that certain HCPCS codes we proposed would be reclassified as capped rental items. We invited comments on this section.

C. Responses to Comments on the Clarification of the Definition of Routinely Purchased Durable Medical Equipment (DME)

We received approximately 172 comments regarding the clarification of the definition of Routinely Purchased DME. CMS received comments from DME suppliers, manufacturers, professional, state and national trade associations, physicians, physical therapists (PTs), speech pathologists, occupational therapists (OTs), beneficiaries and their caregivers, the Veterans Administration (VA), and a state government representative. The comments and our responses are summarized below.

Comment: Several commenters noted the clarification of the definition of routinely purchased durable medical equipment relies on 1986/87 as the base year and instead suggested using 2010/11 as a base year for determining new items classified under routinely purchased category.

Response: We do not agree with this comment. In this final rule, we are not revising the definition given our longstanding interpretation regarding section 1834(a)(2) of the Act. Although there have been numerous amendments to section 1834(a) over the years to address payment of certain DME, there have been no amendments to revise the definition of routinely purchased DME. Payment on a capped rental basis avoids lump sum purchases of expensive equipment that is only needed on a short term basis and is more economical than purchase. If the equipment is needed on a long term basis, beneficiaries will take over ownership following 13 months of continuous use. In addition, we did not propose to revise the base period in the definition for routinely purchased DME at 42 CFR § 414.220(a)(2). We are therefore not adopting this suggestion to revise the base period for the definition of routinely purchased DME equipment under 42 CFR § 414.220(a)(2).

Comment: Many commenters contended that reclassifying certain codes from the routinely purchased DME category to capped rental DME would result in additional administrative burden for suppliers. Commenters reacted unfavorably to repeated billings for monthly rental claims for as long as the item is medically necessary up until title transfers at the end of the 13th month rental period.

Response: While we understand certain billing procedures for capped rental items differ from and may be more administratively burdensome than billing procedures for routinely purchased items, this does not negate the fact that items must be classified in accordance with the rules of the statute and regulations.

Comment: One commenter requested a delay in the implementation of the reclassification of the list of codes in our table from routinely purchased DME to capped rental DME. The commenter stated that more time is needed to educate practitioners and patients along with receipt of adequate program guidance. Another comment from a manufacturer requested a substantial delay in implementation of the capped rental system for Speech Generating Devices (SGDs).

Response: Items that are not in compliance with the existing definition of routinely purchased DME will be classified as capped rental items and paid for in accordance with the rules set forth in 42 CFR 414.229 for items not currently included in a CBP that are furnished on or after April 1, 2014. The dates for re-classification of items affected by this rule that are currently included in a CBP will be discussed later in the preamble. We do not agree with the comment that a substantial delay in implementation of the reclassification of SGDs is necessary. Suppliers and practitioners will have more than three months to become familiar with payment rules and billing procedures related to capped rental

items and to prepare for this change in classification. In addition, this change in classification only affects payments for these items on or after April 1, 2014. We recognize that consumers, occupational and physical therapists and disability advocacy groups have expressed concerns with these changes to acquisition policy for some durable medical equipment which persons with disabilities rely upon, including specialized wheelchairs and speech generating devices. Although we do not anticipate disruptions resulting from the transition from purchase to a capped rental, we understand the important role that this technology plays in maximizing the independence of persons with disabilities and their ability to direct their own care. Accordingly, CMS is committed to carefully monitoring beneficiary access using real-time claims data to ensure that there isn't an adverse impact.

Comment: Several commenters noted some of the codes proposed for reclassification include the term ''replacement only'', such as code E2376 Expandable controller, replacement and K0607 Automatic external defibrillator part; thus, the codes are most likely submitted for payment for beneficiary owned DME instead of DME owned by the supplier during a 13-month capped rental period. Commenters felt it was unrealistic to expect a supplier to rent these items and disable the patient owned equipment should the beneficiary become ineligible for Medicare payment. Another commenter mentioned that some of the transitioning codes are not covered or have lower utilization under Medicare.

Response: We do not agree with these comments. The statute does not differentiate between items paid for under the DME benefit that are base equipment versus items paid for under the DME benefit that are replacement parts for base equipment. With the exception of drugs, which are paid in accordance with a separate payment methodology, all items covered under the DME benefit category are subject to the payment rules mandated by section 1834(a) of the Act. An item is not classified based on utilization, and, under our regulation at 42 CFR 414.229(f), if the beneficiary needs the item for 13 continuous months, title to the item is transferred to the beneficiary after 13 months. Lastly, our review of the codes for reclassification from routinely purchased DME to capped rental indicates coverage under Medicare although the extent of coverage differs by item.

Comment: One commenter noted several of the listed codes have limited coverage under Medicare and so continuing to pay on a lump sum purchase basis for these items will have a minimal impact on Medicare expenditures.

Response: The statute does not provide direction or discretion to classify items under section 1834(a)(2) thru (7) of the Act based on magnitude of expenditures.

Comment: Numerous commenters opposed reclassifying the HCPCS codes for pediatric manual wheelchairs (codes E1232–E1238) and manual tilt in space wheelchairs (code E1161) from the payment class for inexpensive or routinely purchased items to the payment class for capped rental items. Some commenters stated many adult tilt in space wheelchair users require customization of equipment and require adjustment to reflect their unique postural and mobility needs. The commenters stated a concern that payment on a rental basis for these items will increase the risk for orthopedic deformities due to improper support, increase the risk of pressure sores from poorly managed skin integrity, and will contribute to overall costs of medical care. Many commenters stated these items are used for chronic conditions or permanent disabilities, such as quadriplegia, paraplegia, multiple sclerosis, head and spinal injuries, requiring wheelchairs and wheelchair accessories that are constructed of components that are not mass produced which reduces the profit margin compared to the furnishing of power mobility and acute adult manual wheelchairs.

Response: Claims for ''youth'' or ''pediatric'' wheelchairs were submitted using HCPCS code E1091 (Youth Wheelchair, Any Type) from July 1986 through June 1987, and this equipment was paid on a purchase basis 25 percent of the time during this time. This is well below the 75 percent threshold established in the statute; and therefore, classification of pediatric or youth wheelchairs (HCPCS codes E1232–E1238) as capped rental items is required by the regulations. The data from July 1986 through June 1987 also indicates that only 30 percent of all manual wheelchairs were purchased for Medicare beneficiaries during this time. As Medicare claims data from July 1986 through June 1987 does not exist for adult tilt in space wheelchairs (HCPCS code E1161), the data required by the regulation to classify these items as routinely purchased equipment does not exist and these items will therefore be classified as capped rental items in accordance with this rule. We agree that some items may have a higher cost because they are not mass produced; however, such costs are accounted for in the fee schedule amounts that have been set based on supplier charges or price lists. We note that the fee schedule amounts for the pediatric and adult tilt in space manual wheelchairs are more than double, and in some cases triple, the fee schedule amounts established for other manual wheelchairs. We recognize that commenters have expressed concerns with these changes to payment policy for some durable medical equipment which persons with disabilities rely upon, including specialized wheelchairs. Although we do not anticipate disruptions resulting from the transition from purchase to a capped rental, we understand the important role that this equipment plays in maximizing the independence of persons with disabilities and their ability to direct their own care. Accordingly, CMS is committed to carefully monitoring beneficiary access using real-time claims data to ensure that there isn't an adverse impact.

Comment: One commenter raised concern that suppliers spend multiple hours on supplies, labor and parts to customize a wheelchair; therefore, if patients become temporarily institutionalized, regress and need new customized parts, or pass away so that the wheelchair is returned to the supplier, the supplier would have a need to readjust and customize the chair to fit the needs of the next patient.

Response: This rule has no impact on items that meet the definition of customized items at 42 CFR 414.224. For items that are affected by this rule, we agree that some items may have a higher cost because they are not mass produced; however, such costs are accounted for in the fee schedule amounts that have been set based on supplier charges or price lists. We appreciate hearing about the concerns with these changes to payment policy for some durable medical equipment which persons with disabilities rely upon, including specialized wheelchairs. Although we do not anticipate disruptions resulting from the transition from purchase to a capped rental, we understand the important role that this technology plays in maximizing the independence of persons with disabilities and their ability to direct their own care. Accordingly, CMS is committed to carefully monitoring beneficiary access using real-time claims data to ensure that there isn't an adverse impact.

Comment: There were concerns raised by many commenters regarding reclassification of wheelchair options and accessories added to individually

configure wheelchairs to meet long-term mobility needs.

Response: In this final rule, an exception is established so that wheelchair options and accessories furnished for use with purchased complex rehabilitative power wheelchairs can be paid under a routinely purchased basis consistent with 42 CFR 414.229(a)(5). Other expensive wheelchair options and accessories that are paid separate from the rental payments for the wheelchair base and were not routinely purchased from July 1986 through June 1987 fall under the payment category for capped rental items. Payment will therefore be made on a capped rental basis for the options and accessories furnished for use with the rented wheelchair base. As a result, when payment for less than 13 months of continuous use is made for the wheelchair and associated options and accessories, the supplier can furnish the equipment to other patients and receive additional payment for the equipment. If payment is made for 13 months of continuous use of the wheelchair, then title to the wheelchair and all options and accessories will transfer to the beneficiary.

Comment: One commenter recommended CMS should establish that all manual wheelchairs should remain in the routinely purchased category and that options and accessories provided with/for a ''routinely purchased'' wheelchair base should be considered ''routinely purchased'' as well.

Response: With the exception of ultralightweight manual wheelchairs, manual wheelchairs were not routinely purchased under the Medicare program from July 1986 through June 1987. The data from July 1986 through June 1987 indicates that only 30 percent of manual wheelchairs and 55 percent of power wheelchairs were purchased for Medicare beneficiaries during this time. These percentages are well below the 75 percent threshold established in the statute. As discussed above. an exception is established so that wheelchair options and accessories furnished for use with purchased complex rehabilitative power wheelchairs can be paid under a routinely purchased basis consistent with 42 CFR 414.229(a)(5). Wheelchair options and accessories falling under the payment category for capped rental items will be paid for on a rental basis when they are furnished with other wheelchair bases, with title to the equipment transferring to the beneficiary after 13 months of continuous use.

Comment: Many commenters complained that a capped rental payment method will result in a significant financial burden for suppliers who may face challenges securing capital/lines of credit in the current economic environment.

Response: We do not agree with this comment. The capped rental payment method allows suppliers to reclaim capital equipment that is not needed for 13 months of continuous use. While Medicare payments may total 105 percent of the historic purchase price over 13 months of continuous use by a single beneficiary, the item could be rented for significantly more than 13 monthly payments and significantly more than 105 percent of the historic purchase price if it is used by multiple beneficiaries who do not need the item for the full 13 months.

Comment: Commenters stated that the proposed change in payment rules will be adopted by payers other than Medicare and therefore should not be adopted.

Response: Speculation about how other payers will pay for items that are also paid for by Medicare is beyond the scope of this rule and we have not taken such things into consideration when finalizing our policies. We must comply with the requirements of section 1834(a)(2) through (7) of the Act regarding how we classify and pay for DME items.

Comment: Various commenters argued that since the ultralightweight wheelchair (HCPCS code K0005) is classified as routinely purchased equipment, other complex rehabilitative manual wheelchairs (HCPCS codes E1161 and E1232 through E1238) should similarly be classified as routinely purchased equipment.

Response: The ultralightweight wheelchair was classified as routinely purchased equipment based on the regulatory standard (that is, it was acquired for purchase on a national basis at least 75 percent of the time from July 1986 through June 1987). Other manual wheelchairs have not been routinely purchased under the Medicare program. Claims for ''youth'' or ''pediatric'' wheelchairs were submitted using HCPCS code E1091 (Youth Wheelchair, Any Type) from July 1986 through June 1987, and this equipment was paid on a purchase basis 25 percent of the time during this time. This is well below the 75 percent threshold established in the statute; and therefore, classification of pediatric or youth wheelchairs (HCPCS codes E1232—E1238) as capped rental items is required by the regulations. The data from July 1986 through June 1987 also indicates that only 30 percent of all manual wheelchairs were purchased for Medicare beneficiaries during this time. As Medicare claims data from July 1986 through June 1987 does not exist for adult tilt in space wheelchairs (HCPCS code E1161), these items will be classified as capped rental items in accordance with this rule, and this is consistent with the classification of youth or pediatric wheelchairs and for manual wheelchairs in general based on Medicare claims data from July 1986 through June 1987.

Comment: One commenter concurred with our proposal by indicating it is a waste for patients at end stage of life to purchase complex wheelchairs which they then would not use for more than 1–2 years, due to various life ending diseases or due to regression in function, or at an older terminal age. The commenter noted it is advisable to have a system of rental and return, so that the same equipment can be modified, then rented to someone else. This will greatly reduce waste in this area of assistive technology/wheelchair supply and demand.

Response: We appreciate this comment.

Comment: Several commenters supported our proposal permitting a supplier to give the beneficiary the option of purchasing a wheelchair accessory classified as a capped rental item and furnished for use with a complex rehabilitative power wheelchair (that is, furnished to be used as part of the complex rehabilitative power wheelchair) at the time the accessory is furnished. These wheelchair accessory items would be considered as part of the complex rehabilitative power wheelchair and associated purchase option set forth at § 414.229(a)(5).

Response: We appreciate this comment.

Comment: Several commenters urged CMS to extend our proposal to permit a supplier to give the beneficiary the option of purchasing a wheelchair accessory classified as a capped rental item and furnished for use with a complex rehabilitative power wheelchair (that is, furnished to be used as part of the complex rehabilitative power wheelchair) to accessories furnished for use with standard power wheelchairs.

Response: We disagree with this comment. The statute does not provide a purchase option for standard power wheelchairs. Section 1834(a)(7)(A)(iii) provides the purchase agreement option only for complex, rehabilitative, power-driven wheelchairs.

Comment: Some commenters were concerned that Part B coverage and payment for rented DME is no longer allowed when a beneficiary enters a hospital, so the beneficiary will be billed for equipment during the time the beneficiary is in the hospital because the provider would not be able to remove a tilt mechanism from their wheelchair without rendering their chair non-functional.

Response: The Part B benefit for DME and the payment rules at section 1834(a) of the Act do not extend to DME items furnished for use in hospitals. Classification of items under the payment classes established in sections 1834(a)(2) through (7) is not affected by whether or not the item will later be available for use in a hospital. Medicare benefit payments for items used in hospitals may be available under other parts of the program other than the Part B benefit for DME. In addition, suppliers are responsible for submitting claims for payment under the Medicare Part B DMEPOS fee schedule in compliance with our regulations and program instructions, such as those in the Medicare Claims Processing Manual (Pub 100.04), chapter 20, section 30.5.4 which address such temporary interruptions

Comment: Several commenters argued that the estimated program savings are not accurate primarily because the 8 month average use assumed for the items moved from routinely purchased to capped rental is in error because the 8 month average use was established for existing capped rental items, not routinely purchased.

Response: We believe that Medicare data on the average number of monthly rental claims paid for items currently classified as capped rental items is a reasonable proxy for the average number of monthly rental claims that will be paid for items reclassified as a result of this rule and provides an accurate estimate of the impact of this rulemaking on Medicare part B expenditures for DME. Most of the items being reclassified are either wheelchairs or wheelchair accessories. In reviewing the data used to determine that an average of 8 monthly rental payments are made for items currently classified as capped rental items, the average number of paid monthly rental claims per beneficiary drops to 7 when only wheelchairs and wheelchair accessories currently classified as capped rental item are considered. Our goal is to create a reasonable model by which to estimate the fiscal impact of the policy. The method used to calculate the savings is as follows:

- Sum the 2011 allowed charges for the HCPCS that are affected
- Increase the allowed charges by Medicare Advantage add-on
- Apply the annual increases for fee-for-service Medicare Part B population and for fee update to the total expenditures through the year 2023
- Based on claims data, the average duration of use of capped rental equipment is approximately 8 months, which is 2/3 of purchase price.
- So it is assumed that moving an item from routinely purchased to capped rental will on average save 33 percent of the purchased price, which is the factor applied to allowed charges to generate the savings indicated in the proposed rule.

Comment: Several commenters argued that the estimated savings in the rule does not consider the cost of possible increased institutional care.

Response: We do not believe the policy described in this final rule would increase the use of institutional care. We are not reducing the number of items that would be covered or reducing payment for certain DME items such that more institutional care may be needed.

Comment: Some commenters recommended classifying equipment as routinely purchased equipment if any of the following conditions are met: 1) the item is routinely needed for a period exceeding 13 months; 2) the item is intended for use by people with permanent disabilities; 3) the item is designed, manufactured, or assembled for a single individual (not intended to be used by multiple individuals); 4) the item was previously classified as routinely purchased equipment; and 5) other payers routinely pay for the item on a purchase basis.

Response: We disagree with this suggestion. We have interpreted the statutory definition of routinely purchased equipment, as set forth in the regulations, as ''equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987.'' The statute does not contemplate use of additional factors in making determinations regarding whether equipment is routinely purchased, such as the ones raised by the commenters,. Also, we see no reason to revise the longstanding definition of routinely purchased equipment, but we may reconsider the issue in the future if necessary.

Comment: One commenter noted the United States Supreme Court held in Olmstead v. L.C. (527 US 581 (1991)) that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. As noted by the commenter, the Court held that public entities must provide community-based services to persons with disabilities to support them to live independently in the community. The commenter asserts a change in the terms of usage of assistive devices jeopardizes the spirit of the decision made in the Olmstead case. A person can be in a position of not having these devices at time of need.

Response: We do not concur that changing the payment classification of certain codes from routinely purchased DME to capped rental DME jeopardizes the spirit of the decision made in the Olmstead case. Our proposal is not designed to undermine payment of the items; rather it is clarifying the definition of routinely purchased equipment set forth at section § 414.220(a)(2) and reclassifying some codes that are not presently classified consistent with the regulatory definition. In addition, the proposal is not designed to have any impact on coverage of items and services under the Medicare Part B benefit for DME. Such items and services would continue to be available consistent with the statute and regulations. This rule is designed to clarify the payment provisions applicable to accessories used in conjunction with items paid for under section 1834(a) of the Act.

Comment: Some commenters stated that speech generating devices (SGDs) (HCPCS codes E2500–E2510) should not be covered as DME but instead as prosthetic devices.

Response: These comments are outside the scope of the proposed rule, and therefore are not addressed in this final rule. The process for reviewing coverage/benefit category for an item is not addressed in this rule. Information on the process can be found at the Web site *http://www.cms.gov/Medicare/Coverage/DeterminationProcess/index.html*

Comment: Several commenters stated that certain patients may benefit from renting SGDs. One commenter wrote once an individual has the initial assessment, there is often a trial period with one or more devices. The average time for trials is 90 days. One commenter stated a rental may be appropriate for short-term use such as a temporary loss of natural speech due to a surgical procedure or when waiting to purchase one. Another commenter indicated patients may benefit from renting a device for up to 1 year. Furthermore, one commenter supported implementation of a rental payment basis for certain DME to prevent abuse

of the purchase basis system and to help keep co-insurance costs lower when extended over the number of rental months.

Response: We thank the commenters for their helpful comments and agree about the potential benefits of our capped rental policy. We are aware that some manufacturers make their SGC products available on a rental basis so that patients can try out the products to figure out which one best meets their needs. Under the capped rental payment system, the patient will have the ability to obtain a new physician order and change equipment during the rental period to equipment that better meets their medical needs while Medicare rental payments continue up to the point where title to the equipment transfers to the beneficiary after 13 months of continuous use.

Comment: Numerous commenters opposed reclassification of SGDs, indicating that these devices are individually programmed based on each patient's need and access method (that is, eye-gaze, touch screen, switch) and language skills. The commenters stated that these devices are not similar to wheelchairs which are primarily generic in their design and can be used by a wide variety of individuals without significant modifications. Also, the commenters reviewed that patients' caregivers may be accustomed to specific devices used by their patients. One commenter suggested that a SGD is more appropriately analyzed as a complex rehabilitation tool, and as part of that analysis, the importance of integration and customization with the other rehab tools and medical needs of the patient must be considered. Other commenters reiterated that SGDs assist with communication that is essential for an individual's independence and functional living. Another commenter described an analysis of the diagnoses of the patients using SGDs, which shows that an estimate of eight months for a rental is unrealistic given that many SGD patients have a long term need for the device.

Response: We recognize that patients may use long term DME such as SGDs because of chronic conditions or permanent disabilities; however, we believe assigning the appropriate payment category in accordance with the statute and regulations ensures appropriate payment, supplier responsibilities, and beneficiary safeguards. Our final policy is not designed to interfere with patient care or a practitioner's efforts to program SGDs.

Comment: Many commenters claimed that reclassifying SGDs from routinely purchased DME to capped rental DME would cause suppliers to limit the amount of time and attention given to furnishing quality SGDs. Several commenters are concerned suppliers will require patients to switch devices and the devices would be taken away from patients who need them when the patient has reached maximum rental fees. Another commenter raised concerns that suppliers will not furnish SGDs that adequately serves patients who move from one location to another.

Response: The HCPCS codes for SGDs and other DME describe different categories of items. The supplier must furnish the item ordered by the physician to meet the patient's medical needs as required by 42 CFR 424.57(c)(4). Suppliers that are found not in compliance with the DMEPOS supplier standards are not allowed to possess a supplier number and receive Medicare payment for DME in accordance with section 1834(j) of the Act. These standards and requirements are not affected by the methodology used to pay for the item. In addition, regulations at 42 CFR 414.229(g) require that suppliers furnishing capped rental items continue to furnish the item for the full 13-month capped rental period with very limited exceptions and are prohibited from switching the patient's equipment unless the physician orders different equipment, the beneficiary chooses to obtain a newer technology item or an upgraded item, or the equipment is replaced because of loss, theft, or irreparable damage or wear. If the device is used for 13 continuous months, then the supplier is required to transfer title to the equipment to the beneficiary. Regarding patients who relocate near the end of the capped rental period and need to find a new supplier, CMS has been able to work with suppliers of capped rental items in the past to ensure beneficiary access in these situations.

Comment: Numerous comments were concerned that a rental payment method would impact access to SGDs in certain settings such as a hospital or nursing facility. As a result, commenters were concerned because the patient should not need to worry that the device will be taken away when circumstances require the patient to communicate to practitioners in the facilities. Commenters explained the patient may be forced to accept an inappropriate device because the right one for them is not available while in a facility resulting in practitioners and caregivers having difficulty in understanding the patient.

Response: In accordance with the statute, we do not establish payment rules for DME based on how the item is furnished in institutional settings, especially in light of the definition of DME in section 1861(n) of the Act, which defines DME as equipment used in a patient's home.

Comment: One commenter expressed concern that our proposal did not include codes for Accessory for Speech Generating Device, Not Otherwise Classified (HCPCS code E2599) and Accessory for Speech Generating Device, Mounting System (HCPCS code E2512).

Response: We appreciate this comment, but we are not including codes E2599 and E2512 in our list of codes for reclassification at this time because fee schedule amounts for these codes have not been established. When fee schedules are developed, we will review the data for these accessory codes to ensure compliance with the Medicare definition of routinely purchased equipment set forth at 42 CFR § 414.220(a). If a change in payment category is required in the future, CMS expects to provide notice via program instructions.

Comment: Some commenters recommended that the low volume of services for SGDs should exempt these codes from our proposal for reclassification from routinely purchased to capped rental. One commenter stated the proposal from CMS reports $20,170,612 in payments for SGDs in 2012 at an average cost of $7,356 for 2,742 services. The commenter also stated this represents .000008 of the United States population utilizing data from the census bureau.

Response: The payment rules at section 1834(a) of the Act do not classify items under the payment classes based on volume of services. As discussed above, the Medicare definition of routinely purchased equipment is set forth at 42 CFR § 414.220(a)(2) and specifies that routinely purchased equipment means equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. As a result of clarifying and reaffirming this definition, equipment for which claims data did not exist during the 1986/87 period cannot be classified as routinely purchased equipment. This results in such codes being reclassified as capped rental items if they do not fall under any of the other DME payment classes.

Comment: One commenter stated that the pneumatic compression trunk appliance (HCPCS code E0656) and the pneumatic compression chest appliance (HCPCS code E0657), both used in conjunction with pneumatic compression pumps for treatment of lymphedema, are considered routinely

purchased because the common diagnosis that allows reimbursement is lymphedema. The commenter states lymphedema is not curable and can only be managed. When a person has been diagnosed with lymphedema and a pneumatic compression pump has been prescribed, it is never for short term use. Thus, the items should not be reclassified from routinely purchased to capped rental payment method.

Response: The payment rules at section 1834(a) of the Act do not classify items under the payment classes based on diagnosis and intended use. As discussed above, the Medicare definition of routinely purchased equipment is set forth at 42 CFR § 414.220(a)(2) and specifies that routinely purchased equipment means equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. In this final rule, we are reclassifying DME that was not acquired during the period July 1986 through June 1987 or was not acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987, and therefore cannot be classified as routinely purchased DME under 42 CFR 414.220(a). This results in certain codes receiving reclassification to capped rental DME if the codes do not fall under any of the other DME payment classes. We do note that only some of the codes in use during July 1986 through June 1987 that describe pneumatic compression appliances for the arm and leg met the definition of routinely purchased equipment. However, the appliances that were not routinely purchased met the definition of inexpensive equipment under § 414.220(a)(1). The codes for pneumatic compression appliances for the trunk and chest are considerable more expensive than the pneumatic compression appliances for the arm and leg and were not acquired on a purchase basis at least 75 percent of the time during July 1986 through June 1987. Payment will therefore made on a capped rental basis for pneumatic compression appliances for the trunk and chest furnished for use with pneumatic compression pumps. Thus, under the capped rental category whether the pneumatic compression chest appliance device is used short term or long term, payment is made in alignment with the number of months for which the equipment was in use, until the beneficiary no longer needs the device or the rental period has ended.

Comment: One commenter requested reclassification of code K0730 controlled dose inhalation drug delivery system from the routinely purchased to the frequently serviced payment category. The commenter also requested CMS reclassify code E0574, which also describes a nebulizer item, to the frequently serviced payment category.

Response: We are not adopting this suggestion to reclassify codes K0730 and E0574 to the frequently serviced payment category. Section 13543 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) removed nebulizers from the statutory list of items classified under the frequent and substantial servicing payment class effective with respect to items furnished on or after January 1, 1994. In accordance with these provisions, we continue to believe that these devices should not be classified as items under the payment category for items requiring frequent and substantial servicing under § 1834(a)(3)(A) of the Act. As such, we are implementing our proposal to reclassify these codes to the capped rental payment category.

Comment: One commenter opposed reclassification of code E0762 transcutaneous electrical joint stimulation system from the routinely purchased to the capped rental payment category because while significant relief is provided by the system within a short period of time, more significant results are achieved with increased use of the device.

Response: We continue to believe it is appropriate to reclassify code E0762 from the routinely purchased to the capped rental payment category. As discussed above, the Medicare definition of routinely purchased equipment is set forth 42 CFR § 414.220(a)(2) and specifies that routinely purchased equipment means equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. Therefore, DME, including code E0762, for which claims data did not exist during the 1986/87 period cannot be classified as routinely purchased equipment. This results in such codes being reclassified as capped rental items if they do not fall under any of the other DME payment classes. Furthermore, under the capped rental payment method, the supplier owns the equipment during the rental period and title to the equipment transfers to the beneficiary at the end of a 13th month rental period. Thus, whether the device is used short term or long term, payment is made in alignment with the number of months until the beneficiary no longer needs the device or the rental period has ended.

Comment: One commenter stated jaw motion rehabilitation system from Dynasplint (HCPCS code E1700) should not remain routinely purchased because it was previously billed under a capped rental miscellaneous code and it was assigned by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor to code E1700 which contains other less expensive items.

Response: Since HCPCS code assignment is outside the scope of the proposed rule which only concerns the reclassification of code E1700 from the routinely purchased payment category to the capped rental payment category, and we are not addressing this comment in this final rule.

Comment: Some commenters stated that code E0760 for Osteogenesis Ultrasound Stimulator is not DME but is a therapeutic intervention similar to a drug treatment.

Response: These comments are outside the scope of the proposed rule, and therefore are not addressed in this final rule. The process for reviewing coverage/benefit category for an item is not addressed in this rule. Information on the process can be found at the Web site *http://www.cms.gov/Medicare/Coverage/DeterminationProcess/index.html*

Comment: Many commenters raised concerns that code E0760 for Osteogenesis Ultrasound Stimulator remains comparable to electric bone growth stimulators (codes E0747 and E0748) that also treat established nonunion of fractures of long bones and as adjunctive therapy to spinal fusion to improve fusion success rates, which are assigned to the routinely purchased category in accordance with the existing regulatory definition of routinely purchased items. Commenters pointed out the code used to describe osteogenesis stimulators in 1986 through 1987 did not specify the type of stimulator Medicare purchased. Also, commenters noted that code E0760 was initially classified as capped rental DME and reclassified by Medicare to routinely purchased DME based on data from other payers and claims submitted to Medicare.

Response: We recognize the commenters' concerns and in this final rule, we will revise the list of codes by removing code E0760 from the final list of codes for reclassification to the capped rental DME. We agree that HCPCS codes used to routinely pay for the purchase of osteogenesis stimulators in 1986 and 1987 did not differentiate between types of osteogenesis stimulators and therefore, believe that the general category of osteogenesis stimulator are correctly classified as routinely purchase equipment in

accordance with current regulations § 414.220(a)(2).

Comment: Commenters noted that the proposed list of HCPCS codes that would be reclassified as capped rental items includes HCPCS codes that describe products cleared by the FDA for single patient use. Commenters stated that reclassifying these devices as capped rental items goes against their labeling as single patient use devices by the FDA and that some of these devices cannot be cleaned or refurbished for another patient's use. A commenter noted that a change in payment category could affect various levels of market availability including FDA clearance, product marketing or the company's business model. Commenters stated a significant investment of resources and time is required to seek a new FDA label to allow these items to be rented to multiple patients. One commenter objected that reclassification would essentially force devices currently labeled for single patient use to be used off-label as rental equipment. Additionally, one commenter recommended that we amend our regulation to provide that all devices cleared by the FDA as class III devices under the Federal Food, Drug, and Cosmetic Act are classified as routinely purchased equipment.

Response: The payment rules under section 1834(a) of the Act do not classify items under the payment classes based on how they are cleared by the FDA. As discussed above, the Medicare definition of routinely purchased equipment under § 414.220(a)(2) specifies that routinely purchased equipment means equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. As a result of our clarification of this definition, equipment that was not acquired at all during the period July 1986 through June 1987, was not acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987, and therefore, cannot be classified as routinely purchased equipment. This results in such codes being reclassified as capped rental items if they do not fall under any of the other DME payment classes. We agree that manufacturers and suppliers of products should be in compliance with FDA requirements, but we do not believe that FDA requirements dictate how items should be classified under sections 1834(a)(2) through (7) of the Act.

After consideration of comments received on the proposed rule and for the reasons we discussed above and in the proposed rule, we are finalizing our proposals and reclassifying certain items identified in this final rule with the exception of code E0760 which will remain classified as routinely purchased equipment. We did not receive comments regarding the effective dates for the reclassifications of these items from the routinely purchased DME category to capped rental DME. For the reasons discussed in the proposed rule (78 FR 40875), we are finalizing the effective dates for the changes of this section in compliance with the required regulatory process as follows:

- April 1, 2014, for items furnished in all areas of the country if the item is not included in Round 2 or Round 1 Recompete CBP;
- July 1, 2016, for items furnished in all areas of the country if the item is included in a Round 2 CBP and not a Round 1 Recompete CBP and for items included in a Round 1 Recompete CBP but furnished in an area other than one of the 9 Round 1 Recompete areas; and
- January 1, 2017, for items included in a Round 1 Recompete CBP and furnished in one of the nine Round 1 Recompete areas.

The April 1, 2014, effective date was selected in order to ensure that these changes do not occur sooner than 60 days after publication of the final rule for claims processing purposes.

V. Clarification of the 3-Year Minimum Lifetime Requirement (MLR) for DME

DME is covered by Medicare based, in part, upon section 1832(a) of the Act, which describes the scope of benefits under the supplementary medical insurance program (Medicare Part B), to include ''medical and other health services,'' which is further defined under section 1861(s)(6) of the Act to include DME. In addition, section 1861(m)(5) of the Act specifically includes DME in the definition of the term ''home health services.'' In accordance with section 1861(n) of the Act, the term ''durable medical equipment'' includes iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home whether furnished on a rental basis or purchased. The patient's home includes an institution used as his or her home other than an institution that meets the requirements of section 1861(e)(1) or section 1819(a)(1) of the Act. Besides being subject to this provision, the coverage of DME must meet the requirements of section 1862(a)(1)(A) of the Act, which in general excludes from payment any items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and section 1862(a)(6) of the Act, which (except for certain specified exceptions) precludes payment for personal comfort items.

Section 414.202 defines DME as equipment furnished by a supplier or a home health agency that meets the following conditions: (1) Can withstand repeated use; (2) effective with respect to items classified as DME after January 1, 2012, has an expected life of at least 3 years; (3) is primarily and customarily used to serve a medical purpose; (4) generally is not useful to an individual in the absence of an illness or injury; and is appropriate for use in the home. Prior to 2012, the definition for DME did not contain a 3-year minimum lifetime requirement (MLR) although Section 110.1 of chapter 15 of the Medicare Benefit Policy Manual (CMS-Pub. 100–02) provided further guidance with regard to the definition of DME and durability of an item that is when an item is considered durable.

A. Current Issues

On November 10, 2011, CMS issued a final rule in which it revised the definition of DME at § 414.200 by adding a 3-year MLR effective January 1, 2012, that must be met by an item or device in order to be considered durable for the purpose of classifying the item under the Medicare benefit category for DME (76 FR 70228 (November 10, 2011)). Specifically, an additional condition under § 414.200 is that DME must be equipment furnished by a supplier or a home health agency that, effective with respect to items classified as DME after January 1, 2012, has an expected life of at least 3 years. The change to the regulation was designed to further clarify the meaning of the term ''durable'' and provide an interpretation of the statute generally consistent with the DME payment and coverage provisions, including, Medicare program guidance at section 280.1 of chapter 1, part 4 of the Medicare National Coverage Determinations Manual (Pub. 100–03) which specifies that an item can withstand repeated use means that the item could normally be rented and used by successive patients. The 3-year MLR is intended to specify that durable equipment is equipment that can withstand repeated use over an extended period of time. Since the vast majority of items covered under the DME benefit over the years last for 3 or more years, the MLR is intended to clarify the scope of the DME benefit primarily for new items coming on the market or in the process of being developed. The standard set forth in regulations gives manufacturers and the public a clear understanding of how long an item would need to withstand

repeated use in order the meet the durability requirement for DME. The rule also provides clear guidance to CMS and other stakeholders for making consistent informal benefit category determinations (BCDs) and national coverage determinations (NCDs) for DME.

The 3-year MLR is designed to represent a minimum threshold for a determination of durability for a piece of equipment. The 3-year MLR is not an indication of the typical or average lifespan of DME, which in many cases is far longer than 3 years. The 3-year MLR does not apply to disposable supplies or accessories covered for use with DME such as masks, tubing, and blood glucose test strips. The 3-year MLR is prospective only and does not apply to equipment classified as DME before the regulation was effective, that is, January 1, 2012.

We also determined that the 3-year MLR should not apply to equipment classified as DME before the effective date to allow for continued coverage of such equipment that healthcare industry and beneficiaries have come to rely on, regardless of whether those items met the 3-year MLR set forth at 42 CFR 414.202 (76 FR70288). Given that reliance, we indicated we did not intend to reopen those prior decisions and reclassify the equipment in light of the 3-year standard. We believe that continuing Medicare coverage for items that qualified as DME prior to the effective date helps avoid disrupting the continuity of care for the beneficiaries that received such items for medical treatment prior to January 1, 2012.

Beneficiaries have been relying on these items for their treatment to the extent that the items have been covered as DME under Medicare. Furthermore, we believed that a vast majority of the categories of items that were classified as DME before January 1, 2012, did function for 3 or more years. We also noted that the 3-year durability rule would only apply to new products, and, to the extent that a modified product is not a new product, the 3-year MLR would not be applicable.

In response to the public comments that requested further clarification on the application of the grandfathering provision for the 3-year MLR, we noted that we would consider issuing additional guidance to provide further clarification, if necessary (76 FR 70290). For purposes of providing additional guidance on the scope of the grandfathered items under the provision, we invited public comments on this issue.

B. Scope of the 3-Year MLR for DME

Under § 414.202, effective with respect to items classified as DME after January 1, 2012, an item is not considered durable unless it has an expected life of at least 3 years. Therefore, the 3-year MLR applies to new items after January 1, 2012, and does not apply to items covered under the DME benefit on or prior to January 1, 2012. Items classified as DME on or before January 1, 2012, are considered ''grandfathered items'' for the purpose of this requirement, regardless of whether they meet the 3-year rule.

For the purpose of providing further guidance on the scope of the 3-year MLR, in the proposed rule (78 FR 40877), we provided clarification about how we would regard grandfathered items covered as DME prior to the effective date and we requested comments on that clarification. We proposed that if the product is modified (upgraded, refined, reengineered, etc.) after January 1, 2012, the item would still be classified as DME as a grandfathered item unless the modified product now has an expected life that is shorter than the expected lifetime for the item covered as DME prior to January 1, 2012. In this case, we would consider the item, as modified, to be a new item that is subject to the 3-year MLR. For example, equipment covered prior to January 1, 2012, and described by code X has a life of at least 2 years. If, after January 1, 2012, that item is modified such that it is less durable, such that it no longer lasts for the 2 year period, that modification would render the item ''new'' and it would be subject to the 3-year MLR. Therefore, since the new (modified) product does not last 3 years, it would not meet the definition of DME under the regulation and could not be covered or be billed using the code that described the item before it was modified.

We sought comments on this proposed clarification.

C. Response to Comments on the 3-Year MLR for DME

We received approximately 13 comments on the proposed regulation (78FR 40876–40877) regarding clarification of the grandfathering provision of the 3-year MLR for DME. Commenters included medical device manufacturers, suppliers, advocacy groups and coalitions.

Comment: Most commenters acknowledged and appreciated that CMS proposed the clarification of the grandfathering provision of the 3-year MLR for DME.

Response: We thank the commenters for their input and support. We note that the clarification regarding grandfathered items that are modified relates to the durability of the item under the definition, and in particular, whether the modified item has a shorter useful life than the expected lifetime for the items covered prior to January 1, 2012.

Comment: Two commenters supported our clarification in the proposed rule of the grandfathering provision of the 3-year MLR for DME. The commenters believed that the proposed clarification to continue to cover grandfathered items if modified as long as the modification did not shorten its useful life was reasonable and encouraged CMS to adopt it.

Response: We thank the commenters for their support. However, we wish to clarify that the proposed rule addressed how we would regard grandfathered items covered as DME prior to the effective date. We proposed that if a grandfathered product is modified (upgraded, refined, reengineered, etc.), the item would still be classified as a grandfathered item unless the product has been modified to be less durable, such that it now has an expected life that is shorter than the expected lifetime for the item covered as DME prior to January 1, 2012. In this case, we would consider the item, as modified, to lose its grandfathered status and thus it would be treated as a new item that is subject to the 3-year MLR.

Comment: Several commenters indicated that the proposed rule still leaves great uncertainty regarding which modifications will result in products that continue to be, or are no longer, grandfathered. Without specific vignettes or parameters that illustrate how CMS will address these matters when certain new products come onto the market, the guidance in the proposed rule will not resolve the questions that remain. Specifically,

1. If application of new technology renders a product more effective but reduces its minimum lifetime; will the 3-year requirement be applied?

2. It does not provide further details regarding the extent of changes that could be made to an existing DME product such that it would still be subject to grandfathering provision.

3. Must a modified item fall within the same HCPCS code and/or DME product category as a grandfathered item in order for it to also fall within the grandfathering provision and not be considered a new item?

4. If a modification of an existing product results in the designation of another HCPCS code; will this trigger the 3-year requirement?

Response: We thank the commenters for their input. As noted in the final rule (76 FR 70289, 70290 (November 10, 2011)), the 3-year MLR for DME is applied on a prospective basis. That is, the 3-year MLR only applies to new items, meaning items that were not covered as DME on or prior to January 1, 2012. We clarified in the proposed rule (78 FR 40877) that items paid for as DME on or before January 1, 2012, are considered ''grandfathered items'' for the purpose of the 3-year MLR for DME, regardless of whether they meet the 3-year rule. If a grandfathered item is modified (upgraded, refined, reengineered, etc.) after January 1, 2012, the item would still be considered a grandfathered item unless the item has been modified to be less durable, such that it now has an expected life that is shorter than the lifetime for the grandfathered item, which was covered as DME on or prior to January 1, 2012. Therefore, if application of new technology renders a product more effective but reduces its durability; then the product would lose its grandfathered status and the 3-year requirement would apply.

The change we made to the regulation to establish a 3-year MLR for DME was designed to further clarify the meaning of the term ''durable.'' Based on our experience with the Medicare program, the vast majority of items covered as DME last for 3 years or longer; however, the purpose of the grandfathering provision is to ensure continued coverage for the items that were paid as DME before the effective date of the MLR requirement and, to avoid disruption of the continuity of care for the beneficiaries using such equipment. . . . In response to the specific concerns of the commenters, the parameters of the grandfathering provision are:

1. An item paid for as DME on or before January 1, 2012, is considered a grandfathered item for the purpose of the 3-year MLR for DME, regardless of whether they meet the 3-year rule; and

2. A grandfathered item that is modified (upgraded, refined, reengineered, etc.), is still considered a grandfathered item rather than a new item unless the item is less durable, such that it now has an expected life that is shorter than the expected lifetime for the item covered as DME on or prior to January 1, 2012.

Making individual determinations about whether a modified version of an item that was paid as DME on or prior to January 1, 2012, lasts as long as the item that was paid as DME on or prior to January 1, 2012, involves a case-by-case review of the relevant facts. Therefore, specific vignettes or parameters that illustrate how CMS will make these individual determinations could be misleading since it is not possible to illustrate every possible scenario addressing various items paid for as DME in the past and how they could be modified in the future. With regard to comments regarding HCPCS codes, there are a variety of coding changes. A code could be added for a completely new category of items that have never been paid for by Medicare and therefore these items would be subject to the 3-year MLR. Alternatively, a new code could be the result of a coding action whereby existing codes are revised to form a new code or codes. In these cases, the determination regarding whether an item is a grandfathered item not subject to the 3-year MLR will depend on whether the item was paid for as DME on or prior to January 1, 2012, under codes in effect on or prior to January 1, 2012.

Comment: Some commenters stated that the proposed rule does not provide clarity on what is a completely ''new product'' that would never be subject to the grandfathering provision.

Response: A new product is a product that was not paid for as DME on or prior to January 1, 2012, or a grandfathered item that loses its grandfathered status.

Comment: Some commenters indicated that it is unclear what would be considered a modified product that would be subject to the grandfathering provision provided that the modifications do not result in a reduced minimum lifetime of the product. Would a premarket approval product approved after January 1, 2012, that is similar in structure and function to grandfathered products be considered a modified version of the grandfathered products? Is newly cleared 510(k) product considered to be a modified version of the predicate device? It is unclear whether a new product cleared by the FDA through the Premarket Approval (PMA) process as opposed to a PMA supplement approved after January 1, 2012, can be considered to be a modification of a grandfathered product or whether a new product cleared by the FDA through the 510(k) process as substantially equivalent to other, previously cleared, predicate products is considered to be a modification of a predicate device.

Response: A grandfathered product is a specific product (make, manufacturer, model, model number, etc.) that was covered and paid for as DME on or prior to January 1, 2012. Any product that is not a grandfathered product or a grandfathered product that is modified so that it is less durable, such that it now has an expected lifetime that is shorter than the expected lifetime of the product covered as DME on or prior to January 1, 2012, is subject to the 3-year MLR. CMS will continue to consider these issues and provide additional guidance if necessary.

Comment: Several commenters voiced concerns that the final rule will serve as a major deterrent to future investments in new technologies. There may be desirable innovations made to a grandfathered product that would reduce the minimum lifetime of the product. If changes to a product that result in a different HCPCS code assignment or DME product category by definition do not fall within the grandfathering provision then manufacturers do not have the incentive to research and develop a grandfathered product's safety and effectiveness in treating. By eliminating reimbursement under Medicare DME benefit for modified grandfathered products containing innovations that are clinically beneficial to the patients but may reduce the minimum lifetime of those products, the proposed clarification discourages innovation of existing technologies.

Response: We believe that the 3-year MLR to clarify the term durable and the grandfathering provision are reasonable given the 5 year reasonable lifetime requirement, general DME payment rules and industry standards which support the fact that DME items should be able to withstand repeated use. We do not believe the rule is a deterrent. The rule is designed to clarify the grandfathering provision and ensure that such products are not modified to be less durable.

Based upon our experience with the Medicare program, the vast majority of items covered as DME last for 3 years or longer. The purpose of the grandfathering provision is to continue the Medicare coverage for the items that were paid as DME on or prior to the effective date, in order to avoid disruption of the continuity of care for the beneficiaries that had received items for medical treatment on or prior to January 1, 2012.

Comment: A few commenters suggested that instead of using the MLR to determine whether modified DME is a ''new'' device, CMS should focus on whether the modified device has the same clinical application as the grandfathered DME. This criterion would be a better measure of whether the device is ''new'' than whether it meets what a few commenters characterized as an arbitrary MLR rule. CMS should instead establish reasonable parameters under which products should be considered

comparable to existing DME products in order to be subject to the grandfathering provision-any modification, upgrade, redesign, improvement or new indication of an existing DME product that maintains the product's core clinical technology or mechanism of action should be eligible for reimbursement under the DME benefit category.

Response: We thank the commenters for their input. However, our proposal regarding the 3-year MLR with regard to the definition of DME was to clarify the issue of durability as it relates to grandfathering status. Our proposal centered on the lifetime of the product as a result modification (upgraded, refined, reengineered, etc.). We do not believe that issues such as core clinical technology or clinical application to determine whether a modified grandfathered item is a new DME as suggested by the commenters, speaks to the issue of durability with regard to our interpretation of the statutory DME provisions.

Comment: A few commenters expressed concerns that the proposed rule will require manufacturers to undertake expensive testing to demonstrate that their equipment continues to qualify under the grandfathering provision. They questioned whether there is a benchmark for deciding whether the modified device has an MLR that is shorter than the grandfathered device (e.g., is it an MLR that is a year shorter, 90 days shorter, or a day shorter than that of the grandfathered DME?). Commenters believe that, instead of providing clarity, CMS has injected even more subjectivity and ambiguity into the Medicare coverage and coding process and provides virtually no guidance when the minimum lifetime of a modified device does not conclusively meet the 3-year threshold. Commenters stated that, in the past, CMS has stated that it will base these decisions on a review of existing data, but the outcome in these cases ultimately will hinge on subjective interpretation of the data. The commenters note that this type of analysis will be useless in assessing new technologies, which typically are not included in independent comparative studies of the type CMS has said it plans to consult.

Response: We thank the commenters for their input but do not believe that the proposed regulation injects subjectivity and ambiguity into the Medicare coverage and coding process. We are not proposing a new process to determine whether a modified device has an expected life that is shorter than the original grandfathered device; therefore, no new types of tests are needed to make determinations regarding the expected lifetime of products. As discussed previously, we will continue to follow the current BCD process to determine on an individual consideration basis if a modified grandfathered item falls within the grandfathering provision. We will review information and evidence, which a supplier/manufacturer may submit, consistent with the current BCD process to determine the expected life of the equipment. As discussed previously, the BCD process typically involves reviewing information from various sources including but not limited to information related to FDA pre-market clearance, product manuals, operating guides, warranty documents, and standardized test results. The NCD process is available at *http://www.cms.gov/DeterminationProcess/Downloads/FR09262003.pdf*. See also, 68 FR 55638 (September 23, 2003). Additionally, we routinely collect information regarding durability of new products as part of the HCPCS editorial process in order to identify categories of new DME subject to the procedures established in accordance with the mandate of section 531(b) of the Medicare, Medicaid and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA 2000), Public Law 106–554. Based on our experience with the program, this information has been readily available from the manufacturers of these items and other entities submitting requests for changes to the HCPCS. Information on the HCPCS Level II coding process is available at: *http://www.cms.gov/MedHCPCSGenInfo/Downloads/2013_HCPCS_Application.pdf* and *http://www.cms.gov/MedHCPCSGenInfo/08_HCPCSPublicMeetings.asp#TopOfPage*.

Comment: Some commenters argued that in this case, CMS' original concern about disrupting patient care continues to hold true. Commenters claim that the proposal to modify the grandfathering provision of § 414.202 will disrupt the care of beneficiaries using the grandfathered DME. Beneficiaries who have been using the grandfathered DME will no longer have Medicare coverage for the medically necessary device they depend on. Physicians and other practitioners will be unable to order devices that have been proven therapeutically effective for the patients they treat. For these beneficiaries and providers, it will almost certainly be true that they will be left without an equally effective alternative for continuing their care.

Response: We thank the commenters for their input, but we do not agree with the above comment. We note that the proposed rule was designed to clarify the grandfathering provision. The proposed clarification of the grandfathering provision is designed to address how grandfathered products could be modified without losing their grandfathered status. The commenters concerns that beneficiaries who have been using the grandfathered DME will no longer have Medicare coverage for the medically necessary device they depend on or that physicians will be unable to order devices that have been proven therapeutically effective for the patients are inaccurate. On the contrary, the purpose of the grandfathering provision for the 3-year MLR was to continue Medicare coverage for items that were classified as DME on or prior to the effective date, in order to avoid disruption of the continuity of care for the beneficiaries that had already received these items for medical treatment. For the reasons stated above, we do not believe that the clarification of the grandfathering provision will disrupt the continuing care for beneficiaries that are using the grandfathered DME.

Comment: Some commenters urged CMS to convene a study panel to allow stakeholders to collaborate with the agency to examine a few central questions such as whether a modified item must fall within the same HCPCS code and/or DME product category as a grandfathered item in order for it to also fall within the grandfathering provision. Commenters asked CMS to consider convening a stakeholder meeting to solicit views from patients, healthcare providers, DME manufacturers and other health policy experts.

Response: We appreciate the comment. We established the 3-year MLR effective with respect to items classified as DME on or after January 1, 2012, via notice and comment rulemaking. We are clarifying the grandfathering provision for the 3-year MLR via notice and comment rulemaking. In addition, we will continue to follow the current processes including BCD, NCD, Local Coverage Determinations (LCD), and HCPCS codes to implement the 3-year MLR and the grandfathering provision. These processes include meetings with manufacturers in addition to the public where we seek input from the stakeholders. We will continue to receive input from stakeholders consistent with the BCD and NCD process when applying the 3-year MLR and the grandfathering provision. See 68 FR 55634 (September 26, 2003); and *http://www.Cms.gov/DeterminationProcess/Downloads/*

FR09262003.pdf. See also, information on the HCPCS Level II coding process at: *http://www.cms.gov/MedHCPCSGenInfo/Downloads/2013_HCPCS_Application.pdf. http://www.cms.gov/MedHCPCSGenInfo/08_HCPCSPublicMeetings.asp#TopOfPage*.

Comment: Some commenters stated that as other payers follow Medicare guidelines, it is important to revise ill-conceived Medicare policy now before regulations that harm people with disabilities and chronic conditions are replicated at the State level.

Response: This comment is outside the scope of the proposed rule.

Comment: One commenter stated that CMS proposes to clarify the scope and application of the MLR ''grandfathering'' provision by stipulating that products will lose the grandfather status if the modified product will have an expected life that is shorter than three years. In other words, the commenter believes the proposed rule would result in non-coverage of any grandfathered item that is modified.

Response: We thank the commenter for the input. However, the statement in the above comment that a modified product that has an expected life that is shorter than three years will no longer be grandfathered and therefore, lose coverage status is inaccurate. We proposed that a product covered as DME prior to 2012 that is modified would still be grandfathered as long as the expected lifetime of the product is equal to or greater than the lifetime of the product covered prior to 2012. Under this proposal, if the product lost grandfathered status (because the modification reduced the expected lifetime of the product covered prior to 2012), the product would be subject to the 3-year MLR. The application of 3-year MLR would determine whether product would be otherwise covered under the definition. For grandfathered items that have a lifetime shorter than 3-years, modifications that reduce such lifetime generally would result in the product no longer meeting the definition given the application of the 3-year MLR (because the grandfathered status was lost). However, for grandfathered products that have a lifetime greater than 3 years, modifications that shorten such lifetime may or may not result in non-coverage under the definition when the 3-year MLR is applied. For example, if a grandfathered product covered as DME prior to 2012 with a lifetime of four years is modified, resulting in a product with a lifetime of two and a half years (and thereby losing grandfathering status), the product would no longer meet the definition of DME, because the 3-year MLR is not met given that the lifetime of the modified product is less than three years. In the same example, if the modification resulted in a reduced lifetime of the product to 3.5 years, the product, even though it lost grandfathering status, would satisfy the 3-year rule, and continue meet the definition of DME.

After consideration of comments received on the proposed rule, we are finalizing the clarification of the grandfathering provision of the 3-year MLR for DME. The 3-year MLR applies, effective January 1, 2012, but does not apply to items covered under the DME benefit on or prior to January 1, 2012 (''grandfathered items''). However, effective April 1, 2014, if the grandfathered item is modified (upgraded, refined, reengineered, etc.), and the modified item now has an expected life that is shorter than the expected lifetime for the item covered as DME prior to January 1, 2012, the modified item will lose grandfathered status. In this case, we would consider the item, as modified, to be a new item that is subject to the 3-year MLR.

VI. Implementation of Budget-Neutral Fee Schedules for Splints, Casts and Intraocular Lenses (IOLs)

A. Background

1. Payment Under Reasonable Charges

Payment for most items and services furnished under Part B of the Medicare program is made through contractors known as Medicare Administrative Contractors (MACs). These contractors were previously referred to as carriers. Prior to 1988, in accordance with section 1842(b) of the Act, payment for most of these items and services was made on a reasonable charge basis by these contractors, with the criteria for determining reasonable charges set forth at 42 CFR part 405, subpart E of our regulations.

Under this general methodology, several factors or ''charge screens'' were developed for determining the reasonable charge for an item or service. In accordance with § 405.503, each supplier's ''customary charge'' for an item or service, or the 50th percentile of charges for an item or service over a 12-month period, was one factor used in determining the reasonable charge. In accordance with § 405.504, the ''prevailing charge'' in a local area, or the 75th percentile of suppliers' customary charges for the item in the locality, was also used in determining the reasonable charge. For the purpose of calculating prevailing charges, a ''locality'' is defined at § 405.505 of our regulations and ''may be a State (including the District of Columbia, a territory, or a Commonwealth), a political or economic subdivision of a State, or a group of States.'' The regulation further specifies that the locality ''should include a cross section of the population with respect to economic and other characteristics.'' In accordance with § 405.506, for certain items, such as parenteral and enteral nutrients, supplies, and equipment, an additional factor referred to as the ''lowest charge level'' was used in determining the reasonable charge for an item or service. In accordance with section 5025 of the Medicare Carriers Manual (HCFA Pub. 14–3) and § 405.509 of our regulations, effective for items furnished on or after October 1, 1985, an additional factor, the ''inflation-indexed charge (IIC),'' was added to the factors taken into consideration in determining the reasonable charge for certain items and services. The IIC is defined in § 405.509(a) as the lowest of the fee screens used to determine reasonable charges for items and services, including supplies, and equipment reimbursed on a reasonable charge basis (excluding physicians' services) that is in effect on December 31 of the previous fee screen year, updated by the inflation adjustment factor. The inflation adjustment factor is based on the current percentage increase in the consumer price index for all urban consumers (United States city average) (CPI–U) for the 12-month period ending June 30. The reasonable charge is generally set based on the lowest of the actual charge for the item or service or the factors described above.

2. Payment Under Fee Schedules

Specific provisions have been added to the Act mandating replacement of the reasonable charge payment methodology with fee schedules for most items and services furnished under Part B of the Medicare program. The phase in of fee schedules to replace reasonable charges for Medicare payment purposes began with the fee schedule for clinical diagnostic laboratory tests in 1988. As of 1997, very few items and services were still paid on a reasonable charge basis, which is a very time consuming and laborious process. Contractors must collect new charge data each year, perform the various calculations, and maintain pricing files and claims processing edits for the various charge screens. For each item that is paid on a reasonable charge basis, administrative funding must be provided to contractors for the purpose of performing these

calculations and maintaining these pricing files. Therefore, replacing reasonable charge payments with fee schedules eliminates the need to fund these efforts and saves money that can be used to implement other parts of the program. Section 4315 of the Balanced Budget Act of 1997 (BBA) amended the Act at section 1842 by adding a new subsection (s). Section 1842(s) of the Act provides authority for implementing statewide or other area wide fee schedules to be used for payment of the following services that were previously on a reasonable charge basis:

- Medical supplies.
- Home dialysis supplies and equipment (as defined in section 1881(b)(8) of the Act).
- Therapeutic shoes.
- Parenteral and enteral nutrients, equipment, and supplies (PEN).
- Electromyogram devices.
- Salivation devices.
- Blood products.
- Transfusion medicine.

For Medicare payment purposes, we interpret the category ''medical supplies'' under section 1842(s) of the Act to include all other items paid on a reasonable charge basis as of 1997 that do not fall under any of the other categories listed in section 1842(s) of the Act. We believe that section 1842(s) of the Act is intended to provide authority for establishing fee schedules for all of the remaining, and relatively small number of items and services still paid for on a reasonable charge basis at the time of enactment in 1997. In light of this provision, we generally consider ''intraocular lenses'' to be paid as ''medical supplies.'' Therefore, in addition to including splints and casts under this category, we also proposed to include intraocular lenses inserted in a physician's office for the purpose of implementing this specific section. Although we recognize the terms ''intraocular lenses'' and ''medical supplies'' are separately identified under § 414.202, we note that such terms are listed for purposes of defining what constitutes orthotic and prosthetic devices (that is, these terms are excluded from such definition), and not intended to suggest these are mutually exclusive things. Accordingly, we do not believe we are precluded from establishing fee schedules for IOLs under the category of medical supplies under section 1842(s) of the Act.

Section 1842(s)(1) of the Act provides that the fee schedules for the services listed above are to be updated on an annual basis by the percentage increase in the CPI–U (United States city average) for the 12-month period ending with June of the preceding year, reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Total payments for the initial year of the fee schedules must be budget-neutral, or approximately equal to the estimated total payments that would have been made under the reasonable charge payment methodology. As explained below, we used this authority to establish fee schedules for parental and enteral nutrition (PEN) items and services for use in paying claims with dates of service on or after January 1, 2002.

On July 27, 1999, we published a notice of proposed rulemaking (64 FR 40534) to establish fee schedules for PEN items and services, splints and casts, intraocular lenses (IOLs) inserted in a physician's office, and various other items and services for which section 1842(s) of the Act provided authority for replacing the reasonable charge payment methodology with fee schedules. After reviewing public comments on the proposed rule, we decided to move ahead with a final rule establishing fee schedules for the Parenteral and Enteral Nutrition (PEN) items and services, but not the other items and services, primarily related to concerns regarding data used for calculating fee schedule amounts for items and service that are no longer paid on a reasonable charge basis. The final rule for implementing the fee schedules for PEN items and services was published on August 28, 2001 (66 FR 45173). For splints and casts, national reasonable charge amounts, updated on an annual basis by the IIC, have been used to pay for the splint and cast materials. Converting these amounts to national fee schedule amounts that are updated by the same index factor used in updating the reasonable charge amounts would result in no change in payment, or 100 percent budget-neutrality. Currently, very few IOLs are inserted in a physician's office nationally. In 2011, total allowed charges for 437 IOLs furnished to 287 beneficiaries equaled $75,914. Since IOLs are considerably low volume items furnished by very few suppliers nationally, there are some states where none of these items are furnished; therefore, charge data for use in calculating prevailing charges, even at the state level, are not available and budget-neutrality is not an issue. If the national average allowed amount for these items were used as the fee schedule amount for the few IOLs that are still inserted in a physician's office, we did not believe that total allowed charges in the first year of the fee schedule would be significantly different than what would otherwise be paid nationally under the current reasonable charge payment methodology. For 2011, the national average allowed charge for covered claims for the 287 beneficiaries receiving IOLs inserted in a physician's office was $174 ($75,914 ÷ 437). In some cases, the allowed charge for specific claims in 2011 was less than $174 and in other cases the allowed charge was more than $174. However, given the low volume of items furnished nationally, the budget impact of paying all of the approximately 437 claims based on the national average allowed amount would be negligible. We believe establishing budget-neutral fee schedule amounts for splints and casts, and IOLs inserted in a physician's office would save government resources in calculating the reasonable charge payment for the low volume items. Therefore, in the proposed rule (78 FR 40878 through 40879), we proposed to establish fee schedules for these items effective for paying claims with dates of service on or after January 1, 2014.

B. Summary of the Proposed Provisions and Responses to Comments on the Implementation of Budget Neutral Fee Schedules for Splints, Casts and IOLs

For the reasons we articulated above, we proposed (78 FR 40879), under section 1842(s) of the Act, to implement fee schedules for splints and casts, and IOLs inserted in a physician's office falling under the category of medical supplies. In addendum C of the proposed rule (78 FR 40879), which can be found on *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Downloads/CMS-1526-P-Addendum-C.pdf,* we inserted the current 2013 reasonable charge amounts for splints, casts and IOLs inserted in a physician's office. The 2013 reasonable charge amounts for splints and casts are gap-filled reasonable charges updated by the CPI-U factor ending with June of the preceding year, in this case June 2012. The 2013 reasonable charge amounts for IOLs inserted in a physician's office that are described by HCPCS code V2632 are estimates of the 2012 average allowed charges for these items and services. With regard to other HCPCS codes for IOLs inserted in a physician's office, Medicare payment was made for one claim for code V2631 over the past ten years and ten claims for code V2630 over the past 6 years. We indicated in Appendix C of the proposed rule that we would gap-fill the fee schedule amounts for HCPCS codes V2630 and V2631. In the case of fee schedule amounts for other prosthetic devices

paid for in accordance with the rules at section 1834(h) of the Act, the fee schedule amounts are gap-filled using fee schedule amounts for comparable items or supplier price lists in accordance with program instructions related to gap-filling fee schedule amounts for DMEPOS items and services located at section 60.3 of chapter 23 of the Medicare Claims Processing Manual (Pub. 100–04). We would not have the entire calendar year estimates for 2013 average allowed charge for IOLs inserted in a physician's office in order to implement the fee schedule amounts for these items effective for paying claims with dates of service on or after January 1, 2014; therefore, we stated we would use the estimate of the 2012 average allowed charge including the percentage increase in the CPI–U for the 24-month period ending with June of 2012, which is 1.7 percent, and June of 2013, which is 1.8 percent, to update the fee-schedule amounts for splints and casts (78 FR 40879). Specifically, we proposed to amend 42 CFR § 414.106 and § 414.100 to include the general rule for updating the fee schedules for splints, casts and IOLs inserted in a physician's office. We also proposed to add § 414.106 and § 414.108 to set forth the fee schedule methodology and updates as explained above for splints, casts, and IOLs inserted in a physician's office. Subject to coinsurance and deductible rules, Medicare payment for these services is to be equal to the lower of the actual charge for the item or the amount determined under the applicable fee schedule payment methodology.

For splints and casts, we proposed national fee schedule amounts for items furnished from January 1, 2014, thru December 31, 2014, based on 2013 reasonable charges updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June 2013 (78 FR 40879). For subsequent years, we proposed that the fee schedule amounts would be updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year, reduced by the productivity adjustment as described in section 1886(b)(3)(B)(xi)(II) of the Act (78 FR 40879).

For IOLs inserted in a physician's office, we proposed national fee schedule amounts for items furnished from January 1, 2014, thru December 31, 2014, based on the national average allowed charge for the item from January 1, 2012 through December 31, 2012, updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 24-month period ending with June 2013. For subsequent years, the fee schedule amounts would be updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year, reduced by the productivity adjustment as described in section 1886(b)(3)(B)(xi)(II) of the Act.

We received one comment on the proposal to implement budget-neutral fee schedules for splints, casts and IOLs inserted in a physician's office from an advocacy group representing doctors of optometry. The issues raised in the comment were specifically in regard to IOLs. We received no comments on the topic of splints and casts.

Comment: The commenter indicated that the statute does not provide specific authority for implementing fee schedules for IOLs as part of the authority for implementing fee schedules for the general category of ''medical supplies'' listed under section 1842(s) of the Act. The commenter indicates that under 42 CFR 414.202, the list of items not considered prosthetics or orthotics separately identifies ''medical supplies'' and ''intraocular lenses,'' and that if intraocular lenses were considered ''medical supplies,'' they would not need to be separately listed in § 414.202.

Response: We disagree with this comment. The terms ''medical supplies'' and ''intraocular lenses'' are listed in 42 CFR 414.202 for the purpose of implementing section 1834(h)(4)(C) of the Act. The regulation clearly states that the definitions in 42 CFR 414.202 are for the purposes of Subpart D—Payment for Durable Medical Equipment and Prosthetic and Orthotic Devices. The term ''medical supplies'' referred to in section 1834(h)(4)(C) of the Act include catheters, catheter supplies, ostomy bags, and supplies related to ostomy care that are specifically furnished by a home health agency. As a result, we implemented § 414.202 consistent with the payment rules under section 1834(h) of the Act, which identifies a different group of items of ''medical supplies'' than those addressed under section 1842(s) of the Act. As we stated in the proposed rule (78 FR 40878), although the terms ''intraocular lenses'' and ''medical supplies'' are separately identified under § 414.202 for purposes of defining what constitutes orthotic and prosthetic devices, the regulation is not intended to suggest these are mutually exclusive items. Indeed, under the Medicare statute and regulations, items and services are identified specifically and generally, as part of larger categories.

We believe our interpretation of this statutory authority is reasonable and that we have been consistent in our interpretation of section 1842(s) of the Act in the past. As we noted above, we proposed to adopt fee schedules for IOLs under this authority in 1999, though we declined to finalize this proposal (64 FR 40534 (July 27, 1999). We continue to interpret the category ''medical supplies'' to include IOLs, splints and casts, and other items paid for on a reasonable charge basis that are not specifically listed as separate categories under section 1842(s). We believe that the intent of section 1842(s) is to provide authority for phasing out reasonable charge payments for those few items and services still paid in accordance with these old payment rules, and therefore, we generally consider ''intraocular lenses'' to be paid as ''medical supplies.'' Accordingly, we do not believe we are precluded from establishing fee schedules for IOLs under the category of medical supplies under section 1842(s) of the Act.

Comment: The commenter also suggested that if we continue with converting the IOLs to fee schedule amounts, then we should delay implementation of the fee schedule amounts so that suppliers of IOLs have more time to learn about and prepare for the change in payment.

Response: We disagree that extra time is needed to prepare for implementation of fee schedule amounts that the statute specifies must be initially budget neutral. Our review of CY 2012 submitted charge data indicates that there is little variation in the charges submitted for the items that have enough claims data information to implement the fee schedule amounts.

Comment: The commenter agreed with us that fee schedule amounts should be a national amount rather than local because several states have no suppliers of IOLs.

Response: We appreciate this comment and have made the fee schedules of IOLs a national fee schedule amount.

After careful review of the comment received and for the reasons we discussed previously, we are finalizing the implementation of budget-neutral fee schedules for splints, casts and IOLs inserted in a physician's office. Part 414, Subpart C of the regulations at 42 CFR are being revised to indicate that the fee schedule amounts for payment for splints and casts furnished in 2014, effective April 1, 2014, is the reasonable

charge amount for 2013, updated by the percentage increase in the CPI–U for the 12-month period ending with June of 2013. We will start paying the national fee schedule amounts specified in Table 11 below for these items on April 1, 2014. Part 414, Subpart C of the regulations at 42 CFR are being revised to indicate that the fee schedule amounts for payment for splints and casts furnished on April 1, 2014, is the reasonable charge amount for 2013, updated by the percentage increase in the CPI–U for the 12-month period ending with June of 2013, and that the fee schedule amounts for payment for IOL inserted in a physician's office on April 1, 2014, is the national average allowed charge for the IOL furnished in calendar year 2012, updated by the percentage increase in the CPI–U for the 24-month period ending with June of 2013. For each year subsequent to 2014 for splints and casts, and IOLs inserted in a physician's office, the fee schedule amounts of the preceding year are updated by the percentage increase in the CPI–U for the 12-month period ending with June of the preceding year, reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

TABLE 11—FINAL FEE SCHEDULE AMOUNTS EFFECTIVE APRIL 1, 2014

2014 Fee Schedule Amounts for Splints and Casts							
A4565	$8.41	Q4013	$15.40	Q4026	$115.34	Q4039	$8.05
Q4001	47.85	Q4014	25.97	Q4027	18.48	Q4040	20.13
Q4002	180.82	Q4015	7.71	Q4028	57.69	Q4041	19.55
Q4003	34.36	Q4016	12.98	Q4029	28.25	Q4042	33.37
Q4004	118.96	Q4017	8.91	Q4030	74.36	Q4043	9.78
Q4005	12.67	Q4018	14.19	Q4031	14.12	Q4044	16.69
Q4006	28.55	Q4019	4.46	Q4032	37.18	Q4045	11.35
Q4007	6.34	Q4020	7.11	Q4033	26.35	Q4046	18.25
Q4008	14.27	Q4021	6.59	Q4034	65.54	Q4047	5.66
Q4009	8.46	Q4022	11.89	Q4035	13.17	Q4048	9.13
Q4010	19.04	Q4023	3.31	Q4036	32.78	Q4049	2.07
Q4011	4.22	Q4024	5.95	Q4037	16.07		
Q4012	9.53	Q4025	36.94	Q4038	40.27		
2014 Fee Schedule Amounts for Intraocular Lenses Implanted in a Physician's Office							
V2630	***	V2631	***	V2632	111.81		

*** No claims submitted in 2012
Note: These fee schedule amounts are effective April 1, 2014.

VII. DMEPOS Technical Amendments and a Correction

A. Background

Medicare pays for various DMEPOS items and services based on payment rules that are set forth in section 1834 of the Act and 42 CFR Part 414, Subpart D. We proposed to make three minor, conforming technical amendments to the existing DMEPOS payment regulations (the title of Subpart D and 42 CFR § 414.200 and § 414.226) (78 FR 40879 through 40880).

B. Summary of the Proposed Provisions and Responses to Comments on the Proposed Technical Amendments and a Correction

We proposed to make three minor, conforming technical amendments and a correction to the existing DMEPOS payment regulations as follows (78 FR 40879 through 40880):

- We proposed to modify the title of ''Subpart D—Payment for Durable Medical Equipment, Prosthetic and Orthotic Devices'' to read ''Subpart D—Payment for Durable Medical Equipment, Prosthetic and Orthotic Devices, and Surgical Dressings'' to reflect that payment for surgical dressings is addressed under this subpart at § 414.220(g).
- In subpart § 414.200, we proposed to modify the phrase ''This subpart implements sections 1834 (a) and (h) of the Act by specifying how payments are made for the purchase or rental of new and used durable medical equipment and prosthetic and orthotic devices for Medicare beneficiaries.'' as follows: ''This subpart implements sections 1834 (a), (h), and (i) of the Act by specifying how payments are made for the purchase or rental of new and used durable medical equipment, prosthetic and orthotic devices, and surgical dressings for Medicare beneficiaries.'' The Omnibus Budget Reconciliation Act of 1993 amended section 1834 of the Act by adding subsection (i), mandating payment on a fee schedule basis for surgical dressings. Although § 414.220(g) addresses this requirement, the regulation at § 414.200 was not updated to indicate that this subpart implements section 1834(i) in addition to sections 1834(a) and (h) of the Act.
- Section 1834(a)(9)(D) of the Act provides authority for creating separate classes of oxygen and oxygen equipment. Section 1834(a)(9)(D)(ii) of the Act prohibits CMS from creating separate classes of oxygen and oxygen equipment that result in expenditures for any year that are more or less than expenditures which would have been made if the separate classes had not been created. In other words, the new classes and payment amounts for oxygen and oxygen equipment must be established so that creating the new classes is annually budget-neutral. In November 2006, we published a final rule (CMS–1304–F) establishing separate classes for oxygen and oxygen equipment and included a methodology for meeting the requirements of section 1834(a)(9)(D)(ii) of the Act by applying annual reductions to the monthly fee schedule amounts for the stationary oxygen equipment class at § 414.226(c)(1)(i) in order to establish budget neutrality for total oxygen and oxygen expenditures for all oxygen classes. Increases in expenditures for oxygen and oxygen equipment that are attributed to higher payment amounts established for new classes of oxygen and oxygen equipment are offset by reducing the monthly payment amount for stationary oxygen equipment. Due to a drafting error in the regulation text portion of the November 2006 final rule, CMS–1304–F (71 FR 65933), 42 CFR § 414.226(c)(6) needs to be corrected. The regulation text at § 414.226(c)(6) mistakenly states that budget neutrality should be achieved by adjusting all

oxygen class rates. Section 414.226(c)(6) should read that only the stationary oxygen equipment rate should be adjusted to achieve budget neutrality. Therefore, we proposed to revise § 414.226(c)(6) to read as follows: ''Beginning in 2008, CMS makes an annual adjustment to the national limited monthly payment rate for items described in paragraph (c)(1)(i) of this section to ensure that such payment rates do not result in expenditures for any year that are more or less than the expenditures that would have been made if such classes had not been established.''

• We also proposed a technical correction to existing 42 CFR § 414.102(c) to conform the regulation governing parenteral and enteral (PEN) nutrients, equipment and supplies covered item fee schedule update with the statute. Although section 1842(s)(1)(B)(ii) of the Act is self-implementing, the PEN nutrients, equipment and supplies payment regulations at 42 CFR 414 Subpart C were not updated to reflect the application of the multifactor productivity adjustment to the CPI–U update factor for 2011 and subsequent calendar years. Therefore, we are revising § 414.102(c) of our regulations to specify that for years 2003 through 2010, the PEN items and services fee schedule amounts of the preceding year are updated by the percentage increase in the CPI–U for the 12-month period ending with June of the preceding year. For each year subsequent to 2010, the PEN items and services fee schedule amounts of the preceding year are updated by the percentage increase in the CPI–U for the 12-month period ending with June of the preceding year, reduced by the productivity adjustment describe in section 1886(b)(3)(B)(xi)(II) of the Act.

We received no public comments on the DMEPOS proposals for technical amendments and a correction. Therefore, for the reasons we previously explained, we are finalizing our proposed modifications to the above regulations.

VIII. Waiver of Delayed Effective Date

In the absence of an appropriation for FY 2014 or a Continuing Resolution, the federal government funding lapsed on October 1, 2013. During the funding lapse, which lasted from October 1, 2013 through October 16, 2013, only excepted operations continued, which largely excluded work on this final rule. Accordingly, most of the work on this final rule was not completed in accordance with our usual schedule for final CY payment rules, which aims for an issuance date of November 1 followed by an effective date of January 1 to ensure that the policies are effective at the start of the calendar year to which they apply.

We ordinarily provide a 60-day delay in the effective date of final rules after the date they are issued. The 60-day delay in effective date can be waived, however, if the agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued. We believe it would be contrary to the public interest to delay the effective date of the ESRD PPS and ESRD QIP portions of this final rule. The ESRD PPS is a calendar-year payment system, and we typically issue the final rule by November 1 of each year to ensure that the payment policies for the system are effective on January 1, the first day of the calendar year to which the policies are intended to apply. CMS also includes in the ESRD PPS final rule its policies for the ESRD QIP because the performance of dialysis facilities under the ESRD QIP has a direct effect on that facility's payment under the ESRD PPS. A dialysis facility's ESRD PPS payment in 2016 will be based, in part, on the policies finalized in this final rule, including the requirement that the facility report certain quality measures beginning January 1, 2014. If the effective date of this final rule is delayed by 60 days, the ESRD PPS and the ESRD QIP policies adopted in this final rule will not be effective until after January 1, 2014. This would be contrary to the public's interest in ensuring that dialysis facilities receive appropriate payments in a timely manner, and that their payments in 2016 properly and completely reflect their performance on quality measures in 2014. In addition, in the case of the ESRD PPS, section 1881(b)(14)(I) of the Act, as added by section 632(a) of the ATRA, requires that, for services furnished on or after January 1, 2014, the Secretary shall make reductions to the single payment for renal dialysis services to reflect the Secretary's estimate of the change in utilization of ESRD-related drugs and biologicals (excluding oral-only ESRD-related drugs) by comparing per patient utilization data from 2007 with such data from 2012. We are finalizing the drug utilization adjustment in this final rule, and in order to adhere to the statutory requirement that the adjustment apply to services furnished on or after January 1, 2014, this final rule must be effective on that date. We note that our waiver of the delayed effective date only applies to the ESRD PPS and ESRD QIP policies that are adopted in this final rule. The delayed effective date for the DMEPOS policies is not waived and these policies will be effective on April 1, 2014, for provisions that clarify the grandfathering provision related to the 3-year MLR for DME, the clarification of the definition of routinely purchased DME, fee schedules for splints and casts, and IOLs inserted in a physician's office, and technical amendments and corrections to existing regulations related to payment for DMEPOS items and services. For the items that we identified that will be reclassified as capped rental items and paid for in accordance with the rules set forth in 42 CFR 414.229, such reclassifications will be effective in three phases beginning on or after April 1, 2014. Items will be reclassified as capped rental items effective April 1, 2014, in all areas of the country if the item is not included in a Round 2 or Round 1 Recompete DMEPOS CBP. Items will be reclassified as capped rental items effective July 1, 2016, in all areas of the country if the item is included in a Round 2 CBP and not a Round 1 Recompete CBP. Items will be classified as capped rental items effective July 1, 2016, when it is furnished in any area of the country that is not in one of the 9 Round 1 Recompete areas if the item is included in a Round 1 Recompete CBP. Finally, items will be classified as capped rental items effective January 1, 2017, when it is furnished in one of the 9 Round 1 Recompete areas if the item is included in a Round 1 Recompete CBP.

IX. Collection of Information Requirements

A. Legislative Requirement for Solicitation of Comments

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection requirement should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

• The need for the information collection and its usefulness in carrying out the proper functions of our agency.

• The accuracy of our estimate of the information collection burden.

• The quality, utility, and clarity of the information to be collected.

• Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

B. Requirements in Regulation Text

In section II.D. of this final rule, we changed the regulatory text for the ESRD PPS in CY 2014. However, the changes that are being made do not impose any new information collection requirements.

C. Additional Information Collection Requirements

This final rule does not impose any new information collection requirements in the regulation text, as specified above. However, this final rule does make reference to several associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections.

1. ESRD QIP

a. Expanded ICH CAHPS Reporting Measure for PY 2016 and Future Payment Years of the ESRD QIP

As stated above in section III.C.2.a of this final rule, we proposed to include in the PY 2016 ESRD QIP an expanded ICH CAHPS reporting measure, which assesses facility usage of the ICH CAHPS survey. Unlike the ICH CAHPS reporting measure finalized in the CY 2013 ESRD PPS final rule (77 FR 67480 through 67481), the proposed expanded ICH CAHPS reporting measure would require facilities to report (via a CMS-approved vendor) survey data to CMS once for PY 2016, and, for PY 2017 and beyond, to administer (via a CMS-approved vendor) a second ICH CAHPS survey and report the second set of survey data to CMS. Therefore, for PY 2016, we estimated the burden associated with this requirement to be the time and effort necessary for facilities to submit (via a CMS-approved vendor) survey results to CMS. For PY 2017 and future payment years, we estimated the burden associated with this requirement is the time and effort necessary for facilities to administer (via a CMS-approved vendor) a second ICH CAHPS survey and submit (via a CMS-approved vendor) the survey results to CMS.

We estimated that approximately 5,506 facilities will treat adult, in-center hemodialysis patients in PY 2016 and, therefore, will be eligible to receive a score on this measure. We further estimated that all 5,506 facilities will report (via a CMS-approved vendor) survey results to CMS, and that it will take each vendor approximately 5 minutes to do so. Therefore, the estimated total annual burden associated with meeting the measure requirements in PY 2016 is 459 hours [(5/60) hours x 5,506 facilities). According to the Bureau of Labor Statistics, the mean hourly wage of a registered nurse is $32.66/hour. Since we anticipate nurses (or administrative staff who would be paid at a lower hourly wage) will submit this data to CMS, we estimated that the aggregate cost of this requirement for PY 2016 will be $14,991 (459 hours x $32.66/hour).

We estimated that approximately 5,693 facilities will treat adult, in-center hemodialysis patients in PY 2017 and, therefore, will be eligible to receive a score on this measure. We estimated that all 5,693 facilities will administer the ICH CAHPS survey through a third-party vendor and arrange for the vendor to submit the data to CMS. We estimated that it would take each patient 30 minutes to complete the survey (to account for variability in education levels) and that approximately 103 surveys per year would be taken per facility. Interviewers from each vendor would therefore spend a total of approximately 52 hours per year with patients completing these surveys (0.5 hours * 103 surveys) or $1,698 (52 hours × $32.66) for an estimated annual burden of $9,666,714 ($1,698 per facility × 5,693 facilities). We previously estimated that the aggregate cost of submitting survey data to CMS is $14,991. Therefore, we estimated that the total annual burden for ESRD facilities to comply with the collection of information requirements associated with the proposed expanded ICH CAHPS measure for PY 2017 and future payment years would be approximately $9,681,705 ($9,666,714 + $14,991) across all ESRD facilities.

We requested comments on these proposals. The comments we received on these proposals and our responses are set forth below.

Comment: One commenter asked CMS to take a global look at the burden placed on dialysis facilities for all aspects of the ESRD QIP.

Response: We appreciate the commenter's suggestion and we clarify that we take an overarching view of provider burden each year during the rulemaking process when we conduct analyses associated with the Collection of Information Requirements.

Comment: One commenter stated that the aggregate costs associated with the collection of information requirements are accurate, but that the costs are too high for facilities and amount to an unfunded mandate.

Response: Although we recognize that the ESRD QIP imposes significant costs to providers, we disagree that those costs are too high or amount to an unfunded mandate. We continue to believe that the ESRD QIP drives improvements in the quality of care for patients with ESRD. We also believe that the benefits for patients far outweigh the costs for providers, and that the ESRD QIP does not amount to an unfunded mandate because it is tied to the reimbursements providers receive through the ESRD Prospective Payment System.

Comment: A few commenters did not agree with the cost estimates in the collection of information requirements because it does not account for the burdens associated with entering data into CROWNWeb, as CROWNWeb is not fully functional.

Response: We understand that members of the ESRD community have reported difficulties accessing and using the CROWNWeb system. As stated above, we are working to address known defects in CROWNWeb, and we look forward to continuing to work with facilities to minimize the burden of entering data into CROWNWeb. We note that entering data in CROWNWeb is a Condition for Coverage for dialysis facilities (§ 494.180(h)), and that CROWNWeb supports the 1995 Paperwork Reduction Act. We will take the commenters' suggestions under advisement in the future when estimating burdens associated with collection of information requirements

Comment: Several commenters did not agree with the cost estimates for the collection of information requirements for the ICH CAHPS measure. These commenters stated that the cost estimates do not accurately capture the cost of using a third party vendor, and that these costs can vary significantly.

Response: We agree that the cost estimates for the ICH CAHPS measure did not include the costs associated with contracting a third-party vendor to conduct the survey. As noted above (see Section III.C.2.a), the costs of these contracts vary significantly. Therefore, we assumed that third party vendors would employ registered nurses to administer the survey. We recognize the estimation method may not be entirely accurate, but we believe it is the most reliable way to generate a single cost estimate.

b. Data Validation Requirements for the PY 2016 ESRD QIP

Section III.C.13 of the proposed rule outlines our data validation proposals. We proposed to randomly sample records from 300 facilities; each

sampled facility would be required to produce up to 10 records; and the sampled facilities will be reimbursed by our validation contractor for the costs associated with copying and mailing the requested records. The burden associated with this validation requirement is the time and effort necessary to submit validation data to a CMS contractor. We estimate that it will take each facility approximately 2.5 hours to comply with these requirements. If 300 facilities are tasked with providing the required documentation, the estimated annual burden for these facilities across all facilities would be 750 hours (300 facilities × 2.5 hours) at a total of $24,495 (750 hours × $32.66/hour) or $81.65 ($24,495/300 facilities) per facility in the sample.

We requested comments on this proposal. We did not receive any comments on this proposal.

2. The clarification of the definition of routinely purchased DME does not contain any new information collection requirements.

3. The clarification of the 3-year MLR for DME does not contain any new information collection requirements.

4. The implementation of Budget-Neutral Fee Schedules for Splints, Casts and IOLs does not contain any new information collection requirements.

X. Economic Analyses

A. Regulatory Impact Analysis

1. Introduction

We examined the impacts of this final rule as required by Executive Order 12866 (September 30, 1993, Regulatory Planning and Review) and Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011). 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). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. Even though this rule has been designated non-economically significant under section 3(f)(1) of Executive Order 12866, it has been reviewed by the Office of Management and Budget. We have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the final rule.

2. Statement of Need

This rule finalizes a number of routine updates for renal dialysis services in CY 2014, implements the fourth year of the ESRD PPS transition, and makes several policy changes to the ESRD PPS. These include updates and changes to the ESRD PPS base rate, the wage index values, the wage index budget-neutrality adjustment factor, the home dialysis training add-on payment, and the outlier payment policy. This rule will also implement section 1881(b)(14)(I), which requires the Secretary, by comparing per patient utilization from 2007 with such data from 2012, to reduce the single payment amount to reflect the Secretary's estimate of the change in the utilization of ESRD-related drugs and biologicals. Failure to publish this final rule would result in ESRD facilities not receiving appropriate payments in CY 2014.

This rule finalizes to implement the ESRD QIP for PY 2016 and beyond by finalizing proposals to adopt measures, scoring, and payment reductions to incentivize improvements in dialysis care as directed by section 1881(h) of the Act. Failure to finalize requirements for the PY 2016 ESRD QIP would prevent continuation of the ESRD QIP beyond PY 2015.

In addition, this final rule clarifies the grandfathering provision related to the 3-year MLR for DME, provides clarification of the definition of routinely purchased DME and reclassifies certain items of DMEPOS, and implements budget-neutral fee schedules for splints and casts, and IOLs inserted in a physician's office. Finally, this final rule makes a few technical amendments and corrections to existing regulations related to payment for DMEPOS items and services.

3. Overall Impact

We estimate that the revisions to the ESRD PPS will result in no increase in payments to ESRD facilities in CY 2014. This includes the amount associated with the increase in the ESRDB market basket reduced by the productivity adjustment, updates to outlier threshold amounts, the inclusion of the Pacific Rim ESRD facilities, updates to the wage index, the change from payments based on 25 percent composite rate system and 75 percent ESRD PPS to 100 percent ESRD PPS for those facilities that opted to be paid under the blend, and the drug utilization adjustment required by section 1881(b)(14)(I), as added by section 632(a) of ATRA.

For PY 2016, we estimate that the requirements related to the ESRD QIP will cost approximately $39,486 ($14,991 for ICH CAHPS measure reporting + $24,495 data validation requirements) and the predicted payment reductions will equal about $15.1 million to result in a total impact from the ESRD QIP requirements of approximately $15.2 million. For PY 2017 and future payment years, we expect the costs associated with the collection of information requirements for the expanded ICH CAHPS measure in the proposed ESRD QIP to be approximately $9.7 million.

We estimate that the changes for implementing the fee schedule amounts from reasonable charge payments will be budget neutral and will have no impact to DMEPOS providers of splints, casts and IOLs inserted in a physician's office.

We estimate that our clarification of the definition of routinely purchased DME and re-classification of certain items as cap rental items would impact certain DMEPOS providers. The estimated overall impact on payments to suppliers is furnished in table 17 below. In addition, suppliers will incur additional expenses in submitting monthly claims for payment on a rental basis versus a single claim for payment on a purchase basis. Suppliers will be positively impacted by this change because they will not have to replace equipment in their inventory as often since they retain title to rented items that are not used on a continuous basis for 13 months by Medicare beneficiaries. We estimate that the clarification of the 3-year MLR for DME would have no impact on DMEPOS suppliers.

B. Detailed Economic Analysis

1. CY 2014 End-Stage Renal Disease Prospective Payment System

a. Effects on ESRD Facilities

To understand the impact of the changes affecting payments to different categories of ESRD facilities, it is necessary to compare estimated payments in CY 2013 to estimated payments in CY 2014. To estimate the impact among various types of ESRD facilities, it is imperative that the estimates of payments in CY 2013 and CY 2014 contain similar inputs. Therefore, we simulated payments only for those ESRD facilities for which we are able to calculate both current payments and new payments.

For this final rule, we used the June 2013 update of CY 2012 National Claims History file as a basis for Medicare dialysis treatments and payments under the ESRD PPS. We updated the 2012 claims to 2013 and 2014 using various

updates. The updates to the ESRD PPS base rate are described in section II.C of this final rule. For those providers that opted to be paid a blended payment amount during the transition, we used the price growth between the established 2013 and 2012 composite rate, drug add-on and part D add-on amounts. In addition we used the CY 2010 amounts as the CY 2013 amounts for Supplies and Other Services, since this category primarily includes the $0.50 administration fee for separately billable Part B drugs and this fee is not increased. Since some ESRD facilities received blended payments during the transition and received payment for ESRD drugs and biologicals based on their average sales price plus 6 percent (ASP+6), we used price growth for the top twelve drugs and biologicals based on ASP+6 percent thru the fourth quarter of 2013. Since the top twelve drugs account for over 99 percent of total former separately billable Part B drug payments, we used a weighted average growth of the top twelve drugs, for the remainder. We updated payments for laboratory tests paid through the laboratory fee schedule to 2013 using the statutory required update. Table 12 shows the impact of the estimated CY 2014 ESRD payments compared to estimated payments to ESRD facilities in CY 2013.

TABLE 12—IMPACT OF CHANGES IN PAYMENTS TO ESRD FACILITIES FOR THE CY 2014 ESRD PPS FINAL RULE

[Percent change in total payments to ESRD facilities (both program and beneficiaries)]

Facility type	Number of facilities	Number of treatments (in millions)	Effect of 2014 changes in outlier policy [4] (percent)	Effect of 2014 changes in wage Indexes (percent)	Effect of 2014 changes in blend of payments (percent)	Effect of 2014 changes in market basket minus productivity update (percent)	Effect of 2014 changes in base rate due to drug utilzation [5] (percent)	Effect of total 2014 changes (percent)
	A	B	C	D	E	F	G	H
All Facilities	5,873	42.7	0.4	0.0	0.2	2.8	−3.3	0.0
Type:								
Freestanding	5,362	39.6	0.4	0.0	0.1	2.8	−3.3	0.0
Hospital based	511	3.1	0.3	0.1	0.9	2.8	−3.2	0.8
Ownership Type:								
Large dialysis organization	4,023	29.7	0.5	0.0	0.0	2.8	−3.3	−0.1
Regional chain	813	6.2	0.4	0.1	0.4	2.8	−3.3	0.2
Independent	601	4.2	0.2	0.1	0.7	2.8	−3.3	0.4
Hospital based [1]	424	2.6	0.3	0.1	0.9	2.8	−3.2	0.7
Unknown	12	0.1	0.4	−0.1	0.2	2.8	−3.3	−0.1
Geographic Location:								
Rural	1,283	7.0	0.4	−0.1	0.2	2.8	−3.3	−0.1
Urban	4,590	35.7	0.4	0.0	0.2	2.8	−3.3	0.0
Census Region:								
East North Central	962	6.4	0.5	−0.1	0.2	2.8	−3.3	−0.1
East South Central	487	3.2	0.5	−0.2	0.0	2.8	−3.3	−0.2
Middle Atlantic	651	5.1	0.4	0.4	0.3	2.8	−3.3	0.6
Mountain	346	2.0	0.3	−0.1	0.2	2.8	−3.3	−0.1
New England	172	1.4	0.4	0.1	0.1	2.8	−3.3	0.0
Pacific [2]	692	5.9	0.2	0.6	0.1	2.8	−3.3	0.3
Puerto Rico and Virgin Islands	43	0.3	0.4	−2.3	0.4	2.8	−3.3	−2.1
South Atlantic	1,307	9.9	0.5	−0.3	0.2	2.8	−3.3	−0.2
West North Central	426	2.2	0.4	−0.2	0.4	2.8	−3.3	0.0
West South Central	787	6.2	0.5	−0.2	0.2	2.8	−3.3	−0.2
Facility Size:								
Less than 4,000 treatments [3]	1,090	3.1	0.4	−0.1	0.3	2.8	−3.3	0.1
4,000 to 9,999 treatments	2,167	11.1	0.4	−0.1	0.2	2.8	−3.3	−0.1
10,000 or more treatments	2,431	27.5	0.4	0.0	0.2	2.8	−3.3	0.0
Unknown	185	1.0	0.6	−0.2	0.3	2.8	−3.3	0.0
Percentage of Pediatric Patients:								
Less than 2%	5,759	42.3	0.4	0.0	0.2	2.8	−3.3	0.0
Between 2% and 19%	47	0.4	0.3	0.1	0.5	2.8	−3.3	0.4
Between 20% and 49%	7	0.0	0.1	−0.2	0.3	2.8	−3.3	−0.4
More than 50%	60	0.1	0.1	0.0	0.0	2.8	−3.3	−0.5

1. Includes hospital-based ESRD facilities not reported to have large dialysis organization or regional chain ownership.
2. Includes ESRD facilities located in Guam, American Samoa, and the Northern Mariana Islands.
3. Of the 1,088 ESRD facilities with less than 4,000 treatments, only 362 qualify for the low-volume payment adjustment. The low-volume payment adjustment is mandated by Congress, and is not applied to pediatric dialysis treatments. The impact to these low-volume ESRD facilities is a 0.4% increase in payments.
4. Includes the effect of including the Pacific Rim ESRD facilities located in Guam, American Samoa, and the Northern Mariana Islands into the ESRD PPS.
5. Includes the effect of adjusting the training add-on payment to $50.16, and the effect of an $8.16 decrease in the base rate due to the drop in drug utilization.
Note: Totals do not necessarily equal the sum of rounded parts, as percentages are multiplicative, not additive.

Column A of the impact table indicates the number of ESRD facilities for each impact category and column B indicates the number of dialysis treatments (in millions). The overall effect of the changes to the outlier payment policy described in section II.B.6. of this final rule is shown in column C. For CY 2014, the impact on all facilities as a result of the changes to the outlier payment policy would be a 0.4 percent increase in estimated payments. The estimated impact of the changes to outlier payment policy ranges from a 0.1 percent to a 0.6 percent increase. All ESRD facility types are anticipated to experience a positive effect in their estimated CY 2014 payments as a result of the outlier policy changes.

Column D shows the effect of the wage index on ESRD facilities and reflects the CY 2014 wage index values for the ESRD PPS payments. ESRD facilities located in the census region of Puerto Rico and the Virgin Islands would receive a 2.3 percent decrease in estimated payments in CY 2014. Since most of the facilities in this category are located in Puerto Rico, the decrease is

primarily due to the reduction in the wage index floor, (which only affects facilities in Puerto Rico in CY 2014). The other categories of types of facilities in the impact table show changes in estimated payments ranging from a 0.3 percent decrease to a 0.6 percent increase due to the update of the wage index.

Column E shows the effect of the change in the blended payment percentage from 25 percent of payments based on the composite rate system and 75 percent based on the ESRD PPS in CY 2013, to 100 percent based on the ESRD PPS in CY 2014, for those facilities that choose to be paid under the transition. The impact on all facilities would be a 0.2 percent increase in estimated payments. The estimated impacts of the change in the blend ranges from a 0.0 percent to 0.9 percent increase.

Column F shows the effect of the ESRDB market basket increase minus productivity adjustment. The impact on all facilities would be a 2.8 percent increase.

Column G shows the effect of the drug utilization adjustment required by section 1881(b)(14)(I) of the Act. For CY 2014, the impact on all facilities as a result of the $8.16 decrease to the base rate, as described in section II.B.2.a, would be a 3.3 percent decrease in estimated payments. The estimated impact ranges from 3.2 percent to 3.3 percent decrease.

Column H reflects the overall impact (that is, the effects of the outlier policy changes, the wage index, the effect of the blended payment percentage change, the effect of the ESRDB market basket increase minus productivity adjustment, and the effect of the drug utilization adjustment required by section 1881(b)(14)(I)). We expect that overall ESRD facilities will experience a 0.0 percent increase in estimated payments in 2014. ESRD facilities in Puerto Rico and the Virgin Islands are expected to receive a 2.1 percent decrease in their estimated payments in CY 2014. This larger decrease is primarily due to the negative impact of the wage index. The other categories of types of facilities in the impact table show impacts ranging from a decrease of 0.5 percent to an increase 0.8 percent in their 2014 estimated payments.

b. Effects on Other Providers

Under the ESRD PPS, ESRD facilities are paid directly for the renal dialysis bundle and other provider types such as laboratories, DME suppliers, and pharmacies, may no longer bill Medicare directly for renal dialysis services. Rather, effective January 1, 2011, such other providers can only furnish renal dialysis services under arrangements with ESRD facilities and must seek payment from ESRD facilities rather than Medicare. Under the ESRD PPS, Medicare pays ESRD facilities one payment for renal dialysis services, which may have been separately paid to suppliers by Medicare prior to the implementation of the ESRD PPS. Therefore, in CY 2014, the fourth year of the ESRD PPS, we estimate that the ESRD PPS will have zero impact on these other providers.

c. Effects on the Medicare Program

We estimate that Medicare spending (total Medicare program payments) for ESRD facilities in CY 2014 will be approximately $8.8 billion. This estimate takes into account a projected increase in fee-for-service Medicare dialysis beneficiary enrollment of 3.1 percent in CY 2014.

d. Effects on Medicare Beneficiaries

Under the ESRD PPS, beneficiaries are responsible for paying 20 percent of the ESRD PPS payment amount. As a result of the projected 0.0 percent overall increase in the final ESRD PPS payment amounts in CY 2014, we estimate that there will be an increase in beneficiary co-insurance payments of 0.0 percent in CY 2014, which translates to approximately $0 million.

e. Alternatives Considered

For this final rule, we considered implementing the full drug utilization adjustment amount in CY 2014. In particular, we could have implemented a one-time reduction of $29.93 to the CY 2014 ESRD PPS base rate. We also considered several transition options. For example, we considered equal reductions over a 3 or 4 year period. We chose to implement the drug utilization adjustment by offsetting the payment update, that is the ESRDB market basket minus productivity increase factor, and other impacts (such as, changes to the outlier thresholds) by a portion of the drug utilization adjustment amount necessary to create an overall impact of zero percent for ESRD facilities from the previous year's payments for CY 2014 and CY 2015. We believe that this approach will minimize disruption in the delivery of critical ESRD services.

2. End-Stage Renal Disease Quality Incentive Program

a. Effects of the PY 2016 ESRD QIP

The ESRD QIP provisions are intended to prevent possible reductions in the quality of ESRD dialysis facility services provided to beneficiaries as a result of payment changes under the ESRD PPS by implementing a ESRD QIP that reduces ESRD PPS payments by up to 2 percent for dialysis facilities that fail to meet or exceed a TPS with respect to performance standards established by the Secretary with respect to certain specified measures. The methodology that we proposed to determine a facility's TPS is described in section III.D.9 of this final rule. Any reductions in ESRD PPS payments as a result of a facility's performance under the PY 2016 ESRD QIP would begin with services furnished on January 1, 2016.

As a result, based on the ESRD QIP outlined in this final rule, we estimate that, of the total number of dialysis facilities (including those not receiving an ESRD QIP TPS), approximately 24 percent or 1,390 of the facilities would likely receive a payment reduction in PY 2016. Facilities that do not receive a TPS are not eligible for a payment reduction.

The ESRD QIP impact assessment assumes an initial count of 5,771 dialysis facilities paid through the PPS. Table 13 shows the overall estimated distribution of payment reductions resulting from the PY 2016 ESRD QIP.

TABLE 13—ESTIMATED DISTRIBUTION OF PY 2016 ESRD QIP PAYMENT REDUCTIONS

Payment reduction	Number of facilities	Percent of facilities (percent)
0.0%	4,483	76.3
0.5%	957	16.3
1.0%	305	5.2
1.5%	70	1.2
2.0%	58	1.0

Note: This table excludes 285 facilities that did not receive a score because they did not have enough data to receive a Total Performance Score.

To estimate whether or not a facility would receive a payment reduction under the proposed approach, we scored each facility on achievement and improvement on several measures we have previously finalized and for which there were available data from CROWNWeb and Medicare claims. Measures used for the simulation are shown in Table 14.

TABLE 14—DATA USED TO ESTIMATE PY 2016 ESRD QIP PAYMENT REDUCTIONS

Measure	Period of time used to calculate achievement thresholds, performance standards, benchmarks, and improvement thresholds	Performance period
Hemoglobin Greater Than 12 g/dL.	Jan 2012–Dec 2012	Jan 2013–Aug 2013.
Vascular Access Type:		
% Fistula	Jan 2012–Dec 2012	Jan 2013–Aug 2013.
% Catheter	Jan 2012–Dec 2012	Jan 2013–Aug 2013.
Kt/V:		
Adult HD	Jan 2012–Dec 2012	Jan 2013–Aug 2013.
Adult PD	Jan 2012–Dec 2012	Jan 2013–Aug 2013.
Pediatric HD	Jan 2012–Dec 2012	Jan 2013–Aug 2013.
Hypercalcemia	July 2012–Dec 2011	Jan 2013–June 2013.

Clinical measures with less than 11 cases for a facility were not included in that facility's TPS. Each facility's TPS was compared to the estimated minimum TPS and the payment reduction table found in section III.C.11 of this proposed rule. Facilities were required to have a score on at least one clinical measure to receive a TPS. For these simulations, the NHSN Bloodstream Infection in Hemodialysis Outpatients and the reporting measures were not included due to lack of data availability. Therefore, the simulated facility TPSs were calculated using only some of the clinical measure scores. Additionally, since data for the reporting measures were not available, facilities were scored at the median, or 5, for each of the three reporting measures.

To estimate the total payment reductions in PY 2016 for each facility resulting from this final rule, we multiplied the total Medicare payments to the facility during the one year period between January 2012 and December 2012 by the facility's estimated payment reduction percentage expected under the ESRD QIP, yielding a total payment reduction amount for each facility: (Total ESRD payment in January 2012 through December 2012 times the estimated payment reduction percentage). For PY 2016 the total payment reduction for all of the 1,390 facilities expected to receive a reduction is approximately $15.1 million ($15,137,161). Further, we estimate that the total costs associated with the collection of information requirements for PY 2016 described in section IX.C.1 of this final rule would be approximately $39.5 thousand for all ESRD facilities. As a result, we estimate that ESRD facilities will experience an aggregate impact of $15.2 million ($39,486 + $15,137,161 = $15,176,647) in PY 2016, as a result of the PY 2016 ESRD QIP.

Table 15 below shows the estimated impact of the finalized ESRD QIP payment reductions to all ESRD facilities for PY 2016. The table details the distribution of ESRD facilities by facility size (both among facilities considered to be small entities and by number of treatments per facility), geography (both urban/rural and by region), and by facility type (hospital based/freestanding facilities). Given that the time periods used for these calculations will differ from those we propose to use for the PY 2016 ESRD QIP, the actual impact of the PY 2016 ESRD QIP may vary significantly from the values provided here.

TABLE 15—IMPACT OF FINALIZED QIP PAYMENT REDUCTIONS TO ESRD FACILITIES FOR PY 2016

	Number of facilities	*Number of treatments 2012 (in millions)*	*Number of facilities with QIP score*	*Number of facilities expected to receive a payment reduction*	*Payment reduction (percent change in total ESRD payments)*
All Facilities	5,873	42.7	5,645	1,390	−0.17
Facility Type:					
Freestanding	5,362	39.6	5,248	1,259	−0.16
Hospital-based	511	3.1	397	131	−0.32
Ownership Type:					
Large Dialysis	4,023	29.7	3,963	966	−0.16
Regional Chain	813	6.2	789	149	−0.13
Independent	601	4.2	563	161	−0.23
Hospital-based (non-chain)	424	2.6	323	112	−0.34
Unknown	12	0.1	7	2	−0.28
Facility Size:					
Large Entities	4,836	35.9	4,752	1,115	−0.15
Small Entities[1]	1,025	6.7	886	273	−0.27
Unknown	12	0.1	7	2	−0.28
Rural Status:					
(1) Yes	1,283	7.0	1,233	288	−0.16
(2) No	4,590	35.7	4,412	1,102	−0.18
Census Region:					
Northeast	806	6.5	772	201	−0.20
Midwest	1,359	8.6	1,286	391	−0.21
South	2,544	19.2	2,490	570	−0.15
West	1,020	7.9	992	186	−0.14

TABLE 15—IMPACT OF FINALIZED QIP PAYMENT REDUCTIONS TO ESRD FACILITIES FOR PY 2016—Continued

	Number of facilities	Number of treatments 2012 (in millions)	Number of facilities with QIP score	Number of facilities expected to receive a payment reduction	Payment reduction (percent change in total ESRD payments)
U.S. Territories[2]	144	0.5	105	42	−0.33
Census Division:					
East North Central	962	6.4	904	310	−0.24
East South Central	487	3.2	476	102	−0.13
Middle Atlantic	651	5.1	615	165	−0.20
Mountain	346	2.0	331	65	−0.16
New England	172	1.4	164	39	−0.20
Pacific	692	5.9	674	126	−0.13
South Atlantic	1,307	9.9	1,269	321	−0.17
West North Central	426	2.2	402	85	−0.15
West South Central	787	6.2	769	152	−0.13
U.S. Territories[2]	43	0.3	41	25	−0.50
Facility Size (# of total treatments)					
Less than 4,000 treatments	1,090	3.1	938	277	−0.26
4,000–9,999 treatments	2,167	11.1	2,147	440	−0.13
Over 10,000 treatments	2,431	27.5	2,422	629	−0.17
Unknown	185	1.0	138	44	−0.24

[1] Small Entities include hospital-based and satellite facilities and non-chain facilities based on DFC self-reported status.
[2] Includes Puerto Rico and Virgin Islands.
[3] Based on claims data through December 2012.

b. Alternatives Considered for the PY 2016 ESRD QIP

In the proposed PY 2016 ESRD QIP, we selected measures that we believe are important indicators of patient outcomes and quality of care as discussed in section III.C of this final rule. Poor management of anemia, for example, can lead to avoidable hospitalizations, decreased quality of life, and death. In order to provide strong incentives to improve patient outcomes in this clinically important area, we considered proposing a clinical measure for Pediatric Iron Therapy. However, upon further review we recognized that we lacked the necessary baseline data to establish achievement thresholds, performance standards, and benchmarks. We, therefore, proposed a reporting measure in order to gather the data we will need to introduce a clinical measure in the future. In the case of the NHSN Bloodstream Event in Hemodialysis Outpatient measure, we considered proposing a reporting measure instead of a clinical measure, because we lacked the necessary baseline data to establish achievement thresholds, performance standards, and benchmarks. However, we decided not to do so. Due to the great impact hospital acquired infections have upon patients and the industry, we believe it is important to begin assessing facilities on the number of these events rather than on merely whether they report these events as soon as possible. Similarly, in the case of the Patient Informed Consent for Anemia Treatment measure, we considered proposing a reporting measure instead of a clinical measure, because we lacked the necessary baseline data to establish achievement thresholds, performance standards, and benchmarks. We decided not to do because we believe that providing counseling on the risks and benefits of anemia treatment, and seeking informed consent for such treatment, is already a standard of clinical care in the ESRD provider community. We also considered proposing the Standardized Hospitalization Ratio Admissions (SHR) measure and the Standardized Mortality Ratio (SMR) measure as reporting measures for the PY 2016 ESRD QIP. We decided not to do so due to outstanding concerns about the measures' validity and reliability. As an alternative, we proposed the Comorbidity reporting measure to provide a reliable source of data that we can use to properly risk-adjust SHR and SMR clinical measures (should we propose to adopt such measures in the future), and to improve our understanding of the risk factors that contribute to morbidity and mortality in the ESRD patient population.

In developing the proposed scoring methodology for the PY 2016 ESRD QIP, we considered several alternatives. For example, we considered weighting the clinical measures at 80 percent and the reporting measures at 20 percent of the TPS. We ultimately decided to propose the weighting methodology used in the PY 2015 ESRD QIP because the ratio of clinical to reporting measures did not change significantly, and also because we wanted to retain a strong incentive for facilities to meet the requirements for the reporting measures. We also considered a number of ways to establish achievement thresholds and benchmarks for the NHSN clinical measure. For example, we considered using baseline data from CYs 2012 through 2013 to set achievement thresholds and benchmarks. However, we ultimately decided to propose to use data from CY 2014 when establishing baseline data for scoring purposes, because facilities were not required to submit twelve full months of NHSN data during CY 2012–2013, and rates of healthcare-acquired infections are susceptible to seasonal variability. In light of the importance of monitoring and preventing infections in the ESRD population, we decided that it would be preferable to propose a clinical measure with equivalent baseline and performance periods, rather than a reporting measure that would have less of a direct impact on clinical practice. We also considered a number of ways to score the Patient Informed Consent for Anemia Treatment clinical measure. In this case, we lacked baseline data that could be used to establish achievement thresholds and benchmarks, so we considered proposing a reporting measure in place of the clinical measure. In light of the importance of the measure, however, we ultimately decided to propose a clinical measure in order to provide a stronger incentive for

facilities to obtain informed consent from patients receiving anemia treatment. In considering possible scoring methodologies for the measure, we specifically considered setting the achievement threshold at 100 percent because we believe that facilities should always obtain informed consent from patients receiving ESA. However, we recognized that unexpected events in the clinical setting might preclude the possibility of obtaining informed consent in every instance, so we ultimately decided to propose to set the achievement threshold for the measure at 92 percent. We selected 92 percent because this would allow facilities with 26 patients to meet the achievement threshold if they failed to obtain informed consent from 2 patients (see section III.C.8 for more details).

3. DMEPOS Provisions

a. Effects of the Implementation of Fee Schedules for Splints, Casts and IOLs

The implementation of fee schedules for use in paying claims for splints, casts, and IOLs inserted in a physician's office would result in administrative savings associated with determining and implementing the Medicare allowed payment amounts for these items. As a result, the agency would save approximately $94,000 in annual administrative expenses for calculating reasonable charge payment amounts and maintaining multiple pricing files necessary for making payment on a reasonable charge basis.

b. Clarification of the 3-Year MLR for DME

We expect no significant impact regarding application of the 3-year MLR for DME. As we noted in the final rule implementing the 3-year MLR, we believe that a vast majority of the categories of items that were classified as DME before January 1, 2012, did function for 3 or more years (76 FR 70289). The 3-year MLR is designed to represent a minimum threshold for determination of durability for equipment that is consistent with the statutory DME payment provisions and applies on a prospective basis, effective January 1, 2012. CMS recognizes that the healthcare industry and beneficiaries have come to rely on items that have qualified as DME prior to January 1, 2012, regardless of whether those items met the 3-year MLR set forth at § 414.202. We note that given that reliance and consistent with the regulation at § 414.202, CMS would not reopen those prior decisions and reclassify the equipment in light of the new 3-year standard. We believe that continuing the Medicare coverage for all the items that qualified as DME on or prior to January 1, 2012, would avoid disrupting the continuity of care for the beneficiaries that received these items for medical treatment prior to January 1, 2012. As noted in the final rule for the 3-year MLR (76 FR 70301, 70311) it is difficult to predict how many different types of new devices will be introduced in the market in the future that may or may not meet the 3-year MLR. However, even absent the 3-year MLR, it is likely that new products which do not meet the 3-year MLR will not qualify as DME based upon our current interpretation of the criteria for DME. It is possible that with the clarification of the 3-year MLR, we would limit what can be covered as DME compared to what we would have covered as DME absent this regulatory clarification. In general, we expect that the 3-year MLR we finalized effective January 1, 2012 (76 FR 70311) and clarification we are now providing of the 3-year MLR would have a minimal, if any, savings impact on the expenditures under program.

c. Definition of Routinely Purchased DME

As discussed in section IV of this final rule, this final rule clarifies the definition of routinely purchased equipment set forth at section § 414.220(a) and re-classifies an expensive item of DME or accessory (over $150) as a capped rental item for which Medicare claims data from July 1986 through June 1987 does not exist or for which Medicare claims data indicates that the item was not acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. Because concerns were brought to our attention on the application of the definition of routinely purchased DME, we performed a review of the approximately 250 HCPCS codes assigned to the routinely purchased category of DME in excess of $150. Based on our review, and given the definition of routinely purchased equipment set forth at section § 414.220, we would classify such items in the capped rental category if the items were not acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987.

This final rule identified the HCPCS codes requiring reclassification from routinely purchased DME to capped rental DME in section IV. The majority of codes relate to manual wheelchairs and wheelchair accessories. Also, accessories of complex rehabilitative power wheelchairs that will be classified as capped rental items and for which suppliers must also offer to the beneficiary on a lump sum purchase basis in accordance with § 414.229(h)(3) of the regulations are noted. Below are shown approximately 14 codes which will be reclassified in two stages effective July 1, 2016, for all items included in competitive bidding programs other than those furnished in the Round 1 Recompete programs and areas; and on January 1, 2017, for those items furnished as part of the Round I Recompete competitive bidding programs.

TABLE 16—ITEMS RECLASSIFIED TO CAPPED RENTAL DME CATEGORY EFFECTIVE JULY 1, 2016 *

HCPCS category	HCPCS
Support Surfaces	E0197.
Walkers	E0140 E0149.
Wheelchairs	E0985 E1020 E1028 E2228 E2368 E2369.
Options/Accessories	E2370 E2375 K0015 K0070.
Wheelchair Seating	E0955.

* Items furnished in accordance with Round 1 Recompete contracts would be reclassified effective January 1, 2017

In Table 17 below, we show estimated savings associated with making payment on a capped rental basis rather than a lump sum purchase basis for items that will be reclassified.

TABLE 17—IMPACT OF ITEMS RECLASSIFIED TO CAPPED RENTAL DME CATEGORY

FY	Impact to the federal government) (in $ millions)
2014	−10
2015	−20
2016	−20
2017	−30
2018	−40

The decrease in expenditures is expected because the changes would eliminate the lump sum purchase method for the certain items, and instead payment would be made under the monthly rental method resulting in lower aggregate payments because many beneficiaries do not rent items for as long as 13 months. In order to prepare our impact on the Medicare program, we reviewed claims data and utilization for all items currently classified as capped rental items from 2009 through 2011 and determined that the weighted average number of allowed monthly rental services for beneficiaries

receiving capped rental items during that period was 8 months. We therefore used 8 months as the estimated number of months beneficiaries would rent items in Table 11 of section IV of the preamble of this final rule that would not have a purchase option. All anticipated savings include the price growth for the covered item fee schedule update factors for DME mandated by section 1834(a)(14) of the Act. In addition, our estimate takes into account projected changes in DME beneficiary enrollment. Furthermore, we reflected the savings for these items that are currently included under any existing competitive bidding program and which will be reclassified from routinely purchased to capped rental effective July 1, 2016.

Approximately $100 million in allowed charges in 2011 are for items that would no longer be eligible for purchase. Under the capped rental payment rules, these items would be rented for up to 13-continuous months, following which title to the equipment would transfer from the supplier to the beneficiary.

C. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars_a004_a-4*), in Table 18 below, we have prepared an accounting statement showing the classification of the transfers and costs associated with the various provisions of this final rule.

TABLE 18—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS AND COSTS/SAVINGS

Category	Transfers
ESRD PPS for CY 2014	
Annualized Monetized Transfers	$0 million.
From Whom to Whom	Federal government to ESRD providers.
Category	Transfers
Increased Beneficiary Co-insurance Payments	$0 million.
From Whom to Whom	Beneficiaries to ESRD providers.
ESRD QIP for PY 2016	
Category	Transfers
Annualized Monetized Transfers	−$15.1 million.*
From Whom to Whom	Federal government to ESRD providers.
Category	Costs
Annualized Monetized ESRD Provider Costs	$39.5 thousand.**

DME Definition of Routinely Purchased DME

Category	Transfers			
Annualized Monetized Transfer Payments	−$23.1 million −$23.6 million	2013 2013	7% 3%	2014–2018 2014–2018
From Whom to Whom	Federal government to Medicare providers.			

* It is the reduced payment to the ESRD facilities, which fall below the quality standards as stated in section III.C.11 of this final rule.
** It is the cost associated with the collection of information requirements for all ESRD facilities.

XI. Regulatory Flexibility Act Analysis **

The Regulatory Flexibility Act (September 19, 1980, Pub. L. 96–354) (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. Approximately 17 percent of ESRD dialysis facilities are considered small entities according to the Small Business Administration's (SBA) size standards, which classifies small businesses as those dialysis facilities having total revenues of less than $35.5 million in any 1 year. Individuals and States are not included in the definitions of a small entity. For more information on SBA's size standards, see the Small Business Administration's Web site at *http://www.sba.gov/content/small-business-size-standards* (Kidney Dialysis Centers are listed as 621492 with a size standard of $35.5 million).

We do not believe ESRD facilities are operated by small government entities such as counties or towns with populations of 50,000 or less, and therefore, they are not enumerated or included in this estimated RFA analysis. Individuals and States are not included in the definition of a small entity.

For purposes of the RFA, we estimate that approximately 17 percent of ESRD facilities are small entities as that term is used in the RFA (which includes small businesses, nonprofit organizations, and small governmental jurisdictions). This amount is based on the number of ESRD facilities shown in the ownership category in Table 12. Using the definitions in this ownership category, we consider the 601 facilities that are independent and the 424 facilities that are shown as hospital-based to be small entities. The ESRD facilities that are owned and operated by LDOs and regional chains would have total revenues of more than $35.5 million in any year when the total revenues for all locations are combined for each business (individual LDO or regional chain), and are not, therefore, included as small entities.

For the ESRD PPS updates in this rule, a hospital-based ESRD facility (as

defined by ownership type) is estimated to receive a 0.4 percent increase in payments for CY 2014. An independent facility (as defined by ownership type) is estimated to receive a 0.7 percent increase in payments for CY 2014.

We solicited comment on the RFA analysis provided. The comments received and our responses are as follows.

Comment: A few commenters requested that CMS improve the impact analysis for small entities. One association requested that we improve transparency for ESRD facilities and that we update our description of small entities. The association provided a study that identified all the ESRD facilities that have $35.5 million in revenues, consistent with the RFA definition of a small entity. The Small Business Administration, Office of Advocacy commented that the rule's transparency would be improved if CMS: 1) improved its description of small entities likely to be impacted by the rule; 2) provided further details on the rule's impacts on affected small ESRD facilities; and 3) entertained reasonable alternatives to the provisions of the proposed rule pursuant to RFA section 603(c). Such alternatives might include adoption of a transition or phase-in period on which CMS solicited comments in the proposed rule. The commenter suggested that CMS provide an impact table tailored to the size standards utilized in the RFA to enable small entities to better anticipate and comment on the impacts of this rule and that we include a margin analysis in the RFA.

Response: We thank the commenters for their suggestions to enhance the RFA analysis. We will take these suggestions into consideration for future rulemaking. We note that CMS publishes a provider level impact table each year. The CY 2014 Final ESRD PPS Facility Level Impact File may be viewed at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html*. We believe that this file for allows adequate transparency and identification for all ESRD facilities. For example, Medicare certified ESRD facilities are identified by provider number, Medicare payments, number of furnished treatments, as well as, rural or urban status.

In section II.C.2.a.v. of this final rule we discuss the implementation of the drug utilization adjustment. Specifically, for CYs 2014 and 2015, we are implementing a transition of the drug utilization adjustment by offsetting the payment update, that is the ESRDB market basket minus productivity increase factor and other impacts (such as, changes to the outlier thresholds), by a portion of the reduction amount necessary to create an overall impact of zero percent for ESRD facilities from the previous year's payments. For CY 2016, we will evaluate how to apply the balance of the reduction when we conduct an analysis of the case-mix adjustments as required by section 632(c) of ATRA and implement the inclusion of oral-only ESRD-related drugs and biologicals as permitted by section 632(b) of ATRA. Following this evaluation, we will determine whether we should apply the balance of the reduction in CY 2016 or provide one additional transition year so that the full amount of the drug utilization adjustment will have been applied to the base rate over a 4-year transition period ending in CY 2017.

Based on the finalized QIP payment reduction impacts to ESRD facilities for PY 2016, we estimate that of the 1,390 ESRD facilities expected to receive a payment reduction, 273 ESRD small entity facilities would experience a payment reduction (ranging from 0.5 percent up to 2.0 of total payments), as presented in Table 13 (''Estimated Distribution of PY 2016 ESRD QIP Payment Reductions'') and Table 15 (''Impact of Proposed QIP Payment Reductions to ESRD Facilities for PY 2016'') above. We anticipate the payment reductions to average approximately $10,890 per facility among the 1,390 facilities receiving a payment reduction, with an average of $12,011 per small entity facilities receiving a payment reduction. Using our projections of facility performance, we then estimated the impact of anticipated payment reductions on ESRD small entities, by comparing the total payment reductions for the 273 small entities expected to receive a payment reduction, with the aggregate ESRD payments to all small entities. We estimate that there are a total of 1,025 small entity facilities. For this entire group of 1,025 ESRD small entity facilities, a decrease of 0.27 percent in aggregate ESRD payments is observed.

Splints and casts, and IOLs affected by this rule are generally furnished by physicians. Approximately 95 percent of physicians are considered to be small entities for the purposes of the RFA. Individuals and states are not included in the definition of a small entity. The reasonable charge payment amounts for splints and casts are based on national reasonable charge amounts increased each year by the 12-month percentage change in the CPI–U ending June of the previous year. These national inflation-indexed charges can easily be converted to fee schedule amounts with no impact on the national Medicare payment amounts for these items. Therefore, the fee schedule amounts that will take effect on April 1, 2014, for splints and casts would be the same as the reasonable charge amounts that will take effect on April 1, 2014, for these items. This final rule will have no impact on small businesses that furnish these items. Given that Medicare pays for very few IOLs inserted in a physician's office, these entities do not rely on Medicare payment for these items to support their businesses. Because the fee schedule amounts that would take effect on April 1, 2014, for IOLs inserted in a physician's office would be based on the national average allowed charge for the item, the payment amounts these entities would receive under the fee schedule will be, on average, the same amounts they are currently paid for these items when considering the small national volume of claims as a whole. For example, in 2011, the average allowed charge for an IOL inserted in a physician's office was $174 for just 287 cases nationwide. If a particular physician office is a small business that charges less than $174 per IOL, a national fee schedule amount of $174 could increase payment for this small business for this item. Alternatively, if a particular physician office is a small business that charges more than $174 per IOL, a national fee schedule amount of $174 could decrease payment for this small business for this item. However, with only 287 cases nationwide, implementing a national fee of $174 would not have a significant impact on any physician office that is a small business because the volume of claims indicates that the small businesses are not relying on payment for these items to fund their businesses (physician practices) as a whole. Therefore, we expect that the overall impact of this rule on small businesses that are physician offices that insert IOLs covered by Medicare would be minimal. Approximately 85 percent of suppliers of DMEPOS in general are considered to be small entities for the purposes of the RFA.

We expect that the impact of moving certain expensive DME items from the routinely purchased payment class to the capped rental payment class on small business will be minimal since the suppliers would still receive 105 percent of the purchase fee for items that are rented for the full 13-month capped rental period. In addition, the supplier would retain ownership of

equipment that is not used for 13 months and can furnish the equipment to another beneficiary, beginning a new, separate 13-month capped rental period for the same item.

Therefore, the Secretary has determined that this final rule 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 a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Any such regulatory impact 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. We do not believe this final rule will have a significant impact on operations of a substantial number of small rural hospitals because most dialysis facilities are freestanding. While there are 162 rural hospital-based dialysis facilities, we do not know how many of them are based at hospitals with fewer than 100 beds. However, overall, the 162 rural hospital-based dialysis facilities will experience an estimated 0.2 percent increase in payments. As a result, this final rule is not estimated to have a significant impact on small rural hospitals. Therefore, the Secretary has determined that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

XII. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year $100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold is approximately $141 million. This final rule does not include any mandates that would impose spending costs on State, local, or Tribal governments in the aggregate, or by the private sector, of $141 million.

XIII. Federalism Analysis

Executive Order 13132 on Federalism (August 4, 1999) 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. We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that it will not have substantial direct effects on the rights, roles, and responsibilities of States, local or Tribal governments.

XIV. Congressional Review Act

This final rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and has been transmitted to the Congress and the Comptroller General for review.

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

XV. Files Available to the Public Via the Internet

This section lists the Addenda referred to in the preamble of this final rule. Beginning in CY 2012, the Addenda for the annual ESRD PPS proposed and final rulemakings will no longer appear in the **Federal Register**. Instead, the Addenda will be available only through the Internet. We will continue to post the Addenda through the Internet.

Readers who experience any problems accessing the Addenda that are posted on the CMS Web site at *http://www.cms.gov/ESRDPayment/PAY/list.asp*, should contact Michelle Cruse at (410) 786–7540.

List of Subjects

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END–STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

■ 1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883 and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Pub.L. 106–113 (113 Stat. 1501A–332), sec. 3201 of Pub.L. 112–96 (126 Stat. 156), and sec. 632 of Pub. L. 112–240 (126 Stat. 2354)

§ 413.174 [Amended]

■ 2. Section 413.174 (f)(6) (as added on August 12, 2010 at 75 FR 49198, and effective on January 1, 2014) is amended by removing ''January 1, 2014'' and by adding in its place ''January 1, 2016''.

§ 413.237 [Amended]

■ 3. Section 413.237 (a)(1)(iv) is amended by removing ''excluding'' and by adding in its place ''including''; and by removing ''January 1, 2014'' and adding in its place ''January 1, 2016''.

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

■ 4. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C.1302, 1395hh, and 1395rr(b)(1)).

■ 5. The heading for subpart C is revised to read as follows:

Subpart C—Fee Schedules for Parenteral and Enteral Nutrition (PEN) Nutrients, Equipment and Supplies, Splints, Casts, and Certain Intraocular Lenses (IOLs)

* * * * *

■ 6. Section 414.100 is revised to read as follows:

§ 414.100 Purpose.

This subpart implements fee schedules for PEN items and services, splints and casts, and IOLs inserted in a physician's office as authorized by section 1842(s) of the Act.

■ 7. Section 414.102 is amended by revising paragraphs (a) introductory text, (a)(2), (b)(1), and (c) to read as follows:

§ 414.102 General payment rules.

(a) *General rule.* For PEN items and services furnished on or after January 1, 2002, and for splints and casts and IOLs inserted in a physician's office on or after April 1, 2014, Medicare pays for the items and services as described in paragraph (b) of this section on the basis of 80 percent of the lesser of—-

* * * * *

(2) The fee schedule amount for the item or service, as determined in accordance with §§ 414.104 thru 414.108.

(b) * * *

(1) CMS or the carrier determines fee schedules for parenteral and enteral nutrition (PEN) nutrients, equipment, and supplies, splints and casts, and IOLs inserted in a physician's office, as specified in §§ 414.104 thru 414.108.

* * * * *

(c) *Updating the fee schedule amounts.* For the years 2003 through 2010 for PEN items and services, the fee schedule amounts of the preceding year are updated by the percentage increase in the CPI–U for the 12-month period ending with June of the preceding year. For each year subsequent to 2010 for PEN items and services and for each year subsequent to 2014 for splints and casts, and IOLs inserted in a physician's office, the fee schedule amounts of the preceding year are updated by the percentage increase in the CPI–U for the 12-month period ending with June of the preceding year, reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

■ 8. Section 414.106 is added to read as follows:

§ 414.106 Splints and casts.

(a) *Payment rules.* Payment is made in a lump sum for splints and casts.

(b) *Fee schedule amount.* The fee schedule amount for payment for an item or service furnished in 2014 is the reasonable charge amount for 2013, updated by the percentage increase in the CPI–U for the 12-month period ending with June of 2013.

■ 9. Section 414.108 is added to read as follows:

§ 414.108 IOLs inserted in a physician's office.

(a) *Payment rules.* Payment is made in a lump sum for IOLs inserted in a physician's office.

(b) *Fee schedule amount.* The fee schedule amount for payment for an IOL furnished in 2014 is the national average allowed charge for the IOL furnished from in calendar year 2012, updated by the percentage increase in the CPI–U for the 24-month period ending with June of 2013.

■ 10. Revise the heading to Subpart D to read as follows:

Subpart D—Payment for Durable Medical Equipment, Prosthetic and Orthotic Devices, and Surgical Dressings

* * * * *

■ 11. Section § 414.200 is revised to read as follows:

§ 414.200 Purpose

This subpart implements sections 1834(a), (h) and (i) of the Act by specifying how payments are made for the purchase or rental of new and used durable medical equipment, prosthetic and orthotic devices, and surgical dressings for Medicare beneficiaries.

■ 12. Section 414.226 is amended by revising paragraph (c)(6) to read as follows:

§ 414.226 Oxygen and oxygen equipment

* * * * *

(c) * * *

(6) Beginning in 2008, CMS makes an annual adjustment to the national limited monthly payment rate for items described in paragraph (c)(1)(i) of this section to ensure that such payment rates do not result in expenditures for any year that are more or less than the expenditures that would have been made if such classes had not been established.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program).

Dated: November 20, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 21, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 431

Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 431

[CMS–1450–F]

RIN 0938–AR52

Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses

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

ACTION: Final rule.

SUMMARY: This final rule will update the Home Health Prospective Payment System (HH PPS) rates, including the national, standardized 60-day episode payment rates, the national per-visit rates, the low-utilization payment adjustment (LUPA) add-on, and the non-routine medical supply (NRS) conversion factor under the Medicare prospective payment system for home health agencies (HHAs), effective January 1, 2014. As required by the Affordable Care Act, this rule establishes rebasing adjustments, with a 4-year phase-in, to the national, standardized 60-day episode payment rates; the national per-visit rates; and the NRS conversion factor. In addition, this final rule will remove 170 diagnosis codes from assignment to diagnosis groups within the HH PPS Grouper, effective January 1, 2014. Finally, this rule will establish home health quality reporting requirements for CY 2014 payment and subsequent years and will clarify that a state Medicaid program must provide that, in certifying HHAs, the state's designated survey agency carry out certain other responsibilities that already apply to surveys of nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF–IID), including sharing in the cost of HHA surveys. For that portion of costs attributable to Medicare and Medicaid, we will assign 50 percent to Medicare and 50 percent to Medicaid, the standard method that CMS and states use in the allocation of expenses related to surveys of nursing homes.

DATES: These regulations are effective on January 1, 2014.

FOR FURTHER INFORMATION CONTACT: Hillary Loeffler, (410)786–0456, for general information about the HH PPS.

Joan Proctor, (410) 786–0949, for information about the HH PPS Grouper and ICD–10 Conversion.

Kristine Chu, (410) 786–8953, for information about rebasing and the HH payment reform study and report.

Mollie Knight, (410) 786–7948, for information about the HH market basket.

Kim Roche, (410) 786–3524, for information about the HH quality reporting program.

Lori Teichman, (410) 786–6684, for information about HH CAHPS®.

Jenny Filipovits, (410) 786–8141, for information about cost allocation of survey expenses.

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Acronyms

In addition, because of the many terms to which we refer by abbreviation in this final rule, we are listing these abbreviations and their corresponding terms in alphabetical order below:

ACA The Affordable Care Act.
ACH LOS Acute care hospital length of stay.
ADL Activities of daily living.
AHRQ Agency for Healthcare Research and Quality.
APU Annual payment update.
BBA Balanced Budget Act of 1997 (Pub. L. 105–33, enacted August 5, 1997).
BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106–113, enacted November 29, 1999).
CAD Coronary artery disease.
CAGR Compound Annual Growth Rate.
CAH Critical access hospital.
CAHPS® Consumer assessment of healthcare providers and systems.
CBSA Core-based statistical area.

CASPER Certification and survey provider enhanced reports.
CHF Congestive heart failure.
CMI Case-mix index.
CMP Civil monetary penalties.
CMS Centers for Medicare & Medicaid Services.
CoPs Conditions of participation.
COPD Chronic obstructive pulmonary disease.
CVD Cardiovascular disease.
CY Calendar year.
DG Diagnostic group.
DHHS Department of Health and Human Services.
DM Diabetes mellitus.
DME Durable medical equipment.
DRA Deficit Reduction Act of 2005 (Pub. L. 109–171, enacted February 8, 2006).
FDL Fixed dollar loss.
FFP Federal financial participation.
FI Fiscal intermediaries.
FR **Federal Register**.
FY Fiscal year.
GEM General equivalency mapping.
HAVEN Home assessment validation and entry system.
HCC Hierarchical condition categories.
HCIS Health care information system.
HH Home health.
HHAs Home health agencies.
HHCAHPS® Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey.
HH PPS Home health prospective payment system.
HHQRP Home Health Quality Reporting Program.
HHRG Home health resource group.
HIPAA Health Insurance Portability Accountability Act of 1996 (Pub. L. 104–191, enacted August 21, 1996).
HIPPS Health insurance prospective payment system.
ICD–9 International Classification of Diseases, 9th Edition.
ICD–9–CM International Classification of Diseases, 9th Edition, Clinical Modification.
ICD–10 International Classification of Diseases, 10th Edition.
ICD–10–CM International Classification of Diseases, 10th Edition, Clinical Modification.
ICF–IID Intermediate care facilities for individuals with intellectual disabilities.
IH Inpatient hospitalization.
IPPS Acute Inpatient Prospective Payment System
IRF Inpatient rehabilitation facility.
LTCH Long-term care hospital.
LUPA Low-utilization payment adjustment.
MAC Medicare Administrative Contractor.
MAP Measure applications partnership.
MedPAC Medicare Payment Advisory Commission.
MEPS Medical Expenditures Panel Survey.
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173, enacted December 8, 2003).
MSA Metropolitan statistical areas.
MSS Medical Social Services.
NF Nursing facility.
NQF National Quality Forum.
NRS Non-routine supply.
OASIS Outcome & Assessment Information Set.
OBRA Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100–2–3, enacted December 22, 1987).
OCESAA Omnibus Consolidated and Emergency Supplemental Appropriations Act (Pub. L. 105–277, enacted October 21, 1998).
OES Occupational employment statistics.
OIG Office of Inspector General.
OT Occupational therapy.
OMB Office of Management and Budget.
P4R Pay-for-reporting.
PAC–PRD Post-Acute Care Payment Reform Demonstration.
PEP Partial episode payment [Adjustment].
POC Plan of care.
PRRB Provider Reimbursement Review Board.
PT Physical therapy.
QAP Quality assurance plan.
QIES CMS Health Care Quality Improvement System.
PRRB Provider Reimbursement Review Board.
RAP Request for anticipated payment.
RF Renal failure.
RFA Regulatory Flexibility Act (Pub. L. 96–354, enacted on September 19, 1980).
RHHIs Regional home health intermediaries.
RIA Regulatory impact analysis.
SCHIP State Children's Health Insurance Program
SLP Speech-language pathology.
SN Skilled nursing.
SNF Skilled nursing facility.
TEP Technical Expert Panel.
UMRA Unfunded Mandates Reform Act of 1995 (Pub. L. 104–04, enacted on March 22, 1995).

I. Executive Summary

A. Purpose

This rule updates the payment rates for home health agencies (HHAs) for calendar year (CY) 2014, as required under section 1895(b) of the Social Security Act (the Act), including the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit rates, and the NRS conversion factor, required under section 3131(a) of the Patient Protection and Affordable Care Act of 2010 (Pub. L 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L 111–152) (collectively referred to as the ''Affordable Care Act''). This rule will also address: International Classification of Diseases, 9th Edition (ICD–9) Grouper refinements; implementation of the International Classification of Diseases, 10th Edition (ICD–10); a budget neutral adjustment to the case-mix weights; updates to the payment rates by the HH payment update percentage (for this final rule, the HH market basket); adjustments for geographic differences in wage levels; outlier payments; the submission of quality data; and additional payments for services provided in rural areas. This rule also clarifies state Medicaid program requirements related to the cost of HHA surveys.

B. Summary of the Major Provisions

In this final rule, we will remove 170 diagnosis codes from assignment to diagnosis groups within the HH PPS Grouper, effective January 1, 2014. In addition, on October 1, 2014, we will begin the use of ICD–10–CM codes within the HH PPS Grouper.

For CY 2014, we are adjusting the case-mix weights in order to reduce the average case-mix weight for CY 2012 from 1.3464 to 1.0000, in a budget neutral manner. As required by section 3131(a) of the Affordable Care Act, we are rebasing the national, standardized 60-day episode payment amount, the national per-visit rates and the NRS conversion factor. The rebasing adjustments will occur over the next four years. The rebasing adjustments will reduce the national, standardized 60-day episode payment amount in each year from CY 2014 to CY 2017 by $80.95, which is 3.5 percent of the national, standardized 60-day episode payment amount as of the date of enactment of the Affordable Care Act ($2,312.94 in CY 2010). In each year from CY 2014 to CY 2017, the rebasing adjustments will increase the national per-visit payment amounts by 3.5 percent of the national per-visit payment amounts in CY 2010 as described in section IV.D.2. The rebasing adjustments will reduce the NRS conversion factor in each year from CY 2014 to CY 2017 by 2.82 percent. We will use three LUPA add-on factors in calculating the LUPA add-on payment amount for LUPA episodes that are the only episode or the first episode in a sequence of adjacent episodes. We will update the home health wage index and increase payment rates for CY 2014 by 2.3 percent as described in section IV.E.4.

We will continue work on the home health study required by section 3131(d) of the Affordable Care Act, which will assess the costs associated with providing access to care to patients with high severity of illness, low income patients, and/or patients in medically underserved areas. Additionally, we will continue to use Outcome & Assessment Information Set (OASIS) data, claims data, and patient experience of care data, as forms of quality data to meet the requirement that HHAs submit data appropriate for the measurement of HH care quality for the annual payment update (APU) for

2014. We will implement two claims-based measures of quality for HH patients who were recently hospitalized, as these patients are at an increased risk of additional acute care hospital use. We are also reducing the number of HH quality measures currently reported to HHAs.

Lastly, we will review each state's allocation of costs for HHA surveys for compliance with OMB Circular A–87 principles and the statutes in 2014 with the goal of ensuring full compliance no later than July 2014. This rule will clarify that a state Medicaid program must provide that, in certifying HHAs, the state's designated survey agency must carry out certain other responsibilities that already apply to surveys of nursing facilities (NF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF–IID), including sharing in the cost of HHA surveys. For that portion of costs attributable to Medicare and Medicaid, we will assign 50 percent to Medicare and 50 percent to Medicaid.

C. Summary of Costs and Benefits

TABLE 1—SUMMARY OF COSTS, BENEFITS AND TRANSFERS

Provision description	Total costs	Total benefits	Transfers
CY 2014 HH PPS Payment Rate Update.	N/A	The benefits of this final rule include paying more accurately for the delivery of home health services.	The overall economic impact of this final rule is an estimated $200 million in decreased payments to HHAs.
Cost Allocation of HHA Survey Expenses..	N/A	The benefits of this rule include clarifying that state Medicaid programs must share in the cost of HHA surveys. For that portion of costs attributable to Medicare and Medicaid, we would assign 50 percent to Medicare and 50 percent to Medicaid..	If implemented in the beginning of FY 2014 we project that aggregate Medicare and Medicaid home health survey costs in FY 2014 would be approximately $37.2 million. As these costs would be assigned 50 percent to Medicare and 50 percent to Medicaid for each state, the anticipated aggregate Medicaid share would amount to $18.6 million. The cost of surveys is treated as a Medicaid administrative cost, reimbursable at the professional staff rate of 75 percent. At this rate the maximum net state costs for Medicaid matching funds incurred in FY 2014 would be approximately $4.65 million, spread out across all states and 2 territories. However, the proposed adherence date of July FY 2014 would reduce the Medicaid aggregate share to $4.65 million and the state Medicaid share to approximately $1.16 million. The federal Medicaid share will reflect the remaining $3.49 million, with an adherence date of July FY 2014. Some state Medicaid programs may currently pay for HHA surveys to some extent, but the amount is unknown.

II. Background

A. Statutory Background of the Home Health PPS

The Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33, enacted August 5, 1997), significantly changed the way Medicare pays for Medicare HH services. Section 4603 of the BBA, added section 1895 of the Act, which mandated the development of the HH PPS. Until the implementation of a HH PPS on October 1, 2000, HHAs received payment under a retrospective reimbursement system.

Section 1895 of the Act entitled ''Prospective Payment For Home Health Services'' mandated the development of a HH PPS for all Medicare-covered HH services that were paid on a reasonable cost basis. Section 1895(b)(1) of the Act requires the Secretary to establish a HH PPS for all costs of HH services paid under Medicare.

Section 1895(b)(3)(A) of the Act requires the following: (1) The computation of a standard prospective payment amount that includes all costs for HH services that would have been covered and paid for on a reasonable cost basis had the HH PPS not been in effect and that such amounts be initially based on the most recent audited cost report data available to the Secretary; and (2) adjustment of the standardized prospective payment amount to account for the effects of case-mix and wage levels among HHAs.

Section 1895(b)(3)(B) of the Act addresses the annual update to the standard prospective payment amounts by the HH applicable percentage increase. Section 1895(b)(4) of the Act governs the payment computation. Sections 1895(b)(4)(A)(i) and (b)(4)(A)(ii) of the Act require the standard prospective payment amount to be adjusted for case-mix and geographic differences in wage levels. Section 1895(b)(4)(B) of the Act requires the establishment of an appropriate case-mix change adjustment factor for significant variation in costs among different units of services.

Similarly, section 1895(b)(4)(C) of the Act requires the establishment of wage adjustment factors that reflect the relative level of wages, and wage-related costs applicable to HH services furnished in a geographic area compared to the applicable national average level. Under section 1895(b)(4)(C) of the Act, the wage-adjustment factors used by the Secretary may be the factors used under section 1886(d)(3)(E) of the Act.

Section 1895(b)(5) of the Act gives the Secretary the option to make additions or adjustments to the payment amount otherwise paid in the case of outliers due to unusual variations in the type or amount of medically necessary care. Section 3131(b)(2) of the Affordable Care Act, amended section 1895(b)(5) of the Act, so that if the Secretary provides for an outlier policy, total outlier payments in a given year would not exceed 2.5 percent of total payments projected or estimated and that the standard prospective payment (or amounts) are reduced by 5 percent. The provision also made permanent a 10 percent agency-level outlier payment cap.

In accordance with the statute, we published a final rule in the July 3, 2000 **Federal Register** (65 FR 41128) to implement the HH PPS. The July 2000 final rule established requirements for the new HH PPS for HH services as required by section 4603 of the BBA, as subsequently amended by section 5101 of the Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESAA) for Fiscal Year 1999, (Pub. L. 105–277, enacted October 21, 1998); and by sections 302, 305, and 306 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement

Act (BBRA) of 1999, (Pub. L. 106–113, enacted November 29, 1999). The requirements include the implementation of a HH PPS for HH covered services, consolidated billing requirements, and a number of other related policies. The HH PPS described in that rule replaced the retrospective reasonable cost-based system that was used by Medicare for the payment of HH services under Part A and Part B. For a complete and full description of the HH PPS as required by the BBA, see the July 2000 HH PPS final rule (65 FR 41128 through 41214).

Section 5201(c) of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171, enacted February 8, 2006) added a new section 1895(b)(3)(B)(v) to the Act, requiring HHAs to submit data for purposes of measuring health care quality, and links the quality data submission to the annual applicable percentage increase. This data submission requirement is applicable for CY 2007 and each subsequent year. If an HHA does not submit quality data, the HH payment update percentage increase is reduced by 2 percentage points. In the CY 2007 HH PPS final rule (71 FR 65884, 65935), we implemented the pay-for-reporting requirement of the DRA, which was codified at § 484.225(h) and (i). The HH quality reporting requirement was implemented on January 1, 2007.

The Affordable Care Act made additional changes to the HH PPS. Section 3131(c) of the Affordable Care Act amended section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173, enacted on December 8, 2003) as amended by section 5201(b) of the DRA. The amended section 421(a) of the MMA now requires, for HH services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act) for episodes and visits ending on or after April 1, 2010, and before January 1, 2016, that the Secretary increase, by 3 percent, the payment amount otherwise made under section 1895 of the Act.

Section 3131(a) of the Affordable Care Act mandates that, starting in CY 2014, the Secretary must apply an adjustment to the national, standardized 60-day episode payment amount and other amounts applicable under section 1895(b)(3)(A)(i)(III) of the Act to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. In addition, section 3131(a) of the Affordable Care Act mandates that this rebasing adjustment must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the payment amount (or amounts) as of the date of enactment (March 23, 2010) under section 1895(b)(3)(A)(i)(III) of the Act, and be fully implemented in CY 2017.

B. System for Payment of Home Health Services

Generally, Medicare makes payment under the HH PPS on the basis of a national, standardized 60-day episode payment rate that is adjusted for the applicable case-mix and wage index. The national, standardized 60-day episode rate includes the six HH disciplines (skilled nursing, HH aide, physical therapy (PT), speech-language pathology (SLP), occupational therapy (OT), and medical social services (MSS)). Payment for non-routine medical supplies is no longer part of the national, standardized 60-day episode rate and is computed by multiplying the relative weight for a particular non-routine supply (NRS) severity level by the NRS conversion factor (See section IV.D.4.e. of this final rule). Payment for durable medical equipment (DME) covered under the HH benefit is made outside the HH PPS. To adjust for case-mix, the HH PPS uses a 153-category case-mix classification system to assign patients to a home health resource group (HHRG). The clinical severity level, functional severity level, and service utilization are computed from responses to selected data elements in the OASIS assessment instrument and are used to place the patient in a particular HHRG. Each HHRG has an associated case-mix weight, which is used in calculating the payment for an episode. Specifically, the 60-day episode base rate is multiplied by the case-mix weight when determining the payment for an episode.

For episodes with four or fewer visits, Medicare pays national per-visit rates based on the discipline(s) providing the services. An episode consisting of four or fewer visits within a 60-day period receives what is referred to as a low-utilization payment adjustment (LUPA) episode. Medicare also adjusts the national, standardized 60-day episode payment rate for certain intervening events that are subject to a partial episode payment adjustment (PEP adjustment). For certain cases that exceed a specific cost threshold, an outlier adjustment may also be available.

C. Updates to the HH PPS

As required by section 1895(b)(3)(B) of the Act, we have historically updated the HH PPS rates annually in the **Federal Register**. The August 29, 2007 final rule with comment period set forth an update to the 60-day national episode rates and the national per-visit rates under the HH PPS for CY 2008. The CY 2008 HH PPS final rule included an analysis performed on CY 2005 HH claims data, which indicated a 12.78 percent increase in the observed case-mix since 2000. Case-mix represents the variations in conditions of the patient population served by the HHAs. Subsequently, a more detailed analysis was performed on the 2005 case-mix data to evaluate if any portion of the 12.78 percent increase was associated with a change in the actual clinical condition of HH patients. We examined data on demographics, family severity, and non-HH Part A Medicare expenditures to predict the average case-mix weight for 2005. We identified 8.03 percent of the total case-mix change as real, and therefore, decreased the 12.78 percent of total case-mix change by 8.03 percent to get a final nominal case-mix increase measure of 11.75 percent (0.1278 * (1—0.0803) = 0.1175).

To account for the changes in case-mix that were not related to an underlying change in patient health status, we implemented a reduction, over 4 years, to the national, standardized 60-day episode payment rates. That reduction was to be 2.75 percent per year for 3 years beginning in CY 2008 and 2.71 percent for the fourth year in CY 2011. In the CY 2011 HH PPS final rule (76 FR 68532), we updated our analyses of case-mix change and finalized a reduction of 3.79 percent, instead of 2.71 percent, for CY 2011 and deferred finalizing a payment reduction for CY 2012 until further study of the case-mix change data and methodology was completed.

In the CY 2012 HH PPS final rule (76 FR 68526), we updated the 60-day national episode rates and the national per-visit rates. In addition, as discussed in the CY 2012 HH PPS final rule (76 FR 68528), our analysis indicated that there was a 22.59 percent increase in overall case-mix from 2000 to 2009 and that only 15.76 percent of that overall observed case-mix percentage increase was due to real case-mix change. As a result of our analysis, we identified a 19.03 percent nominal increase in case-mix. To fully account for the 19.03 percent nominal case-mix growth, which was identified from 2000 to 2009, we finalized a 3.79 percent payment reduction in CY 2012 and a 1.32 percent payment reduction for CY 2013.

In the CY 2013 HH PPS final rule (77 FR 67078), we implemented a 1.32

percent reduction to the payment rates for CY 2013 to account for nominal case-mix growth from 2000 through 2010. When taking into account the total measure of case-mix change (23.90 percent) and the 15.97 percent of total case-mix change estimated as real from 2000 to 2010, we obtained a final nominal case-mix change measure of 20.08 percent from 2000 to 2010 (0.2390 * (1—0.1597) = 0.2008). To fully account for the remainder of the 20.08 percent increase in nominal case-mix beyond that which was accounted for in previous payment reductions, we estimated that the percentage reduction to the national, standardized 60-day episode rates for nominal case-mix change would be 2.18 percent. We considered proposing a 2.18 percent reduction to account for the remaining increase in measured nominal case-mix; however, we moved forward with the 1.32 percent payment reduction to the national, standardized 60-day episode rates in the CY 2012 HH PPS final rule (76 FR 68532).

III. Summary of the Provisions of the Proposed Rule

The CY 2014 HH PPS proposed rule (78 FR 40272) included the following proposals and updates:

A. ICD–9–CM Grouper Refinements, Effective January 1, 2014

- We proposed to remove 170 ICD–9–CM diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper, effective January 1, 2014.

B. International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) Conversion and Diagnosis Reporting on Home Health Claims

- We notified the home health industry that on October 1, 2014, we are implementing the use of ICD–10–CM codes within our HH PPS Grouper. We provided the industry with a link to the CMS Web site that contains the draft HH PPS Grouper ICD–10–CM translation list along with a proposed schedule for releasing the draft and final ICD–10–CM HH PPS Groupers.
- We notified HHAs that to ensure additional compliance with ICD–10–CM Coding Guidelines, we will be adopting additional claims processing edits for all HH claims effective October 1, 2014. The HH claims containing inappropriate principal or secondary diagnosis codes will be returned to the provider and will have to be corrected and resubmitted to be processed and paid.

C. Adjustment to the HH PPS Case-Mix Weights

- We analyzed preliminary 2012 claims data, which showed an average case-mix weight for 2012 of 1.3517. We proposed to reduce the average case-mix weight for 2014 from 1.3517 to 1.0000. We proposed that the decrease in the weights from 1.3517 to 1.0000 would be added back into the national, standardized 60-day episode payment amount and serve as the starting point for the rebasing adjustment calculation.

D. Rebasing the National, Standardized 60-day Episode Payment Rate, LUPA Per-Visit Payment Amounts, and Nonroutine Medical Supply (NRS) Conversion Factor

1. Rebasing the National, Standardized 60-Day Episode Payment Amount

In the proposed rule, we estimated that the 2013 average cost per episode was $2,559.59. The 2013 estimated average payment per episode was $2,963.65. When comparing the 2013 costs to 2013 payments, we obtained a difference of −13.63 percent, or a reduction of 3.60 percent over four years in equal increments using a compound annual growth rate (CAGR) formula (($2,559.59/$2,963.65)$^{1/4}$ −1). Since the Affordable Care Act states that the adjustment(s) may be no more than 3.5 percent in a given year, we proposed a reduction to the national, standardized 60-day episode rate of 3.50 percent in each year from CY 2014 through CY 2017.

2. Rebasing the Low-Utilization Payment Adjustment (LUPA) Per-Visit Payment Amounts

In the proposed rule, when comparing 2013 estimated average costs per-visit to 2013 payments per-visit for each of six disciplines, we obtained differences ranging from +19.48 percent for skilled nursing up to +33.11 percent for physical therapy. If the increases were phased-in over four years in equal increments using a CAGR formula, the annual increases would range from +4.55 percent for skilled nursing to +7.41 percent for physical therapy. Since the Affordable Care Act states that the adjustment(s) may be no more than 3.5 percent in a given year, we proposed an increase to each of the six per-visit payment rates of 3.50 percent in each year from CY 2014 through CY 2017.

3. Rebasing the Nonroutine Medical Supply (NRS) Conversion Factor

In the proposed rule, when comparing the 2013 estimated average NRS payment per episode of $48.38 to the 2013 estimated average NRS cost per episode of $43.58; we obtained a difference of −9.92 percent (($43.58 − $48.38)/$48.38). Phasing-in the 9.92 percent reduction over 4 years in equal increments using a CAGR formula would result in an annual reduction of 2.58 percent. Therefore, we proposed to reduce payments each year, from CY 2014 through CY 2017, by 2.58 percent.

E. CY 2014 Home Health Payment Rate Update

We proposed to continue to use OASIS data, claims data, and patient experience of care data as forms of quality data to meet the reporting requirement that HHAs submit data appropriate for the measurement of home health care quality for CY 2014 and each subsequent year thereafter until further notice. We proposed that the measures reported on Home Health Compare continue to meet the requirement to make data available to the public until further notice; we proposed to add two new claims-based measures: (1) Re-hospitalization During the First 30 Days of a Home Health Stay, and (2) Home Health Emergency Department Use Without Readmission; and to reduce the number of home health quality measures currently reported to HHAs individually. We stated that we plan to include information regarding the requirements of the HH Conditions of Participation (CoPs) related to submission of OASIS assessments and the necessity of submitting both start of episode and end of episode assessments in order to calculate quality measures. We did not propose changes to HH CAHPS and we stated that we plan to continue this requirement and data collection activities.

In the proposed rule, we stated that we would update the HH PPS payment rates by the HH PPS payment update percentage of 2.4 percent and we proposed, consistent with long-standing policy, to update the home health wage index using the pre-floor, pre-reclassified hospital wage index for 2014. We also proposed to offset the overall impact from the use of the updated wage index on the national, standardized 60-day episode payment rate and the national per-visit rates using a standardization factor. Finally, we proposed to create three LUPA add-on factors, rather than a single LUPA add-on amount.

F. Outlier Policy

We did not propose changes to our outlier policy.

G. Payment Reform: Home Health Study and Report

Section 3131(d) of the Affordable Care Act requires the Secretary to assess costs associated with providing access to care for patients with high severity of illness, low income patients, and/or patients in medically underserved areas. It also gives the Secretary the authority to analyze other factors in the HH PPS and allows for demonstration authority to test the PPS changes. Finally, it requires the Secretary to make recommendations for legislation or administrative action, if needed, in a Report to Congress due no later than March 1, 2014. We provided an update on the status of the Report to Congress in the proposed rule.

H. Cost Allocation of Survey Expenses

We proposed that Medicaid responsibilities for home health surveys be explicitly recognized in the state Medicaid program and that CMS will review each state's allocation of costs for HHA surveys for adherence to OMB Circular A–87 principles in 2014, with the goal of ensuring full adherence no later than July 2014. For that portion of costs attributable to Medicare and Medicaid, CMS will assign 50 percent to Medicare and 50 percent to Medicaid. This is the standard method that CMS and states use in the allocation of expenses related to surveys of nursing homes.

IV. Provisions of the Proposed Rule and Response to Comments

We received approximately 84 timely responses, many of which contained multiple comments on the CY 2014 HH PPS proposed rule (78 FR 40272) from the public. We received comments from various trade associations, HHAs, individual registered nurses, physicians, clinicians, health care industry organizations, and health care consulting firms. The following sections, arranged by subject area, include a summary of the public comments received, and out responses.

A. ICD–9–CM Grouper Refinements, Effective January 1, 2014

As stated in the CY 2014 HH PPS proposed rule, CMS clinical staff (along with clinical and coding staff from Abt Associates (our support contractor) and 3M (our HH PPS Grouper maintenance contractor), completed a thorough review of the ICD–9–CM codes included in our HH PPS Grouper. The HH PPS Grouper, which is used by the CMS OASIS submission system, is the official grouping software of the HH PPS. As a result of that review, we identified two categories of codes, made up of 170 ICD–9–CM diagnosis codes, which we proposed to remove from assignment to one of our diagnosis groups within the HH PPS Grouper, effective January 1, 2014. The first category (Category 1 in Table 2) included ICD–9–CM codes that, based upon clinical judgment, were ''too acute'', meaning that this condition could not be appropriately cared for in a HH setting. These codes likely reflect conditions the patient had prior to the HH admission (for example, while being treated in a hospital setting). It is anticipated that the condition progressed to a less acute state, or is completely resolved for the patient to be cared for in the home setting (and that often times another diagnosis code will have been a more accurate reflection of the patient's condition in the home). The second category (Category 2 in Table 2) included codes that, based upon clinical judgment, reflect a condition that does not require HH intervention, would not impact the HH plan of care (POC), or would not result in additional resource use when providing HH services to the patient. Table 2 includes all 170 ICD–9–CM diagnosis codes that we proposed to remove from assignment to one of our diagnosis groups within the HH PPS Grouper, effective January 1, 2014, along with the category classification.

TABLE 2—ICD–9–CM CODES REMOVED FROM DIAGNOSIS GROUP ASSIGNMENT IN THE HH PPS GROUPER AS OF JANUARY 1, 2014

ICD–9–CM Code	ICD–9–CM Long Description	Category
003.1	Salmonella septicemia	1
250.20	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled	1
250.21	Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled	1
250.22	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled	1
250.23	Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled	1
250.30	Diabetes with other coma, type II or unspecified type, not stated as uncontrolled	1
250.31	Diabetes with other coma, type I [juvenile type], not stated as uncontrolled	1
250.32	Diabetes with other coma, type II or unspecified type, uncontrolled	1
250.33	Diabetes with other coma, type I [juvenile type], uncontrolled	1
282.42	Sickle-cell thalassemia with crisis	1
282.5	Sickle-cell trait	2
282.62	Hb-SS disease with crisis	1
282.64	Sickle-cell/Hb-C disease with crisis	1
282.69	Other sickle-cell disease with crisis	1
285.1	Acute posthemorrhagic anemia	1
289.52	Splenic sequestration	1
333.81	Blepharospasm	2
333.84	Organic writers' cramp	2
333.93	Benign shuddering attacks	2
333.94	Restless legs syndrome	2
348.5	Cerebral edema	1
401.0	Malignant essential hypertension	1
414.12	Dissection of coronary artery	1
447.2	Rupture of artery	1
493.21	Chronic obstructive asthma with status asthmaticus	1
530.21	Ulcer of esophagus with bleeding	1
530.4	Perforation of esophagus	1
530.7	Gastroesophageal laceration-hemorrhage syndrome	1
530.81	Esophageal reflux	2
530.82	Esophageal hemorrhage	1
531.00	Acute gastric ulcer with hemorrhage, without mention of obstruction	1
531.01	Acute gastric ulcer with hemorrhage, with obstruction	1

TABLE 2—ICD–9–CM CODES REMOVED FROM DIAGNOSIS GROUP ASSIGNMENT IN THE HH PPS GROUPER AS OF JANUARY 1, 2014—Continued

ICD–9–CM Code	ICD–9–CM Long Description	Category
531.10	Acute gastric ulcer with perforation, without mention of obstruction	1
531.11	Acute gastric ulcer with perforation, with obstruction	1
531.20	Acute gastric ulcer with hemorrhage and perforation, without mention of obstruction	1
531.21	Acute gastric ulcer with hemorrhage and perforation, with obstruction	1
531.31	Acute gastric ulcer without mention of hemorrhage or perforation, with obstruction	1
531.40	Chronic or unspecified gastric ulcer with hemorrhage, without mention of obstruction	1
531.41	Chronic or unspecified gastric ulcer with hemorrhage, with obstruction	1
531.50	Chronic or unspecified gastric ulcer with perforation, without mention of obstruction	1
531.51	Chronic or unspecified gastric ulcer with perforation, with obstruction	1
531.60	Chronic or unspecified gastric ulcer with hemorrhage and perforation, without mention of obstruction	1
531.61	Chronic or unspecified gastric ulcer with hemorrhage and perforation, with obstruction	1
531.71	Chronic gastric ulcer without mention of hemorrhage or perforation, with obstruction	1
531.91	Gastric ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	1
532.00	Acute duodenal ulcer with hemorrhage, without mention of obstruction	1
532.01	Acute duodenal ulcer with hemorrhage, with obstruction	1
532.10	Acute duodenal ulcer with perforation, without mention of obstruction	1
532.11	Acute duodenal ulcer with perforation, with obstruction	1
532.20	Acute duodenal ulcer with hemorrhage and perforation, without mention of obstruction	1
532.21	Acute duodenal ulcer with hemorrhage and perforation, with obstruction	1
532.31	Acute duodenal ulcer without mention of hemorrhage or perforation, with obstruction	1
532.40	Chronic or unspecified duodenal ulcer with hemorrhage, without mention of obstruction	1
532.41	Chronic or unspecified duodenal ulcer with hemorrhage, with obstruction	1
532.50	Chronic or unspecified duodenal ulcer with perforation, without mention of obstruction	1
532.51	Chronic or unspecified duodenal ulcer with perforation, with obstruction	1
532.60	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, without mention of obstruction.	1
532.61	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, with obstruction	1
532.71	Chronic duodenal ulcer without mention of hemorrhage or perforation, with obstruction	1
532.91	Duodenal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	1
533.00	Acute peptic ulcer of unspecified site with hemorrhage, without mention of obstruction	1
533.01	Acute peptic ulcer of unspecified site with hemorrhage, with obstruction	1
533.10	Acute peptic ulcer of unspecified site with perforation, without mention of obstruction	1
533.11	Acute peptic ulcer of unspecified site with perforation, with obstruction	1
533.20	Acute peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction.	1
533.21	Acute peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction	1
533.31	Acute peptic ulcer of unspecified site without mention of hemorrhage and perforation, with obstruction.	1
533.40	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, without mention of obstruction.	1
533.41	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, with obstruction	1
533.50	Chronic or unspecified peptic ulcer of unspecified site with perforation, without mention of obstruction.	1
533.51	Chronic or unspecified peptic ulcer of unspecified site with perforation, with obstruction	1
533.60	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction.	1
533.61	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction.	1
533.71	Chronic peptic ulcer of unspecified site without mention of hemorrhage or perforation, with obstruction.	1
533.91	Peptic ulcer of unspecified site, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	1
534.00	Acute gastrojejunal ulcer with hemorrhage, without mention of obstruction	1
534.01	Acute gastrojejunal ulcer, with hemorrhage, with obstruction	1
534.10	Acute gastrojejunal ulcer with perforation, without mention of obstruction	1
534.11	Acute gastrojejunal ulcer with perforation, with obstruction	1
534.20	Acute gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction	1
534.21	Acute gastrojejunal ulcer with hemorrhage and perforation, with obstruction	1
534.31	Acute gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction	1
534.40	Chronic or unspecified gastrojejunal ulcer with hemorrhage, without mention of obstruction	1
534.41	Chronic or unspecified gastrojejunal ulcer, with hemorrhage, with obstruction	1
534.50	Chronic or unspecified gastrojejunal ulcer with perforation, without mention of obstruction	1
534.51	Chronic or unspecified gastrojejunal ulcer with perforation, with obstruction	1
534.60	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction.	1
534.61	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, with obstruction	1
534.71	Chronic gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction	1
534.91	Gastrojejunal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	1

TABLE 2—ICD–9–CM CODES REMOVED FROM DIAGNOSIS GROUP ASSIGNMENT IN THE HH PPS GROUPER AS OF JANUARY 1, 2014—Continued

ICD–9–CM Code	ICD–9–CM Long Description	Category
535.01	Acute gastritis, with hemorrhage	1
535.11	Atrophic gastritis, with hemorrhage	1
535.21	Gastric mucosal hypertrophy, with hemorrhage	1
535.31	Alcoholic gastritis, with hemorrhage	1
535.41	Other specified gastritis, with hemorrhage	1
535.51	Unspecified gastritis and gastroduodenitis, with hemorrhage	1
535.61	Duodenitis, with hemorrhage	1
535.71	Eosinophilic gastritis, with hemorrhage	1
536.1	Acute dilatation of stomach	1
537.3	Other obstruction of duodenum	1
537.4	Fistula of stomach or duodenum	1
537.6	Hourglass stricture or stenosis of stomach	1
537.83	Angiodysplasia of stomach and duodenum with hemorrhage	1
537.84	Dielulafoy lesion (hemorrhagic) of stomach and duodenum	1
540.0	Acute appendicitis with generalized peritonitis	1
540.1	Acute appendicitis with peritoneal abscess	1
540.9	Acute appendicitis without mention of peritonitis	1
541	Appendicitis, unqualified	1
542	Other appendicitis	1
543.0	Hyperplasia of appendix (lymphoid)	1
557.0	Acute vascular insufficiency of intestine	1
560.0	Intussusception	1
560.1	Paralytic ileus	1
560.2	Volvulus	1
560.81	Intestinal or peritoneal adhesions with obstruction (postoperative) (postinfection)	1
560.89	Other specified intestinal obstruction	1
560.9	Unspecified intestinal obstruction	1
562.02	Diverticulosis of small intestine with hemorrhage	1
562.03	Diverticulitis of small intestine with hemorrhage	1
562.12	Diverticulosis of colon with hemorrhage	1
562.13	Diverticulitis of colon with hemorrhage	1
567.0	Peritonitis in infectious diseases classified elsewhere	1
567.1	Pneumococcal peritonitis	1
567.21	Peritonitis (acute) generalized	1
567.22	Peritoneal abscess	1
567.23	Spontaneous bacterial peritonitis	1
567.29	Other suppurative peritonitis	1
567.31	Psoas muscle abscess	1
567.38	Other retroperitoneal abscess	1
567.81	Choleperitonitis	1
567.82	Sclerosing mesenteritis	1
567.89	Other specified peritonitis	1
567.9	Unspecified peritonitis	1
568.81	Hemoperitoneum (nontraumatic)	1
569.3	Hemorrhage of rectum and anus	1
569.43	Anal sphincter tear-old	2
569.83	Perforation of intestine	1
569.85	Angiodysplasia of intestine with hemorrhage	1
569.86	Dieulafoy lesion (hemorrhagic) of intestine	1
572.0	Abscess of liver	1
572.1	Portal pyemia	1
574.00	Calculus of gallbladder with acute cholecystitis, without mention of obstruction	1
574.01	Calculus of gallbladder with acute cholecystitis, with obstruction	1
574.10	Calculus of gallbladder with other cholecystitis, without mention of obstruction	1
574.11	Calculus of gallbladder with other cholecystitis, with obstruction	1
574.21	Calculus of gallbladder without mention of cholecystitis, with obstruction	1
574.30	Calculus of bile duct with acute cholecystitis, without mention of obstruction	1
574.31	Calculus of bile duct with acute cholecystitis, with obstruction	1
574.41	Calculus of bile duct with other cholecystitis, with obstruction	1
574.51	Calculus of bile duct without mention of cholecystitis, with obstruction	1
574.60	Calculus of gallbladder and bile duct with acute cholecystitis, without mention of obstruction	1
574.61	Calculus of gallbladder and bile duct with acute cholecystitis, with obstruction	1
574.71	Calculus of gallbladder and bile duct with other cholecystitis, with obstruction	1
574.80	Calculus of gallbladder and bile duct with acute and chronic cholecystitis, without mention of obstruction.	1
574.81	Calculus of gallbladder and bile duct with acute and chronic cholecystitis, with obstruction	1
574.91	Calculus of gallbladder and bile duct without cholecystitis, with obstruction	1
575.0	Acute cholecystitis	1
575.2	Obstruction of gallbladder	1
575.3	Hydrops of gallbladder	1
575.4	Perforation of gallbladder	1

TABLE 2—ICD–9–CM CODES REMOVED FROM DIAGNOSIS GROUP ASSIGNMENT IN THE HH PPS GROUPER AS OF JANUARY 1, 2014—Continued

ICD–9–CM Code	ICD–9–CM Long Description	Category
576.1	Cholangitis	1
576.2	Obstruction of bile duct	1
576.3	Perforation of bile duct	1
577.0	Acute pancreatitis	1
578.0	Hematemesis	1
578.9	Hemorrhage of gastrointestinal tract, unspecified	1
873.63	Broken tooth—uncomplic	2
998.11	Hemorrhage complicating a procedure	1
998.12	Hematoma complicating a procedure	1
998.2	Accidental puncture or laceration during a procedure, not elsewhere classified	1

Analysis of the most current, complete CY 2012 claims data (a full year of CY 2012 claims data versus the preliminary data from the first half of CY 2012 used for the CY 2014 HH PPS proposed rule) shows that the average case-mix weight before the removal of the codes in Table 2 was 1.3555. It is estimated that the removal of the 170 codes in Table 2 results in an average case-mix weight for CY 2012 of 1.3464. As described above, clinical judgment is that these codes are ''too acute,'' meaning that this condition could not be appropriately cared for in a HH setting (Category 1) or would not impact the HH POC or result in additional resource use (Category 2). Therefore, the inclusion of these diagnosis codes in the Grouper was producing inaccurate overpayments.

The following is a summary of the comments we received regarding the proposed ICD–9–CM Grouper Refinements.

Comment: A few commenters agreed with our assessment that many of the conditions that we proposed to remove are too acute to be treated in a home health setting (category 1 codes from Table 2).

Response: We thank the commenters for their support in our efforts to remove conditions that are ''too acute'' to be treated the HH setting from assignment to one of our diagnosis groups within the HH PPS Grouper.

Comment: There were several commenters who believed that the removal of the category 1 ICD–9–CM codes (''too acute'') from our diagnosis groups would limit the scope of physician/medical practice in the home. Other commenters stated that removal of category 1 codes from assignment to one of our diagnosis groups could lead to increased hospital length of stay and could limit access to home health care, especially for patients living in rural areas. Other commenters believed that removal of category 1 diagnoses would mean a reduction of the accuracy of the information reported for payment and that physicians would be compelled to change the diagnosis codes upon hospital discharge for the post-acute management of the patient.

Response: We recognize the valuable services being provided to Medicare beneficiaries in the home health environment and understand the goal of home health services is to help reduce hospitalizations, empower patients to be active participants in their health care, and to practice patient-centered care. The intent of the removal of category 1 diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper is neither to limit access to home health care nor to limit the practice of appropriate health care in the home.

We proposed to remove category 1 ICD–9–CM diagnosis codes from our diagnosis groups to ensure greater compliance with ICD–9–CM Coding Guidelines and to assure home health providers are accurately describing the patient characteristics that impact the home health plan of care. Per the ICD–9–CM Coding Guidelines, ''list first the ICD–9–CM code for the diagnosis, condition, problem, or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided.'' For home health services, the diagnosis coding should reflect the reason the patient requires home health services and interventions.

In the CY 2014 HH PPS proposed rule, the category 1 codes proposed to be removed from assignment to one of our diagnosis groups within the HH PPS Grouper are not conditions that would be treated in an individual's home. For example, ICD–9–CM code, 447.2, Rupture of Artery, would be an emergency situation and treatment for such a condition could not be safely treated in the home environment. One commenter provided the following scenario: ''your average COPDer has chronic obstructive asthma, they catch an infection and go into status asthmaticus and go to the hospital for treatment. After a couple of days, they are sent home with a home care referral. Wouldn't the diagnosis be 493.21 (chronic obstructive asthma with status asthmaticus)?'' We agree that the staticus asthmaticus is a condition a hospital would treat during the hospital stay because it refers to a patient's failure to respond to therapy administered during an asthmatic episode and is a life threatening complication that requires emergency care. However, once the patient is discharged from the hospital, the staticus asthmaticus is no longer active and the patient could be safely discharged back into the community. Clinically, a patient with active staticus asthmaticus could not be safely treated in the home environment, as is the case with all of the category 1 conditions. However, this is not to say that patients who have had these conditions, were treated for the acute presentation, exacerbation or complication, and have been discharged with a home health referral, are not eligible for home health services. In referring to the commenter's clinical scenario above, an appropriate diagnostic code for a home care intervention could be reported as: COPD (496.0) or chronic obstructive asthma (493.2). In fact, patients who have had these conditions and have been treated in the inpatient or outpatient setting may benefit from home health services in treating the sequelae or aftercare that is needed for these conditions.

It is our expectation that home health agencies, who receive referrals for patients who have been treated for these acute conditions, will continue to provide the aftercare services required. The home health care that is required by these patients is the aftercare services and interventions to help reduce any post-acute complications and readmissions. Home health providers are in the ideal position to help in the recovery of the individuals who have

suffered from these acute conditions. Therefore, we do not expect that the removal of these proposed ICD–9–CM codes from one of our diagnosis groups will limit access to needed home health care services for those living in either urban or rural areas. We also do not believe that the scope of physician/medical practice in the home environment will be limited by this proposal. We believe that a physician, using his or her best clinical judgment, would not make a home health care referral for the initial treatment of the listed conditions as these conditions would usually warrant more intensive interventions at presentation. We do believe that a physician would make a home health referral for the aftercare treatment that would be required as a result of these conditions or as a result of the initial treatment of these conditions. Many of the clinical scenarios provided by commenters addressed the home health interventions that were being provided for patients who had been treated in an inpatient or outpatient setting for these conditions. The referral for the home health services and interventions were actually for the aftercare services needed for these conditions.

We do not support physicians changing diagnoses at hospital discharge but we do expect that they will continue to use their clinical expertise and judgment when making home health care referrals to meet the medically necessary aftercare needs of their patients. Additionally, it is the responsibility of the home health providers to contact, as necessary, any referring physician for clarification of all conditions that the prompted the home health referral and the services being requested for the post-acute management of these patients.

Comment: We received a few comments expressing the concern for the increased administrative costs associated with the ICD–9–CM coding requirements. Other commenters were concerned that the removal of these codes would affect Part B claims and believed that denial rates would increase as a result. A few commenters believed that the only reason to remove these codes from assignment to one of our diagnosis groups within the HH PPS Grouper is to further reduce reimbursement.

Response: We disagree that there are increased administrative costs or that this policy would impact Part B claims and result in claims denials. The basis for removal of these codes is to encourage compliance with ICD–9–CM coding guidelines and ensures that conditions that are either too acute to be treated in a home health setting or do not represent the resources assigned to a diagnosis group are removed to ensure appropriate reimbursement for home health services and not to simply reduce reimbursement. We recognize that by removing these ICD–9–CM codes from assignment to one of our diagnosis groups within the HH PPS Grouper some home health providers may have to change coding practices. However, compliance with the ICD–9–CM Coding Guidelines has been a longstanding policy. In our regulations at 45 CFR 162.1002, the Secretary adopted the ICD–9–CM code set, including The Official ICD–9–CM Guidelines for Coding and Reporting. We believe there are ample, available resources in regards to the ICD–9–CM Coding Guidelines to support home health providers to determine the appropriate ICD–9–CM diagnosis codes for all healthcare documentation requirements. These free resources are available at the following links: *http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html?redirect=/ICD9ProviderDiagnosticCodes/*, *http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx*, or on the CDC's Web site at: *http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf*.

While physicians use their clinical judgment to determine the principal diagnosis (or diagnoses) of their patients, we do not require them to determine the actual codes associated with those diagnoses for inclusion on the OASIS assessment of home health claims. Our intent in removing category 1 conditions is to ensure that all healthcare providers, including home health care providers, are following the ICD–9–CM Coding Guidelines to paint the most accurate picture of their patient population, as well as the services they are providing in the home health environment. We do not expect that there will be an increase in any denial of claims for appropriate, medically necessary, home care services.

Comment: Several commenters stated that there is ''no clinical evidence'' to support the removal of some of the 170 diagnosis codes. Most notably, some commenters believed that post-hemorrhagic anemia, acute pancreatitis, abscess of the liver, and gastrointestinal disorders were appropriate diagnoses to treat in the home environment. These commenters stated patients with these diagnoses require ongoing home care for services such as home infusion of antibiotics and total parenteral nutrition, wound care, drain care, lab work, and symptom management. Other commenters stated the esophageal reflux and restless leg syndrome should remain in the HH PPS Grouper as these two conditions require increased nursing interventions for evaluation and monitoring, such as nutritional status and side effects from medications.

Response: In the CY 2014 HH PPS proposed rule, we did state that the review of these ICD–9–CM diagnosis codes (those under Category 1 on Table 2,) included CMS clinical staff (including doctors and nurses) as well as with the clinicians and certified coding staff from Abt Associates (our support contractor) and 3M (our HH PPS Grouper maintenance contractor). This review received input from a variety of clinicians to ensure that the proposed removal of any diagnosis codes would be done in a thoughtful, clinically responsible manner. Additionally, data analysis by Abt Associates reveals that most home health providers are appropriately coding the aftercare codes for the home care services required for these conditions after they have been stabilized from their acute state. The analysis reveals that most of the 162 category 1 codes that we proposed to remove from assignment to one of our diagnosis groups within the HH PPS Grouper are not commonly reported codes on the OASIS assessment (see Table 3). As a result, we do not believe that these codes will have a significant impact on the current coding patterns of a majority of home health care providers.

TABLE 3—TOTAL NUMBER OF EPISODES FOR SELECTED ICD–9–CM DIAGNOSIS CODES, CY 2012

ICD-9-CM code	ICD-9-CM long description	Number of episodes, CY 2012
003.1	Salmonella septicemia	24
250.20	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled	1,056
250.21	Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled	34

TABLE 3—TOTAL NUMBER OF EPISODES FOR SELECTED ICD–9–CM DIAGNOSIS CODES, CY 2012—Continued

ICD-9-CM code	ICD-9-CM long description	Number of episodes, CY 2012
250.22	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled	466
250.23	Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled	29
250.30	Diabetes with other coma, type II or unspecified type, not stated as uncontrolled	332
250.31	Diabetes with other coma, type I [juvenile type], not stated as uncontrolled	65
250.32	Diabetes with other coma, type II or unspecified type, uncontrolled	60
250.33	Diabetes with other coma, type I [juvenile type], uncontrolled	13
282.42	Sickle-cell thalassemia with crisis	29
282.62	Hb-SS disease with crisis	382
282.64	Sickle-cell/Hb-C disease with crisis	49
282.69	Other sickle-cell disease with crisis	110
285.1	Acute posthemorrhagic anemia	26,547
289.52	Splenic sequestration	9
348.5	Cerebral edema	237
401.0	Malignant essential hypertension	34,207
414.12	Dissection of coronary artery	49
447.2	Rupture of artery	145
493.21	Chronic obstructive asthma with status asthmaticus	7,765
530.21	Ulcer of esophagus with bleeding	442
530.4	Perforation of esophagus	252
530.7	Gastroesophageal laceration-hemorrhage syndrome	407
530.82	Esophageal hemorrhage	183
531.00	Acute gastric ulcer with hemorrhage, without mention of obstruction	1,334
531.01	Acute gastric ulcer with hemorrhage, with obstruction	62
531.10	Acute gastric ulcer with perforation, without mention of obstruction	249
531.11	Acute gastric ulcer with perforation, with obstruction	20
531.20	Acute gastric ulcer with hemorrhage and perforation, without mention of obstruction	109
531.21	Acute gastric ulcer with hemorrhage and perforation, with obstruction	25
531.31	Acute gastric ulcer without mention of hemorrhage or perforation, with obstruction	49
531.40	Chronic or unspecified gastric ulcer with hemorrhage, without mention of obstruction	1,105
531.41	Chronic or unspecified gastric ulcer with hemorrhage, with obstruction	24
531.50	Chronic or unspecified gastric ulcer with perforation, without mention of obstruction	128
531.51	Chronic or unspecified gastric ulcer with perforation, with obstruction	4
531.61	Chronic or unspecified gastric ulcer with hemorrhage and perforation, with obstruction	119
531.60	Chronic or unspecified gastric ulcer with hemorrhage and perforation, without mention of obstruction	13
531.71	Chronic gastric ulcer without mention of hemorrhage or perforation, with obstruction	41
531.91	Gastric ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	249
532.00	Acute duodenal ulcer with hemorrhage, without mention of obstruction	835
532.01	Acute duodenal ulcer with hemorrhage, with obstruction	40
532.10	Acute duodenal ulcer with perforation, without mention of obstruction	257
532.11	Acute duodenal ulcer with perforation, with obstruction	38
532.20	Acute duodenal ulcer with hemorrhage and perforation, without mention of obstruction	92
532.21	Acute duodenal ulcer with hemorrhage and perforation, with obstruction	5
532.31	Acute duodenal ulcer without mention of hemorrhage or perforation, with obstruction	27
532.40	Chronic or unspecified duodenal ulcer with hemorrhage, without mention of obstruction	562
532.41	Chronic or unspecified duodenal ulcer with hemorrhage, with obstruction	3
532.50	Chronic or unspecified duodenal ulcer with perforation, without mention of obstruction	132
532.51	Chronic or unspecified duodenal ulcer with perforation, with obstruction	12
532.60	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, without mention of obstruction.	57
532.61	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, with obstruction	7
532.71	Chronic duodenal ulcer without mention of hemorrhage or perforation, with obstruction	15
532.91	Duodenal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	73
533.00	Acute peptic ulcer of unspecified site with hemorrhage, without mention of obstruction	663
533.01	Acute peptic ulcer of unspecified site with hemorrhage, with obstruction	23
533.10	Acute peptic ulcer of unspecified site with perforation, without mention of obstruction	96
533.11	Acute peptic ulcer of unspecified site with perforation, with obstruction	4
533.20	Acute peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction.	65
533.21	Acute peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction	27
533.31	Acute peptic ulcer of unspecified site without mention of hemorrhage and perforation, with obstruction.	67
533.40	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, without mention of obstruction.	693
533.41	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, with obstruction	17
533.50	Chronic or unspecified peptic ulcer of unspecified site with perforation, without mention of obstruction.	128
533.51	Chronic or unspecified peptic ulcer of unspecified site with perforation, with obstruction	8
533.60	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction.	53

TABLE 3—TOTAL NUMBER OF EPISODES FOR SELECTED ICD–9–CM DIAGNOSIS CODES, CY 2012—Continued

ICD-9-CM code	ICD-9-CM long description	Number of episodes, CY 2012
533.61	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction.	9
533.71	Chronic peptic ulcer of unspecified site without mention of hemorrhage or perforation, with obstruction.	72
533.91	Peptic ulcer of unspecified site, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	266
534.00	Acute gastrojejunal ulcer with hemorrhage, without mention of obstruction	116
534.01	Acute gastrojejunal ulcer, with hemorrhage, with obstruction	7
534.10	Acute gastrojejunal ulcer with perforation, without mention of obstruction	20
534.11	Acute gastrojejunal ulcer with perforation, with obstruction	6
534.20	Acute gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction	15
534.21	Acute gastrojejunal ulcer with hemorrhage and perforation, with obstruction	2
534.31	Acute gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction	6
534.40	Chronic or unspecified gastrojejunal ulcer with hemorrhage, without mention of obstruction	103
534.41	Chronic or unspecified gastrojejunal ulcer, with hemorrhage, with obstruction	8
534.50	Chronic or unspecified gastrojejunal ulcer with perforation, without mention of obstruction	26
534.51	Chronic or unspecified gastrojejunal ulcer with perforation, with obstruction	1
534.60	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction.	6
534.61	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, with obstruction	1
534.71	Chronic gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction	3
534.91	Gastrojejunal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	32
535.01	Acute gastritis, with hemorrhage	652
535.11	Atrophic gastritis, with hemorrhage	108
535.21	Gastric mucosal hypertrophy, with hemorrhage	13
535.31	Alcoholic gastritis, with hemorrhage	61
535.41	Other specified gastritis, with hemorrhage	332
535.51	Unspecified gastritis and gastroduodenitis, with hemorrhage	659
535.61	Duodenitis, with hemorrhage	91
535.71	Eosinophilic gastritis, with hemorrhage	3
536.1	Acute dilatation of stomach	23
537.3	Other obstruction of duodenum	280
537.4	Fistula of stomach or duodenum	343
537.6	Hourglass stricture or stenosis of stomach	14
537.83	Angiodysplasia of stomach and duodenum with hemorrhage	304
537.84	Dielulafoy lesion (hemorrhagic) of stomach and duodenum	50
540.0	Acute appendicitis with generalized peritonitis	764
540.1	Acute appendicitis with peritoneal abscess	458
540.9	Acute appendicitis without mention of peritonitis	656
541.	Appendicitis, unqualified	385
542.	Other appendicitis	43
543.0	Hyperplasia of appendix (lymphoid)	4
557.0	Acute vascular insufficiency of intestine	1,453
560.0	Intussusception	145
560.1	Paralytic ileus	2,050
560.2	Volvulus	1,057
560.81	Intestinal or peritoneal adhesions with obstruction (postoperative) (postinfection)	1,355
560.89	Other specified intestinal obstruction	1,310
560.9	Unspecified intestinal obstruction	12,860
562.02	Diverticulosis of small intestine with hemorrhage	230
562.03	Diverticulitis of small intestine with hemorrhage	189
562.12	Diverticulosis of colon with hemorrhage	2,699
562.13	Diverticulitis of colon with hemorrhage	2,193
567.0	Peritonitis in infectious diseases classified elsewhere	30
567.1	Pneumococcal peritonitis	8
567.21	Peritonitis (acute) generalized	213
567.22	Peritoneal abscess	2,715
567.23	Spontaneous bacterial peritonitis	219
567.29	Other suppurative peritonitis	210
567.31	Psoas muscle abscess	318
567.38	Other retroperitoneal abscess	230
567.81	Choleperitonitis	33
567.82	Sclerosing mesenteritis	116
567.89	Other specified peritonitis	107
567.9	Unspecified peritonitis	910
568.81	Hemoperitoneum (nontraumatic)	265
569.3	Hemorrhage of rectum and anus	2,161
569.83	Perforation of intestine	2,610
569.85	Angiodysplasia of intestine with hemorrhage	196

TABLE 3—TOTAL NUMBER OF EPISODES FOR SELECTED ICD–9–CM DIAGNOSIS CODES, CY 2012—Continued

ICD-9-CM code	ICD-9-CM long description	Number of episodes, CY 2012
569.86	Dieulafoy lesion (hemorrhagic) of intestine	15
572.0	Abscess of liver	1,134
572.1	Portal pyemia	25
574.00	Calculus of gallbladder with acute cholecystitis, without mention of obstruction	1,850
574.01	Calculus of gallbladder with acute cholecystitis, with obstruction	435
574.10	Calculus of gallbladder with other cholecystitis, without mention of obstruction	1,205
574.11	Calculus of gallbladder with other cholecystitis, with obstruction	184
574.21	Calculus of gallbladder without mention of cholecystitis, with obstruction	425
574.30	Calculus of bile duct with acute cholecystitis, without mention of obstruction	308
574.31	Calculus of bile duct with acute cholecystitis, with obstruction	190
574.41	Calculus of bile duct with other cholecystitis, with obstruction	81
574.51	Calculus of bile duct without mention of cholecystitis, with obstruction	371
574.60	Calculus of gallbladder and bile duct with acute cholecystitis, without mention of obstruction	187
574.61	Calculus of gallbladder and bile duct with acute cholecystitis, with obstruction	125
574.71	Calculus of gallbladder and bile duct with other cholecystitis, with obstruction	41
574.80	Calculus of gallbladder and bile duct with acute and chronic cholecystitis, without mention of obstruction.	86
574.81	Calculus of gallbladder and bile duct with acute and chronic cholecystitis, with obstruction	36
574.91	Calculus of gallbladder and bile duct without cholecystitis, with obstruction	58
575.0	Acute cholecystitis	4,728
575.2	Obstruction of gallbladder	131
575.3	Hydrops of gallbladder	20
575.4	Perforation of gallbladder	90
576.1	Cholangitis	1,556
576.2	Obstruction of bile duct	1,417
576.3	Perforation of bile duct	21
577.0	Acute pancreatitis	8,033
578.0	Hematemesis	287
578.9	Hemorrhage of gastrointestinal tract, unspecified	23,650
998.11	Hemorrhage complicating a procedure	369
998.12	Hematoma complicating a procedure	2,337
998.2	Accidental puncture or laceration during a procedure, not elsewhere classified	635

Source: Medicare claims data for episodes ending in CY 2012 (as of June 30, 2013) for a 100 percent sample of beneficiaries for which we had a linked OASIS assessment.

Furthermore, the National Guideline Clearinghouse, a public resource for evidence-based clinical practice guidelines, was also consulted to determine the most current standards of practice regarding these conditions. The evidence-based practice guidelines further lend support that the proposed category 1 diagnosis codes, including those mentioned by the commenters, are conditions that typically warrant initial acute care interventions either in the inpatient, outpatient or emergency department setting. Clinical practice guidelines for a variety of conditions can be found at the National Clearinghouse Guidelines Web site at the following: *http://www.guideline.gov/browse/by-topic-detail.aspx?id=11560&ct=1*.

We are in agreement with the commenters who stated that patients with these acute diagnoses require ongoing home care for services such as home infusion of antibiotics and total parenteral nutrition, wound care, drain care, lab work, and symptom management. These are aftercare services that are required by patients who have been diagnosed and initially treated for the listed diseases or diagnoses. These aftercare services are ideally provided by home health providers and these services can be safely administered in the home environment as long as Medicare beneficiaries meet home health care eligibility requirements. As discussed earlier, there are appropriate ICD–9–CM aftercare codes that can be listed on the OASIS assessment to more fully explain the home health care interventions being provided. We are stating that those codes should be listed on the OASIS assessment form to best explain the reasons for the home health encounter. The disease states precipitating these services can still be listed on the OASIS assessment, but they are not the primary reason for the home health interventions. Therefore, these ICD–9–CM diagnosis codes would not be part of the HH PPS Grouper as there are other aftercare diagnosis codes which are more appropriate to be listed as the reason for home health needs per ICD–9–CM Coding Guidelines.

As for the ICD–9–CM diagnosis codes mentioned by the commenters, ''esophageal reflux'' and ''restless leg syndrome'', that are classified as Category 2 in Table 2 (meaning these codes that would not require HH intervention, would not impact the HH plan of care, or would not result in additional resource use when providing HH services to the patient), these two codes listed as the primary diagnosis alone do not necessarily warrant home health interventions. The fact that an individual has been diagnosed with either of these chronic conditions does not provide sufficient cause for an increase in home health resource use. They can be listed on the OASIS assessment to more fully describe the home health patient, but the expectation is that a stable, chronic condition would not be listed as the primary reason for the home health referral or the need for home health interventions. However, for acute exacerbations or complications from these two conditions, there are other ICD–9–CM diagnosis codes within the HH PPS Grouper that more specifically identify the need for home health services and the interventions that would be required for their management. We are stating that providers should first list those

appropriate ICD–9–CM diagnosis codes if they are the primary reason for home health services, have an impact on the home health plan of care or would result in additional home health resources.

Comment: Some commenters made the recommendation that CMS should form a workgroup with other home health stakeholders to further determine whether these ICD–9–CM diagnosis codes should be removed from the HH PPS Grouper. A few commenters believed that we should delay removing these diagnosis codes until the implementation of ICD–10–CM on October 1, 2014. Several commenters acknowledged that most of these codes are inappropriate for use in the home health setting because of the high acuity level associated with the initial treatment of these conditions.

Response: We believe that sufficient analysis and discussion has been conducted regarding the removal of these 170 ICD–9–CM diagnosis codes. In the CY 2014 HH PPS proposed rule, we noted that the review of these ICD–9–CM diagnosis codes included CMS clinical staff (including doctors and nurses) as well as with the clinicians and certified coding staff from Abt Associates (our support contractor) and 3M (our HH PPS Grouper maintenance contractor). This review received input from a variety of clinicians to ensure that the proposed removal of any diagnosis codes would be done in a thoughtful, clinically responsible manner. We do not believe that delaying the effective date of this proposal to correspond to the implementation of ICD–10–CM is necessary because these codes are infrequently used diagnosis codes on the OASIS assessment and only a small number of home health providers will be impacted by their removal from the HH PPS Grouper.

Comment: A few commenters believed that removal of these 170 ICD–9–CM diagnosis codes would have a detrimental impact on Accountable Care Organization (ACO) and Independence at Home (IAH) demonstration programs.

Response: We disagree that the removal of these diagnosis codes would have a detrimental impact on current demonstration programs. For participation in IAH demonstration programs eligibility requirements are as stated: ''Eligibility criteria are designed to target the most costly beneficiaries with advanced chronic illnesses and substantial disabilities. Beneficiaries must be entitled to Part A and enrolled in Part B, not enrolled in a Medicare Advantage plan or a Program for All-Inclusive Care for the Elderly, and cannot be enrolled in a practice that is part of the Medicare Shared Savings Program or other shared savings demonstrations. Applicable beneficiaries are defined as Medicare FFS patients who have at least two chronic illnesses, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease, ischemic heart disease, stroke, dementias such as Alzheimer's disease, neurodegenerative diseases, and other diseases and conditions designated by the Secretary that result in high costs. Rather than specifying a list of chronic conditions, CMS, for purposes of this demonstration, is defining chronic disease or condition to mean a disease or medical condition that is expected to last for more than 1 year, limits what a person can do, and requires ongoing medical monitoring. Beneficiaries must also need human assistance with two or more activities of daily living (ADLs), have had a non-elective hospital admission within the last 12 months, and have used acute or sub-acute rehabilitation services within the last 12 months. Although practices will report chronic conditions and ADL limitations, chronic conditions and ADLs are subject to medical record audit.[1]'' The goal of ACOs is to provide coordinated care across various health care providers and care transitions. With this type of care model, the expectation is collaborative, coordinated care will result in high quality, cost-effective care. We expect that with each care transition, the appropriate ICD–9–CM codes, per ICD–9–CM Coding Guidelines, would be listed on comprehensive assessment and claims forms. Hospital at home programs typically focus on chronic conditions that typically have exacerbation risks such as congestive heart failure, chronic obstructive pulmonary disease and cellulitis. As such, removal of the ICD–9–CM diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper should not have an impact on programs such as ACO and IAH demonstrations.

Comment: A few commenters stated that the removal of these 170 diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper goes against the technological advancements of telemedicine and telehealth. Other commenters believed that this change could create a potential professional liability risk issue.

Response: We do not believe the removal of these seldom used diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper would impede any advances in technology or innovations in the delivery of care. Home health delivers care to those Medicare beneficiaries who are homebound but require ongoing health care services. We believe that the primary method for this care in the home health environment is hands-on care, meaning healthcare providers come to the individual's home to provide the care and services needed based on the comprehensive assessment and home health plan of care in collaboration with the patient and the referring physician. Telehealth and telemedicine should be considered an adjunct to, not a replacement of, the variety of comprehensive home health care services available for eligible Medicare beneficiaries. We do encourage all healthcare providers, across all healthcare settings to be innovative in their delivery of services and to incorporate models of care to fully utilize technology to best meet the needs of their patient populations. Section 1895(e) of the Act governs the HH PPS and provides that telehealth services are outside the scope of the Medicare home health benefit and HH PPS. The law does not permit the substitution or use of a telecommunications system to provide any covered home health services paid under the home health PPS, or any covered home health service paid outside of the HH PPS. As stated in our regulations at § 409.48(c), a visit is an episode of personal contact with the beneficiary by staff of the home health agency (HHA), or others under arrangements with the HHA for the purposes of providing a covered service. The provision clarifies that there is nothing to preclude an HHA from adopting telemedicine or other technologies that they believe promote efficiencies, but that those technologies will not be specifically recognized or reimbursed by Medicare under the home health benefit.

In addition, we do not believe that by removing the proposed ICD–9–CM diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper that there will be any increased liability risks on providers. We do believe that referring physicians will continue to use their best clinical judgment to diagnose, to make treatment recommendations, and to determine the appropriate services and resources needed for the delivery of quality, safe care for their patients. Collaboration and communication between referring physicians and home health providers are two factors to help minimize risk

[1] *https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/IAH_Solicitation.pdf*

when caring for Medicare beneficiaries who are receiving home health services.

Comment: A couple of commenters stated that our removal of the 170 codes from assignment to one of our diagnosis groups within the HH PPS Grouper serves only to reduce overall payments by 0.5 percent, reducing overall payments by $100 million in 2014 alone.

Response: As outlined in the CY 2014 HH PPS proposed rule, the removal of the 170 codes encourages compliance with ICD–9–CM coding guidelines and ensures that conditions that are either too acute to be treated in a home health setting or do not represent the resources assigned to a diagnosis group are removed from assignment to one of our diagnosis groups within the HH PPS Grouper. We contend that the removal of these codes is appropriate, either because these conditions cannot be appropriately treated in a home health setting, or because these conditions do not impact the home health plan of care and result in overpayments to HHAs.

Comment: A few commenters stated that the removal of these diagnosis codes may impact the accuracy of the HH PPS case-mix model.

Response: We proposed to remove the 170 codes from assignment to one of our diagnosis groups within the HH PPS Grouper because we concluded that the codes were not reflecting actual conditions being treated or that the condition had no impact on resource use. We note that the HH PPS case-mix model was originally designed with general code categories. Since the basis for proposing to remove the 170 diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper was that either (a) they were not reflecting the actual condition being treated in home health, or (b) the condition would not impact resource use, eliminating them should have minimal impact on the accuracy of the HH PPS case-mix model. The impact of any single diagnosis on a case mix assignment depends on the accumulation of points from other conditions. It is often the case that the clinical component in the case-mix model does not change because of the removal of one source of points. Those agencies that are treating patients with conditions in category 2, will no longer receive additional reimbursement for conditions that do not require the same level of resources as other conditions within that diagnosis group (see Table 4).

TABLE 4—AVERAGE RESOURCES FOR SELECTED ICD–9–CM DIAGNOSIS CODES COMPARED TO AVERAGE RESOURCES FOR THE DIAGNOSIS GROUP, CY 2012

ICD–9–CM Code	ICD–9–CM long description	Mean resources	Mean resources for diagnosis group	Number of episodes, CY 2012
282.5	Sickle-cell trait	521.62	493.49	340
333.81	Blepharospasm	565.55	598.95	110
333.84	Organic writers' cramp	111.76	598.95	1
333.93	Benign shuddering attacks	595.90	598.95	4
333.94	Restless legs syndrome (RLS)	507.32	598.95	25,655
530.81	Esophageal reflux	499.01	510.45	726,692
569.43	Anal sphincter tear (healed) (old)	352.26	510.45	7
873.63	Open wound of tooth (broken) (fractured) (due to trauma), without mention of complication.	447.74	635.52	21

Source: Medicare claims data for episodes ending in CY 2012 (as of June 30, 2013) for a 100 percent sample of beneficiaries for which we had a linked OASIS assessment.

Comment: A commenter stated that CMS should delay the removal of codes until after ICD–10–CM implementation similar to the delay granted to Inpatient Rehabilitation Facilities because the full cost ramifications cannot be predicted without a crosswalk of codes and values from ICD–9–CM to ICD–10–CM. Commenters also requested that the removal of the 170 diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper be done in a budget neutral manner.

Response: To prevent additional inaccurate overpayments and because the payment impact has been analyzed, we do not agree that a delay in removing these codes until after ICD–10–CM implementation is warranted. As we stated above, we contend that the removal of these codes from assignment to one of our diagnosis groups within the HH PPS Grouper is appropriate either because these conditions cannot be appropriately treated in a home health setting, or because these conditions would not impact the home health plan of care and result in overpayments to HHAs. We will provide the ICD–10–CM codes and the diagnostic group to which the codes are assigned in the ICD–10–CM Grouper, which will be posted to our Web site in July 2014.

Comment: A couple of commenters stated that their analysis of the impact showed a greater impact and contended that this demonstrates common use of these codes.

Response: We based our payment impact analysis upon 2012 claims data and assumptions were included in our analysis whereby for certain conditions we believe that coding behavior adjustments would result in the assignment of another diagnosis code within the same diagnosis group leading to the same case-mix weight as what is currently awarded.

Comment: A commenter stated that in 2000, when the HH PPS was created, costs and revenues were based on appropriately identified ICD–9–CM codes, including the 170 proposed for deletion.

Response: In 2000, the HH PPS identified ICD–9–CM codes and awarded points specific to orthopedic, neurologic and diabetes. A majority of these 170 codes were not included in the 2000 HH PPS. In addition, most of the diagnosis codes included in the 2000 HH PPS were assigned at the code category level with the exception of certain orthopedic, neurologic and diabetic conditions within a particular code category which based upon clinical judgment and coding practices were inappropriate for home care. In the 2008 refinement, we added additional diagnosis groups and specified the appropriate four and five digit diagnosis codes. In our review of the current diagnosis codes in preparation for transition to ICD–10–CM reporting, we found that these 170 codes were mistakenly included.

Comment: A commenter agreed with our assessment that many of the conditions were too acute or did not

impact the plan of care but requested additional guidance from CMS in reducing coding errors by educating home health agencies on common coding errors, publish frequently asked questions and open door forums on this issue.

Response: It is our intent to provide ongoing communication, collaboration and education with home health providers to ensure that adequate guidance is provided. This communication will not be limited to the release of Change Requests, which can be found on our home health Web site at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html.* Additionally, we encourage all interested stakeholders to participate in the CMS Home Health and Hospice Open Door Forums where questions, concerns and issues can be addressed with specialists within CMS. Information regarding Open Door Forums can be found on our Web site at *http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/index.html.*

Final Decision: We are finalizing the removal of 170 ICD–9–CM diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper as proposed, effective January 1, 2014.

B. International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) Conversion and Diagnosis Reporting on Home Health Claims

1. International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) Conversion

The compliance date for adoption of the ICD–10–CM and ICD–10–PCS Medical Data Code Set is October 1, 2014, as announced in the September 5, 2012 final rule, ''Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD–10–CM and ICD–10–PCS) Medical Data Code Sets'' (77 FR 54664). Under that final rule, the transition to ICD–10–CM is required for entities covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–191, enacted on August 21, 1996). CMS, along with our support contractors, Abt Associates and 3M, have spent the last 2 years implementing a process for the transition from the use of ICD–9–CM diagnosis codes to ICD–10–CM diagnosis codes within the HH PPS Grouper. As we outlined in section IV.A in this final rule and also in the CY 2014 HH PPS proposed rule (78 FR 40276), we began this process with a review of the ICD–9–CM codes included in our HH PPS Grouper and identified certain codes that should be removed from assignment to one of our diagnosis groups within the HH PPS Grouper, and thus will not be included in our translation list of ICD–9–CM to ICD–10–CM codes.

3M produced a translation list using the General Equivalency Mappings (GEMs) tool. That translation list, produced by the GEMs tool, was then reviewed and revised to ensure the included codes are appropriate for use in the HH setting, based upon ICD–10–CM coding guidance. Modifications included:

- *Elimination of codes with ''initial encounter'' extensions listed in the GEMs translation.* ICD–10–CM codes that begin with S and T are used for reporting traumatic injuries, such as fractures and burns. These codes have a 7th character that indicates whether the treatment is for an initial encounter, subsequent encounter or a sequela (a residual effect (condition produced) after the acute phase of an illness or injury has terminated). The GEMs translation mapped ICD–9–CM traumatic injury codes to ICD–10–CM codes with the 7th character for an initial encounter. This extension is intended to be used when the patient is receiving active treatment such as surgical treatment, an emergency department encounter, or evaluation and treatment by a new physician. These initial encounter extension codes are not appropriate for care in the HH setting and were deleted. Code extensions D, E, F, G, H, J, K, M, N, P, Q and R indicate the patient is being treated for a subsequent encounter (care for the injury during the healing or recovery phase) and were included in the translation list in place of the initial encounter extensions. For example, S72.024A ''Nondisplaced fracture of epiphysis (separation) (upper) of right femur, initial encounter for closed fracture'' was deleted and S72.024D, S72.024E, S72.024F, S72.024G, S72.024H, S72.024J, S72.024K, S72.024M, S72.024N, S72.024P, S27.024Q, and S72.024R were retained for the reporting of aftercare provided by the HHA.
- *Elimination of codes for non-specific conditions when the clinician should be able to identify a more specific diagnosis based on clinical assessment.* The initial GEMs translation included non-specific codes, for example, ICD–10–CM code L02.519 ''cutaneous abscess of unspecified hand''. These have been deleted from the translation list whenever a more specific diagnosis could be identified by the clinician performing the initial assessment. The example code above (L02.519) was deleted because the clinician should be able to identify which hand had the abscess, and therefore, would report the injury using the code that specifies the right or left hand.
- *The diagnostic group (DG) assignment of ICD–10–CM codes in the translation replicates the ICD–9–CM assignment whenever possible.* Since ICD–9–CM to ICD–10–CM translation is not a 1-to-1 mapping process, there were cases where the DG assignment was ambiguous. When there was a conflict (such as two ICD–9–CM codes being translated to a single ICD–10–CM code that covered both conditions), DG assignment was based on clinical appropriateness and comparisons of relative resource use data (when available), such that the code was assigned to single DG that included other codes with similar resource use.

A draft list of ICD–10–CM codes to be included in the HH PPS Grouper was developed based upon the process outlined above, and 3M, our HH PPS Grouper maintenance contractor, is in the process of building and testing a Grouper version for use starting October 1, 2014, when OASIS–C1, the new version of the OASIS assessment which will use ICD–10–CM diagnosis codes, will be implemented. The draft translation list was made available on the CMS HHA Center Web site at *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.* We plan to post the draft ICD–10–CM HH PPS Grouper via the CMS Web site on or before July 1, 2014. We also plan to share the draft ICD–10–CM HH PPS Grouper with those vendors that have registered as beta-testers in advance of posting the draft ICD–10 HH PPS Grouper on the CMS Web site. The purpose of early release to the beta testers is to identify any significant issues early in the process. Providers who are interested in enrolling as a beta site can obtain more information on the HH PPS Grouper Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/CaseMixGrouperSoftware.html.*

The following is a summary of the comments we received regarding the adoption of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) Conversion.

Comment: One commenter suggested that CMS consider providing additional

lead time for software vendors and agencies to test and make the systems changes necessary to submit ICD–10–CM claims on October 1, 2014. The commenter suggested that the draft Grouper be made available by May 1, 2014 versus July 1, 2014.

Response: In consultation with our support contractor a timeline was built for implementation of an ICD–10–CM Grouper. The timeline requires a translation list and final decisions on logic to be completed prior to the release of a draft Grouper. The translation list and final decisions on logic will not be completed early enough for us to commit to an earlier delivery date than July 1, 2014.

Comment: One commenter stated that they are not able to fully assess the cost impact of the transition from ICD–9–CM to ICD–10–CM reporting without a crosswalk of codes and code values.

Response: The diagnostic group assignment of ICD–10–CM codes in our draft list of codes replicates the ICD–9–CM assignment where possible. Because there is not a 1-to-1 mapping process, we cannot always directly and succinctly crosswalk ICD–9–CM codes to ICD–10–CM codes. However, we have provided the ICD–10–CM codes and the diagnostic group to which the codes were assigned. We plan to have the ICD–10–CM Grouper posted to our Web site in July 2014 for use by home health agencies.

Comment: One commenter expressed concern that the elimination of certain non-specific ICD–10–CM codes would increase the administrative burden on home health agencies by requiring a higher level of expertise in coding and one commenter expressed concern about the administrative costs associated with the implementation of the ICD–10–CM reporting.

Response: The only non-specific ICD–10–CM codes that were not included in our translation were those where the clinician could identify a more specific diagnosis during the initial assessment. We believe that requiring more specific coding does not increase administrative burden but rather encourages the reporting of a specific, more accurate, diagnosis based upon the assessment performed in compliance with ICD–10–CM coding guidelines that requires coding to the highest level of specificity. We note that transition to ICD–10–CM is required for entities covered by the Health Insurance Portability and Accountability Act of 1996 and the compliance date for adoption of the ICD–10–CM and ICD–10–PCS Medical Data Code Set is October 1, 2014, as announced in the **Federal Register**, September 5, 2012 final rule (77 FR 54664), ''Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD–10–CM and ICD–10–PCS) Medical Data Code Sets. The Secretary has announced that all entities, including HHAs, must be in compliance with adoption of ICD–10–CM and ICD–10–PCS Medical Data Code Set October 1, 2014.

2. Diagnosis Reporting on Home Health Claims

Adherence to ICD–9–CM and ICD–10–CM coding guidelines when assigning diagnosis codes is required under HIPAA. 3M conducted analysis of OASIS records and claims from CY 2011 and found that some HHAs were not complying with ICD–9–CM coding guidelines. Section 1.A.6 in the 2012 ICD–9–CM Coding Guidelines require that the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a ''use additional code'' note at the etiology code, and a ''code first'' note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation. In most cases, the title of these manifestation codes will include ''in diseases classified elsewhere'' or ''in conditions classified elsewhere.'' Codes with these phrases in the title are generally manifestation codes. ''In diseases classified elsewhere'' or ''in conditions classified elsewhere'' codes are never permitted to be used as first listed or principal diagnosis codes and they must be listed following the underlying condition. In ICD–10–CM, the same coding convention applies and can be found in section 1.A.13 of the ICD–10–CM guidance. Note, however, that there are also other manifestation codes that do not have ''in diseases classified elsewhere'' or ''in conditions classified elsewhere'' in their title. For such codes a ''use additional code'' note will still be present, and the rules for coding sequencing still apply. It should be noted that several dementia codes, which are not allowable as principal diagnoses per ICD–9–CM coding guidelines, are under the classification of ''Mental, Behavioral and Neurodevelopmental Disorders.'' According to section 1.A6 of the ICD–9–CM coding guidelines for ''Mental, Behavioral and Neurodevelopmental Disorders'', dementias that fall under this category are ''most commonly a secondary manifestation of an underlying causal condition.'' To ensure additional compliance with ICD–10–CM Coding Guidelines, we noted in the CY 2014 HH PPS proposed rule that we will be adopting additional claims processing edits for all HH claims effective October 1, 2014. HH claims containing inappropriate principal or secondary diagnosis codes will be returned to the provider and will have to be corrected and resubmitted to be processed and paid. Additional details describing the specific edits that will be applied will be announced through a change request, an accompanying Medicare Learning Network article, and other CMS communication channels, such as the HH, Hospice, and DME Open Door Forum.

Finally, effective October 1, 2014, with the implementation of ICD–10–CM diagnosis code reporting, we anticipate that HHAs will be able to report all of the conditions included in the HH PPS Grouper as a primary or secondary diagnosis. There will no longer be a need for any conditions to be reported in the payment diagnosis field because all of the ICD–10–CM codes included in our HH PPS Grouper will be appropriate for reporting as a primary or secondary condition. As such, we are retiring Appendix D of OASIS (also referred to as Attachment D), effective October 1, 2014. All necessary guidance for providers is provided in the ICD–10–CM Coding Guidelines.

No comments were received regarding the clarification on Diagnosis Reporting on Home Health Claims.

C. Adjustment to the HH PPS Case-Mix Weights

As described in section IV.D. of this rule, we are rebasing the national, standardized 60-day episode payment rate. In the CY 2014 proposed rule, we stated that a goal of rebasing is to reset the base payments under the HH PPS. When the HH PPS was created, we expected that the average case-mix weight would be around 1.0000, but analysis has shown that it has consistently been above 1.0000 since the start of the HH PPS. Therefore, as part of rebasing, for CY 2014, we proposed to use the 2012 case-mix weights, but lower them to an average case-mix weight of 1.0000. We also proposed to increase the national, standardized 60-day episode payment rate by the same factor used to lower the rates to 1.0000, making the downward adjustment to the weights budget neutral. As we noted in the proposed rule, in applying the same reduction factor to each weight we are still maintaining the relative values in the weight set. Preliminary CY 2012 claims data on non-LUPA episodes

starting from January 1, 2012 to May 31, 2012 showed that the average case-mix weight for non-LUPA episodes in 2012 was 1.3517. In the CY 2014 proposed rule, we stated that as more 2012 data become available, we planned to update the estimated average case-mix weight for CY 2012 and adjust the case-mix weights and budget neutrality factor accordingly.

The following is a summary of the comments we received regarding the proposed adjustment to the HH PPS case-mix weights.

Comment: One commenter supported the case-mix update reset, particularly given the proposed changes to rebase the HH payments

Response: We thank the commenter for the comment.

Comment: Commenters stated that CMS did not account for the removal of the ICD–9–CM codes from the case-mix system, which is estimated to drop the average case-mix weight from 1.3517 to 1.3417, in either the adjustment to the case-mix weights or the payment rates.

Response: We find these comments compelling and we plan to change the adjustment to the weights so that it reflects the estimated average case-mix after the removal of the ICD–9–CM codes from assignment to one of our diagnosis groups within the HH PPS Grouper. See also section IV.D. where we discuss how using the average case-mix in CY 2012, after the removal of the ICD–9–CM codes from assignment to one of our diagnosis groups within the HH PPS Grouper, is used in the national, standardized 60-day episode payment rate rebasing adjustment calculation.

Comment: One commenter stated that the approach does not account for genuine increases in case-mix due to real increases in the severity of need since the inception of the HH PPS which are caused by earlier and sicker hospital discharges, technology improvements which allow for complex cases to be cared for at the home, improvements in accuracy of OASIS, and increased therapy needs which indicate a higher level of patient acuity. Other commenters stated that the 1.0000 level set at the beginning of the HH PPS should have been higher and that patients' severity, as well as their resource needs have changed since the HH PPS.

Response: As we stated in the proposed rule, we are lowering the weights to an average of 1.0000 (by dividing each weight using the same divisor) so that the national, standardized 60-day episode payment rate is the average payment per episode. The lowering of the weights to 1.0000 is a way to reset the system. We note that in lowering the weights to average 1.0000, we correspondingly inflate the national, standardized 60-day episode payment rate, of which the inflation includes both real and nominal case-mix. The adjustment to the case-mix weights is therefore budget neutral. In other words, we are completely offsetting the reduction in the weights (to average value of 1.0000) by increasing the national, standardized 60-day episode payment rate. Increases in the costs of patient care since the inception of the HH PPS, which would reflect treating patients with a higher average level of severity, are reflected in the FY 2011 cost data used in the rebasing calculation and accounted for in the rebasing adjustments. The data and methodology for calculating the rebasing adjustments are described in section IV.D. of this final rule.

Comment: One commenter stated that while the proposed case-mix weight adjustments might be budget neutral in the aggregate, it would not be so on a weight-by-weight basis, and the impact on many agencies would be additional reductions in reimbursements, beyond the rebasing reductions. In addition, one commenter stated that the proposal to reduce each of the 153 Home Health Resource Groups (HHRGs) was arbitrary in its attempt to achieve an aggregate case-mix benchmark without regard for the impact of rebasing on specific clinical scenarios. Another commenter stated that CMS should either abandon or delay the case-mix weight adjustments and rebasing approach and spend the next year performing a realistic analysis of true HHA costs and beneficiary needs for home health services. Similarly, a commenter stated that CMS has not assessed whether the number of HHRGs is appropriate or whether the payment for each is adequate. Several commenters stated that CMS should complete an analysis of the adequacy of the case-mix weights this year and encouraged CMS to undertake a comprehensive review of the case-mix weights during the coming year for the CY 2015 rule.

Response: The adjustment to the case-mix weights was performed in a budget neutral way. We increased the national, standardized 60-day episode payment rate by the same factor used to lower the case-mix weights to 1.0000 to determine the starting point for rebasing, so the average payment for agencies is the same with the case-mix weights decreased as the average payment for agencies if the weights were not decreased to 1.0000 and the national, standardized 60-day episode payment was not increased. In the CY 2012 HH PPS final rule (76 FR 68526), we recalibrated the case-mix weights. We plan to examine the effects of the CY 2012 recalibration as cost report data become available. In addition, we are currently in the process of reassessing the entire case-mix system. We recently awarded a new research and technical assistance contract to Abt Associates to examine the findings of the home health study, monitor potential impacts of rebasing and other recent policy changes, and develop payment reform options to ensure access to care for vulnerable populations and address payment vulnerabilities in the current payment system.

Final Decision: Since the CY 2014 proposed rule, we analyzed a full year of CY 2012 claims data (the most current, complete data available), rather than claims data from the first six months of CY 2012, and the results indicate that the average case-mix weight for non-LUPA episodes in 2012 was 1.3547. However, since we are finalizing the removal of 170 ICD–9–CM diagnosis codes from the HH PPS grouper, effective January 1, 2014, we estimate the average case-mix weight for non-LUPA episodes in 2012 would decrease to 1.3464 with those codes removed. Therefore, for CY 2014, we will reduce the average case-mix weight for 2012 from 1.3464 to 1.0000. The CY 2014 weights shown in Table 5 were obtained by dividing the CY 2013 weights (which are the same weights as those finalized in CY 2012 rulemaking) by 1.3464. To offset the effect of resetting the case-mix weights such that the average is 1.0000, we inflate the national, standardized 60-day episode payment rate by the same factor (1.3464) used to decrease the weights. The result will be the starting point from which rebasing adjustments are implemented.

As noted in the CY 2014 proposed rule, we plan to continue to evaluate and potentially revise the case-mix weights relative to one another as more recent utilization and cost report data become available. We also plan to continue to monitor case-mix growth (both real and nominal case-mix growth), and address it accordingly in the future.

TABLE 5—FINAL CY 2014 CASE-MIX WEIGHTS

Payment group	Description	Clinical, functional, and service levels	2013 HH PPS case-mix weights	2014 HH PPS case-mix weights
10111	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F1S1	0.8186	0.6080
10112	1st and 2nd Episodes, 6 Therapy Visits	C1F1S2	0.9793	0.7273
10113	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F1S3	1.1401	0.8468
10114	1st and 2nd Episodes, 10 Therapy Visits	C1F1S4	1.3008	0.9661
10115	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F1S5	1.4616	1.0856
10121	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F2S1	1.0275	0.7631
10122	1st and 2nd Episodes, 6 Therapy Visits	C1F2S2	1.1657	0.8658
10123	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F2S3	1.3039	0.9684
10124	1st and 2nd Episodes, 10 Therapy Visits	C1F2S4	1.4421	1.0711
10125	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F2S5	1.5804	1.1738
10131	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F3S1	1.1233	0.8343
10132	1st and 2nd Episodes, 6 Therapy Visits	C1F3S2	1.2520	0.9299
10133	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F3S3	1.3807	1.0255
10134	1st and 2nd Episodes, 10 Therapy Visits	C1F3S4	1.5094	1.1211
10135	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F3S5	1.6381	1.2167
10211	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F1S1	0.8340	0.6194
10212	1st and 2nd Episodes, 6 Therapy Visits	C2F1S2	1.0302	0.7652
10213	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F1S3	1.2265	0.9109
10214	1st and 2nd Episodes, 10 Therapy Visits	C2F1S4	1.4228	1.0567
10215	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F1S5	1.6190	1.2025
10221	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F2S1	1.0429	0.7746
10222	1st and 2nd Episodes, 6 Therapy Visits	C2F2S2	1.2166	0.9036
10223	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F2S3	1.3903	1.0326
10224	1st and 2nd Episodes, 10 Therapy Visits	C2F2S4	1.5641	1.1617
10225	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F2S5	1.7378	1.2907
10231	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F3S1	1.1387	0.8457
10232	1st and 2nd Episodes, 6 Therapy Visits	C2F3S2	1.3029	0.9677
10233	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F3S3	1.4671	1.0896
10234	1st and 2nd Episodes, 10 Therapy Visits	C2F3S4	1.6313	1.2116
10235	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F3S5	1.7956	1.3336
10311	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F1S1	0.9071	0.6737
10312	1st and 2nd Episodes, 6 Therapy Visits	C3F1S2	1.1348	0.8428
10313	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F1S3	1.3624	1.0119
10314	1st and 2nd Episodes, 10 Therapy Visits	C3F1S4	1.5900	1.1809
10315	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F1S5	1.8177	1.3500
10321	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F2S1	1.1160	0.8289
10322	1st and 2nd Episodes, 6 Therapy Visits	C3F2S2	1.3211	0.9812
10323	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F2S3	1.5262	1.1335
10324	1st and 2nd Episodes, 10 Therapy Visits	C3F2S4	1.7313	1.2859
10325	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F2S5	1.9364	1.4382
10331	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F3S1	1.2118	0.9000
10332	1st and 2nd Episodes, 6 Therapy Visits	C3F3S2	1.4074	1.0453
10333	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F3S3	1.6030	1.1906
10334	1st and 2nd Episodes, 10 Therapy Visits	C3F3S4	1.7986	1.3359
10335	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F3S5	1.9942	1.4811
21111	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F1S1	1.6223	1.2049
21112	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F1S2	1.8331	1.3615
21113	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F1S3	2.0438	1.5180
21121	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F2S1	1.7186	1.2764
21122	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F2S2	1.9496	1.4480
21123	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F2S3	2.1807	1.6197
21131	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F3S1	1.7668	1.3122
21132	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F3S2	2.0252	1.5042
21133	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F3S3	2.2836	1.6961
21211	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F1S1	1.8153	1.3483
21212	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F1S2	2.0224	1.5021
21213	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F1S3	2.2294	1.6558
21221	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F2S1	1.9116	1.4198
21222	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F2S2	2.1389	1.5886
21223	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F2S3	2.3663	1.7575
21231	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F3S1	1.9598	1.4556
21232	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F3S2	2.2145	1.6448
21233	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F3S3	2.4691	1.8339
21311	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F1S1	2.0453	1.5191
21312	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F1S2	2.2682	1.6846
21313	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F1S3	2.4911	1.8502
21321	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F2S1	2.1415	1.5905
21322	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F2S2	2.3848	1.7712
21323	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F2S3	2.6280	1.9519
21331	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F3S1	2.1897	1.6263

TABLE 5—FINAL CY 2014 CASE-MIX WEIGHTS—Continued

Payment group	Description	Clinical, functional, and service levels	2013 HH PPS case-mix weights	2014 HH PPS case-mix weights
21332	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F3S2	2.4603	1.8273
21333	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F3S3	2.7309	2.0283
22111	3rd+ Episodes, 14 to 15 Therapy Visits	C1F1S1	1.6822	1.2494
22112	3rd+ Episodes, 16 to 17 Therapy Visits	C1F1S2	1.8730	1.3911
22113	3rd+ Episodes, 18 to 19 Therapy Visits	C1F1S3	2.0638	1.5328
22121	3rd+ Episodes, 14 to 15 Therapy Visits	C1F2S1	1.7628	1.3093
22122	3rd+ Episodes, 16 to 17 Therapy Visits	C1F2S2	1.9791	1.4699
22123	3rd+ Episodes, 18 to 19 Therapy Visits	C1F2S3	2.1954	1.6306
22131	3rd+ Episodes, 14 to 15 Therapy Visits	C1F3S1	1.9247	1.4295
22132	3rd+ Episodes, 16 to 17 Therapy Visits	C1F3S2	2.1305	1.5824
22133	3rd+ Episodes, 18 to 19 Therapy Visits	C1F3S3	2.3362	1.7351
22211	3rd+ Episodes, 14 to 15 Therapy Visits	C2F1S1	1.8508	1.3746
22212	3rd+ Episodes, 16 to 17 Therapy Visits	C2F1S2	2.0460	1.5196
22213	3rd+ Episodes, 18 to 19 Therapy Visits	C2F1S3	2.2412	1.6646
22221	3rd+ Episodes, 14 to 15 Therapy Visits	C2F2S1	1.9314	1.4345
22222	3rd+ Episodes, 16 to 17 Therapy Visits	C2F2S2	2.1521	1.5984
22223	3rd+ Episodes, 18 to 19 Therapy Visits	C2F2S3	2.3729	1.7624
22231	3rd+ Episodes, 14 to 15 Therapy Visits	C2F3S1	2.0933	1.5547
22232	3rd+ Episodes, 16 to 17 Therapy Visits	C2F3S2	2.3035	1.7109
22233	3rd+ Episodes, 18 to 19 Therapy Visits	C2F3S3	2.5136	1.8669
22311	3rd+ Episodes, 14 to 15 Therapy Visits	C3F1S1	2.0747	1.5409
22312	3rd+ Episodes, 16 to 17 Therapy Visits	C3F1S2	2.2878	1.6992
22313	3rd+ Episodes, 18 to 19 Therapy Visits	C3F1S3	2.5009	1.8575
22321	3rd+ Episodes, 14 to 15 Therapy Visits	C3F2S1	2.1553	1.6008
22322	3rd+ Episodes, 16 to 17 Therapy Visits	C3F2S2	2.3940	1.7781
22323	3rd+ Episodes, 18 to 19 Therapy Visits	C3F2S3	2.6326	1.9553
22331	3rd+ Episodes, 14 to 15 Therapy Visits	C3F3S1	2.3172	1.7210
22332	3rd+ Episodes, 16 to 17 Therapy Visits	C3F3S2	2.5453	1.8904
22333	3rd+ Episodes, 18 to 19 Therapy Visits	C3F3S3	2.7734	2.0599
30111	3rd+ Episodes, 0 to 5 Therapy Visits	C1F1S1	0.6692	0.4970
30112	3rd+ Episodes, 6 Therapy Visits	C1F1S2	0.8718	0.6475
30113	3rd+ Episodes, 7 to 9 Therapy Visits	C1F1S3	1.0744	0.7980
30114	3rd+ Episodes, 10 Therapy Visits	C1F1S4	1.2770	0.9485
30115	3rd+ Episodes, 11 to 13 Therapy Visits	C1F1S5	1.4796	1.0989
30121	3rd+ Episodes, 0 to 5 Therapy Visits	C1F2S1	0.8421	0.6254
30122	3rd+ Episodes, 6 Therapy Visits	C1F2S2	1.0263	0.7623
30123	3rd+ Episodes, 7 to 9 Therapy Visits	C1F2S3	1.2104	0.8990
30124	3rd+ Episodes, 10 Therapy Visits	C1F2S4	1.3945	1.0357
30125	3rd+ Episodes, 11 to 13 Therapy Visits	C1F2S5	1.5787	1.1725
30131	3rd+ Episodes, 0 to 5 Therapy Visits	C1F3S1	0.9352	0.6946
30132	3rd+ Episodes, 6 Therapy Visits	C1F3S2	1.1331	0.8416
30133	3rd+ Episodes, 7 to 9 Therapy Visits	C1F3S3	1.3310	0.9886
30134	3rd+ Episodes, 10 Therapy Visits	C1F3S4	1.5289	1.1355
30135	3rd+ Episodes, 11 to 13 Therapy Visits	C1F3S5	1.7268	1.2825
30211	3rd+ Episodes, 0 to 5 Therapy Visits	C2F1S1	0.7361	0.5467
30212	3rd+ Episodes, 6 Therapy Visits	C2F1S2	0.9591	0.7123
30213	3rd+ Episodes, 7 to 9 Therapy Visits	C2F1S3	1.1820	0.8779
30214	3rd+ Episodes, 10 Therapy Visits	C2F1S4	1.4049	1.0434
30215	3rd+ Episodes, 11 to 13 Therapy Visits	C2F1S5	1.6278	1.2090
30221	3rd+ Episodes, 0 to 5 Therapy Visits	C2F2S1	0.9091	0.6752
30222	3rd+ Episodes, 6 Therapy Visits	C2F2S2	1.1136	0.8271
30223	3rd+ Episodes, 7 to 9 Therapy Visits	C2F2S3	1.3180	0.9789
30224	3rd+ Episodes, 10 Therapy Visits	C2F2S4	1.5225	1.1308
30225	3rd+ Episodes, 11 to 13 Therapy Visits	C2F2S5	1.7269	1.2826
30231	3rd+ Episodes, 0 to 5 Therapy Visits	C2F3S1	1.0022	0.7444
30232	3rd+ Episodes, 6 Therapy Visits	C2F3S2	1.2204	0.9064
30233	3rd+ Episodes, 7 to 9 Therapy Visits	C2F3S3	1.4386	1.0685
30234	3rd+ Episodes, 10 Therapy Visits	C2F3S4	1.6568	1.2305
30235	3rd+ Episodes, 11 to 13 Therapy Visits	C2F3S5	1.8751	1.3927
30311	3rd+ Episodes, 0 to 5 Therapy Visits	C3F1S1	0.9324	0.6925
30312	3rd+ Episodes, 6 Therapy Visits	C3F1S2	1.1609	0.8622
30313	3rd+ Episodes, 7 to 9 Therapy Visits	C3F1S3	1.3893	1.0319
30314	3rd+ Episodes, 10 Therapy Visits	C3F1S4	1.6178	1.2016
30315	3rd+ Episodes, 11 to 13 Therapy Visits	C3F1S5	1.8463	1.3713
30321	3rd+ Episodes, 0 to 5 Therapy Visits	C3F2S1	1.1054	0.8210
30322	3rd+ Episodes, 6 Therapy Visits	C3F2S2	1.3154	0.9770
30323	3rd+ Episodes, 7 to 9 Therapy Visits	C3F2S3	1.5254	1.1329
30324	3rd+ Episodes, 10 Therapy Visits	C3F2S4	1.7353	1.2888
30325	3rd+ Episodes, 11 to 13 Therapy Visits	C3F2S5	1.9453	1.4448
30331	3rd+ Episodes, 0 to 5 Therapy Visits	C3F3S1	1.1985	0.8902

TABLE 5—FINAL CY 2014 CASE-MIX WEIGHTS—Continued

Payment group	Description	Clinical, functional, and service levels	2013 HH PPS case-mix weights	2014 HH PPS case-mix weights
30332	3rd+ Episodes, 6 Therapy Visits	C3F3S2	1.4222	1.0563
30333	3rd+ Episodes, 7 to 9 Therapy Visits	C3F3S3	1.6460	1.2225
30334	3rd+ Episodes, 10 Therapy Visits	C3F3S4	1.8697	1.3887
30335	3rd+ Episodes, 11 to 13 Therapy Visits	C3F3S5	2.0935	1.5549
40111	All Episodes, 20+ Therapy Visits	C1F1S1	2.2546	1.6745
40121	All Episodes, 20+ Therapy Visits	C1F2S1	2.4117	1.7912
40131	All Episodes, 20+ Therapy Visits	C1F3S1	2.5419	1.8879
40211	All Episodes, 20+ Therapy Visits	C2F1S1	2.4364	1.8096
40221	All Episodes, 20+ Therapy Visits	C2F2S1	2.5936	1.9263
40231	All Episodes, 20+ Therapy Visits	C2F3S1	2.7238	2.0230
40311	All Episodes, 20+ Therapy Visits	C3F1S1	2.7140	2.0157
40321	All Episodes, 20+ Therapy Visits	C3F2S1	2.8712	2.1325
40331	All Episodes, 20+ Therapy Visits	C3F3S1	3.0014	2.2292

D. Rebasing the National, Standardized 60-day Episode Payment Amount, LUPA Per-Visit Payment Amounts, and Nonroutine Medical Supply (NRS) Conversion Factor

1. Rebasing the National, Standardized 60-Day Episode Payment Amount

Section 3131(a) of the Affordable Care Act requires that starting in CY 2014, the Secretary must apply an adjustment to the national, standardized 60-day episode payment amount and other amounts applicable under section 1895(b)(3)(A)(i)(III) of the Act to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. In addition, section 3131(a) of the Affordable Care Act requires that this rebasing must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the payment amount (or amounts) as of the date of enactment (March 23, 2010) under section 1895(b)(3)(A)(i)(III) of the Act, and be fully implemented by CY 2017.

In the CY 2014 HH PPS proposed rule, we described our extensive analysis of cost report and claims data and proposed rebasing adjustments to the national, standardized 60-day episode payment amount, the LUPA per-visit payment amounts, and the NRS conversion factor. We used FY 2011 cost report data as of December 31, 2012; which was the latest, complete cost report data available at the time of the analysis.

a. Trimming Methodology, Audit Results and Weighting

In the CY 2014 HH PPS proposed rule, we described the trimming methodology used to obtain a more robust estimate of costs, which consisted of longitudinal and cross-sectional trims. After applying the trimming methodology, 6,252 cost reports were left in the 2011 sample, out of 10,327 cost reports. These cost reports were then used to estimate the average cost per visit and average cost per episode for 2011.

In addition, we described the results of the audits of 100 FY 2010 HHA Medicare cost reports. We stated that when comparing the pre-audit sample data to the post-audit sample data, we observed an average reduction of 8 to 9 percent in the costs per visit across all disciplines, except medical social services which averaged a 5 percent reduction in the allowable costs per visit. These audited costs per visit across the disciplines reduced the average cost per episode by 7.8 percent when comparing the pre-audit data to the post-audit adjusted data. The results of the audits indicate that the trimmed sample used for this rule likely over-estimates the average cost per visit and average cost per episode for providers.

After applying the trimming methodology to the 2011 Medicare cost reports, we computed the estimated mean cost per visit per discipline by dividing the total costs for a discipline by the total number of visits in our sample. We then applied weights to the sample to ensure that the costs per visit, per discipline used to calculate the average costs per episode were nationally representative. Using the nationally-weighted average costs per visit from the trimmed FY 2011 HHA Medicare cost report sample and the visits per episode estimates for each discipline from 2011 national claims data, we estimated the 2011 average cost per episode. As shown in Table 6, we multiplied the average cost per visit by the average number of visits for each of the six disciplines and summed the results to generate an estimated 60-day episode cost for 2011 of $2,453.71. This methodology used to calculate the episode cost is consistent with the methodology used in setting the 60-day episode base rate for the HH PPS in 2000. We note that the 2011 estimated cost per episode includes normal, PEP, and outlier episodes.

TABLE 6—2011 AVERAGE COSTS PER VISIT AND AVERAGE NUMBER OF VISITS FOR A 60-DAY EPISODE

Discipline	2011 Average costs per visit	2011 Average number of visits	2011 60-Day episode costs
Skilled Nursing	$131.51	9.43	$1,240.14
Home Health Aide	65.22	2.80	182.62
Physical Therapy	160.69	4.86	780.95
Occupational Therapy	159.55	1.15	183.48
Speech–Language Pathology	170.80	0.21	35.87
Medical Social Services	218.91	0.14	30.65

TABLE 6—2011 AVERAGE COSTS PER VISIT AND AVERAGE NUMBER OF VISITS FOR A 60-DAY EPISODE—Continued

Discipline	2011 Average costs per visit	2011 Average number of visits	2011 60-Day episode costs
Total		18.59	2,453.71

Source: CY 2011 Medicare claims data and 2011 Medicare cost report data as of December 31, 2012.

b. Calculating the Estimated Average Cost per Episode

In the CY 2014 HH PPS proposed rule, to determine the rebasing adjustment to the 60-day national, standardized episode payment amount, we compared the 2013 estimated average payment per episode to the 2013 estimated average cost per episode. To calculate the 2013 estimated average cost per episode, we first applied an adjustment to account for the visit distribution change observed in claims data from 2011 to 2012. We compared the 2011 estimated cost per episode using the 2011 visit distribution to the 2011 estimated cost per episode using the 2012 visit distribution. In the CY 2014 HH PPS proposed rule, we stated that the 2011 estimated cost per episode is $2,453.71 when using the 2011 visit profile and is $2,443.34 when using the 2012 visit profile. We calculated an adjustment factor to account for the visit differences between 2011 and 2012 (1 + (2,443.34–2,453.71)/2,453.71 = 0.9958). The 2012 visit profile in the CY 2014 HH PPS proposed rule was calculated using preliminary CY 2012 claims data for episodes starting on or before May 31, 2012. We also stated in the CY 2014 HH PPS proposed rule that we planned to update the 2012 visit distribution as more data become available, and therefore, the estimated cost per episode may change slightly. Using the most current, complete CY 2012 data for this final rule (a full year of claims data), we re-examined the 2012 visit distribution and re-calculated the 2011 estimated cost per episode using the updated 2012 visit profile ($2,448.95). The adjustment factor was also re-calculated to account for the change in the number of visits between 2011 and 2012 (1 + (2,448.95–2,453.71)/2,453.71 = 0.9981). The CY 2011 visit distribution, the CY 2012 visit distribution using partial CY 2012 data as described in the CY 2014 HH PPS proposed rule, and the CY 2012 visit distribution using complete CY 2012 data are shown in Table 7. We note that since complete CY 2013 claims data was not available at the time of this final rule, we did not make any adjustments for changes in the visit distribution from CY 2012 to CY 2013 as part of developing the estimated CY 2013 average cost per episode.

TABLE 7—COMPARISON OF THE 2011 AND 2012 VISIT DISTRIBUTION FROM CLAIMS DATA

Discipline	2011 Average number of visits per episode	2012 Average number of visits per episode (published in CY 2014 HH PPS proposed rule)	2012 Average number of visits per episode (using full CY 2012 data)
Skilled Nursing	9.43	9.39	9.44
Home Health Aide	2.80	2.62	2.63
Physical Therapy	4.86	4.88	4.86
Occupational Therapy	1.15	1.15	1.16
Speech-Language Pathology	0.21	0.23	0.23
Medical Social Services	0.14	0.14	0.14
Total Number of Visits per Episode	18.59	18.41	18.46

Source: CY 2011 Medicare claims data, CY 2012 Medicare claims data as of December 31, 2012 for episodes starting between January 1, 2012 and May 31, 2012, and CY 2012 Medicare claims data (as of June 2013) for episodes ending on or before December 31, 2012 for which we had a linked OASIS assessment.

After applying the adjustment to account for the visit distribution change between 2011 and 2012, we calculate the estimated average cost per episode for CY 2013 by multiplying the estimated, average cost per episode by the HH market basket for 2012 and by the HH market basket for 2013 (Table 8). When setting the 60-day episode base rate for the HH PPS in 2000, we also updated costs from cost reports by the HH market basket to reflect expected inflation. We note that the 2013 estimated cost per episode shown in Table 8 reflects the updated 2012 visit profile, and therefore numbers have changed slightly from the CY 2014 HH PPS proposed rule.

TABLE 8—2013 ESTIMATED COST PER EPISODE

2011 Estimated cost per episode	Factor for 2011–2012 visit distribution difference	2012 HH market basket	2013 HH market basket	2013 Estimated cost per episode
$2,453.71	× 0.9981	× 1.024	× 1.023	= $2,565.51

c. Calculating the Estimated Average Payment per Episode

To develop the 2013 estimated average payment per episode, in our updated analyses for this final rule, we start with the CY 2012 national, standardized 60-day episode payment rate and apply a number of factors. In the CY 2014 HH PPS proposed rule, we proposed to reset the average case-mix weight from 1.3517 to 1.0000 and increased the CY 2012 60-day episode payment rate by 1.3517. Since we are resetting the average case-mix weight from 1.3464 to 1.0000 (see section IV.C. of this rule), we increase the CY 2012 60-day episode payment rate by 1.3464. As such, the numbers in Table 9 are different from the numbers in the CY 2014 HH PPS proposed rule. The 60-day episode payment rate in CY 2012 was $2,138.52. By inflating the CY 2012 60-day episode payment rate by the budget neutrality factor to account for the downward adjustment of the weights to an average case-mix of 1.0000, we obtain the average CY 2012 payment per episode. Then by applying the CY 2013 payment policy updates (the 1.32 percent payment reduction for nominal case-mix growth and the 1.3 percent HH payment update percentage), we obtain the estimated average CY 2013 payment per episode. We note that the Medicare cost reports do not differentiate between normal, PEP, and outlier episodes in the reporting of costs per discipline. Therefore, the CY 2013 estimated average cost per episode includes costs for normal, PEP, and outlier episodes. To compare the episode payment to the average cost of an episode, we add the dollars from the 2.5 percent outlier pool back into the payment per episode. Later, in our calculation of the CY 2014 national, standardized 60-day episode payment rate, we remove the outlier dollars (see Tables 20 and 21 in section IV.E.4.b. of this rule).

TABLE 8—2013 ESTIMATED COST PER EPISODE

2012 National, standardized 60-day episode payment rate	Budget neutrality factor to account for case-mix weight adjustment to 1.0000	2013 Payment reduction for nominal case-mix growth	2013 HH Payment update percentage	Outlier adjustment	2013 Estimated average payment per episode
$2,138.52	× 1.3464	× 0.9868	× 1.013	÷ 0.975	=$2,952.03

d. Calculating the Rebasing Adjustment to the National, Standardized 60-day Episode Payment Amount

In the CY 2014 HH PPS proposed rule, we compared the 2013 estimated average payment per episode to the 2013 estimated average cost per episode and obtained a difference of −13.63 percent (($2,559.59 − $2,963.65)/$2,963.65). We stated that phasing-in the −13.63 percent adjustment over 4 years in equal increments would result in an annual reduction to the national, standardized 60-day payment rate of 3.60 percent, determined using a compound annual growth rate (CAGR) formula (($2,559.59/$2,963.65) $^{1/4}$ − 1 = −0.0360). Given the 3.5 percent limit set in statute, we proposed to reduce the national, standardized 60-day episode payment amount by 3.5 percent in each year, 2014 through 2017. For this final rule, when comparing the updated 2013 estimated average cost per episode and 2013 estimated average payment per episode we obtained a difference of −13.09 percent (($2,565.51—$2,952.03)/$2,952.03), as shown in Table 10. Phasing-in the −13.09 percent over 4 years in equal increments would result in an annual reduction of 3.45 percent, determined using a CAGR formula.

TABLE 10—COMPARISON OF THE AVERAGE PAYMENT PER EPISODE TO THE AVERAGE COST PER EPISODE

2013 Payment per episode	2013 Estimated cost per episode	Percentage change
$2,952.03	$2,565.51	−13.09

In order to align episode payments with costs, we would implement a −3.45 percent rebasing adjustment to the national, standardized 60-day episode payment rate each year from 2014 through 2017. Our initial interpretation of section 3131(a) of the Affordable Care Act for the CY 2014 HH PPS proposed rule reflects how one would ideally rebase a payment system and supports a −3.45 percent rebasing adjustment to the national, standardized 60-day episode payment rate. However, commenters stated that since the statute specifies that the rebasing adjustments ''may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of the date of enactment of the Patient Protection and Affordable Care Act'', the maximum adjustment of 3.5 percent should be calculated using the CY 2010 payment rates. Upon further review of the specific language in the statute, we agree with the commenters. Therefore, as specified by statute, the rebasing adjustment is limited to 3.5 percent of the CY 2010 national, standardized 60-day episode payment rate of $2,312.94 (74 FR 58106), or $80.95.

The −3.45 percent rebasing adjustment to the 2013 national, standardized 60-day payment rate described above exceeds the maximum adjustment specified by statute of $80.95. A −3.45 percent rebasing adjustment would result in a decrease of $99.56 for CY 2014 ($2,952.03 * 0.975 (remove the outlier dollars that we put back in the rates for comparison purposes as described above) * 1.0026 (wage index standardization factor as described in section IV.E.4.b of this final rule) * 0.0345 = $99.56). In addition, a −3.45 percent rebasing adjustment for CY 2015 through 2017 would also exceed the maximum adjustment allowed under statute of $80.95. Given that a −3.45 percent adjustment for CY 2014 through CY 2017 would result in larger dollar amount reductions than the maximum dollar amount allowed under section 3131(a) of $80.95, we are limited to implementing a reduction of $80.95 to the national, standardized 60-day episode payment amount each year for CY 2014 through CY 2017.

2. Rebasing the Low Utilization Payment Adjustment (LUPA) Per-Visit Payment Amounts

For episodes with four or fewer visits, Medicare pays on the basis of a national per-visit amount by discipline, referred to as a LUPA.

a. Calculating the Rebasing Adjustment to the LUPA Per-Visit Amounts

As stated in the CY 2014 HH PPS proposed rule, to determine the rebasing adjustment for the national per-visit payment rates, we compared the current national per-visit payment rates to the estimated cost per visit, per discipline. The 2013 estimated per-visit costs per discipline are shown in Table 11. The 2011 per-visit costs per discipline are the same as those derived for the rebasing of the national, standardized 60-day episode payment rate (see Table 6). The average cost per-visit for NRS from the cost report sample is added to the 2011 estimated per-visit costs per discipline (see section IV.D.3. of this rule for more information on the calculation of the average NRS cost per visit). The per-visit costs are then increased by the HH market basket in 2012 and 2013 to obtain an estimate of the 2013 costs per visit, per discipline.

TABLE 11—2013 ESTIMATED AVERAGE COST PER-VISIT, PER-DISCIPLINE

Discipline	2011 Estimated average cost per visit	Average NRS cost per visit	2012 HH market basket	2013 HH market basket	2013 Estimated average cost per visit
Skilled Nursing	$131.51	+ $2.26	× 1.024	× 1.023	= $140.13
Home Health Aide	65.22	+ $2.26	× 1.024	× 1.023	= $70.69
Physical Therapy	160.69	+ $2.26	× 1.024	× 1.023	= $170.70
Occupational Therapy	159.55	+ $2.26	× 1.024	× 1.023	= $169.50
Speech-Language Pathology	170.80	+ $2.26	× 1.024	× 1.023	= $181.29
Medical Social Services	218.91	+ $2.26	× 1.024	× 1.023	= $231.69

Similar to the methodology used to determine the rebasing adjustment to the national, standardized 60-day episode payment rate, we took the current 2013 national per-visit payment rates and, for comparison purposes only, put the dollars from the 2.5 percent outlier pool back into the payment rates (see Table 12). This allows us to compare the CY 2013 cost per-visit, per-discipline on the Medicare cost reports (which includes normal and outlier episodes) to the CY 2013 payment per-visit, per discipline.

TABLE 12—2013 NATIONAL PER-VISIT PAYMENT RATES

Discipline	2013 Per-visit payment rates (excluding outlier pool)	Outlier adjustment	2013 Per-visit payment rates (including outlier pool)
Skilled Nursing	$114.35	÷ 0.975	= 117.28
Home Health Aide	51.79	÷ 0.975	= $53.12
Physical Therapy	125.03	÷ 0.975	= 128.24
Occupational Therapy	125.88	÷ 0.975	= 129.11
Speech-Language Pathology	135.86	÷ 0.975	= 139.34
Medical Social Services	183.31	÷ 0.975	= 188.01

When comparing the national per-visit payment rate, per discipline for LUPA episodes to the 2013 estimated average cost per-visit, per-discipline, we observe that costs per visit are higher than the 2013 national per-visit payment rates (see Table 13), ranging from +19.5 percent to +33.1 percent.

TABLE 13—DIFFERENCES BETWEEN THE CY 2013 PER VISIT PAYMENT RATES AND THE CY 2013 ESTIMATED AVERAGE COST PER VISIT

Discipline	2013 Per-visit payment rates	2013 Estimated average cost per visit	Percentage change
Skilled Nursing	$117.28	$140.13	+ 19.48
Home Health Aide	53.12	70.69	+ 33.08
Physical Therapy	128.24	170.70	+ 33.11
Occupational Therapy	129.11	169.50	+ 31.28
Speech-Language Pathology	139.34	181.29	+ 30.11
Medical Social Services	188.01	231.69	+ 23.23

We stated that phasing-in the adjustments, ranging from + 19.48 percent to + 33.11 percent in Table 13 above, over 4 years in equal increments, would result in annual increases ranging from 4.55 to 7.41 percent, determined using a compound annual growth rate (CAGR) formula. Given the 3.5 percent limit set in statute, we proposed to increase the per-visit payment rates by 3.5 percent every year from 2014 to 2017 in order to better

align the national per-visit payment amounts with costs. However, the statute limits the rebasing adjustment that can be applied. As explained in more detail below, several commenters stated that since the statute specifies that the rebasing adjustments ''may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of the date of enactment of the Patient Protection and Affordable Care Act'', the maximum adjustment of 3.5 percent should be calculated using the CY 2010 payment rates. Upon further review of the specific language in the statute, we agree with the commenters. Therefore, because of the language in the statute, we are limited to increasing the national per-visit payment amounts by no more than the amounts outlined in Table 14 below.

TABLE 14—MAXIMUM ADJUSTMENTS TO THE NATIONAL PER-VISIT PAYMENT RATES, NOT TO EXCEED 3.5 PERCENT OF THE AMOUNT(S) IN CY 2010

Discipline	2010 National per-visit payment rates	Maximum 3.5% adjustment to per-visit rates
Skilled Nursing	$113.01	$3.96
Home Health Aide	51.18	1.79
Physical Therapy	123.57	4.32
Occupational Therapy	124.40	4.35
Speech-Language Pathology	134.27	4.70
Medical Social Services	181.16	6.34

Source: (74 FR 58107).

The annual increases ranging from 4.55 to 7.41 percent determined using a CAGR formula and the percentage changes in Table 13 above would exceed the maximum adjustments allowed under statute for CY 2014 through 2017 (see Table 15 below). In addition, increasing the national per-visit payment rates by 3.5 percent each year, as proposed, would also exceed the maximum adjustments allowed under statute given that the rebasing adjustments cannot be more than 3.5 percent of the CY 2010 national per-visit rates in any given year (see Table 15 below). Therefore, we are limited to implementing the dollar amount increases to the national per-visit payment rates outlined in Table 14 above each year, CY 2014 through CY 2017.

TABLE 15—CAGR AND PROPOSED 3.5 PERCENT DOLLAR INCREASES AND THE MAXIMUM ADJUSTMENTS TO THE NATIONAL PER-VISIT PAYMENT RATES, NOT TO EXCEED 3.5 PERCENT OF THE AMOUNT(S) IN CY 2010

Discipline	2013 National per-visit payment rates	Wage Index standardization [1]	CAGR percent increase	CAGR dollar amount increase	Proposed 3.5 percent dollar amount increase	Maximum 3.5% adjustment to per-visit rates
Skilled Nursing	$114.35	$114.42	4.55	$5.21	$4.00	$3.96
Home Health Aide	51.79	51.82	7.41	3.84	1.81	1.79
Physical Therapy	125.03	125.11	7.41	9.27	4.38	4.32
Occupational Therapy	125.88	125.96	7.04	8.87	4.41	4.35
Speech-Language Pathology	135.86	135.94	6.80	9.24	4.76	4.70
Medical Social Services	183.31	183.42	5.36	9.83	6.42	6.34

[1] Column 2 is multiplied by the wage index standardization factor for the national per-visit payment rates of 1.0006 as described in section IV.E.4.b.

3. Rebasing the Nonroutine Medical Supply (NRS) Conversion Factor

Payments for NRS are currently paid for by multiplying one of six severity levels by the NRS conversion factor. When the HH PPS was implemented on October 1, 2000, the national, standardized 60-day episode payment rate included an amount for NRS that was calculated based on costs from audited FY 1997 cost reports and the average cost of NRS unbundled and billed through Medicare Part B (65 FR 41180). The NRS costs for all the providers in the audited cost report sample were weighted to represent the national population. That weighted total was divided by the number episodes for the providers in the audited cost report sample, to obtain an average cost per episode for NRS of $43.54. Added to this amount was $6.08 to account for the average cost of unbundled NRS billed through Medicare Part B, resulting in a total of $49.62 included in the national, standardized 60-day episode payment rate to account for NRS.

As stated in our CY 2008 HH PPS proposed rule, after the HH PPS went into effect, we received comments and correspondence expressing concern about the cost of supplies for certain patients with ''high'' supply costs (72 FR 25427, May 4, 2007). We acknowledged that, in general, NRS use is unevenly distributed across episodes of care. Therefore, we created an NRS conversion factor of $52.35 (the amount CMS originally included in the national, standardized 60-day episode payment rate of $49.62, updated by the market basket, and after an adjustment to account for nominal change in case-mix) that is further adjusted by one of six severity levels to ensure that the variation in NRS usage is more appropriately reflected in the HH PPS (72 FR 49852, August 29, 2007). Using additional variables from OASIS items and targeting certain conditions expected to be predictors of NRS use based on clinical considerations, a classification algorithm puts cases into one of the six severity levels and a regression model was used to develop the payment weights associated with each severity level. For more detail on how the final six NRS severity levels and associated payment weights were

developed please see the CY 2008 HH PPS final rule (72 FR 49850, August 29, 2007). The 2008 NRS conversion factor has been updated by HH payment update percentages in years 2009 through 2013. The CY 2013 NRS conversion factor is $53.97 and CY 2013 NRS payments range from $14.56 for severity level 1 to $568.06 for severity level 6 (77 FR 67102).

a. Calculating the Rebasing Adjustment to the NRS Conversion Factor

In rebasing the NRS conversion factor as described in the CY 2014 HH PPS proposed rule, we used the trimmed sample of 6,252 cost reports from FY 2011, as described in section IV.D.1. of this rule, to calculate a visit-weighted estimate of NRS costs per visit. We additionally weight these estimates to be nationally representative based on the same factors described in section IV.D.1. of this rule (that is, facility type, urban/rural status, and facility size). The 2011 average NRS cost per visit was calculated to be $2.26.

To calculate a 2011 estimated average NRS cost per episode for the CY 2014 HH PPS proposed rule, we multiplied the average NRS costs per visit of $2.26 by the average number of visits per episode of 18.59 from 2011 claims data for a 2011 estimated average NRS cost per episode of $42.01. This amount was then adjusted to reflect the change in the average number of visits from 18.59, using 2011 claims data, to 18.41, using preliminary 2012 claims data ((1+ ((18.41–18.59)/18.59))= 0.9903). We then inflated the result by the 2012 and 2013 HH market basket for a 2013 estimated average NRS cost per episode of $43.58. For this final rule, using the more current, complete CY 2012 claims data, the average number of visits in 2012 decreases to 18.46. Therefore, the adjustment for the change in the average number of visits per episode between CY 2011 and CY 2012 will be ((1+ 18.46 – 18.59)/18.59)) = 0. 9930). We then inflate the result by the 2012 and 2013 HH market basket for a 2013 estimated average NRS cost per episode of $43.53 as shown in Table 16.

TABLE 16—2013 ESTIMATED AVERAGE NRS COST PER EPISODE

2011 Estimated average NRS cost per episode	Adjustment for change in average episode visits (2011 to 2012)	2012 Market basket update (2.4)	2013 Market basket update (2.3)	2013 Estimated average NRS cost per episode
$42.01	× 0.9930	× 1.024	× 1.023	$43.70

To compare the 2013 estimated average NRS cost per episode to 2013 estimated average NRS payment per episode, for the CY 2014 HH PPS proposed rule we used preliminary 2012 claims data for non-LUPA episodes and the CY 2013 NRS conversion factor of $53.97 to calculate the estimated 2013 average NRS payment per episode of $48.38. For this final rule, using the more current, complete CY 2012 claims data shows that the distribution of episodes amongst the six severity levels differs from the distribution used when the NRS conversion factor and relative weights were established in CY 2008, as shown in Table 17.

TABLE 17—PERCENTAGE OF EPISODES BY NRS SEVERITY LEVEL

Severity level	Relative weight	Percent of episodes, CY 2008 final rule	Percent of episodes, CY 2012
1	0.2698	63.7	69.3
2	0.9742	20.6	16.7
3	2.6712	6.7	6.4
4	3.9686	5.4	4.3
5	6.1198	3.2	3.0
6	10.5254	0.3	0.3

Source: The CY 2008 HH PPS Final Rule (72 FR 49852, August 29, 2007) and CY 2012 Medicare claims data (as of June 30, 2013) for non-LUPA HH episodes ending on or before December 31, 2012 for which we had a linked OASIS assessment.

Note(s): The distribution of episodes used to establish the CY 2008 relative weights was based on CY 2004 and CY 2005 claims data and a sample consisting of all agencies whose total charges reported on their 2001 claims matched their total charges reported in their 2001 cost reports (72 FR 49852).

In the proposed rule, when comparing the 2013 estimated average NRS payment per episode of $48.38 to the 2013 estimated average NRS cost per episode of $43.58; we obtained a difference of −9.92 percent (($43.58–$48.38)/$48.38). Phasing-in the 9.92 percent reduction over 4 years in equal increments, using a CAGR formula, would result in an annual reduction of 2.58 percent. Using the updated distribution of CY 2012 claims by severity level and the relative weights in Table 17 with the CY 2013 conversion factor of $53.97, the CY 2013 estimated average NRS payment per episode is $49.00. Comparing the 2013 estimated average NRS cost per episode to the 2013 estimated average NRS payment per episode, we obtain a difference of −10.82 percent (($43.70–$49.00)/$49.00). Phasing-in the −10.82 percent adjustment over 4 years in equal increments, using a CAGR formula, will result in an annual reduction of 2.82 percent, or $1.52 in CY 2014 ($53.97 x 0.0282 = $1.52). This $1.52 does not exceed 3.5 percent of the CY 2010 NRS conversion factor, which is calculated to be $1.87 ($53.34 x 0.035). We noted in the CY 2014 HH PPS proposed rule that during our analysis of NRS costs and payments, we found that a significant number of providers listed charges for NRS on the home health claim, but those same providers did not list any NRS costs on their cost reports. Specifically, out of the 6,252 cost reports from FY 2011, as described in section IV.D.1.of this rule, 1,756 cost reports (28.1 percent) reported NRS charges in their claims, but listed $0

NRS costs on their cost reports. Given the need for extensive trimming of the cost reports as well as the findings from the audits and our analysis of NRS payments and costs, we are exploring possible additional edits to the cost report and quality checks at the time of submission to improve future cost reporting accuracy (78 FR 40290). For more information on the rebasing analyses performed, refer to the technical reports for both the proposed and final rules available on the CMS Home Health Agency (HHA) Center Web site at: *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html?redirect=/center/hha.asp*.

The following is a summary of the comments we received regarding the proposed rebasing adjustments to the National, Standardized 60-day Episode Payment Amount, LUPA Per-Visit Payment Amounts, and the (NRS) Conversion Factor.

Comment: Commenters stated that the maximum allowable rebasing reduction should be calculated from the CY 2010 standardized base amount, not the CY 2013 average payment. The commenters stated that the Affordable Care Act refers to ''the date of enactment'' and since the Affordable Care Act was enacted on March 23, 2010, CY 2010 payment amounts should be used when calculating the maximum allowable reduction for rebasing. In addition, commenters argued that the limit should be calculated using the national standardized episode payment rate, rather than the episode payment rate multiplied by the average case-mix.

Response: While we interpreted the statutory language differently for the CY 2014 HH PPS proposed rule and believe that the proposed rule reflects the how one would ideally rebase a payment system, upon further review, we agree with the commenters regarding the date of enactment and will use the CY 2010 payment rates to determine whether any of the rebasing adjustments exceed 3.5 percent.

Comment: MedPAC was supportive of the proposed adjustments to the payment amounts, but expressed concerns that the proposed rebasing adjustment to the national, standardized 60 day episode amount of −3.5 percent will be too modest and leave agencies with substantial profit opportunities. MedPAC stated that much of the annual rebasing reductions will be offset by the payment update for each year in 2014 to 2017 and estimates that the cumulative net payment reduction to the national, standardized 60-day episode payment amount after four years will equal approximately 4 percent. MedPAC noted that the rebasing reductions are smaller than the net reductions implemented in 2010 through 2013, a period when the base rate was reduced by 7.6 percent, and noted that the four-year cumulative net effect of the rebasing reductions is smaller than the 4.89 percent estimated one-year payment reduction for CY 2011. MedPAC stated that they recommended to the Congress that the statute should be changed so that rebasing could be implemented in a shorter period and also recommended that the market basket updates be eliminated to bring costs closer to payments than the current approach.

Response: We thank MedPAC for their comments. As MedPAC noted, we proposed a 3.5 percent reduction to the CY 2013 national, standardized 60-day episode payment rate for CY 2014 and an additional 3.5 percent in each year 2015 through CY 2017. However, we do not have the statutory authority to either shorten the 4-year phase-in period or eliminate the annual payment updates. As brought to our attention by commenters, the maximum rebasing adjustment amounts are now calculated using 3.5 percent of the CY 2010 payment rates. Consequently, for this final rule that requirement results in a $80.95 dollar reduction to the national, standardized 60-day episode payment amount in each year from CY 2014 through CY 2017 as described in section IV.D.1.d above. This is equivalent to a 2.81 percent reduction to the national, standardized 60-day episode payment rate for 2014 rather than a 3.45 percent reduction.[2]

Comment: Several commenters stated that CMS should not implement the proposed payment reductions. Commenters stated that the proposed payment reductions may impact quality of care and diminish health care system efficiency, as well as limit provider's ability to participate in broader delivery system reform efforts. Specifically, commenters stated that home health care prevents hospital readmissions and is less costly than other post-acute settings, and that the rebasing adjustments may increase the use of more costly institutional care, like hospitals, which is against the goal of health care reform to improve outcomes and care coordination, prevent hospitalizations and re-hospitalizations, and reduce costs. A commenter stated that patient outcomes have improved and that spending in FY 2011 is similar to FY 1996, indicating that reductions are not needed. Another commenter stated that CMS should ensure that the final rebasing policy reflects the goals to improve patient care and outcomes, encourage coordination among providers, and appropriately manage the cost of care without harming patient affordability, quality, or access.

Response: Section 3131(a) of the Affordable Care Act requires that the HH PPS payment amount(s) ''shall be adjusted by a percentage determined appropriate by the Secretary to reflect factors such as the changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant.'' In their 2013 Report to Congress, MedPAC stated that ''the number and types of visits in a home health episode changed significantly after the HH PPS was introduced, although the payments were based on the older, higher level of use and costs''.[3] Furthermore, based on analysis of FY 2011 cost report data, the 60-day episode costs, the per-visit rate costs, and NRS costs have changed since the start of the HH PPS (65 FR 41184) and CMS is implementing adjustments to the HH PPS payment amounts to reflect those changes. The goal of the adjustments is to align payment with costs, similar to what was done when setting the original base rate and per-visit amounts, and the methodology to determine the rebasing adjustment is very similar to the methodology used to set the original base rate and per-visit amounts. CMS plans to monitor the effects of the rebasing adjustments on access and quality of care for any unintended effects.

Comment: One commenter stated that the differences between cost and payment may be related to fraud and abuse and that targeted efforts to address fraud or examination of Medicare eligibility policies rather than across the board cuts should be implemented. One commenter stated that instead of finalizing the rebasing proposal, CMS should start the development of a new payment methodology for the therapy component of the HH PPS that accurately bases payment on the severity of the patient and the necessary resources to treat the condition, rather than basing payment on thresholds. Other commenters stated

[2] $2,952.03 * 0.975 (remove the outlier dollars that we put back in the rates for comparison purposes) * 1.0026 (wage index standardization factor as describe in section IV.E.4.b of this final rule) = $2,885.71. $2885.71 − $80.95 = $2,804.76. ($2,804.76 − $2,885.71)/$2,885.71 = 2.81%)

[3] MedPAC. ''Chapter 2: Assessing payment adequacy and updating payments in fee-for-service Medicare.'' Report to the Congress—Medicare Payment Policy. March 2013, p. 34.

that CMS should either abandon or delay the case-mix weight adjustments and rebasing approach and spend the next year performing a realistic analysis of true home health agency costs and beneficiary needs for home health services.

Response: Section 3131(a) of the Affordable Care Act requires a four year phase-in of rebasing, in equal increments, to start in CY 2014 and be fully implemented in CY 2017. Therefore, based on statutory requirements, rebasing cannot be delayed or eliminated once we have determined that rebasing is necessary. Differences between estimated episode costs and payments indicate a need to better align payment with costs and therefore, rebasing of the HH PPS payment amounts is needed. We intend to explore these commenters' concerns in ongoing research. We recently awarded a contract to Abt Associates to explore the findings and any recommendations from the home health study mandated by section 3131(d) of the Affordable Care Act, reassess the case-mix system, monitor potential impacts of rebasing and other recent payment policy changes, and develop reform options to ensure continued access and quality of care as well as address potential vulnerabilities in the current payment system.

Comment: Commenters stated that the proposed reductions puts the nation's economic recovery at risk since it targets the home health sector and the home health care community has been a primary driver of job growth.

Response: The impact of the rebasing adjustments for CY 2014 is estimated to be approximately −2.7 percent as described in section VII. However, the net impact for CY 2014, given all the payment changes for CY 2014, including the payment update percentage, is estimated at −1.05 percent. This net reduction over the four years is much smaller than some previous net reductions implemented in single payment years, such as the net reduction finalized in CY 2011. In CY 2011, CMS estimated that the net impact of the payment policies for that year to be −4.89 percent. Yet, according to MedPAC, the home health industry did not seem to be adversely impacted as the number of home health agencies from 2010 to 2011 grew from 11,654 to 12,199 and the number of home health episodes from 2010 to 2011 grew similarly, with 6.8 million episodes in 2010 and 6.9 million episodes in 2011.[4] Therefore, we do not expect that the rebasing adjustments for CY 2014 will have a significant impact but we will be monitoring the impact of rebasing on access to home health care.

Comment: One commenter argued that language in section 3143 of the Affordable Care Act prohibits CMS from implementing rate rebasing as proposed because it will result in the reduction of guaranteed home health benefits, and that the guaranteed home health benefits include reasonable access to a provider that accepts Medicare payment.

Response: Section 3143 of the Affordable Care Act reads that ''Nothing in the provisions of, or amendments made by, this Act shall result in the reduction of guaranteed home health benefits under title XVIII of the Social Security Act.'' We interpret this to mean that with regards to the statutory language at 1814(a)(2)(C), 1835(a)(2)(A), 1861(m) and 1861(kk), there are to be no changes to the scope of coverage under the Medicare home health benefit. The Congress inserted the rebasing provision into section 1895 of the Act (Prospective Payment System of Home Health Services), which calls for the rebasing of the amount(s) applicable under that section of the Act. We fully intend to monitor the effects of any adjustment made to the payment amounts in this final rule for any unintended results, including any substantial impact on access to care. We also note that, as mandated in section 3131(a) of the Affordable Care Act, MedPAC will conduct a study on the rebasing implementation, which will include impact analysis on access to care, and submit a Report to Congress no later than January 1, 2015, along with any potential recommendations, if necessary.

Comment: Commenters stated that the rebasing reductions will drive payments below costs in almost every state by 2017, causing access issues and impacting quality of care. Commenters stated that by setting the payment at costs, it guarantees that 50 percent of the HHAs will be paid less than cost by CY 2017 and that a margin is needed to meet normal business operational needs, such as the need for capital funding, keeping staff and attracting new staff, and investment in new technologies and care delivery models. One commenter stated that there is no precedent in payment adjustments that call for the estimation of profit margins regardless of type of entity and the ''elimination of entire average, estimated margins'' for the industry. The commenter recommended that CMS engage in an in-depth analysis and study of the economics at play in the home health marketplace in determining the level of profit/margin that is reasonable to offer and stated that home health agencies have little other revenue, such as commercial insurance revenue, to help counter reductions in Medicare payment and that agencies have little opportunity for margin outside of Medicare.

Response: The rebasing methodology used to develop the proposed rebasing adjustments is very similar to the methodology used in 2000 where the episode rate and per-visit amounts were equated to the estimated costs per episode or per visit. Notably, in 2000, even though the episode and per-visit amounts were aligned with the expected cost for HH PPS episodes, there were high margins in the first year of the HH PPS, in large part due to HHAs providing fewer visits than anticipated. In addition, MedPAC stated in their March 2013 Report to the Congress, ''Margins have stayed high since 2001 because annual increases in payment have exceeded growth in costs. The Commission's review of the annual change in cost per episode suggests that cost growth has been minimal, typically less than 1 percent. In some years, a decline has been observed. Average payments per episode have generally increased from year to year, driven by market basket increases and increases in the average case-mix index.''

While we calculated the proposed adjustments for rebasing by aligning payment to costs, we did not factor in potential opportunities for HHAs to increase efficiencies into the calculation of the rebasing adjustments. We also note that the rebasing adjustments to the national, standardized 60-day episode payment rate for CY 2014 through 2017 will be lower than the proposed adjustments given that we cannot implement a reduction that exceeds 3.5 percent of the CY 2010 national, standardized 60-day episode payment rate of $2,312.94 or a reduction greater than $80.95 in a given year. Similar to 2000, we expect that in the upcoming years HHAs will increase efficiencies in some operating areas and institute mechanisms to better control costs. In their 2013 Report to Congress, MedPAC stated ''low cost growth or no cost growth has been typical for home health care, and in some years we have observed a decline in cost per episode. The ability of HHAs to keep costs low has contributed to the high margins under the Medicare PPS.''

In addition, the rebasing adjustments over the next four years will be partly offset by the HH PPS payment update percentage and, therefore, the net

[4] MedPAC. ''Chapter 9: Home Health Care Services.'' Report to the Congress—Medicare Payment Policy. March 2013, p. 194–195.

impact on HHAs will be smaller than payment reductions absorbed by the industry in previous years. We plan to monitor the impact of the rebasing adjustments for any unintended consequences. As noted above, as mandated in section 3131(a) of the Affordable Care Act, MedPAC will conduct a study on the rebasing implementation, which will include impact analysis on access to care, quality outcomes, the number of home health agencies, and rural, urban, for-profit, and non-profit agencies, and submit a Report to Congress no later than January 1, 2015, along with any potential recommendations.

Comment: Commenters stated that the rural add-on only applies to episodes through December 2016 and therefore, the rural communities and frontier areas may be hit hard in 2017 by the combination of the rebasing adjustments and the expiration of the rural add-on policy. Commenters asked CMS to do a more thorough investigation of health care costs in rural areas. Commenters stated rural area HHAs experience higher costs in part due to longer drive times to reach rural residents.

Response: Thank you for the comment. We plan to continue to explore the costs associated with rural areas. We are currently in the process of implementing a ''Frontier Community Health Integration Project'' demonstration that may be useful in providing information on whether there are substantial cost differences between urban and rural areas, driven primarily by increased transportation costs. However, we note that in their 2013 Report to Congress, MedPAC stated that the use of the ''broad targeted add-on, providing the same payment for all rural areas regardless of access, results in rural areas with the highest utilization drawing a disproportionate share of the add-on payments.'' MedPAC stated that ''70 percent of the episodes that received the add-on payments in 2011 were in rural counties with utilization significantly higher than the national average'' and recommended that Medicare target payment adjustments for rural areas to those areas that have access challenges. We will take MedPAC's recommendation into account when assessing cost differences between urban and rural areas.

Comment: Commenters stated that the proposed rebasing policy will have unintended impacts for vulnerable patients, such as those with higher costs or more complex care needs. Commenters stated that CMS should not implement rebasing until the study required under section 3131(d) of the Affordable Care Act is completed and the report is delivered to the Congress. Commenters stated that the study directs CMS to look at the cost of treating certain subgroups and that the study was intended to be coupled with rebasing, stating that the CY 2014 policies will be implemented just months before the statutory deadline for the Report to Congress on the study. The commenters asked CMS to consider the findings of the study and the risks associated with the rebasing adjustments for vulnerable populations and re-assess the proposed reductions. Some commenters stated that CMS should consider incorporating findings from the Visiting Nurse Associations of America (VNAA) Vulnerable Patient study into the rebasing methodology. Commenters stated that the VNAA Vulnerable Patient study found that Medicare home health episodes for patients with certain characteristics, such as those with poorly controlled chronic conditions, lower median household incomes or serious or frail status, have significantly lower reimbursement compared to cost than other patients. Commenters also cited types of beneficiaries which may be vulnerable, including but not limited to African and Hispanic home health beneficiaries and mentally-ill patients. Commenters stated that the CY 2014 HH PPS proposed rule needs to consider and adopt protective measures to ensure access to care for vulnerable patients.

A commenter also asked if CMS considered the aging of the American and Medicare population, the increase in the awareness and acceptance of home health as a viable health care option, and the increase in incentives for hospitals to discharge patients earlier resulting in a higher patient acuity for home health patients in the rebasing analysis. The commenter recommended that CMS implement a study of the 1999 consultant's report by the National Science Foundation to assess the comparability of patient needs presented in 1999 versus patient needs being present in 2013 and implement a research effort to look at the changes in home health care since 2000.

Response: We agree with the commenters that the case-mix system and home health study findings should be examined and addressed. However, the findings and recommendations of the study will not be final until spring of next year and section 3131(a) of the Affordable Care Act mandates that CMS implement rebasing starting in CY 2014. The home health study did take into account the findings from the VNAA Vulnerable Patient study and as noted, we recently awarded a contract to Abt Associates to perform follow-on work to the home health study. The contractor will further explore findings and recommendations from the home health study, reassess the case-mix system, monitor potential impacts of rebasing and other recent payment policy changes, and develop reform options to ensure continued access and quality of care for any vulnerable beneficiaries as well as address potential vulnerabilities in the current payment system.

Comment: One commenter stated that there are negative margins associated with the provision of services to Medicaid, uninsured, and managed care patients and that positive Medicare margins are needed to subsidize the cost of providing services to these patients. Another commenter stated that the rule needs to consider the impact of expansion of Medicare Advantage plans and Fully Integrated Dual Advantage plans that will likely decrease Medicare revenues and profit margins.

Response: While industry representatives contend that Medicare payments should subsidize payments from other payers (in large part Medicaid), we disagree. Medicare has never set payments so as to cross-subsidize other payers. Section 1861(v)(1)(A) of the Act states ''under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.'' As MedPAC stated in its March 2011 Report to Congress, cross-subsidization is not advisable for two significant reasons: ''Raising Medicare rates to supplement low Medicaid payments would result in poorly targeted subsidies. Facilities with high shares of Medicare payments—presumably the facilities that need revenues the least—would receive the most in subsidies from the higher Medicare payments, while facilities with low Medicare shares— presumably the facilities with the greatest need—would receive the smallest subsidies. Finally, increased Medicare payment rates could encourage states to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates.[5]''

In addition, we examined the proportion of Medicare-paid visits on the cost reports in our sample and found that the majority of visits recorded on

[5] MedPAC. ''Chapter 7: Skilled Nursing Facility Services.'' Report to the Congress—Medicare Payment Policy. March 2011, p. 159.

the cost report are Medicare-paid visits. As such, the average cost per visit is more representative of Medicare visit costs. We examined whether the average costs per visit may be different for Medicare versus other payers by examining the relationship between the providers' average costs per visit and the provider's proportion of visits that were paid by Medicare. Specifically, we grouped providers with similar proportions of Medicare visits (for example, those with 60–70 percent of visits as Medicare-paid visits and other 10 percentage point groupings) and examined the average costs per visit across the groups. We did not see a consistent relationship between costs and the Medicare share of visits, either across disciplines or across the provider groups.

Comment: Several commenters opposed the use of 6,252 out of 10,327 cost reports for rebasing. One commenter stated that there were about 10 percent of home health agencies that participate in the Medicare program that did not submit cost reports and therefore, did not have their cost data included in the rebasing analysis and one commenter stated that the majority of the agencies trimmed were small agencies, which will be severely impacted by rebasing. Commenters stated that this level of trimming was not necessary to gain reliable data and stated that over 9,000 cost reports were reliable and useable. Commenters noted that for the Hospital Outpatient Prospective Payment System (OPPS), CMS only removed 25 percent of cost reports. Commenters recommended CMS revisit the trim methodology to include as many cost reports as possible.

Response: We appreciate the commenter's concern on the number of providers used in (or excluded from) the HHA rebasing analysis. As stated in the CY 2014 HH PPS proposed rule, 1,629 of the 10,327 cost reports were missing data on total Medicare costs or Medicare payments and 375 cost reports either had missing visits when costs were reported or missing costs when visits were reported. Otherwise stated, approximately 20 percent of the 10,327 Medicare cost reports were incomplete. Of the remaining 8,323 completed Medicare cost reports, approximately 75 percent were included in the rebasing analysis. In the CY 2014 HH PPS proposed rule (78 FR 40285), we provided a complete description of the methods used to trim the cost reports.

We performed analysis on both the trimmed and untrimmed sample. We found that using the trimmed sample resulted in an estimated average cost per episode that was much higher than the estimated cost per episode using the untrimmed cost report sample. The estimated average cost per episode using the untrimmed cost report sample was $1,883.63 compared to $2,453.71 using the trimmed cost report sample. If CMS were to use the untrimmed cost report sample, the percentage for the rebasing reduction, if there was no statutory limit, would likely have been much larger than with the trimmed sample. With regards to the comment about the exclusions of agencies that didn't submit cost report data or the disproportionate exclusion of agencies that were small, as described in section IV.D.1. of this rule, the per-visit costs obtained from the cost reports in our sample were weighted to be nationally representative by facility type, urban/rural status, and facility size. Therefore, the costs per visit used to calculate the estimated episode cost should be nationally representative and appropriately reflect small agencies.

Many of the edits applied are similar to those edits applied in other PPS systems and by MedPAC (including but not limited to, the exclusion of providers with missing Medicare Payments, missing Medicare costs, missing Medicare episodes, and reports that are less than 10 months or greater than 14 months). We continue to believe that our trimming methodology and our weighting methodology is technically appropriate and produces a nationally-representative costs per visit and costs per episode.

Comment: Some commenters stated that the data used for rebasing are outdated and that 2012 cost report data should be used, arguing that the CY 2012 cost reports portray a more accurate picture of providers' financial state. A number of commenters cited that 2012 cost reports would better capture agency costs, such as but not limited to, those associated with the full implementation of face-to-face and therapy requirements and the CY 2012 recalibration. Commenters stated that the 2012 cost reports reflect declining average revenue, increased costs, and lower average margins, particularly among small home health agencies, and that Medicare margins have been declining over the years.

Response: We disagree with the commenter's claim that the cost reports used are not the most current, complete data available for rebasing. As of June 30, 2013, there were over 10,000 FY 2011 freestanding and hospital-based HHA cost reports of which over 90 percent are settled. Also, as of June 30, 2013, there are only about 6,800 FY 2012 freestanding and hospital-based cost reports of which roughly only 60 percent are settled. Therefore, the FY 2011 cost report data is the most complete data available at the time of the rebasing analysis.

In response to the commenter's claims that the CY 2012 cost reports portray a more accurate picture of providers' financial state, we calculated the average costs per visit for a matched sample of 2011 and 2012 providers using our rebasing sample of cost reports described in section IV.D.1 and in the CY 2014 HH PPS proposed rule (78 FR 40284) and preliminary 2012 home health agency Medicare cost report data (approximately 5,700 2012 cost reports). We found that the average costs per visit for all disciplines (home health aide, medical social services, occupational therapy, physical therapy, skilled nursing, and speech-language therapy) remained virtually unchanged (see Table 18), while the total number of visits per episode from 2011 to 2012 dropped from 18.59 to 18.39, as shown in Table 7. This drop in total visits from 2011 to 2012 with virtually no changes in the costs per visit suggest that the 2012 estimated cost per episode may be less than the cost per episode estimated using FY 2011 cost report data.

TABLE 18—AVERAGE COST PER VISIT, 2011 AND 2012

	2011	2012
Skilled Nursing	$ 133.65	$ 133.71
Physical Therapy	161.05	162.81
Occupational Therapy	158.80	159.22
Speech-Language Pathology	170.20	173.06
Medical Social Services	220.91	219.74

TABLE 18—AVERAGE COST PER VISIT, 2011 AND 2012—Continued

	2011	2012
Home Health Aide	69.79	65.63

Source: FY 2011 Medicare cost report data as of December 31, 2012 and FY 2012 Medicare cost report data as of June 30, 2013 for providers who were included in the rebasing sample described in section IV.D.1.a. and for which a FY 2012 cost report was on file. We weighted the average costs per visit in 2012 by size, ownership type, and urban-rural status to mimic the distribution of providers in the 2011 claims used for weighing the 2011 average costs per visit used for rebasing.

In addition, the calculations of the proposed CY 2014 rebasing adjustments include a 2.4 percent and a 2.3 percent increase to account for the market basket CY 2012 and CY 2013 updates, respectively. These updates reflect the latest forecast of the HHA market basket available at the time of rate setting. However, the actual (reflecting historical data rather than a forecast) HHA market basket increase for 2012 is now measured to be 1.7 percent (0.7 percentage points lower than the forecasted increase for CY 2012 of 2.4 percent). Preliminary data also suggests the CY 2013 market basket update of 2.3 percent was overstated by roughly 0.5 percentage points. The home health market basket percentage increases can be found here: *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/mktbskt-summary.pdf*. We would note that the CY 2012 market basket update was based on the 2003-based HHA market basket while the Web site reference above includes the 2010-based HHA market basket increase, which is used for CY 2013 and subsequent years.

Comment: Several commenters stated that CMS should include all home health service costs in its calculation of the cost of care. Commenters stated that the overhead costs of hospital-based home health agencies were not factored into the cost calculations and also listed several costs that they stated are not reflected in the 2011 cost reports, such as new resources needed for the growth of Accountable Care Organizations (ACOs), bundled payment initiatives, Independence at Home program, hospital readmissions reduction program, wage and employee health benefit changes, mandatory employer costs/penalties, HIPAA compliance, work with physicians related to PECOS, and implementation and administration of OASIS–C. Numerous commenters also stated that the CY 2011 cost reports did not reflect new regulatory obligations, such as the costs associated with therapy and face-to-face requirements, HH CAHPS survey requirements and the upcoming implementation of ICD–10–CM.

Several commenters disagreed with CMS' exclusion of non-allowable costs which they state are part of operating a business, such as bad debt, taxes, franchise fees, fundraising costs in a non-profit, marketing costs and business development costs, full administrative and general costs including those that are non-reimbursable under Medicare cost reimbursement principles, and formal and informal home office costs, respiratory therapy, nutritionist, dietician services, health information technology, telehealth, computerized information technology, and documentation time.

Response: Overhead costs of hospital-based home health agencies were factored into the cost calculations as we used cost measures where both direct service and indirect (such as, administrative and general) costs have been allocated to the appropriate cost centers. Please see page 17 of the technical report titled ''Analyses in Support of Rebasing & Updating the Medicare Home Health Payment Rates—CY 2014 Home Health Prospective Payment System Proposed Rule'' available on the CMS Home Health Agency (HHA) Center Web site at: *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html?redirect=/center/hha.asp.*

The 2011 HHA Medicare cost reports used in the rebasing analysis reflect the costs of complying with longstanding regulatory requirements, such as HIPAA, and the implementation of OASIS–C on January 1, 2010, and HH CAHPS survey requirements in the fourth quarter of CY 2010. In addition, the face-to-face encounter requirement mandated by the Affordable Care Act was implemented on January 1, 2011 (with a compliance deadline of April 1, 2011) and therefore, the costs of the face-to-face encounter requirement are likewise accounted for in the 2011 cost reports used for rebasing. The therapy reassessment requirements were implemented on April 1, 2011. We believe that the 2011 cost reports would reflect the costs of complying with the new therapy reassessment requirements as agencies should have begun altering their documentation practices and therapist oversight activities early in 2011 to comply with the reassessment requirements. Nevertheless, we did perform analysis of preliminary 2012 cost report data and found virtually no changes in the costs-per-visit. This in conjunction with the drop in visits from 2011 to 2012 suggests that the 2012 estimated cost-per-episode may be less than the estimated 2011 cost per episode. While we acknowledge that the costs of implementing ICD–10–CM code set, effective October 1, 2014, and of educating physicians on enrollment in PECOS are not reflected in the cost reports we used, we did use the most current, complete cost report data available at the time of issuing this rule to calculate the rebasing adjustments. Section 3131(a) of the Affordable Care Act requires us to rebase payments starting in CY 2014 to be fully phased-in by CY 2017. As stated earlier, as of June 30, 2013, there are only about 6,800 FY 2012 freestanding and hospital-based cost reports of which roughly only 60 percent are settled. Therefore, the FY 2011 cost report data is most complete data currently available and was the data used for the rebasing analysis. We note that while participation in ACOs, bundled payment initiatives and the ''Independence at Home'' program are encouraged, participation is likely to occur among agencies that believe they can ''work smarter'' to achieve the aims of those programs. As with other voluntary programs, agencies self-select into them for a variety of reasons, and not only reasons related to possible costs of participation. Further, the hospital readmission reduction program is aimed at keeping patients with certain conditions from being re-hospitalized within 30 days of discharge and reduces payments to hospitals with excess readmissions. HHAs do not receive reduced payment when excess readmissions occur at a particular hospital. However, we would expect that HHAs would continue to provide quality care so that readmissions are minimized. In addition, we note that the hospital readmissions reduction program could create an incentive for hospitals to make more use of home care as a way to help prevent hospital readmissions.

With regards to the costs included in the rebasing methodology, section 1861(v)(1)(A) states that ''The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services.'' We also note that section 1895(e) of the Act governs the HH PPS and states that telehealth services are outside the scope of the Medicare home health benefit and home health PPS. This provision does not provide coverage or payment for Medicare home health services provided via a telecommunications system. The law does not permit the substitution or use of a telecommunications system to provide any covered home health services paid under the home health PPS, or any covered home health service paid outside of the home health PPS. As set forth in 42 CFR 409.48(c), a visit is an episode of personal contact with the beneficiary by staff of the home health agency (HHA), or others under arrangements with the HHA for the purposes of providing a covered service. The provision clarifies that there is nothing to preclude an HHA from adopting telemedicine or other technologies that they believe promote efficiencies, but that those technologies will not be specifically recognized or reimbursed by Medicare under the home health benefit.

Although commenters took issue with certain non-reimbursable costs not being included in the cost calculations, we note that the home health agency Medicare cost report form has undergone little to no revision since 1985. Prior to the interim payment system (1997–2000), providers were paid at cost for the direct and indirect costs associated with providing skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services along with routine and non-routine medical supplies. While HHAs were receiving cost-based reimbursement, the number of agencies, users and services expanded rapidly in the early 1990s, indicating that non-reimbursable costs were not substantial enough to discourage new agencies from entering the market. When the HH PPS was implemented in 2000, non-reimbursable costs were not considered, nor did the industry comment on the FY 2000 HH PPS proposed rule that they were concerned about non-reimbursable costs being excluded from the cost calculations. After HH PPS implementation, the number of agencies grew once again from approximately 7,500 agencies in 2000 to over 12,000 in 2011. We continue to believe that the cost calculations performed for determining the rebasing adjustments mandated by the Affordable Care Act are appropriate and reflect the direct and indirect costs of home health services rendered to Medicare beneficiaries.

Comment: One commenter stated that there was an ''order of operations'' issue in the methodology used for rebasing. The commenter stated that when CMS first increased the estimated payment rate to account for the weight reductions (that is, the resetting of the average weight to 1.0000), it significantly increased the base to which the 3.5 percent cut was applied. If the same percentage cut were made to the lower pre-neutralized standardized rate, the 3.5 percent cut would have been about 1 percent lower, or $28.92 an episode. The commenter thought that CMS should restore this amount to the base rate.

Response: The starting point to which the rebasing adjustments are applied is the CY 2013 estimated average payment per episode, which we compare to the CY 2013 estimated average costs per episode. The increase in the CY 2012 national, standardized 60-day episode payment rate by the budget neutrality factor is used to estimate CY 2012 average payment. The CY 2012 average payment is then adjusted by the CY 2013 adjustments (nominal case-mix reduction and HH payment update percentage). The increase in the base rate must occur before the rebasing adjustments are applied, not afterwards, as the rebasing adjustment is calculated by comparing average payments to average costs. We also note that the rebasing adjustments cannot exceed 3.5 percent of the CY 2010 payment amounts in absolute terms.

Comment: One commenter stated that CMS' approach ignores regional differences in home health operating margins. Another commenter stated that the methodology ignores the diversity in the home care industry and the populations they serve and that the populations served varies by geography, patient characteristics, case-mix, size, and payer makeup. The commenter stated that under the current rebasing methodology, CMS is making a false assumption that all home care agencies are operating under similar conditions with similar populations, and agencies with smaller margins will not be able to accommodate the lower payment rates. A commenter encouraged CMS to make distinctions between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies, and that CMS should consider setting rates based upon averages among each of the primary groups of HH providers.

Response: We disagree with the commenters claims that our rebasing adjustment methodology ignores the diversity in the home care industry and the populations they serve. First, our approach reflects case-mix which takes into consideration the characteristics of the patients. As always, we welcome suggestions for additional measures that could potentially improve the case-mix adjustment as we continue in our case mix research. Second, as described in section IV.D.1. of this rule, we used urban/rural classification, size class, and agency type (nonprofit, for-profit, government, and facility-based) weights to estimate the national average cost per visit. In addition, the payment system reflects geographic variation in cost by adjusting payments using the wage index and by rural agency payment adjustments. CMS does not design payment rates for different sizes of agencies for several reasons, including that this would weaken incentives for efficient organization of the home health industry by agency size and could impair the program's ability to benefit from economies of scale that affect agency costs.

In addition, we note that in their 2013 Report to Congress, MedPAC stated, ''The need to reset the base rate in Medicare is particularly acute because high margins exist across the range of agency types. Urban, rural, for-profit, and nonprofit agencies have margins in excess of 12 percent. While some agencies have margins significantly lower than average, the Commission's review of agencies in 2007 found that these differences are primarily due to their higher costs. These higher costs do not appear to be related to patient severity, as low-margin agencies, for most measures, did not serve more severely ill patients.''

Comment: One commenter stated that the total Medicare cost and the number of episodes should have been used to calculate the average cost per episode instead of the methodology used by CMS and that the actual payment should have been obtained from cost report data, not simulated. The commenter also stated that the wage index adjustment was not taken into account.

Response: The methodology used the average costs per visit (obtained from the Medicare cost reports) multiplied by the number of Medicare visits per episode (obtained from the Medicare claims) by discipline to calculate the average cost per episode. We believe

that Medicare claims are a more reliable data source; although we note that visit per episode counts on Medicare claims and on Medicare cost reports were similar. The methodology in this rule is the same methodology used for the implementation of the HH PPS base payment rate in FY 2001. In addition, we note that the regulations at 42 CFR 484.215(b) state: ''CMS determines the national mean utilization for each of the six disciplines using home health claims data'' in calculating the national, standardized 60-day episode payment amount. We continue to believe that our methodology was, and continues to be, technically appropriate and best reflects national costs per episode. Lastly, we disagree with the commenter's claim that we did not take into account the wage index adjustment. As stated in the CY 2014 HH PPS proposed rule (78 FR 40296), we apply a standardization factor (1.0017) to eliminate the effects of variation in area wage adjustments among different home health agencies in a budget neutral manner.

Comment: Commenters stated that the CY 2014 HH PPS proposed rule doesn't offer the mathematical calculation CMS used to divide the 13.63 percent difference between payments and costs into four reductions of 3.6 percent, stating that 13.63 divided by 4 is 3.4075. Commenters asked for an explanation of the calculation, indicating that a correction may be needed.

Response: We calculated the 3.6 percent reduction in the CY 2014 HH PPS proposed rule using a CAGR formula. The CAGR formula used to get the 3.6 percent annual reduction for each of the four years was ($2,559.59/$2,963.65) $^{1/4}$–1. The initial target aggregate reduction was determined to be 13.63 percent, which the statute requires to be phased-in over a four year period (2014–2017) in equal increments. The annual reduction necessary to yield 13.63 percent after 4 years is 3.6 percent, because $(1–0.036)^4 = 1–0.1363$.[6]

This method reflects compounding growth rates over time. We note that while we calculated a 3.6 percent reduction for the CY 2014 HH PPS proposed rule, as we discussed earlier in this section, the Affordable Care Act mandates that the rebasing adjustment to the amount (or amounts) be no more than 3.5 percent of the 2010 payment amounts. As noted previously, the maximum adjustment for rebasing the national, standardized 60-day payment rate has been determined to be $80.95.

Comment: One commenter stated that when developing the rebasing adjustment, CMS double counted factors that have already been accounted for in other reimbursement reductions since the enactment of the Affordable Care Act while excluding other factors that should have been considered. The commenter stated that CMS adjusted reimbursement rates multiple times based on the same factors. The commenter stated that the number of visits in a home health episode was already addressed. The commenter stated that between 1998 and 2001, the average number of home health visits per episode dropped from 31.6 to 21.4 and remained at this level through 2009 and that market forces have already corrected imbalances in the number of visits in a home health episode. The commenter also stated that in the CY 2013 HH PPS rule, CMS already considered case-mix data and determined that no further adjustment was necessary. The commenter stated that adjusting reimbursement rates based on case-mix or the mix of services again would be ''double counting.'' In addition, the commenter stated that CMS already accounted for the level of intensity of services in a home health episode through the case-mix payment reductions and further reducing it would be double counting.

Response: As we stated above, in their 2013 Report to Congress, MedPAC stated that ''the number and types of visits in a home health episode changed significantly after the home health PPS was introduced, although the payments were based on the older, higher level of use and costs'' (p. 34). The episode payment amount has not been updated to reflect the change in the number of visits since the start of the HH PPS and therefore, CMS is not double counting the change in the number of visits. CMS is also not double counting the mix of services or level of intensity of services in the episode. The average number of visits per discipline per episode used when setting the base rate in 2000 is different from the average number of visits per discipline using 2011 claims data (Table 19). In addition, as indicated by the cost per visit per discipline differences between the per visit rates used to develop the 2000 base rate and the per visit rates calculated from FY 2011 data, the intensity of the services in the episode likely have also changed. CMS has not previously updated the national, standardized episode payment rate to reflect the total visit changes per episode, the change in the mix of services, and the change in the intensity of services. The case-mix reductions which the commenter mentions were implemented to align the payment with patient severity and to account for the nominal increases in the reported case-mix, changes not related to real increases in patient severity, by home health agencies. The goal of rebasing is to align the national, standardized payment rate and other applicable amounts with episode costs, similar to what was done when developing the episode payment rate in 2000. Given the differences in episode payment and costs and the differences in the assumed composition of visits and intensity when developing the base rate versus the composition of visits and intensity reflected in the 2011 cost report and claims data, CMS proposed that a rebasing adjustment be applied to the national, standardized episode payment amount for rebasing.

TABLE 19—AVERAGE NUMBER OF VISITS, CY 1998 AND CY 2011

	Average number of visits used to develop 2000 base rate (CY 1998 claims data)	Average number of visits from CY 2011 claims data
Home Health Aide	13.4	2.80
Medical Social Services	0.32	0.14
Occupational Therapy	0.53	1.15
Physical Therapy	3.05	4.86

[6] Due to rounding, there is a 0.01 percentage point difference between the calculated and reported numbers.

TABLE 19—AVERAGE NUMBER OF VISITS, CY 1998 AND CY 2011—Continued

	Average number of visits used to develop 2000 base rate (CY 1998 claims data)	Average number of visits from CY 2011 claims data
Skilled Nursing	14.08	9.43
Speech-Language Pathology	0.18	0.21

Source: 65 FR 41171 and CY 2011 Medicare claims data.

Comment: A commenter stated that the methodology relies on proxies for payment and cost determinations when the information is readily available from cost report data. The commenter stated that the proxies CMS used are different than the actual episode costs and payments on the cost report and the combined difference between the actual and proxy calculation should lead to a lower rebasing adjustment than the adjustment proposed. The commenter recommended that CMS use direct data rather than the proxies used in the CY 2014 HH PPS proposed rule. The commenter also stated that the methodology fails to account for and address the wide range in revenue/cost per episode experienced by HHAs and that a single payment rate adjusted with the current ''weak'' adjusters leads to payment inaccuracies that require a rate ''cushion'' to maintain access to care. The commenter stated that CMS should look at all ways of calculating average costs of home health services, such as look into the median instead of the mean, and look into the multiple options for forecasting cost and payment trends. The commenter stated that all calculation options should be explored and evaluated and the option that would result in the ''the greatest degree of financial stability'' should be implemented. Another commenter urged CMS to ensure the methodology used to determine the rebasing adjustments is accurate.

Response: We believe that Medicare home health care providers overall have benefited from a substantial rate ''cushion'' under the HH PPS, as margin estimates over the years demonstrate. Because the margin has been so large, while we have seen little change in patient characteristics and relatively little change in aggregate resources used to care for the patients, we infer that access to care does not appear to be a problem. Furthermore, we have had no direct indications of access problems. Although it is possible that reducing the large rate ''cushion'' could create financial pressures, we believe many circumstances and considerations other than patient clinical status enter into the decision of the amount of resources per episode; the multiplicity of such factors is suggested by the large portion of variability in resources or margins unexplained by statistical models in recent studies of potential case mix variables. Our statistical analysis of margins suggests that many of these factors are agency-related, and therefore they may need examination by agencies to ensure efficient service delivery. Outlier payments are also available to agencies for those episodes whose imputed cost exceeds a threshold amount for each case-mix group HHRG due to unusual variations in the type or amount of medically necessary care. We anticipate that continuing studies of improvements to the case mix adjustment methodology will lead to a stronger case mix adjustment before the rebasing phase-in is complete. We welcome suggestions for new measures that are suitable for incorporation into the case mix adjuster.

With regards to the comment about using the median rather than the mean, the median is typically used in order to avoid having extreme values unduly influence the measure of the typical value. We have already trimmed the cost report sample to avoid having extreme values influence the average value to some degree. We also do not believe the upper and lower values, after the trimming, are skewing the mean but rather that the upper and lower values reflect legitimate payments obtained from cleaned up data and therefore, the mean should be used. Also, using an average accounts precisely for the costs incurred by the industry because the mean times the number of units equals the total costs. With a median, one may be accounting for more or less than the industry's total costs. In addition, the median calculated by the commenter was likely done at the agency level rather than the episode level, giving smaller agencies with higher costs more weight than the episode level average. In the rebasing methodology for this final rule, CMS makes use of the fact that much of the utilization is in lower-cost, large agencies, which would not be reflected if the median was used.

We disagree with the commenter's suggestion that the Medicare claims data is a proxy and should not be used to calculate the average costs per episode. We believe that Medicare claims are a more reliable data source and its use is consistent with the methodology used in setting the 60-day episode base rate for the HH PPS in 2000. In addition, we note that in at 42 CFR 484.215(b), ''CMS determines the national mean utilization for each of the six disciplines using home health claims data'' in calculating the national, standardized 60-day episode payment amount and we believe that the use of claims data to calculate the average estimated payment more accurately reflects the actual payment agencies received.

Comment: A commenter stated that fraudulent payment should be excluded from the payment history statistics and recommended that CMS ''restart'' the rebasing efforts, consulting with specific working groups comprised of industry and patient advocacy groups.

Response: Section 3131(a) of the ACA mandates that rebasing be implemented starting in CY 2014 so the rebasing adjustments must be implemented beginning on January 1, 2014. We note that claims in CY 2011 and CY 2012 that were subsequently denied before the creation of the Standard Analytical Files (SAF) used for this analysis were excluded.

Comment: One commenter stated that in the CY 2014 HH PPS proposed rule, there was no indication whether the audited HHAs were provided appeals rights and that the limited audit is unreliable for use in calculating payment rates. The commenter recommended that CMS continue to reject a downward adjustment to the average costs per visit calculation as a result of the audit findings since the HHAs audited do not represent the universe of HHAs, the auditors' findings were not subject to review, and cost report auditing is ''an ancient process which hasn't been done for years''. In

addition, a commenter stated that the 8 percent of costs were disallowed for unspecified reasons. Another commenter stated that home health agencies have no incentives for ensuring the accuracy of their cost reports and the data is inaccurate and not representative of the costs that agencies actually incur and that there is no way to determine the accuracy of the reports that CMS included in the sample. Commenters stated that the cost report does not separate costs between payers and the costs solely attributed to Medicare cannot be isolated and are higher than the costs for other payers.

Response: We contracted with a Medicare Administrative Contractor (MAC) to conduct audits on 2010 Medicare cost reports of 100 home health agencies. Since two providers did not provide the information needed to complete the audit, the MAC audited 98 HHA cost reports. As stated in the CY 2014 HH PPS proposed rule, the audited providers overstated their costs by about 8 percent. The overstatement of their costs was due to the inappropriate inclusion of costs, including but not limited to, excess salary expense and/or excess owner's compensation, private duty nursing costs, luxury auto expenses, non-allowable costs for marketing/advertising/public relations, Federal Tax returns for an HHA owner, landscaping fees for an HHA owner's home, and lobbying expenses. We note that any HHA that received an adjustment based on the audit of their cost report was sent a revised Notice of Program Reimbursement (NPR) letter. With each NPR, there was an attachment explaining the appeal rights to the provider. To date, none of the freestanding HHAs or the hospital-based HHAs filed an appeal.

We disagree with the commenters' claim that home health agencies have no incentives for ensuring the accuracy of their cost reports and that the CR data are inaccurate and not representative of the costs that agencies actually incur. Each HH cost report is required to be certified by the Officer or Director of the home health agency. Specifically, the HHA Medicare Cost Report (MCR) Form (CMS–1728–94) states the following:

> ''I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Home Health Agency Cost Report and the Balance Sheet and Statement of Revenue and Expenses prepared by ____ (provider name(s) and number(s) for the cost report beginning ____ and ending ____, and that to the best of my knowledge and belief, it is a true, correct and complete report prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.''

We also note that the HHA MCR referenced statement above includes the following:

> ''Misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.''

As always, we encourage providers to fill out the Medicare cost reports as accurately as possible.

Comment: Another commenter stated that CMS should look at the impact of the rebasing reductions on agencies that already have either negative or low margins. A commenter stated that MedPAC projected a smaller margin for freestanding HHAs than CMS calculated and that while the CMS projection is not an overall Medicare margin, the comparison shows the risks of CMS' approach to rebasing. The commenter stated that they projected a smaller margin in 2013 than CMS projected and suggested that the rebasing adjustment be no more than 1.75 percent in the aggregate in each of the years of rebasing phase-in. In addition, commenters performed their own impact analysis and provided the results of their analysis in the comment. Commenters stated that their analysis showed that 47 of the 50 States as well as District of Columbia will experience negative margins by 2017 if the rebasing adjustments are implemented, thereby causing access issues. Commenters stated that some states have negative margins currently or may have negative margins as early as CY 2014 if the rebasing adjustments are implemented. Providers from various states, such as but not limited to New Hampshire, North Carolina, South Carolina, Indiana, New Jersey, New York, Kansas, Michigan, Washington, Massachusetts, Pennsylvania, Virginia, Rhode Island, Connecticut, Texas, Hawaii, and California, stated that many if not all of the agencies in their state will have negative margins by 2017 if the rebasing adjustments are implemented. Commenters stated that they project that nearly three quarters of all home health agencies nationwide will experience net operating losses and that the national average Medicare margin will drop to −9.77 percent in 2017. A number of commenters stated that the rebasing cut is reminiscent of the actual impact of the interim payment system, which ''wiped out 31 percent of home health agencies between 1997 and 2000.'' Commenters stated that small to medium sized businesses would be disproportionately affected by the rebasing adjustments, including those operating in medically-underserved areas, and that this impact should have been assessed and quantified by CMS. Commenters also stated that hospital-based home health providers will be disproportionately affected by the rebasing cuts and that they treat patients with higher acuity or who are more complex. Commenters stated that hospital-based agencies already have negative margins and HHAs should be given an opportunity to generate a margin needed for ongoing investments to improve care. Other commenters stated that non-profit agencies would be adversely affected by the rebasing adjustments.

Response: It is important to note that the commenters' views on the impact of the rebasing reductions on margin are starkly different from MedPAC's predictions of HHA Medicare margins. As stated in their comment, MedPAC estimates that the cumulative net payment reduction to the national, standardized 60-day episode payment amount after four years will equal approximately 4 percent. MedPAC expressed concerns that the rebasing reductions were too modest and will do little to reduce home health agencies' unusually high profitability under Medicare, stating that payments are at an inappropriately high level for all agencies. In addition, in their 2013 Report to Congress, MedPAC recommended that rebasing should be implemented in two years and that the payment updates be eliminated. MedPAC stated in their 2013 Report to Congress, ''The Patient Protection and Affordable Care Act of 2010 includes reductions in payments for home health care, but these policies will leave home health agencies with margins well in excess of cost. Overpaying for home health services has negative financial consequences for the federal government and raises the Medicare premiums beneficiaries pay.''

We conducted analysis similar to that of the National Association for Home Care and Hospice (NAHC) on Medicare margins for 2011 as result of comments received (8,623 usable 2011 cost reports). We found that approximately 30 percent of HHAs reported having a negative margin in 2011. In addition, 10 percent of HHAs had negative margins for at least two of the past five years

(from 2007–2011), while 5 percent of HHAs, half of which were hospital-based HHAs, were operating with negative margins for all of the past five years (from 2007–2011). We question how an HHA can still be operating after at least 5 years with negative margins and whether these HHAs have incentives to report negative margins (such as cost shifting/allocation by hospitals amongst their various units). If we assume no behavior change, similar to analysis completed by NAHC, the data suggest that approximately 70 percent of HHAs would be operating with negative margins by 2017 when we take into account the proposed 3.5 percent reduction to the national, standardized 60-day payment rate and other proposed payment changes in the proposed rule. However, we also performed an analysis examining the accuracy of margin predictions. For our analysis, we developed margin predictions using prior year cost report data and predicted margins for future years given the policy changes finalized for the future years. We then compared the predicted margin to the actual margin calculated. Specifically, we used 2007, 2008, 2009, and 2010 cost report data and predicted margins one, two, and three years later. We then used cost report data to calculate the actual margins for those years. Our analysis showed that the actual margin is approximately three percentage points higher than the predicted median margin for each additional year of prediction. For example, using 2008 cost report data and predicting margins for 2009, 2010, and 2011, applying the payment policies implemented in each year and increasing costs by the full market basket update each year, the actual median margins were three, six, and nine percentage points higher than the predicted median margin, respectively. Similarly, the percentage of providers estimated to have negative margins is overestimated by five percentage points per year of prediction, on average. As such, we estimate that if the proposed payment changes were finalized, approximately 43 percent—not 70 percent— of providers would have negative margins in CY 2017 and that of the 43 percent of providers predicted to have negative margins, 77 percent of these providers already reported negative margins in 2011.

We note that the final rebasing adjustment to the national, standardized 60-day episode payment rate after incorporating complete 2012 claims data and comments received is an approximate reduction of 2.8 percent for 2014–2017 and the overall impact of all of the rebasing adjustments is about −2.7 percent. Re-running the margins analysis using the finalized payment changes and adjusting our predicted margins to account for differences we observed between previous predicted margins and actual margins, we estimated that approximately 40 percent of providers will have negative margins in CY 2017 and that of the 40 percent of providers predicted to have negative margins, 83 percent of these providers already reported negative margins in 2011.

With regards to comments about the interim payment system, we note that in their 2013 Report to Congress, MedPAC stated that during the interim payment system (1997–2000), when payments dropped by about 50 percent in two years, many agencies exited the program. However, new agencies entered the program (about 200 new agencies a year) and existing agencies expanded their service areas to enter markets left by exiting agencies. This is due in part to the low capital requirements for home health care services that allow the industry to react rapidly when the supply of agencies changes or contracts. Reviews of access found that access to care remained adequate during this period despite a substantial decline in the number of agencies (Liu *et al.* 2003).

Comment: Commenters stated that CMS should look at the impact of rebasing on LUPA episodes. A commenter stated that patients receiving LUPAs may be vulnerable beneficiaries and that agencies with higher LUPA numbers may have lower or negative overall margins. In addition, the commenter stated that if the normal episodes are rebased to estimated cost, but the LUPA episodes are paid at less than cost, the overall effect on agencies with any LUPA episodes will be negative margins. One commenter stated that CMS should study LUPA services and payment and adjust overall payment to at least cover the costs incurred by agencies serving the patients. Specifically, commenters stated that the rebasing adjustments for LUPA per visit payments should be higher than 3.5 percent a year and that the 3.5 percent limit in the Affordable Care Act refers to the overall impact of the rebasing changes, not the individual rebasing adjustment amounts. Another commenter stated that CMS should closely review the statutory provision to determine whether there is flexibility to further raise the LUPA payments and if not, to seek legislative authority that would permit payments to be raised to the estimated level of cost, stating that LUPA episodes guard against the incentive to get a full 60-day episode payment for episodes with low visit counts. In contrast, one commenter stated that they were concerned the proposed increases to LUPA episodes may encourage HHAs to stint therapy services to Medicare beneficiaries receiving care and further exacerbate the issue of cherry-picking in post-acute care settings. Commenters stated that CMS should make changes to LUPA payments separately from other policies in the rule and commenter cited the LUPA add-on payment as an example. A commenter suggested that CMS could eliminate the outlier adjustment in calculating the per-visit rates since outlier payments have been significantly below the 2.5 percent target for the last several years. Other commenters suggested that CMS rebase the system or fix the LUPA system by adding LUPA floor or non-LUPA episode percentage caps at the agency level instead of implementing reductions.

Response: We believe that the better reading of the statute requires us to apply rebasing adjustments to the individual payment amounts, not aggregate amounts. Therefore, we are applying the rebasing adjustments to the individual payment amounts. In addition, given the interpretation of the 3.5 percent limit as of the date of enactment of the Affordable Care Act, as mentioned by a commenter, the LUPA per-visit amounts will be increased by the maximum dollar limit calculated using CY 2010 payment amounts, as shown in Table 14. This results in slightly lower increases to the LUPA rates than originally proposed in the CY 2014 HH PPS proposed rule. We share commenters' concerns about the incentive issues surrounding LUPA payments. We re-examined our LUPA add-on methodology but did not find a basis for revising our proposal for rebasing the add-on. We note that we plan to monitor LUPA episodes and further examine LUPA-related payment policies in the new contract awarded to Abt Associates to perform follow-on work for the home health study and monitor impacts of rebasing and other recent payment changes.

Comment: Several commenters stated that they were concerned that the costs of NRS for hospital-based home health agencies were not captured since Form CMS–2552–10 doesn't allow the reporting of these Medicare costs.

Response: NRS costs for hospital-based HHAs were included in calculation of the 2011 average NRS cost per visit. These costs are to be reported on CMS form 2552–10, worksheet H, line 12.

Comment: A commenter stated that in the CY 2014 HH PPS proposed rule, CMS states that there are a significant number of agencies that did not properly report NRS cost on their cost report, yet CMS seemed to use their data in rebasing the NRS Conversion Factor. The commenter urged CMS to either recalculate the NRS rebasing using validated, accurate data, or hold off on rebasing the NRS Conversion Factor until better data becomes available.

Response: In the CY 2014 HH PPS proposed rule, we noted that a significant number of HHAs (1,756) listed charges for NRS on the home health claim, but did not list any NRS costs on the cost report (78 FR 40290). As we stated in the CY 2014 HH PPS proposed rule, we calculated the average NRS cost per visit using the same cost report sample used to calculate the other adjustments to the national, standardized 60-day episode payment amount and the national per-visit rates, thus maintaining a consistent approach (78 FR 40289). We remind the industry again that each home health cost report is required to be certified by the Officer or Director the home health agency. We also welcome suggestions for improving compliance and accuracy on cost reports within the current cost reporting forms.

Comment: Commenters stated that the CY 2014 HH PPS proposed rule did not include a detailed and cumulative quantitative analysis of the impact and economic effects of the proposed provisions nor a cumulative cost analysis or quantification of the rule's projected future costs that is required for any economically significant regulation under Executive Orders 13563 and 12866. Commenters also stated that CMS should take into account the other Affordable Care Act mandated reductions (adjustments to the home health market basket updates, productivity adjustments, and outlier payment reduction), case-mix reductions, and sequestration, when developing the rebasing adjustments. A commenter stated that the impact analysis should look at access to care and should describe the locales where care is provided rather than gross aggregate impacts. The commenter stated that the impact analysis should look at the overall impact on the financial viability of HHAs rather than on the reduction in revenue and should look at the overall impact on Medicare spending in all relevant sectors, such as the inpatient hospitalization and skilled nursing facility care. Another commenter stated that CMS should consider the role that HHAs play in reducing the overall costs of health care by treating patients in a lower cost setting than institutional care. Many commenters stated that a multi-year analysis of the impact of the payment cuts should be performed, instead of a one-year impact analysis.

Response: Executive Orders 13563 and 12866 require us to assess the costs, benefits, and transfer effects of rulemaking. Because the most quantifiable impact of the rule is the transfer effect associated with Medicare payments (revenues), we focus our analysis on the impact of various policy proposals on payments from one year to the next. While we acknowledge that many factors and statutory requirements affect home health agencies, given the lack of data on local market conditions and individual provider's operations, we cannot provide the detailed analysis suggested by the commenters. We note that the net reduction in payments to HHAs in this final rule of 1.05 percent for CY 2014 is less than the net reduction in the proposed rule of 1.5 percent and less than the net reductions in prior years, notably the −4.89 percent net reduction in payments to HHAs in CY 2011.

Executive Order 13563 specifies, to the extent practicable, agencies should assess the costs of cumulative regulations. However, given potential utilization pattern changes, wage index changes, changes to the market basket forecasts, and unknowns regarding future policy changes, we believe it is neither practicable nor appropriate to forecast the cumulative impact of the rebasing adjustments on Medicare payments to HHAs for future years at this time. Changes to the Medicare program may continue to be made as a result of the Affordable Care Act, or new statutory provisions. Although these changes may not be specific to the HH PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes would make it difficult to predict accurately the full scope of the impact upon HHAs for future years beyond CY 2014.

Comment: Commenters stated that contrary to the Regulatory Flexibility Act (RFA), the CY 2014 HH PPS proposed rule doesn't include a detailed analysis of its impact on small businesses. A commenter also cited the Data Quality Act, stating there are detailed analytic requirements on federal agencies prior to issuing economically significant regulations. Commenters noted that the CY 2014 HH PPS proposed rule was of sufficient concern to the U.S. Small Business Administration that it felt compelled to issue a Regulatory Alert to HHAs and other small businesses to submit comments on the CY 2014 HH PPS proposed rule. Another commenter stated that most home health agencies meet the U.S. Small Business Administration's definition of a small business and that the smallest home health agencies already have net negative Medicare margins and serve a disproportionate share of vulnerable patient populations. A commenter submitted a report on the impact of home health rebasing on small business as well as a state level impact analysis of rebasing performed by two contractors.

Response: 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 $7.0 million to $34.5 million in any 1 year. For the purposes of the RFA, we estimate that almost all HHAs are small entities as that term is used in the RFA. The economic impact assessment is based on estimated Medicare payments (revenues) and HHS's practice in interpreting the RFA is to consider effects economically ''significant'' only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. However, the estimated impact for CY 2014 in the CY 2014 HH PPS proposed rule was −1.5 percent, under the threshold of 3–5 percent to be considered significant. Included in table 33 in section VII is an estimate of the impacts according to HHA type, area, and number of first episodes. According to the impact table for this final rule, the overall estimated impact is −1.05 percent, with HHAs that have less than 100 first episodes experiencing estimated decreases in Medicare revenues of −1.27 percent and HHAs with 1,000 or more first episodes experiencing estimated decreases in Medicare revenues of −0.90 percent.

While commenters mentioned the Data Quality Act (section 515(a) of the Treasury and General Government Appropriations Act for Fiscal Year 2001 (Pub. L. 106–554)) in public comments, they did not state that CMS was not in compliance. The Data Quality Act directed the OMB to issue government-wide guidelines that provide policy and procedural guidance to federal agencies for ensuring and maximizing the quality, objectivity, utility, and integrity of information, including statistical

information, disseminated by federal agencies. We believe that we have complied with section 3131(a) of the Affordable Care Act in a straightforward and transparent manner and that we adhered to the principles of the Data Quality Act by ensuring that the information provided to the industry was of sufficient quality, objectivity, utility, and integrity. We provided the industry with detailed information on our calculations in the preamble of the CY 2014 HH PPS proposed rule as well supporting documentation in the form of a public use file and a technical rebasing report posted on the HHA Center Web site at: *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html*.

Comment: Another commenter recommended that CMS develop a detailed plan for monitoring the impact of any HH PPS payment reductions (such as by examining measures relating to beneficiary access, quality of care and beneficiary experience of care) and that CMS commit to reporting to Congressional Committees of jurisdiction, the Medicare Payment Advisory Commission, and the public the results of this ongoing monitoring effort. The commenter stated that CMS should use authority available to the agency to ensure Medicare beneficiaries have appropriate access to home health.

Response: As we noted above, we recently awarded a contract to Abt Associates that will, among other things, develop and implement a system for monitoring access to care. We will make every effort to ensure that beneficiaries, and in particular vulnerable patient populations, continue to have access to quality home health care. We believe the four year phase-in of the rebasing adjustment will lessen any impact on access as HHAs develop ways to increase efficiencies while maintaining quality of care. As mandated in section 3131(a) of the Affordable Care Act and also noted above, MedPAC will conduct a study on the rebasing implementation, which will include an impact analysis on access to care, and submit a Report to Congress no later than January 1, 2015, along with any potential recommendations, if necessary.

Final Decisions:

Based on comments received, and section 3131(a) statutory language describing the maximum adjustment amounts for rebasing, we are finalizing a $80.95 reduction to the national, standardized 60-day episode payment rate in each year, CY 2014 through CY 2017. Section 3131(a) of the Affordable Care Act requires that the rebasing adjustment must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the payment amount (or amounts) as of the date of enactment (March 23, 2010). As described earlier, the maximum adjustment for the national, standardized 60-day payment rate is calculated to be $80.95 ($2,312.94 * 0.035). When determining the CY 2014 base payment amount, we will apply the $80.95 reduction to the CY 2013 base payment amount (which has been increased due to the resetting of the case-mix weights to 1.0000). Please see Section E for more details on the finalized CY 2014 payment rates. For CY 2015 through CY 2017, we will apply a $80.95 reduction to the previous year's base payment amount prior to the annual HH PPS payment update percentage.

Similar to the rebasing adjustment for the national, standardized 60-day payment rate, we are finalizing equal dollar adjustments to the per-visit payment amounts for CY 2014 through CY 2017, as shown in Tables 14 and 15. The adjustments to the national per-visit payment rates are capped at 3.5 percent of the national per-visit payment amounts in CY 2010, which are lower than the CY 2013 per-visit amounts. Therefore, the maximum adjustments to the national per-visit payment rates allowed by statute, and finalized in this final rule, are lower than the adjustments we proposed.

We are finalizing a reduction to the NRS conversion factor in each year from 2014 through 2017 of 2.82 percent, or $1.52 in CY 2014. Taking into account the statutory language stating that the amount of any adjustment for the year may not exceed 3.5 percent of the amount as of the date of enactment of the Affordable Care Act, we determined, as described in the preamble language above, that the final reduction to the NRS conversion factor of 2.82 percent in CY 2014 would not exceed 3.5 percent of the CY 2010 NRS conversion factor of $53.34 (53.34 * 0.035 = $1.87). In addition, we believe there is a very low likelihood that future adjustments of −2.82 percent in CY 2015 through 2017 would ever exceed the statutory limit. As such, we are finalizing a reduction to the NRS conversion factor of 2.82 percent each year from CY 2014 through CY 2017.

Section IV.E.4 contains the finalized payment rates for CY 2014 for the National, Standardized 60-day Episode Payment Amount, LUPA Per-Visit Payment Amounts, and Nonroutine Medical Supply (NRS) Conversion Factor, accounting for the rebasing adjustments.

E. CY 2014 Home Health Payment Rate Update

1. CY 2014 HH Market Basket Update

Section 1895(b)(3)(B) of the Act, as amended by section 3401(e) of the Affordable Care Act, adds new clause (vi) which states, ''After determining the home health market basket percentage increase . . . the Secretary shall reduce such percentage . . . for each of 2011, 2012, and 2013, by 1 percentage point. The application of this clause may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year.'' Therefore, as mandated by the Affordable Care Act, for CYs 2011, 2012, and 2013, the HH market basket update was reduced by 1 percentage point. For CY 2014, there is no such percentage reduction. Therefore, the HH PPS payment update percentage increase to the CY 2014 payment rates will be the full HH market basket update.

Section 1895(b)(3)(B) of the Act requires that the standard prospective payment amounts for CY 2014 be increased by a factor equal to the applicable HH market basket update for those HHAs that submit quality data as required by the Secretary. The HH PPS market basket update for CY 2014 is 2.3 percent. This is based on Global Insight Inc.'s third quarter 2013 forecast, utilizing historical data through the second quarter of 2013. The HH market basket was rebased and revised in CY 2013. A detailed description of how we derive the HHA market basket is available in the CY 2013 HH PPS final rule (77 FR 67080, 67090).

The following is a summary of the comments we received regarding the home health market basket update.

Comment: A commenter supports CMS's proposal to provide a full market basket increase. The commenter further requests that CMS support future market basket increases, which are important to HHAs feeling the impact of several years of market basket reductions. The commenter also states that providers are preparing for a productivity adjustment cut effective in 2015.

Response: We appreciate the comment in support of using the full market basket update. The reductions to the market basket updates in previous years had been required by various statutes. Likewise, the productivity adjustment that would begin in CY 2015 is a statutory requirement and as such, we do not have the authority to waive

the application of the productivity adjustment.

Final Decision: For CY 2014, as required by section 1895(b)(3)(B) of the Act, the HH PPS payment update percentage will be 2.3 percent.

e. Home Health Care CAHPS® Survey (HHCAHPS®)

In the CY 2013 HH PPS final rule (77 FR 67094), we stated that the HH quality measures reporting requirements for Medicare-certified agencies includes the CAHPS® HH Care (HHCAHPS®) Survey for the CY 2013 APU. We maintained the stated HHCAHPS® data requirements for CY 2013 that were set out in the CY 2012 HH PPS final rule, and in the CY 2013 HH PPS final rule, for the continuous monthly data collection and quarterly data submission of HHCAHPS® data.

(1) Background and Description of HHCAHPS®

As part of the HHS' Transparency Initiative, we have implemented a process to measure and publicly report patient experiences with home health care, using a survey developed by the Agency for Healthcare Research and Quality's (AHRQ's) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program and endorsed by the NQF in March 2009 (NQF Number 0517). The HHCAHPS® survey is part of a family of CAHPS® surveys that asks patients to report on and rate their experiences with health care. The Home Health Care CAHPS® (HHCAHPS®) survey presents home health patients with a set of standardized questions about their home health care providers and about the quality of their home health care.

Prior to this survey, there was no national standard for collecting information about patient experiences that will enable valid comparisons across all HHAs. The history and development process for HHCAHPS® has been described in previous rules and it also available on the official HHCAHPS® Web site at *https://homehealthcahps.org* and in the annually-updated *HHCAHPS® Protocols and Guidelines Manual,* which is downloadable from *https://homehealthcahps.org*.

For public reporting purposes, we report five measures from the HHCAHPS® Survey—three composite measures and two global ratings of care that are derived from the questions on the HHCAHPS® survey. The publicly reported data are adjusted for differences in patient mix across HHAs. We update the HHCAHPS® data on Home Health Compare on *www.medicare.gov* quarterly. Each HHCAHPS® composite measure consists of four or more individual survey items regarding one of the following related topics:

- Patient care (Q9, Q16, Q19, and Q24);
- Communications between providers and patients (Q2, Q15, Q17, Q18, Q22, and Q23); and
- Specific care issues on medications, home safety, and pain (Q3, Q4, Q5, Q10, Q12, Q13, and Q14).

The two global ratings are the overall rating of care given by the HHA's care providers (Q20), and the patient's willingness to recommend the HHA to family and friends (Q25).

The HHCAHPS® survey is currently available in English, Spanish, Chinese, Russian, and Vietnamese. The OMB Number on these surveys is the same (0938–1066). All of these surveys are on the Home Health Care CAHPS® Web site, *https://homehealthcahps.org*. We will continue to consider additional language translations of the HHCAHPS® in response to the needs of the home health patient population.

All of the requirements about home health patient eligibility for the HHCAHPS® survey and conversely, which home health patients are ineligible for the HHCAHPS® survey are delineated and detailed in the *HHCAHPS® Protocols and Guidelines Manual,* which is downloadable at *https://homehealthcahps.org*. Home health patients are eligible for HHCAHPS® if they received at least two skilled home health visits in the past 2 months, which are paid for by Medicare or Medicaid.

Home health patients are *ineligible* for inclusion in HHCAHPS® surveys if one of these conditions pertains to them:

- Are under the age of 18;
- Are deceased prior to the date the sample is pulled;
- Receive hospice care;
- Receive routine maternity care only;
- Are not considered survey eligible because the state in which the patient lives restricts release of patient information for a specific condition or illness that the patient has; or
- No Publicity patients, defined as patients who on their own initiative at their first encounter with the HHAs make it very clear that no one outside of the agencies can be advised of their patient status, and no one outside of the HHAs can contact them for any reason.

We stated in previous rules that Medicare-certified HHAs are required to contract with an approved HHCAHPS® survey vendor. Medicare-certified agencies also must provide on a monthly basis a list of their patients served to their respective HHCAHPS® survey vendors. Agencies are not allowed to influence at all how their patients respond to the HHCAHPS® survey.

HHCAHPS® survey vendors are required to attend introductory and all update trainings conducted by CMS and the HHCAHPS® Survey Coordination Team, as well as to pass a post-training certification test. We now have approximately 30 approved HHCAHPS® survey vendors. The list of approved HHCAHPS® survey vendors is available at *https://homehealthcahps.org*.

(2) HHCAHPS® Oversight Activities

We stated in prior final rules that all approved HHCAHPS® survey vendors are required to participate in HHCAHPS® oversight activities to ensure compliance with HHCAHPS® protocols, guidelines, and survey requirements. The purpose of the oversight activities is to ensure that approved HHCAHPS® survey vendors follow the *HHCAHPS® Protocols and Guidelines Manual.* As stated previously in the CY 2010, CY 2011, CY 2012, and CY 2013 final rules, all approved survey vendors must develop a Quality Assurance Plan (QAP) for survey administration in accordance with the *HHCAHPS® Protocols and Guidelines Manual.* An HHCAHPS® survey vendor's first QAP must be submitted within 6 weeks of the data submission deadline date after the vendor's first quarterly data submission. The QAP must be updated and submitted annually thereafter and at any time that changes occur in staff or vendor capabilities or systems. A model QAP is included in the *HHCAHPS® Protocols and Guidelines Manual.* The QAP must include the following:

- Organizational Background and Staff Experience
- Work Plan
- Sampling Plan
- Survey Implementation Plan
- Data Security, Confidentiality and Privacy Plan
- Questionnaire Attachments

As part of the oversight activities, the HHCAHPS® Survey Coordination Team conducts on-site visits to all approved HHCAHPS® survey vendors. The purpose of the site visits is to allow the HHCAHPS® Coordination Team to observe the entire HHCAHPS® Survey implementation process, from the sampling stage through file preparation and submission, as well as to assess data security and storage. The HHCAHPS® Survey Coordination Team reviews the HHCAHPS® survey vendor's survey systems, and assesses administration

protocols based on the *HHCAHPS® Protocols and Guidelines Manual* posted at *https://homehealthcahps.org*. The systems and program site visit review includes, but is not limited to the following:

- Survey management and data systems;
- Printing and mailing materials and facilities;
- Telephone call center facilities;
- Data receipt, entry and storage facilities; and
- Written documentation of survey processes.

After the site visits, HHCAHPS® survey vendors are given a defined time period in which to correct any identified issues and provide follow-up documentation of corrections for review. HHCAHPS® survey vendors are subject to follow-up site visits on an as-needed basis.

In the CY 2013 HH PPS final rule (77 FR 67094, 67164), we codified the current guideline that all approved HHCAHPS® survey vendors fully comply with all HHCAHPS® oversight activities. We included this survey requirement at § 484.250(c)(3).

(3) HHCAHPS® Requirements for the CY 2015 APU

In the CY 2013 HH PPS final rule (77 FR 67094), we stated that for the CY 2015 APU, we will require continued monthly HHCAHPS® data collection and reporting for 4 quarters. The data collection period for CY 2015 APU includes the second quarter 2013 through the first quarter 2014 (the months of April 2013, through March 2014). HHAs are required to submit their HHCAHPS® data files to the HHCAHPS® Data Center for the second quarter 2013 by 11:59 p.m., e.d.t. on October 17, 2013; for the third quarter 2013 by 11:59 p.m., e.s.t. on January 16, 2014; for the fourth quarter 2013 by 11:59 p.m., e.d.t. on April 17, 2014; and for the first quarter 2014 by 11:59 p.m., e.d.t. on July 17, 2014. These deadlines are firm; no exceptions are permitted.

We will continue to exempt HHAs receiving Medicare certification on or after April 1, 2013, from the full HHCAHPS® reporting requirement for the CY 2015 APU because these HHAs will not have been Medicare-certified throughout the period of April 1, 2012 through March 31, 2013. These HHAs do not need to complete a HHCAHPS® Participation Exemption Request form for the CY 2015 APU.

We require that all HHAs that had fewer than 60 HHCAHPS®-eligible unduplicated or unique patients in the period of April 1, 2012, through March 31, 2013 are exempt from the HHCAHPS® data collection and submission requirements for the CY 2015 APU. Agencies with fewer than 60 HHCAHPS®-eligible, unduplicated or unique patients in the period of April 1, 2012, through March 31, 2013 are required to submit their patient counts on the HHCAHPS® Participation Exemption Request form for the CY 2015 APU, posted on *https://homehealthcahps.org* on April 1, 2013, by 11:59 p.m., e.d.t. on January 16, 2014. This deadline is firm, as is true of all quarterly data submission deadlines.

(4) HHCAHPS® Requirements for the CY 2016 APU

For the CY 2016 APU, we require continued monthly HHCAHPS® data collection and reporting for 4 quarters. The data collection period for the CY 2016 APU includes the second quarter 2014 through the first quarter 2015 (the months of April 2014 through March 2015). HHAs will be required to submit their HHCAHPS® data files to the HHCAHPS® Data Center for the second quarter 2014 by 11:59 p.m., e.d.t. on October 16, 2014; for the third quarter 2014 by 11:59 p.m., e.s.t. on January 15, 2015; for the fourth quarter 2014 by 11:59 p.m., e.d.t. on April 16, 2015; and for the first quarter 2015 by 11:59 p.m., e.d.t. on July 16, 2015. These deadlines will be firm; no exceptions will be permitted.

We will exempt HHAs receiving Medicare certification after the period in which HHAs do their patient count (April 1, 2013 through March 31, 2014) on or after April 1, 2014, from the full HHCAHPS® reporting requirement for the CY 2016 APU, because these HHAs will not have been Medicare-certified throughout the period of April 1, 2013, through March 31, 2014. These HHAs will not need to complete a HHCAHPS® Participation Exemption Request form for the CY 2016 APU.

We require that all HHAs that had fewer than 60 HHCAHPS®-eligible unduplicated or unique patients in the period of April 1, 2013, through March 31, 2014 are exempt from the HHCAHPS® data collection and submission requirements for the CY 2016 APU, upon completion of the Participation Exemption Request form. Agencies with fewer than 60 HHCAHPS-eligible, unduplicated or unique patients in the period of April 1, 2013, through March 31, 2014, will be required to submit their patient counts on the HHCAHPS® Participation Exemption Request form for the CY 2016 APU posted on *https://homehealthcahps.org* on April 1, 2014, by 11:59 p.m., e.s.t. on January 15, 2015. This deadline will be firm, as will be all of the quarterly data submission deadlines.

(5) HHCAHPS® Reconsiderations and Appeals Process

HHAs should monitor their respective HHCAHPS® survey vendors to ensure that vendors submit their HHCAHPS® data on time, by accessing their HHCAHPS® Data Submission Reports on *https://homehealthcahps.org*. This will help HHAs ensure that their data are submitted in the proper format for data processing to the HHCAHPS® Data Center.

We will continue the HHCAHPS® reconsiderations and appeals process that we have finalized and that we have used for the CY 2012 APU and for the CY 2013 APU. We have described the HHCAHPS® reconsiderations process requirements in the Technical Direction Letter that CMS sends to the affected HHAs, on or about the first Friday in September. HHAs have 30 days from their receipt of the Technical Direction Letter informing them that they did not meet the HHCAHPS requirements for the CY period, to send all documentation that supports their requests for reconsideration to CMS. It is important that the affected HHAs send in comprehensive information in their reconsideration letter/package because CMS will not contact the affected HHAs to request additional information or to clarify incomplete or inconclusive information. If clear evidence to support a finding of compliance is not present, the 2 percent reduction in the APU will be upheld. If clear evidence of compliance is present, the 2 percent reduction for the APU will be reversed. We will notify affected HHAs by about mid-December. If we determine to uphold the 2 percent reduction, the HHA may further appeal the 2 percent reduction via the Provider Reimbursement Review Board (PRRB) appeals process.

The following is a summary of the comments we received regarding HHCAHPS®:

Comment: We received a comment that supported HHCAHPS® as a useful tool for quality improvement and for empowering patients as equal partners in their plans of health care. This commenter said that member providers have used the HHCAHPS® survey to identify high-risk patients and to provide additional care support to them in managing their illnesses.

Response: We are very happy to hear these statements of support for HHCAHPS® and to learn about how providers are using the survey for quality improvement.

Comment: We received a comment that HHCAHPS® is an unfunded administrative burden on HHAs as a mandate that requires significant time to work with CMS's approved vendor selected by the provider.

Response: The collection of the patient's perspectives of care data for similar CAHPS® surveys, such as Hospital CAHPS®, follow the same model where providers pay the approved survey vendors for the HHCAHPS® data collection, and CMS pays for the HHCAHPS® survey vendor approval process, survey vendor training, technical support and assistance for home health agencies and for the vendors, monitoring and oversight of the vendors, and data analysis and public reporting of the HHCAHPS® survey data. HHAs are strongly encouraged to report their respective HHCAHPS® costs on their cost reports but should note that the HHCAHPS® costs are not reimbursable under the HH PPS. CMS strongly encourages HHAs to shop around for the best cost value for them before choosing and contracting with an approved HHCAHPS® vendor to conduct the HHCAHPS® survey on their behalf.

Comment: We received comments that CMS requires the use of external CMS-approved vendors but holds the home health agencies responsible for assuring that these vendors perform properly. These commenters emphasized that CMS should change this policy and monitor the performance of the outside vendors and penalize the vendors, not the home health agencies, if the vendors fail to perform.

Response: We believe that HHAs must monitor their vendors to ensure that vendors submit data on time, by using the information that is available to them on the HHCAHPS® Data Submission Reports. This will also ensure that data is submitted in the proper format, and will subsequently be successfully submitted to the HHCAHPS® Data Center.

If CMS or the CMS Data Warehouse contractor become aware that an HHCAHPS vendor has significant issues that would put HHAs at risk for not meeting the APU requirements, CMS and the CMS Contractor will immediately alert the affected HHAs. The intent of this alert is to provide these agencies with sufficient time to switch vendors and to ensure that the HHAs will not be penalized if their data collection activities are interrupted because of circumstances outside of their control. HHAs are strongly encouraged to call email *hhcahps@rti.org* or telephone RTI, the federal contractor, at (866) 354–0954, to change vendors and to ensure that their HHCAHPS® data collection will continue. HHAs are always advised to check the official HHCAHPS® Web site, *https://homehealthcahps.org* for all information about HHCAHPS®. In the event that CMS has found problems with a vendor, we would also note this next to the vendor name on the vendor list that is posted on *https://homehealthcahps.org*. If we find that a vendor does not comply with HHCAHPS® protocols and guidelines for the implementation of the HHCAHPS® survey, or correct their deficiencies in a timely manner, then we will remove that vendor from the approved list.

Final Decision: We are not recommending any changes as a result of comments received.

f. Summary of Changes in CY 2014 for the HHCAHPS® Survey

For the CY 2014 HH PPS Final Rule, we are finalizing the proposed requirements for HHCAHPS® as proposed in the CY 2014 HH PPS Proposed Rule.

g. For Further Information on the HHCAHPS® Survey

We strongly encourage HHAs to learn about the survey and view the HHCAHPS® Survey Web site at the official Web site for the HHCAHPS® at *https://homehealthcahps.org*. HHAs can also send an email to the HHCAHPS® Survey Coordination Team at *HHCAHPS@rti.org*, or telephone toll-free (1–866–354–0985) for more information about HHCAHPS®.

2. Home Health Quality Reporting Program (HHQRP)

a. General Considerations Used for Selection of Quality Measures for the HHQRP

The successful development of the HH Quality Reporting Program (HHQRP) that promotes the delivery of high quality healthcare services is our paramount concern. We seek to adopt measures for the HHQRP that promote efficient and safer care. Our measure selection activities for the HHQRP takes into consideration input we receive from the Measure Applications Partnership (MAP), convened by the National Quality Forum (NQF). The MAP is a public-private partnership comprised of multi-stakeholder groups convened for the primary purpose of providing input to CMS on the selection of certain categories of quality and efficiency measures, as required by section 1890A(a)(3) of the Social Security Act (the Act). By February 1st of each year, the NQF must provide that input to CMS. Input from the MAP is located at *http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx*. For more details about the pre-rulemaking process, see the FY 2013 IPPS/LTCH PPS final rule at 77 FR 53376 (August 31, 2012). We also take into account national priorities, such as those established by the National Priorities Partnership at *http://www.qualityforum.org/npp/*, the HHS Strategic Plan *http://www.hhs.gov/secretary/about/priorities/priorities.html*, and the National Strategy for Quality Improvement in Healthcare located at *http://www.ahrq.gov/workingforquality/nqs/nqsplans.pdf*.

To the extent practicable, we have sought to adopt measures that have been endorsed by the national consensus organization, under contract to endorse standardized healthcare quality measures pursuant to section 1890 of the Act, recommended by multi-stakeholder organizations, and developed with the input of providers, purchasers/payers, and other stakeholders.

b. Background and Quality Reporting Requirements

Section 1895(b)(3)(B)(v)(II) of the Act states that ''each home health agency shall submit to the Secretary such data that the Secretary determines are appropriate for the measurement of health care quality. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause.''

In addition, section 1895(b)(3)(B)(v)(I) of the Act states that ''for 2007 and each subsequent year, in the case of a home health agency (HHA) that does not submit data to the Secretary in accordance with subclause (II) with respect to such a year, the HH market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points.'' This requirement has been codified in regulations at § 484.225(i). HHAs that meet the quality data reporting requirements are eligible for the full HH market basket percentage increase. HHAs that do not meet the reporting requirements are subject to a 2 percentage point reduction to the HH market basket increase.

Section 1895(b)(3)(B)(v)(III) of the Act further states that ''[t]he Secretary shall establish procedures for making data submitted under sub clause (II) available to the public. Such procedures shall ensure that a HHA has the opportunity to review the data that is to be made

public with respect to the agency prior to such data being made public.''

As codified at § 484.250(a), we established that the quality reporting requirements could be met by the submission of OASIS assessments and HH Care Consumer Assessment of Healthcare Providers and Systems Survey (HHCAHPS®). CMS has provided quality measures to HHAs via the Certification and Survey Provider Enhanced Reports (CASPER) reports available on the CMS Health Care Quality Improvement System (QIES) since 2002. A subset of the HH quality measures has been publicly reported on the HH Compare Web site since 2003. The CY 2012 HH PPS final rule (76 FR 68576), identifies the current HH QRP measures. The selected measures that are made available to the public can be viewed on the HH Compare Web site located at *http://www.medicare.gov/HHCompare/Home.asp*.

As stated in the CY 2012 and CY2013 HH PPS final rules (76 FR 68575 and 77 FR 67093, respectively), we finalized that we will also use measures derived from Medicare claims data to measure HH quality.

c. OASIS Data Submission and OASIS Data for Annual Payment Update

The HH conditions of participation (CoPs) at § 484.55(d) require that the comprehensive assessment must be updated and revised (including the administration of the OASIS) no less frequently than: (1) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a beneficiary elected transfer, significant change in condition, or discharge and return to the same HHA during the 60-day episode; (2) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests; and (3) at discharge.

It is important to note that to calculate quality measures from OASIS data, there must be a complete quality episode, which requires both a Start of Care (initial assessment) or Resumption of Care OASIS assessment and a Transfer or Discharge OASIS assessment. Failure to submit sufficient OASIS assessments to allow calculation of quality measures, including transfer and discharge assessments, is failure to comply with the CoPs.

HHAs do not need to submit OASIS data for those patients who are excluded from the OASIS submission requirements under the HH CoPs § 484.1 through § 484.265. As described in the December 23, 2005 Medicare and Medicaid Programs: Reporting Outcome and Assessment Information Set Data as Part of the Conditions of Participation for Home Health Agencies final rule (70 FR 76202), we define the exclusion as those patients:

- Receiving only nonskilled services;
- For whom neither Medicare nor Medicaid is paying for HH care (patients receiving care under a Medicare or Medicaid Managed Care Plan are not excluded from the OASIS reporting requirement);
- Receiving pre- or post-partum services; or
- Under the age of 18 years.

As set forth in the CY 2008 HH PPS final rule (72 FR 49863), HHAs that become Medicare-certified on or after May 31 of the preceding year are not subject to the OASIS quality reporting requirement nor any payment penalty for quality reporting purposes for the following year. For example, HHAs certified on or after May 31, 2013 are not subject to the 2 percentage point reduction to their market basket update for CY 2014. These exclusions only affect quality reporting requirements and do not affect the HHA's reporting responsibilities as announced in the December 23, 2005 final rule, Medicare and Medicaid Programs; Reporting Outcome and Assessment Information Set Data as Part of the Conditions of Participation for Home Health Agencies (70 FR 76202).

d. Home Health Care Quality Reporting Program Requirements for CY 2014 Payment and Subsequent Years

(1) Submission of OASIS Data

For CY 2014, we proposed to consider OASIS assessments submitted by HHAs to CMS in compliance with HH CoPs and Conditions for Payment for episodes beginning on or after July 1, 2012, and before July 1, 2013 as fulfilling one portion of the quality reporting requirement for CY 2014. This time period will allow for 12 full months of data collection and will provide us with the time necessary to analyze and make any necessary payment adjustments to the payment rates for CY 2014. We proposed to continue this pattern for each subsequent year beyond CY 2014, considering OASIS assessments submitted in the time frame between July 1 of the calendar year 2 years prior to the calendar year of the Annual Payment Update (APU) effective date and July 1 of the calendar year 1 year prior to the calendar year of the APU effective date as fulfilling the OASIS portion of the quality reporting requirement for the subsequent APU.

The following is a summary of the comments we received regarding the submission of OASIS assessments to fulfill one portion of the quality reporting requirement for CY 2014 Payment and Subsequent Years.

Comment: Several commenters supported the proposals regarding considering OASIS assessments as fulfilling one portion of the quality reporting requirement for CY2014 and each subsequent year. We received no comments in opposition.

Response: We appreciate the commenters' support for the proposals.

Final Decision: After considering all of the comments we received, we are finalizing the proposals as proposed. CMS will consider OASIS assessments submitted by HHAs to CMS in compliance with the HH CoPs and Conditions for Payment for episodes beginning on or after July 1, 2012, and before July for episodes beginning on or after July 1, 2012, and before July 1, 2013 as fulfilling one portion of the quality reporting requirement for CY 2014. We will also continue this pattern for each subsequent year beyond CY 2014, considering OASIS assessments submitted for episodes beginning on July 1st of the calendar year 2 years prior to the calendar year of the APU effective date and ending June 30th of the calendar year 1 year prior to the calendar year of the APU effective date as fulfilling the OASIS portion of the HH quality reporting requirement. HHA OASIS assessments will be considered complete if they comply with the HH CoPs and Conditions for Payment that apply to the applicable year.

(2) Home Health Rehospitalization and Emergency Department (ED) Use Without Readmission Claims-Based Measures

We proposed to adopt two claims-based measures: (1) Rehospitalization during the first 30 days of HH; and (2) Emergency Department Use without Hospital Readmission during the first 30 days of HH. These measures were included on the Measures Under Consideration list reviewed by the MAP in December 2012 and the MAP supported the direction of both measures. The Rehospitalization during the first 30 days of HH measure estimates the risk-standardized rate of unplanned, all-cause hospital readmissions for patients who had an acute inpatient hospitalization in the 5 days before the start of their HH stay and were admitted to an acute care hospital during the 30 days following the start of the HH stay. The Emergency Department Use without Readmission measure estimates the risk-standardized rate of unplanned, all-cause use of an emergency department for patients who

had an acute inpatient hospitalization in the 5 days before the start of a HH stay and used an emergency department, yet were not admitted to an acute care hospital during the 30 days following the start of a HH stay.

We worked to develop a set of quality measures to report on HH patients who are recently hospitalized as these patients are at an increased risk of acute care hospital use, either through inpatient admission or emergency department use without inpatient admission. Addressing unplanned hospital readmissions is a high priority for HHS as our focus continues on promoting patient safety, eliminating healthcare associated infections, improving care transitions, and reducing the cost of healthcare. Readmissions are costly to the Medicare program and have been cited as sensitive to improvements in coordination of care and discharge planning for patients. Rates of rehospitalization remain substantial with 14.4 percent of HH patients experiencing an unplanned rehospitalization in the first 30 days of care. Currently, HHAs focus on measures of acute care hospitalization (applied to all HH patients) as a measure of their effectiveness. We will continue to publicly report the Acute Care Hospitalization and Emergency Department Use without Hospitalization measures, as these measures apply to all home health patients and will continue to be useful in selecting a home health agency. The rehospitalization measures will allow HHAs to further target patients who entered HH after a hospitalization.

The measures of acute care utilization by previously hospitalized patients are developed out of the NQF endorsed claims-based measures: (1) Acute Care Hospitalization (NQF #0171); and (2) Emergency Department Use without Hospitalization (NQF #0173) to better capture acute care hospitalizations and use of an emergency department for patients who are recently discharged from the hospital. These rehospitalization measures are harmonized with NQF-endorsed Hospital-Wide Risk-Adjusted All-Cause Unplanned Readmission Measure (NQF #1789) (*see http://www.qualityforum.org/Publications/2012/07/Patient_Outcomes_All-Cause_Readmissions_Expedited_Review_2011.aspx*) finalized for the Hospital IQR Program in the FY 2013 IPPS/LTCH PPS Final Rule (77 FR 53521 through 53528). Further, to the extent appropriate, the HH rehospitalization measures are harmonized with this measure and other measures of readmission rates developed for post-acute care (PAC) settings.

We intend to seek NQF endorsement of the: (1) Rehospitalization during the first 30 days of HH; and (2) Emergency Department Use without Readmission during the first 30 days of HH measures. We proposed to begin reporting feedback to HHAs on performance on these measures in CY 2014. These measures will be added to Home Health Compare for public reporting in CY 2015. Additional details pertaining to these measures, including technical specifications, can be found at the HH Quality Initiative Web page located at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html*.

We solicited public comment on our proposed quality measures: (1) Rehospitalization during the first 30 days of HH; and (2) Emergency Department Use without Hospital Readmission during the first 30 days of HH. We also proposed to provide feedback to HHAs on performance of these measures in CY 2014. The following is a summary of the comments we received regarding these two quality measures:

Comment: Several commenters stated that they support the addition of the proposed quality measures to the HHQRP. One commenter specifically supported the proposal for reporting feedback to HHAs on performance of these measures in CY 2014. We also received a number of comments stating that, according to the Measures Application Partnership (MAP) report from January of 2013, the proposed quality measures required further development and encouraging CMS to submit them for NQF endorsement prior to full implementation and public reporting.

Response: We appreciate the commenters' support for the addition of the proposed quality measures to the HHQRP. We are finalizing the proposal to provide feedback to HHAs on performance of these measures in CY 2014. In December 2012, the MAP supported the direction of both measures because they address the PAC/LTC core concept of avoidable admissions. The MAP did acknowledge that the measures should be appropriately risk adjusted to accommodate variations in population. The risk model was developed and then minimally changed as a result of comment to this rule. The final list of risk factors will be posted on cms.gov by December 6, 2013. We plan to submit the two quality measures for NQF endorsement by the submission deadline of December 6, 2013. These measures will be added to Home Health Compare for public reporting in CY2015.

Comment: One commenter requested that CMS clarify what course of action it would take if NQF fails to endorse the proposed quality measures. The commenter also stated that their understanding of section 1890 of the Act is that CMS is required to use endorsed measures in its quality reporting programs.

Response: As noted in the response to the previous comment, we plan to submit the measures for NQF endorsement in the fourth quarter of CY 2013. However, based on our interpretation of section 1895(b)(3)(B)(v) of the Act, we may adopt measures for the HHQRP that are not NQF-endorsed. If NQF does not endorse the proposed quality measures, CMS will consider NQF's rationale for not endorsing the measures and decide how to proceed.

Comment: Several commenters stated that the proposed quality measures are too similar to the existing Acute Care Hospitalization and Emergency Department Use without Hospitalization measures. Several additional commenters were uncertain about how the proposed measures differ from the measures of Acute Care Hospitalization and ED Use currently published on Home Health Compare or were unaware that the Acute Care Hospitalization and ED Use without Hospitalization are currently part of the HHQRP measure set. These commenters recommended that CMS modify the proposed measures so that they are more similar to the existing measures. We also received a number of comments stating that if we finalize the proposed quality measures we should consider removing the existing Acute Care Hospitalization and Emergency Department Use without Hospitalization measures from the HHQRP because publicly reporting all four measures might be confusing for HHAs and the public.

Response: The two quality measures we proposed are different from the existing NQF-endorsed Acute Care Hospitalization and ED Use without Hospitalization measures. The proposed quality measures specifically target the previously hospitalized home health population, whereas the existing, NQF-endorsed Acute Care Hospitalization and Emergency Department Use without Hospitalization measures evaluate home health agencies on their care for all of their Medicare patients. While the proposed quality measures apply only to patients who were hospitalized in the five days prior to starting home health, which includes only about 35 percent of

HH patients, the Acute Care Hospitalization and Emergency Department Use without Hospitalization measures apply to the entire home health population covered by original Medicare. In addition, the Acute Care Hospitalization measure includes hospitalizations that occur during the first 60 days of home care, and the proposed Rehospitalization measure only applies to the first 30 days of home care. We believe that the two quality measure sets can be used in conjunction to evaluate home health care quality, and that, by comparing home health agencies on both sets of claims-based measures, consumers can gain a more complete and accurate picture of how much acute care is used by patients of the agencies.

Comment: One commenter requested that CMS clarify the source of a statistic cited in the proposed rule, namely the 14.4 percent of HH patients experiencing an unplanned rehospitalization in the first 30 days of HH care and also requested that CMS clarify the reason for the difference between the national average rate of unplanned rehospitalization in the first 30 days of HH care (14.4 percent) and the national average rate for the Acute Care Hospitalization rate published on Home Health Compare (17 percent).

Response: We appreciate the comments. The statistic that 14.4 percent of HH patients experience an unplanned rehospitalization in the first 30 days of HH care is calculated by applying the specifications for the Rehospitalization during the first 30 days of HH measure to 12 months of fee-for-service Medicare claims (July 2011 through June 2012). The Rehospitalization during the first 30 days of HH measure is only calculated for Medicare fee-for-service patients because encounter data is available through fee-for-service claims. The 17 percent national average hospitalization rate represents hospitalizations during the first 60 days of home health for all Medicare fee-for-service patients, calculated according to the specifications for the Acute Care Hospitalization measure.

Comment: One commenter stated that CMS appears to take the position that 14.4 percent of HH patients experiencing an unplanned rehospitalization in the first 30 days of HH care is an unacceptable number. The commenter noted that a portion of those readmissions may be unavoidable.

Response: We thank the commenter for the comment. We agree with the commenter that some readmissions to the hospital and emergency department visits may not be preventable. We believe that HHAs can provide the highest quality care and coordination of care for their patients so that the rate of preventable readmissions is reduced.

Comment: With regards to the Emergency Department Use without Hospital Readmission during the first 30 days of HH measure, one commenter stated that CMS should take into account the increase in the number of urgent care centers in certain areas of the country, which could skew the performance rates for the Emergency Department Use without Hospital Readmission during the first 30 days of HH measure across different HHAs across the country.

Response: We appreciate the comment. We are investigating the impact of urgent care centers on these measures. While we expect that urgent care sometimes substitutes for Emergency Department use, the availability of urgent care centers should similarly impact all agencies in an area similarly, and thus performance on the ED Use without Hospital Readmission measure should still be meaningfully compared among agencies in the same area.

Comment: One commenter expressed concern that the proposed quality measures do not consider the length of time that the patient has been receiving HH care before requiring rehospitalization or treatment in the emergency department.

Response: We appreciate the commenter's concern. We examined the relationship between time in home health and hospitalizations and found that home health patients experience a nearly constant hazard of hospitalization per day. By measuring rehospitalizations over a fixed 30 day window (rather than over the entire home health episode) the relationship between length of stay and rehospitalization is mitigated. While we acknowledge that other approaches could also be appropriate, we chose the fixed measurement window approach for simplicity and to be consistent with the existing NQF endorsed measures of Acute Care Hospitalization and ED Use.

Comment: One commenter stated that they do not support the five-day timeframe used to specify the eligible patient population and encouraged further analysis of how the time interval between hospital discharge and home health admission impacts subsequent patient outcomes. The commenter expressed particular concern that some hospitals may delay home health admission until 3 days after hospital discharge in an attempt to maximize DRG reimbursement.

Response: We appreciate the commenter's feedback. We believe that the five-day timeframe used to specify the eligible patient population for the measures is appropriate. Shortening the 5 day window is undesirable for several reasons. First, it would exclude some patients from the measures who are not cared for in any other post-acute setting. Additionally, a shorter window (such as a two-day window to be consistent with the CoPs) may encourage agencies to delay the start of care for particularly unstable patients so that they are not held accountable for the rehospitalization of such patients.

Comment: One commenter asked how short Skilled Nursing Facility (SNF) stays occurring between hospital discharge and start of HH care are accounted for in the measures.

Response: The measure specifications exclude patients who receive care from another post-acute setting, such as a SNF or an IRF between hospital discharge and start of home health are excluded from both measures.

Comment: One commenter stated that HHAs may not be entirely responsible for a patient's return to an emergency room or inpatient acute care facility, since HHAs follow orders prescribed by the physician. The commenter stated that an HHA does not have the authority to override the physician's decision to admit the HH patient to an inpatient acute care facility.

Response: We appreciate the commenter's concern. We understand that Emergency Department use or Hospitalization is sometimes necessary. We do believe, however, that the care that a patient receives from a HHA can reduce the need for that patient to be readmitted to the hospital.

Comment: We received a number of comments stating that agencies should not be held responsible for patients who are readmitted to an acute-care setting within 30 days of entering HH, if these patients have been discharged from home health for appropriate reasons (for example, the patient is no longer homebound or is no longer in need of skilled services) within the 30-day period. One commenter requested that CMS clarify whether patients discharged from HH care within the 30-day measurement period would be included or excluded from the proposed quality measures.

Response: We appreciate the comments. We believe that the care and education provided by HHAs can have a positive impact on the health status and self-care processes of many of the these patients, even if they were discharged due to appropriate reasons such as no longer being homebound

and/or no longer in need of skilled care. Therefore home health care can reduce the likelihood of hospital readmission even after the patient is discharged from the HHA. Thus, as documented in the measure specifications, patients who are discharged from home health within the 30-day observation period are counted in the denominators of the quality measures.

Comment: Two commenters stated that they are concerned about the impact of the increasing use of ''observation stays'' in lieu of inpatient admission on the rates of the proposed quality measures, since there may be significant variation in the use of observation stays versus inpatient admission within a state, region, or the United States.

Response: We appreciate the commenters' concern. Observation stays that begin in a hospital emergency department will be captured on the Emergency Department Use without Hospital Readmission during the first 30 days of HH measure rather than in the Rehospitalization measure, as these events are billed to Medicare as outpatient services rather than inpatient services.

Comment: Two commenters expressed support for the proposed exclusions for both measures. We also received a number of comments stating that it is unclear whether and how CMS excludes planned hospitalizations from the proposed quality measures.

Response: We appreciate the commenters' support for the exclusions. Additionally, we would like to point out that the specifications for the measures clarify that the measures exclude planned hospitalizations using the same algorithm as the NQF-endorsed Hospital-Wide All-Cause Unplanned Readmission (HWR) measure. This algorithm identifies planned hospitalizations based on diagnostic and procedural information available on claims data. Those specifications can be found at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html*.

Comment: One commenter requested that CMS clarify the term ''risk-standardized'' as it is used in the proposed rule to describe the proposed quality measures.

Response: We would like to clarify that the term ''risk-standardized,'' which appears in the section of the proposed rule that describes the proposed quality measures, is interchangeable with ''risk-adjusted,'' that is, the quality measures are risk-adjusted to account for beneficiary factors that may affect rates of hospitalization but are outside of the HHA's control.

Comment: Several commenters expressed concerns that the proposed quality measures do not appropriately take into account other settings where the patient may have received care.

Response: We appreciate the commenters' concern. The specifications for the measures exclude home health stays in which the patient received treatment in another setting between hospital discharge and the start of home health as these patients' outcomes may be affected by this intervening care. In addition, the risk adjustment model takes into account settings in which the beneficiary received care prior to hospitalization by examining Medicare fee-for-service claims in the 30 days prior to the start of the HH stay. We believe that the measures appropriately take into account other settings.

Comment: Several commenters stated that they support the proposed approach to risk adjustment. Additionally, we received a number of comments stating that CMS should include other risk factors in the risk adjustment model. One commenter stated that it is unclear why certain OASIS items have been included and others have been excluded.

Response: We appreciate the commenters' support for the risk adjustment approach. We also appreciate the comment that additional data derived from OASIS may be useful as risk adjustment factors for the measures. Currently, CMS has chosen to include all the Activities of Daily Living (ADLs) information that is readily available on Medicare claims as risk adjustment factors, including composite measures of Dressing Upper or Lower Body, Bathing, Toileting, Transferring, and Ambulation. However, incorporating additional OASIS data elements into the risk adjustment model would require the ability to match OASIS assessments to claims accurately, which is currently infeasible.

Comment: One commenter stated that CMS should take into account additional patient characteristics such as race, ethnicity, and religion, which may influence a patient's preference to be hospitalized, in the risk adjustment model.

Response: While risk-adjustment is used to ensure that measured rates are comparable across agencies with different patient populations, CMS believes that adjusting for race, ethnicity, or religion would obscure disparities in outcomes between more advantaged and less advantaged groups. We note, however, that we have examined disparities between subpopulations defined by race, age, and gender for the measures; this information was included in the technical brief posted for public comment through the Measures Management Blueprint process on the CMS Quality Measures Public Comment from June 25, 2013 to August 26, 2013.

Comment: One commenter stated that CMS should make public a clear list of the risk adjustment factors used to calculate the proposed measures.

Response: The technical specifications that were available for these measures at the time we issued the proposed rule included a list of types of risk factors that were included in a preliminary risk-adjustment model. We subsequently minimally refined the risk adjustment model in response to the public comments received during the Measures Management Blueprint process. The refinements involved statistical categorization and were not substantive; the types of risk factors are unchanged from those noted in the technical specifications. By December 6, 2013, we will post the final technical specifications on the Home Health Quality Initiative page, which will include a list of all risk adjustment factors and model coefficients for each factor.

Comment: Several commenters stated that they support alignment of the proposed quality measures with the readmission measures of hospitals and other post-acute care providers. We also received several comments stating that CMS should adopt disease-specific readmission measures to align disease specific quality improvement efforts in HHAs with hospitals and across care settings. Several commenters stated that the proposed quality measures do not align with the Hospital 30-day Readmission measure, which only includes three causes—Myocardial Infarction (MI), Heart Failure (HF), and Pneumonia.

Response: We appreciate the support for the alignment of the quality measures with the readmission measures of hospitals and other post-acute care providers. Currently, the measures align with the NQF-endorsed Hospital-Wide All Cause Unplanned Readmission measure. We also appreciate the recommendation to develop disease-specific readmission measures across care settings. We will take into account the recommendation to develop disease-specific readmission measures across care settings as part of future measure development work.

Comment: Several commenters stated that they support the use administrative

claims data to calculate the proposed quality measures.

Response: We thank the commenters for their support.

Comment: We received a number of comments stating that CMS should seek broader input from the home health care community and public when developing the proposed quality measures and home health quality measures in general.

Response: We thank the commenters for the comment. We do seek input from the home health community and the general public through the CMS Quality Measures Public Comment Page on cms.gov. Development of all four home health claims-based measures, including the two proposed measures, was also informed by outreach conducted for the 2011 Home Health Value-based Purchasing Report to Congress, including expert interviews and a listening session. Additionally, the home health measures technical expert panel (initially convened in late 2010) reviewed and discussed the measures. To maintain transparency in future measure development work, CMS will continue to seek input from the public.

Final Decision: After consideration of the comments received, we are finalizing the adoption of the two claims-based measures: (1) Re-hospitalization during the first 30 days of HH; and (2) Emergency Department Use without Hospital Readmission during the first 30 days of HH. We will provide feedback to HHAs on their measure rates in CY 2014.

(3) Elimination of Stratification by Episode Length Process Measures

We are exploring ways to reduce the number of HH quality measures reported to HHAs on confidential CASPER reports. We proposed to reduce the total number of measures on the CASPER reports by beginning to report only all-episodes measures for 9 process measures currently also stratified by episode length. We solicited comments on this proposal to simplify the reporting of process measures, which is based on the recommendation from the MAP to achieve greater parsimony in these measures. Currently there are 97 quality measures included on the CASPER reports, of which 45 are process measures. This reduction will decrease the total number of HH quality measures to 79 and reduce the number of process measures from 45 to 27. This change will enable HHAs to obtain the information they require for quality improvement activities related to the process measures in a less burdensome manner. Reducing the number of measures also facilitates the future development and implementation of other superior HH measures.

Nine measures currently stratified by episode length on CASPER reports include:

- Depression Interventions Implemented.
- Diabetic Foot Care and Patient/Caregiver Education Implemented.
- Heart Failure Symptoms Addressed.
- Pain Interventions Implemented.
- Treatment of Pressure Ulcers Based on Principles of Moist Wound Healing Implemented.
- Pressure Ulcer Prevention Implemented.
- Drug Education on All Medications Provided to Patient/Caregiver.
- Potential Medication Issues Identified and Timely Physician Contact.
- Falls Prevention Steps Implemented.

For each of these nine measures, three versions of each measure are currently included on CASPER reports. The three versions are: (1) Short term episodes of care; (2) long term episodes of care; and (3) all episodes of care. We proposed to eliminate the stratification by episode length, so that these measures are reported only for ''all episodes of care''. Thus, we proposed to eliminate the ''short term'' and ''long term episodes of care'' measures from CASPER reports. This will remove 18 process measures from the current CASPER reports. Of note, only the ''short term episodes of care'' measures are currently reported on HH Compare. These will be replaced with the analogous ''all episodes of care'' measures.

No data will be lost in the elimination of the ''short and long term episodes of care'' measures as the ''all episodes of care'' measures capture all care interventions, regardless of episode length. Using only the ''all episodes of care'' measures will substantially increase the number of HHAs eligible for public reporting of these measures.

The following is a summary of the comments we received regarding the proposal to eliminate stratification by episode length process measures.

Comment: Several commenters stated that they support this proposal. We received no comments in opposition. We also received a few comments requesting that CMS give HHAs continued access to HHQRP data files to allow them to calculate their own short-term and long-term rates and to benchmark their performance on those rates against other HHAs.

Response: We appreciate the commenters' feedback. We understand that the HHAs need access to detailed data to inform their quality improvement efforts. However, the CASPER system currently does not support access to patient-level data for process measures so agencies will not be able to calculate separate rates for short-term versus long-term patients. We will examine adding such functionality to future revisions of CASPER reports.

Final Response: After consideration of the comments received, we are finalizing policies related to the reduction of the number of process measures as proposed. We will reduce the total number of measures on the CASPER reports by reporting only all-episode measures for 9 process measures currently also stratified by episode length. We will eliminate the stratification by episode length by removing the ''short term'' and ''long term episodes of care'' measures from the CASPER reports so that the measures are only reported for all episodes of care. The ''short term episodes of care'' measures currently publicly reported on Home Health Compare will be replaced with the analogous ''all episodes of care'' measures.

To summarize, we are finalizing the proposals to continue to use a HHA's submission of OASIS assessments for episodes between July 1 of the calendar year two years prior to the calendar year of the APU effective date and June 30 of the calendar year one year prior to the calendar year of the APU effective date as fulfilling one portion of the quality reporting requirement for each payment year; to adopt two claims-based measures: (1) Rehospitalization during the first 30 days of HH; and (2) Emergency Department Use without Hospital Readmission during the first 30 days of HH, to begin reporting feedback to HHAs on performance on these measures in CY 2014; and to reduce the number of process measures reported on the CASPER reports by eliminating the stratification by episode length for 9 process measures.

3. Home Health Wage Index

Sections 1895(b)(4)(A)(ii) and (b)(4)(C) of the Act require the Secretary to provide appropriate adjustments to the proportion of the payment amount under the HH PPS that account for area wage differences, using adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of HH services. For CY 2014, as in previous years, we are proposing to base the wage index adjustment to the labor portion of the HH PPS rates on the most recent pre-floor and pre-reclassified hospital wage index. We will apply the appropriate wage index value to the labor portion of

the HH PPS rates based on the site of service for the beneficiary (defined by section 1861(m) of the Act as the beneficiary's place of residence). Previously, we determined each HHA's labor market area based on definitions of metropolitan statistical areas (MSAs) issued by the OMB. We have consistently used the pre-floor, pre-reclassified hospital wage index data to adjust the labor portion of the HH PPS rates. We believe the use of the pre-floor, pre-reclassified hospital wage index data results in an appropriate adjustment to the labor portion of the costs, as required by statute.

In the CY 2006 HH PPS final rule for (70 FR 68132), we began adopting revised labor market area definitions as discussed in the OMB Bulletin No. 03–04 (June 6, 2003). This bulletin announced revised definitions for MSAs and the creation of micropolitan statistical areas and core-based statistical areas (CBSAs). The bulletin is available online at *www.whitehouse.gov/omb/bulletins/b03-04.html*. In addition, OMB published subsequent bulletins regarding CBSA changes, including changes in CBSA numbers and titles. The OMB bulletins are available at *http://www.whitehouse.gov/omb/bulletins/index.html*.

For CY 2014, as in previous years, we will use the most recent pre-floor, pre-reclassified hospital wage index as the base for the wage index adjustment to the labor portion of the HH PPS rates. However, the FY 2014 pre-floor, pre-reclassified hospital wage index does not reflect OMB's new area delineations, based on the 2010 Census (outlined in OMB Bulletin 13–01, released on February 28, 2013), as those changes were not published until the Hospital Inpatient Prospective Payment System (IPPS) proposed rule (78 FR 27553) was in advanced stages of development. We intend to make changes to the FY 2015 hospital wage index based on the newest CBSA changes in the FY 2015 IPPS proposed rule. Therefore, if CMS incorporates OMB's new area delineations, based on the 2010 Census, in the FY 2015 hospital wage index, those changes will also be reflected in the CY 2015 HH wage index.

Finally, we will continue to use the methodology discussed in the CY 2007 HH PPS final rule (71 FR 65884) to address those geographic areas in which there were no IPPS hospitals, and thus, no hospital wage data on which to base the calculation of the HH PPS wage index. For rural areas that do not have IPPS hospitals, and therefore, lack hospital wage data on which to base a wage index, we will use the average wage index from all contiguous CBSAs as a reasonable proxy. For rural Puerto Rico, we do not apply this methodology due to the distinct economic circumstances that exist there, but instead continue using the most recent wage index previously available for that area (from CY 2005). For urban areas without IPPS hospitals, we use the average wage index of all urban areas within the state as a reasonable proxy for the wage index for that CBSA. For CY 2014, the only urban area without IPPS hospital wage data is Hinesville-Fort Stewart, Georgia (CBSA 25980).

The wage index values are available on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html*.

The following is a summary of the comments we received regarding the home health wage index.

Comment: Several commenters expressed concern that HHAs compete with hospitals and hospices for skilled clinicians, yet the wage indices for home health, hospice, and hospitals vary widely within a specific geographic region. While hospitals can reclassify to neighboring CBSAs or take advantage of the rural floor, HHAs do not have this ability. Commenters believed that this results in inadequate home health cost adjustments that negatively impact HHAs ability to recruit and retain nurses and therapists in a highly competitive health care labor market. Commenters suggested that CMS develop regulatory and legislative remedies to the continuing problem of wage index disparity. Commenters urge CMS to implement a policy to limit the wage index variations between provider types within CBSAs and adjacent markets. Commenters requested that CMS allow HHAs the same reclassification as hospitals if they provide services in the same service area. Commenters suggest that rural floors be set for HHAs.

Response: As previously stated in the CY 2009 HH PPS final rule, (74 FR 58105), the regulations that govern the HH PPS do not provide a mechanism for allowing HHAs to seek geographic reclassification or to utilize the rural floor provisions that exist for IPPS hospitals. The rural floor provision in section 4410 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) is specific to hospitals. The reclassification provision found in section 1886(d)(10) of the Act is also specific to hospitals.

Comment: A commenter believed that using the pre-floor, pre-reclassified hospital wage index is inadequate for adjusting home health costs. The commenter cites the unpredictable year-to-year swings in wage index values. The commenter stated that CMS's decision to switch from MSAs to CBSAs seven years ago has had serious financial ramifications for HHAs in various parts of the country. The commenter questioned the accuracy and completeness of hospital cost reports.

Response: We believe that adjusting payments based on the CBSA areas is the best available method of compensating for differences in labor markets. The HH PPS used a 50/50 blend of the MSA-based and the CBSA-based wage indexes in CY 2006. Since CY 2007, the HH PPS has utilized the CBSA-based wage index in its entirety. In regard to the accuracy and completeness of hospital cost reports, we utilize efficient mechanisms to ensure the accuracy of the hospital cost report data and resulting wage index. The HH PPS uses the pre-floor, pre-reclassified hospital wage index. This wage index is calculated based on cost report data from hospitals paid under the IPPS. All IPPS hospitals are required to complete the wage index survey (Worksheet S–3, Parts II and III) of their Medicare cost reports. Our intermediaries perform desk reviews on all hospitals' Worksheet S–3 wage data, and we run edits on the wage data to further ensure the accuracy and validity of the wage data. In addition, HHAs may submit comments on the hospital wage index during the annual IPPS rulemaking. We believe that our review processes result in an accurate collection of wage data.

Comment: A commenter requested that CMS publish the methodology for arriving at the wage index used by the HH PPS.

Response: The HH PPS uses the pre-floor, pre-reclassified hospital wage index. The methodology for calculating the pre-floor, pre-reclassified hospital wage index is published annually in the IPPS final rule. The FY 2014 IPPS final rule is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html*.

Comment: A commenter urged CMS to expedite its review of the wage index and implement a system that not only recognizes variations between localities, but also treats all provider types within a local market equitably. Until such a system is in place, the commenter urged CMS to implement and adjust the 2014 wage index in such a way as to limit the wage index disparity between provider types within a given CBSA to no more than 10 percent. A commenter recommended that until the wage index

can be adjusted, that HHAs be given interim wage index parity adjustments similar to that which hospitals in the same geographic area receive.

Response: The hospital wage index is updated in a budget neutral manner. Establishing limits on how much a wage index may increase or decrease from year-to-year is not consistent with budget neutrality. As noted above, the geographic reclassifications and adjustments that hospitals may apply for are not available to providers other than hospitals.

Comment: A commenter stated that differences in the occupational personnel pool and costs between hospitals and HHAs make use of the hospital wage index inappropriate in the home health setting. The commenter further stated that using the hospital wage index is inappropriate because hospitals benefit from institutional efficiencies which HHAs are not afforded. The commenter asked CMS to develop a home health specific wage index. The commenter stated that until CMS develops a home health specific wage index, he will support CMS' proposal to incorporate OMB's new area delineations in the CY 2015 HH wage index as the improved specificity should provide some relief. In addition, several other commenters recommended that CMS reform or implement a new HH wage index system.

Response: Our previous attempts at either proposing or developing a home health specific wage index were not well received by the home health industry. Generally, the volatility of the home health wage data, and the resources needed to audit and verify those data, make it difficult to ensure that such a wage index accurately reflects the wages and wage-related costs applicable providing home health services. We believe that a HH specific wage index should be more reflective of the wages and salaries in a specific area, be based upon stable data sources, and significantly improve our ability to determine HH payments without being overly burdensome.

Comment: A commenter noted that dropping critical access hospitals (CAHs) from the calculation of the wage index, beginning in 2004, compromises the accuracy and appropriateness of using a hospital wage index to determine the labor costs of HHAs providing services in rural areas.

Response: Although the pre-floor, pre-reclassified hospital wage index does not include data from CAHs, we believe it reflects the relative level of wages and wage-related costs applicable to providing home health services.

Final Decision: For CY 2014, we will use the FY 2014 pre-floor, pre-reclassified hospital wage index as the wage index adjustment to the labor portion of the HH PPS rates.

4. CY 2014 Payment Update

a. National, Standardized 60-Day Episode Payment Rate

The Medicare HH PPS has been in effect since October 1, 2000. As set forth in the July 3, 2000 final rule (65 FR 41128), the base unit of payment under the Medicare HH PPS is a national, standardized 60-day episode payment rate. As set forth in 42 CFR 484.220, we adjust the national, standardized 60-day episode payment rate by a case-mix relative weight and a wage index value based on the site of service for the beneficiary.

To provide appropriate adjustments to the proportion of the payment amount under the HH PPS to account for area wage differences, we apply the appropriate wage index value to the labor portion of the HH PPS rates. The labor-related share of the case-mix adjusted 60-day episode rate will continue to be 78.535 percent and the non-labor-related share will continue to be 21.465 percent as set out in the CY 2013 HH PPS final rule (77 FR 67068). The CY 2014 HH PPS rates use the same case-mix methodology as set forth in the CY 2008 HH PPS final rule with comment period (72 FR 49762) and adjusted as described in section III.C. of this rule. The following are the steps we take to compute the case-mix and wage-adjusted 60-day episode rate:

(1) Multiply the national 60-day episode rate by the patient's applicable case-mix weight.

(2) Divide the case-mix adjusted amount into a labor (78.535 percent) and a non-labor portion (21.465 percent).

(3) Multiply the labor portion by the applicable wage index based on the site of service of the beneficiary.

(4) Add the wage-adjusted portion to the non-labor portion, yielding the case-mix and wage adjusted 60-day episode rate, subject to any additional applicable adjustments.

In accordance with section 1895(b)(3)(B) of the Act, this document constitutes the annual update of the HH PPS rates. Section 484.225 sets forth the specific annual percentage update methodology. In accordance with § 484.225(i), for a HHA that does not submit HH quality data, as specified by the Secretary, the unadjusted national prospective 60-day episode rate is equal to the rate for the previous calendar year increased by the applicable HH market basket index amount minus two percentage points. Any reduction of the percentage change will apply only to the calendar year involved and will not be considered in computing the prospective payment amount for a subsequent calendar year.

Medicare pays the national, standardized 60-day case-mix and wage-adjusted episode payment on a split percentage payment approach. The split percentage payment approach includes an initial percentage payment and a final percentage payment as set forth in § 484.205(b)(1) and § 484.205(b)(2). We may base the initial percentage payment on the submission of a request for anticipated payment (RAP) and the final percentage payment on the submission of the claim for the episode, as discussed in § 409.43. The claim for the episode that the HHA submits for the final percentage payment determines the total payment amount for the episode and whether we make an applicable adjustment to the 60-day case-mix and wage-adjusted episode payment. The end date of the 60-day episode as reported on the claim determines which calendar year rates Medicare will use to pay the claim.

We may also adjust the 60-day case-mix and wage-adjusted episode payment based on the information submitted on the claim to reflect the following:

- A low utilization payment provided on a per-visit basis as set forth in § 484.205(c) and § 484.230.
- A partial episode payment adjustment as set forth in § 484.205(d) and § 484.235.
- An outlier payment as set forth in § 484.205(e) and § 484.240.

b. CY 2014 National, Standardized 60-Day Episode Payment Rate

The CY 2014 national, standardized 60-day episode payment rate will be $2,869.27 as calculated in Table 20. To determine the CY 2014 national, standardized 60-day episode payment rate, we start with the CY 2013 average payment per episode ($2,952.03) calculated in section IV.D.1. of this rule. We remove the 2.5 percent for outlier payments that we put back in the rates as described in section IV.D.1. of this rule, and subsequently apply a standardization factor of 1.0026 to the national, standardized 60-day episode rate to ensure budget neutrality in episode payments using the 2014 wage index. The application of a standardization factor was also done when setting the initial national, standardized 60-day episode payment rate for the HH PPS in 2000 per section 1895(3)(A)(i) of the Act. The Act required that the 60-day episode base

rate and other applicable amounts be standardized in a manner that eliminates the effects of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner. To calculate the standardization factor, we simulated total payments for non-LUPA episodes using the 2014 wage index and compared it to our simulation of total payments for non-LUPA episodes using the 2013 wage index. By dividing the total payments using the 2014 wage index by the total payments using the 2013 wage index, we obtain a standardization factor of 1.0026. We note that since we are implementing the adjustment to the case-mix weights in a budget neutral manner, there is no standardization factor needed to ensure budget neutrality in episode payments using the 2014 case-mix relative values. We then apply the $80.95 reduction (which is 3.5 percent of the CY 2010 national, standardized 60-day episode rate of $2,312.94) and, lastly, we update payments by the CY 2014 HH payment update percentage of 2.3 percent.

TABLE 20—CY 2014 60-DAY NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT

CY 2013 Estimated average payment per episode	Outlier adjustment factor	Standardization factor	CY 2014 Rebasing adjustment	CY 2014 HH market basket update	CY 2014 National, standardized 60-day episode payment
$2,952.03	× 0.975	× 1.0026	− $80.95	× 1.023	= $2,869.27

The CY 2014 national, standardized 60-day episode payment rate for an HHA that does not submit the required quality data is updated by the CY 2014 HH market basket update (2.3 percent) minus 2 percentage points and is shown in Table 21.

TABLE 21—FOR HHAS THAT DO NOT SUBMIT THE QUALITY DATA—CY 2014 NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT

CY 2013 Estimated average payment per episode	Outlier adjustment factor	Standardization factor	CY 2014 Rebasing adjustment	CY 2014 HH Market basket update minus 2 percentage points	CY 2014 National, standardized 60-day episode payment
$2,952.03	× 0.975	× 1.0026	− $80.95	× 1.003	= $2,813.18

c. National Per-Visit Rates

The national per-visit rates are used to pay LUPAs and are also used to compute imputed costs in outlier calculations. The per-visit rates are paid by type of visit or HH discipline. The six HH disciplines are as follows:

- Home health aide (HH aide);
- Medical Social Services (MSS);
- Occupational therapy (OT);
- Physical therapy (PT);
- Skilled nursing (SN); and
- Speech-language pathology (SLP).

To calculate the CY 2014 national per-visit rates, we start with the CY 2013 national per-visit rates. We then apply a wage index budget neutrality factor of 1.0006 to ensure budget neutrality for LUPA per-visit payments after applying the 2014 wage index, and increase each of the six per-visit rates by the maximum rebasing adjustments described in section IV.D of this rule. We calculate the wage index budget neutrality factor by simulating total payments for LUPA episodes using the 2014 wage index and comparing it to simulated total payments for LUPA episodes using the 2013 wage index. We note that the LUPA per-visit payments are not calculated using case-mix weights and therefore, there is no case-mix standardization factor needed to ensure budget neutrality in LUPA payments. Finally, the per-visit rates for each discipline are then updated by the CY 2014 HH payment update percentage of 2.3 percent. The national per-visit rates are adjusted by the wage index based on the site of service of the beneficiary. The per-visit payment amounts for LUPAs are separate from the LUPA add-on payment amount, which is paid for episodes that occur as the only episode or initial episode in a sequence of adjacent episodes. The CY 2014 national per-visit rates are shown in Tables 22 and 23.

TABLE 22—CY 2014 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA

HH Discipline type	CY 2013 Per-visit payment	Wage index budget neutrality factor	CY 2014 Rebasing adjustment	CY 2014 HH Market basket update	CY 2014 Per-visit payment
Home Health Aide	$51.79	× 1.0006	+ $1.79	× 1.023	$54.84
Medical Social Services	183.31	× 1.0006	+ 6.34	× 1.023	194.12
Occupational Therapy	125.88	× 1.0006	+ 4.35	× 1.023	133.30
Physical Therapy	125.03	× 1.0006	+ 4.32	× 1.023	132.40
Skilled Nursing	114.35	× 1.0006	+ 3.96	× 1.023	121.10
Speech-Language Pathology	135.86	× 1.0006	+ 4.70	× 1.023	143.88

The CY 2014 per-visit payment rates for an HHA that does not submit the required quality data are updated by the CY 2014 HH payment update percentage (2.3 percent) minus 2 percentage points and is shown in Table 23.

TABLE 23—CY 2014 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

HH Discipline type	CY 2013 Per-visit rates	Wage index budget neutrality factor	CY 2014 Rebasing adjustment	CY 2014 HH Market basket update minus 2 percentage points	CY 2014 Per-visit rates
Home Health Aide	$51.79	× 1.0006	+ $1.79	× 1.003	$53.77
Medical Social Services	183.31	× 1.0006	+ 6.34	× 1.003	190.33
Occupational Therapy	125.88	× 1.0006	+ 4.35	× 1.003	130.70
Physical Therapy	125.03	× 1.0006	+ 4.32	× 1.003	129.81
Skilled Nursing	114.35	× 1.0006	+ 3.96	× 1.003	118.73
Speech-Language Pathology	135.86	× 1.0006	+ 4.70	× 1.003	141.06

d. Low-Utilization Payment Adjustment (LUPA) Add-On Factor

For episodes with four or fewer visits, Medicare pays on the basis of a national per-visit amount by discipline, referred to as a LUPA. As stated in our CY 2008 HH PPS proposed rule, after the HH PPS went into effect, we received comments and correspondence suggesting that the LUPA payment rates do not adequately account for the front-loading of costs in an episode. Commenters suggested that because of the small number of visits in a LUPA episode, HHAs have little opportunity to spread the costs of lengthy initial visits over a full episode (72 FR 25424). In response to comments received, we conducted an initial descriptive analysis of visit log data from prior to the establishment of the HH PPS, showing that initial visits were 25 to 50 percent longer than subsequent visits in LUPA episodes that occur as the only or initial episode. These results indicated that payment for LUPA episodes may not offset the full cost of initial visits. Therefore, as specified in the CY 2008 HH PPS final rule, LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes are adjusted by applying an additional amount to the LUPA payment before adjusting for area wage differences (72 FR 49849).

The CY 2008 LUPA add-on amount was calculated using a large representative sample of claims from 2005 (72 FR 49848). The analysis examined minute data for skilled nursing, physical therapy, and speech-language pathology (SLP) as, per the Medicare CoPs at § 484.55(a)(1) and (a)(2), only these three disciplines are allowed to conduct the initial assessment visit. The analysis showed that the average excess of minutes for the first visit in LUPA episodes that were the only episode or an initial LUPA in a sequence of adjacent episodes was 38.5 minutes for the first visit if SN, 25.1 minutes for the first visit if PT, and 22.6 minutes for the first visit if SLP. Those excess minutes were then expressed as a proportion of the average number of minutes for all non-first visits in non-LUPA episodes (42.5 minutes, 45.6 minutes, and 48.6 minutes for SN, PT, and SLP, respectively). These proportions (90.6 percent, 55.0 percent, and 46.5 percent for SN, PT, and SLP, respectively) were used to inflate the LUPA per-visit payment rates. Finally, using an appropriate set of weights representing the share of LUPA first visits for SN (77.8 percent), PT (21.7 percent) and SLP (0.5 percent), we calculated a LUPA add-on payment amount of $87.93 for LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes (Table 24). When the LUPA add-on payment amount was implemented in CY 2008, to account for the additional payment to LUPA episodes and maintain budget neutrality, a reduction was made to the national, standardized 60-day episode payment rate (72 FR 49849).

TABLE 24—CALCULATION OF THE LUPA ADD-ON AMOUNT, CY 2008

	Skilled nursing	Physical therapy	Speech-Language pathology
(1) Proportional increase in minutes for an initial visit over non-initial visits	90.59%	55.04%	46.50%
(2) CY 2008 Per-Visit Amounts	$ 104.91	$ 114.71	$124.54
(3) Excess cost for initial visits (1*2)	$ 95.04	$ 63.14	$ 57.91
(4) Percent of initial assessment visits provided by this discipline	77.8%	21.7%	0.5%
(5) Add-on amount per discipline (3*4)	$73.94	$13.70	$0.29
(6) Total LUPA add-on Amount (Sum of row 5)	$87.93		

For this final rule we used the same methodology used to establish the LUPA add-on amount for CY 2008. Specifically, we updated the analysis using 100 percent of LUPA episodes and a 20 percent sample of non-LUPA first episodes from CY 2012 claims data. The analysis shows that the average excess of minutes for the first visit in LUPA episodes that were the only episode or an initial LUPA in a sequence of adjacent episodes are 37.27 minutes for the first visit if SN, 31.69 minutes for the first visit if PT, and 31.56 minutes for the first visit if SLP. The average minutes for all non-first visits in non-LUPA episodes are 44.10 minutes for SN, 47.30 minutes for PT, and 50.37 minutes for SLP. Those excess minutes expressed as a proportion of the average minutes for all non-first visits in non-LUPA episodes are 84.51 percent for SN, 67.00 percent for PT, and 62.66 percent for SLP. We used these proportions to inflate the LUPA per-visit payment rates in Table 22 of $121.10 for SN, $132.40 for PT, and $143.88 for

SLP. We then calculated a set of weights representing the share of LUPA first visits for SN (81.97 percent), PT (17.61 percent) and SLP (0.42 percent) and using these weights, we calculated a LUPA add-on payment amount of $99.89 for LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes.

In lieu of a single LUPA add-on payment amount of $99.89, to ensure that the LUPA add-on amount equitably reflects the excess cost for an initial visit for each of the three disciplines (SN, PT, and SLP), we proposed to multiply the per-visit payment amount for the first SN, PT, or SLP visit in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes by 1 + the proportional increase in minutes for an initial visit over non-initial visits. Using complete CY 2012 claims data, the LUPA add-on factors are calculated to be: 1.8451 for SN; 1.6700 for PT; and 1.6266 for SLP. For example, for LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes, if the first skilled visit is SN, the payment for that visit will be $223.44 (1.8451 multiplied by $121.10). For more information on the analyses performed to update the LUPA add-on amount, please refer to the technical report titled ''Analyses in Support of Rebasing & Updating the Medicare Home Health Payment Rates—CY 2014 Home Health Prospective Payment System Final Rule'' available on the CMS Home Health Agency (HHA) Center Web site at: *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html?redirect=/center/hha.asp.*

The following is a summary of the comments we received regarding the LUPA add-on factors.

Comment: We received one comment that was supportive of the proposed LUPA add-on factors and no comments in opposition.

Response: We appreciate the commenter's support and we believe that proposed creation of three LUPA add-on factors will result in more accurate LUPA add-on payments reflecting the discipline that performed the initial assessment visit.

Final Decision: We are finalizing three LUPA add-on factors to be used in calculating the LUPA add-on payment amount. Those three factors are 1.8451 for skilled nursing, 1.6700 for physical therapy and 1.6266 for speech-language pathology when that discipline is the first skilled visit in a LUPA episode that occurs as the only episode or an initial episode in a sequence of adjacent episodes.

e. Nonroutine Medical Supply Conversion Factor Update

Payments for NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. To determine the CY 2014 NRS conversion factor, we start with the 2013 NRS conversion factor ($53.97) and apply the 2.82 percent rebasing adjustment calculated in section IV.D.3. of this rule (1–0.0282 = 0.9718). We then update the conversion factor by the CY 2014 HH market basket update (2.3 percent). We do not apply a standardization factor as the NRS payment amount calculated from the conversion factor is not wage or case-mix adjusted when the final claim payment amount is computed. The NRS conversion factor for CY 2014 is $53.65 as shown in Table 25.

TABLE 25—CY 2014 NRS CONVERSION FACTOR FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA

CY 2013 NRS conversion factor	2014 Rebasing adjustment	2014 HH market basket update	CY 2014 NRS conversion factor
$53.97	× 0.9718	× 1.023	= $53.65

Using the CY 2014 NRS conversion factor ($53.65), the payment amounts for the six severity levels are shown in Table 26.

TABLE 26—CY 2014 NRS PAYMENT AMOUNTS FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA

Severity level	Points (scoring)	Relative weight	NRS Payment amount
1	0	0.2698	$14.47
2	1 to 14	0.9742	52.27
3	15 to 27	2.6712	143.31
4	28 to 48	3.9686	212.92
5	49 to 98	6.1198	328.33
6	99+	10.5254	564.69

For HHAs that do not submit the required quality data, we again begin with the CY 2013 NRS conversion factor ($53.97) and apply the −2.82 percent rebasing adjustment calculated in section IV.D.3. of this rule (1 − 0.0282= 0.9718). We then update the NRS conversion factor by the CY 2014 HH market basket update of 2.3 percent, minus 2 percentage points. The CY 2014 NRS conversion factor for HHAs that do not submit quality data is shown in Table 27.

TABLE 27—CY 2014 NRS CONVERSION FACTOR FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

CY 2013 NRS Conversion factor	2014 Rebasing adjustment	CY 2014 HH market basket update minus 2 percentage points	CY 2014 NRS Conversion factor
$53.97	× 0.9718	× 1.003	$52.61

The payment amounts for the various severity levels based on the updated conversion factor for HHAs that do not submit quality data are calculated in Table 28.

TABLE 28—CY 2014 NRS PAYMENT AMOUNTS FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Severity level	Points (scoring)	Relative weight	NRS Payment amount
1	0	0.2698	$14.19
2	1 to 14	0.9742	51.25
3	15 to 27	2.6712	140.53
4	28 to 48	3.9686	208.79
5	49 to 98	6.1198	321.96
6	99+	10.5254	553.74

5. Rural Add-On

Section 421(a) of the MMA required, for HH services furnished in a rural areas (as defined in section 1886(d)(2)(D) of the Act), for episodes or visits ending on or after April 1, 2004, and before April 1, 2005, that the Secretary increase the payment amount that otherwise will have been made under section 1895 of the Act for the services by 5 percent.

Section 5201 of the DRA amended section 421(a) of the MMA. The amended section 421(a) of the MMA required, for HH services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act), on or after January 1, 2006 and before January 1, 2007, that the Secretary increase the payment amount otherwise made under section 1895 of the Act for those services by 5 percent.

Section 3131(c) of the Affordable Care Act amended section 421(a) of the MMA to provide an increase of 3 percent of the payment amount otherwise made under section 1895 of the Act for HH services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act), for episodes and visits ending on or after April 1, 2010, and before January 1, 2016.

Section 421 of the MMA, as amended, waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Act applicable to HH services furnished during a period to offset the increase in payments resulting in the application of this section of the statute. The following is a summary of the comments we received regarding HH services provided in rural areas.

Comment: A commenter noted that heavy mileage, travel time, poor roads and other factors increase the expense of serving rural patients and stated that decreasing Medicare payments will impact HHA's ability to serve rural beneficiaries.

Response: We believe that Medicare home health services are integral to the healthcare of many beneficiaries, including those who reside in rural areas. For episodes and visits ending on or after April 1, 2010, and before January 1, 2016, payments for services provided to patients in rural areas are increased by 3 percent as required by section 3131(c) of the Affordable Care Act.

Comment: A commenter recommends that CMS implement a population density factor by zip code during the calculation of the labor portion of the payment amount to account for increased costs of providing services in less densely populated (primarily rural) areas. The commenter states that the population density adjustment would reduce excess reimbursement for services provided in densely populated urban areas and congregate living facilities. The commenter recommends that the adjustment be budget neutral or perhaps result in a cost savings.

Response: We do not have evidence that a population density adjustment is appropriate. While rural HHAs cite the added cost of long distance travel to provide care for their patients, urban/non-rural HHAs cite added costs associated with needed security measures and traffic volume.

Final Decision: For CY 2014, HH payment rates for services provided to beneficiaries in rural areas will be increased by 3 percent as mandated by section 3131(c) of the Affordable Care Act. The 3 percent rural add-on is applied to the national, standardized 60-day episode payment rate, national per-visit rates, and NRS conversion factor when HH services are provided in rural (non-CBSA) areas. Refer to Tables 29 through 32 for these payment rates.

TABLE 29—CY 2014 PAYMENT AMOUNTS FOR 60-DAY EPISODES FOR SERVICES PROVIDED IN A RURAL AREA

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2014 National, standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	CY 2014 Rural national, standardized 60-day episode payment rate	CY 2014 National, standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	CY 2014 Rural national, standardized 60-day episode payment rate
$2,869.27	× 1.03	$2,955.35	$2,813.18	× 1.03	$2,897.58

TABLE 30—CY 2014 PER-VISIT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA

	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
HH Discipline type	CY 2014 Per-visit rate	Multiply by the 3 percent rural add-on	CY 2014 Rural per-visit rate	CY 2014 Per-visit rate	Multiply by the 3 percent rural add-on	CY 2014 Rural per-visit rate
HH Aide	$54.84	× 1.03	$56.49	$53.77	× 1.03	$55.38
MSS	194.12	× 1.03	199.94	190.33	× 1.03	196.04

TABLE 30—CY 2014 PER-VISIT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA—Continued

HH Discipline type	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
	CY 2014 Per-visit rate	Multiply by the 3 percent rural add-on	CY 2014 Rural per-visit rate	CY 2014 Per-visit rate	Multiply by the 3 percent rural add-on	CY 2014 Rural per-visit rate
OT	133.30	× 1.03	137.30	130.70	× 1.03	134.62
PT	132.40	× 1.03	136.37	129.81	× 1.03	133.70
SN	121.10	× 1.03	124.73	118.73	× 1.03	122.29
SLP	143.88	× 1.03	148.20	141.06	× 1.03	145.29

TABLE 31—CY 2014 NRS CONVERSION FACTOR FOR SERVICES PROVIDED IN RURAL AREAS

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2014 Conversion factor	Multiply by the 3 percent rural add-on	CY 2014 Rural conversion factor	CY 2014 Conversion factor	Multiply by the 3 percent rural add-on	CY 2014 Rural conversion factor
$53.65	× 1.03	$55.26	$52.61	× 1.03	$54.19

TABLE 32—CY 2014 NRS PAYMENT AMOUNTS FOR SERVICES PROVIDED IN RURAL AREAS

Severity level	Points (Scoring)	For HHAs that DO submit quality data (CY 2014 NRS conversion factor=$55.26)		For HHAs that DO NOT submit quality data (CY 2014 NRS conversion factor=$54.19)	
		Relative weight	Total NRS payment amount for rural areas	Relative weight	Total NRS payment amount for rural areas
1	0	0.2698	$14.91	0.2698	$14.62
2	1 to 14	0.9742	53.83	0.9742	52.79
3	15 to 27	2.6712	147.61	2.6712	144.75
4	28 to 48	3.9686	219.30	3.9686	215.06
5	49 to 98	6.1198	338.18	6.1198	331.63
6	99+	10.5254	581.63	10.5254	570.37

F. Outlier Policy

1. Background

Section 1895(b)(5) of the Act allows for the provision of an addition or adjustment to the national, standardized 60-day case-mix and wage-adjusted episode payment amounts in the case of episodes that incur unusually high costs due to patient care needs. Prior to the enactment of the Affordable Care Act, section 1895(b)(5) of the Act stipulated that projected total outlier payments could not exceed 5 percent of total projected or estimated HH payments in a given year. In the Medicare Program; Prospective Payment System for Home Health Agencies final rule published on July 3, 2000 (65 FR 41188 through 41190), we described the method for determining outlier payments. Under this system, outlier payments are made for episodes whose estimated costs exceed a threshold amount for each HHRG. The episode's estimated cost is the sum of the national wage-adjusted per-visit payment amounts for all visits delivered during the episode. The outlier threshold for each case-mix group or PEP adjustment is defined as the 60-day episode payment or PEP adjustment for that group plus a fixed-dollar loss (FDL) amount. The outlier payment is defined to be a proportion of the wage-adjusted estimated cost beyond the wage-adjusted threshold. The threshold amount is the sum of the wage and case-mix adjusted PPS episode amount, payment amount for NRS, and the wage-adjusted FDL amount. The proportion of additional costs over the outlier threshold amount paid as outlier payments is referred to as the loss-sharing ratio.

2. Regulatory Update

In the CY 2010 HH PPS final rule (74 FR 58080 through 58087), we discussed excessive growth in outlier payments, primarily the result of unusually high outlier payments in a few areas of the country. Despite program integrity efforts associated with excessive outlier payments in targeted areas of the country, we discovered that outlier expenditures still exceeded the 5 percent, target and, in the absence of corrective measures, would continue do to so. Consequently, we assessed the appropriateness of taking action to curb outlier abuse. To mitigate possible billing vulnerabilities associated with excessive outlier payments and adhere to our statutory limit on outlier payments, we adopted an outlier policy that included a 10 percent agency-level cap on outlier payments. This cap was implemented in concert with a reduced FDL ratio of 0.67. These policies resulted in a projected target outlier pool of approximately 2.5 percent. (The previous outlier pool was 5 percent of total HH expenditures.) For CY 2010, we first returned 5 percent of these dollars back into the national, standardized 60-day episode payment rates, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor. Then, we reduced the CY 2010 rates by 2.5 percent to account for the new outlier pool of 2.5 percent. This outlier policy was adopted for CY 2010 only.

3. Statutory Update

As we noted in the CY 2011 HH PPS final rule (75 FR 70397 through 70399), section 3131(b)(1) of the Affordable Care Act amended section 1895(b)(3)(C) of the Act. As amended, the provision,

''Adjustment for outliers,'' states that ''The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to HH services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to 5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period.'' In addition, section 3131(b)(2) of the Affordable Care Act amended section 1895(b)(5) of the Act by re-designating the existing language as section 1895(b)(5)(A) of the Act, and revising it to state that the Secretary, ''subject to [a 10 percent program-specific outlier cap], may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year or year may not exceed 2.5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.''

As such, beginning in CY 2011, our HH PPS outlier policy is that we reduce payment rates by 5 percent and target up to 2.5 percent of total estimated HH PPS payments to be paid as outliers. To do so, we first returned the 2.5 percent held for the target CY 2010 outlier pool to the national, standardized 60-day episode payment rates, the national per visit rates, the LUPA add-on payment amount, and the NRS conversion factor for CY 2010. Then, we reduced the rates by 5 percent as required by section 1895(b)(3)(C) of the Act, as amended by section 3131(b)(1) of the Affordable Care Act. For CY 2011 and subsequent calendar years we target up to 2.5 percent of estimated total payments to be paid as outlier payments, and apply a 10 percent agency-level outlier cap.

4. Loss-Sharing Ratio and Fixed Dollar Loss (FDL) Ratio

For a given level of outlier payments, there is a trade-off between the values selected for the FDL ratio and the loss-sharing ratio. A high FDL ratio reduces the number of episodes that can receive outlier payments, but makes it possible to select a higher loss-sharing ratio, and therefore, increase outlier payments for outlier episodes. Alternatively, a lower FDL ratio means that more episodes can qualify for outlier payments, but outlier payments per episode must then be lower.

The FDL ratio and the loss-sharing ratio must be selected so that the estimated total outlier payments do not exceed the 2.5 percent aggregate level (as required by section 1895(b)(5)(A) of the Act). Historically, we have used a value of 0.80 for the loss-sharing ratio which, we believe, preserves incentives for agencies to attempt to provide care efficiently for outlier cases. With a loss-sharing ratio of 0.80, Medicare pays 80 percent of the additional estimated costs above the outlier threshold amount. We did not propose a change to the loss-sharing ratio in the HH PPS proposed rule (78 FR 40301). In the CY 2011 HH PPS final rule (75 FR 70398), in targeting total outlier payments as 2.5 percent of total HH PPS payments, we implemented an FDL ratio of 0.67, and we maintained that ratio in CY 2012. Simulations based on CY 2010 claims data completed for the CY 2013 HH PPS final rule showed that outlier payments were estimated to comprise approximately 2.18 percent of total HH PPS payments in CY 2013, and as such, we lowered the FDL ratio from 0.67 to 0.45. We stated that lowering the FDL ratio to 0.45, while maintaining a loss-sharing ratio of 0.80, achieved an effective balance of compensating for high-cost episodes while allowing more episodes to qualify as outlier payments (77 FR 67080). The national, standardized 60-day episode payment amount is multiplied by the FDL ratio. That amount is wage-adjusted to derive the wage-adjusted FDL amount, which is added to the case-mix and wage-adjusted 60-day episode payment amount to determine the outlier threshold amount that costs have to exceed before Medicare will pay 80 percent of the additional estimated costs.

For this final rule, simulating payments using more complete CY 2012 claims data (a full year of data rather than preliminary data from the first half of 2012) and the CY 2013 payment rates (77 FR 67100 through 67105); we estimate that outlier payments in CY 2013 would comprise 1.79 percent of total payments. Based on simulations using CY 2012 claims data, the CY 2014 payments rates in section IV.E., and an FDL ratio of 0.45; we estimate that outlier payments in CY 2014 would comprise approximately 1.86 percent of total HH PPS payments in CY 2014. Given the increases to the CY 2014 national per-visit payment rates and the national, standardized 60-day episode payment rate as a result of making the case-mix adjustment in section IV.C budget neutral and the starting point for the rebasing calculations in section IV.D, our analysis estimates a 0.07 percentage point increase in outlier payments as a percent of total HH PPS payment. We further estimate that by the end of the 4-year phase-in period required by the Affordable Care Act, estimated outlier payments as a percent of total HH PPS payments will be approximately 2.07 percent. We did not propose a change to the FDL ratio or loss-sharing ratio for CY 2014 as we believed that maintaining an FDL of 0.45 and a loss-sharing ratio of 0.80 are appropriate given the percentage of outlier payments is estimated to increase as a result of the increasing the national per-visit amounts through the rebasing adjustments and the claims data showing any utilization changes that may have resulted from decreasing the FDL of 0.45 in CY 2013 would not be available for analysis until next year.

5. Outlier Relationship to the HH Payment Study

As we discuss in section IV.G. of this final rule, section 3131(d) of the Affordable Care Act requires CMS to conduct a study and report on developing HH PPS payment revisions that will ensure access to care and payment for patients with high severity of illness. Our Report to Congress containing this study's recommendations is due no later than March 1, 2014. Section 3131(d)(1)(A)(iii) of the Affordable Care Act, in particular, states that this study may include analysis of potential revisions to outlier payments to better reflect costs of treating Medicare beneficiaries with high levels of severity of illness.

Although we did not propose any changes to the outlier policy, the following is a summary of the comments we received regarding outlier payments.

Comment: Several commenters stated that estimated outlier payments as a percent of total payments for CY 2014 is below the budgeted amount of 2.5 percent and that the FDL ratio and/or loss-sharing ratio should be set so that estimated outlier payments as a percent of total payments would reach 2.5 percent. One commenter stated that because the national, standardized 60-day episode payment rate is increased as a result of the adjustment to the case-mix weights in section IV.C., fewer episodes qualify for outlier payments, contributing to estimated outlier payments falling short of 2.5 percent of total payments.

Response: We did not propose a change to the FDL ratio for CY 2014 as the claims data showing any utilization changes that may have resulted from an FDL of 0.45 would not be available for analysis until next year. In addition, we

note that the percentage of outlier payments is estimated to increase as a result of both increasing the national per-visit amounts over the next four years (which will increase an episode's imputed costs) and as a result of decreasing the national, standardized 60-day episode payment rate over the next four years (which will decrease the fixed-dollar loss threshold amount). We are also concerned that if we decreased the FDL ratio or increased the loss-sharing ratio we could potentially pay more than 2.5 percent of estimated total payments as outlier payments and that episodes without unusual variations in the type or amount of medically necessary care would qualify for outlier payments, which is contrary to the intent of the policy. Consequently, for the above stated reasons, we believe that we should not make any changes/revisions to our outlier payment methodology at this time.

Comment: One commenter recommended that CMS eliminate outlier payments in their entirety and return the 2.5 percent withhold to the base payment rates.

Response: We are required in section 1895(b)(5)(A) of the Act, to include an outlier pool of an amount that is 2.5 percent. We do believe that the statute allows the Secretary the discretion as to whether or not to have an outlier policy under the HH PPS. To date, analysis on the outlier policy has not been conducted. We plan to look into whether or not an outlier policy remains to be appropriate as well as ways to maintain an outlier policy for episodes that incur unusually high costs due to patient care needs without qualifying episodes of care that do not meet that criteria or are potentially fraudulent. We recently awarded a new contract to address any findings from the home health study required by section 3131(d) of the Affordable Care Act, monitor the potential impact of the rebasing adjustments and other recent payment changes, and develop payment options to ensure ongoing access to care for vulnerable populations, which may include potential revisions to the outlier payment methodology to better reflect costs of treating Medicare beneficiaries with high levels of severity of illness.

Comment: A few commenters stated that they do not believe that the 10 percent agency-level cap on outlier payments is an effective fraud fighting policy and recommended that CMS exempt certain HHAs that serve high-cost patients with multiple clinical issues from the10 percent agency-level cap.

Response: The 10 percent agency-level cap on outlier payments is a statutory requirement in section 1895(b)(5)(B) of the Act and thus we do not have the authority to rescind this policy or exempt HHAs from this provision.

Final Decision: We are finalizing no change to the FDL ratio or loss sharing ratio for CY 2014. However, we will continue to monitor outlier payments and continue to explore ways to maintain an outlier policy for episodes that incur unusually high costs due to patient care needs without qualifying episodes of care that do not meet that criteria.

The Office of Inspector General (OIG) released a Management Implications Report in August of 2013 that concluded there is a ''systemic weakness that results in Medicare coverage of unnecessary home health care for diabetic patients''. The OIG report noted that investigations show that the majority of beneficiaries involved in fraudulent schemes have a primary diagnosis of diabetes that OIG Special Agents found falsified medical records documenting patients having hand tremors and poor vision that preventing them from drawing insulin in a syringe, visually verifying the correct dosage, and injecting the insulin themselves, when the patients did not in fact suffer those symptoms.

In light of the OIG report, we conducted analysis and simulations performed on CY 2012 claims data. We found that nearly 44 percent of the episodes that would qualify for outlier payments had a primary diagnosis of diabetes and 16 percent of episodes that would quality for outlier payments had a primary diagnosis of ''Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled.'' Our simulations also estimated that approximately 81 percent of outlier payments would be paid to proprietary agencies and that approximately two-thirds of outlier payments would be paid to HHAs located in Florida (27 percent), Texas (24 percent) and California (15 percent).

We conducted additional analyses on episodes in our simulations that would have resulted in outlier payments over $10,000. Of note, 95 percent of episodes that would have resulted in outlier payments over $10,000 were for patients with a primary diagnosis of diabetes or long-term use of insulin, most were concentrated in Florida, Texas, New York and California and Oklahoma, and on average, these outlier episodes had 160 skilled nursing visits in a 60-day episode of care.[7] Given that nearly half of all outlier cases in our simulation that would qualify for outlier payments have a primary diagnosis of diabetes and the OIG's assertion that there is a ''systemic weakness that results in Medicare coverage of unnecessary home health care for diabetic patients'' and investigations show that the majority of beneficiaries involved in fraudulent schemes have a primary diagnosis of diabetes, we believe that our current outlier payment methodology needs to be re-examined and potentially revised. With nearly 16 percent of episodes simulated to qualify for outlier payments having a primary diagnosis of ''Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled'' we believe that episodes that do not have unusual variations in the type or amount of medically necessary care are qualifying for outlier payments, potentially through suspect fraudulent billing practices, which is contrary to the intent of the policy. As we have noted in the past (74 FR 580085), we are committed to addressing potentially fraudulent activities, especially those in areas where we see suspicious outlier payments. As we noted above, we plan to examine potential revisions to the outlier payment methodology through a new contract awarded to Abt Associates to address these findings and also any findings from the home health study required by section 3131(d) of the Affordable Care Act.

G. Payment Reform: Home Health Study and Report

Section 3131(d) of the Affordable Care Act requires the Secretary to conduct a study on HHA costs involved with providing ongoing access to care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness (specifically, beneficiaries with ''high levels of severity of illness''). Section 3131(d) of the Affordable Care Act also gives the Secretary the authority to explore methods to revise the HH PPS to account for costs related to patient severity of illness or to improving beneficiary access to care and examine the potential impacts of any potential revisions to the payment system.

[7] This analysis simulated payments using CY 2012 claims data and CY 2012 payment rates. The simulations did not take into account the 10-percent outlier cap. Some episodes may have qualified for outlier payments in the simulations, but were not paid accordingly if the HHA was at or over its 10 percent cap on outlier payments as a percent of total payments.

As we stated in the CY 2013 HH PPS proposed rule (77 FR 41572), we awarded an initial contract to L&M Policy Research in the fall of 2010 to perform exploratory work for the study on the vulnerable patient populations (that is, low-income Medicare beneficiaries, beneficiaries in medically underserved areas, and beneficiaries with high levels of severity of illness). The contractor performed a literature review of potential HH PPS payment vulnerabilities and access issues, established and convened technical expert panel (TEP) meetings and open door forums to help define the vulnerable patient populations and to gain insight on access issues these populations may face, and performed preliminary analysis looking at resource costs versus Medicare reimbursement.

In September 2011, we awarded a subsequent contract to L&M Policy Research, along with subcontractors Avalere Health, Mathematica Policy Research, and Social & Scientific Systems, to develop an analytic plan, perform detailed analysis, and if appropriate, develop recommendations for changes to the HH PPS. In 2012, L&M completed preliminary analyses on HHA costs associated with providing care for vulnerable patient populations. L&M presented their findings at a TEP meeting in December 2012 and received extensive feedback on our analyses. L&M refined their analytic approach based on feedback from the TEP meeting and is in the process of completing the refined analyses. In addition to examining the costs of providing care to vulnerable patient populations, survey data was collected and analyzed to assess whether the vulnerable patient populations experience access issues and identify potential factors that may prevent access to care. Since the CY 2014 HH PPS proposed rule, L&M presented the survey findings and the analyses of HHA costs to the technical expert panel during a webinar and received their feedback. The survey findings and the analyses of HHA costs are currently being reviewed and have not yet been finalized.

The findings from the analysis of HHA costs and the survey on access to care for vulnerable patient populations may be used to develop recommendations on how to revise the current HH PPS to better account for costs and ensure access to care for these beneficiaries. Methods to revise the current HH PPS could include payment adjustments for services that involve either more or fewer resources, changes to reflect resources involved with providing HH services to low-income Medicare beneficiaries or Medicare beneficiaries residing in medically underserved area, and ways outlier payments could be revised to reflect costs of treating Medicare beneficiaries with high severity of illness. In addition, as part of the study, L&M may analyze operational issues involved with potential implementation of potential revisions to the HH payment system.

The Affordable Care Act requires that the Secretary submit a Report to Congress regarding the study no later than March 1, 2014. The report may contain recommendations for revisions to the HH PPS, recommendations for legislation and administrative action, and recommendations for whether further research is needed. The Congress also provided CMS with the authority to conduct a separate demonstration project to perform additional research and further explore recommendations from the study. We plan to provide updates regarding our progress on the HH study in future rulemaking and open door forums.

The following is a summary of the comments we received regarding the Payment Reform: Home Health Study and Report.

Comment: One commenter stated that physical therapists and other home health clinicians should be active participants in the collection of analysis of data gathering in the study and that CMS should provide updates to the stakeholder community on the plan and design of the study.

Response: We are currently in the process of reviewing the study findings but thank the commenter for their interest in being part of the study. We plan to provide updates to the industry and stakeholder community once findings are finalized.

Comment: Several commenters encouraged CMS to review the study results and address any clear access or cost concerns identified in the study in the 2014 rule through the grouper, the case-mix weights, and/or the outlier calculations. Some commenters encouraged CMS to incorporate the findings from the VNAA Vulnerable Patient Study into the case-mix system for CY 2014. Multiple commenters stated that the findings of CMS' home health study and the VNAA Vulnerable Patient Study should be taken into account when finalizing the rebasing provisions.

Many commenters supported CMS' research on costs for vulnerable populations and stated that it is mainly the not-for-profit HHAs that treat the most vulnerable patients and that Medicare does not fully cover the cost of these patients. One commenter recommended that CMS expedite the study research and incorporate suitable adjustments to the HH PPS to ensure that beneficiaries with high levels of severity of illness or other vulnerable populations have appropriate access to home health services.

Response: In September 2013, we awarded a contract to perform follow-on work for the home health study. The new contract with Abt Associates will examine the findings of the home health study, monitor potential impacts of rebasing and other recent policy changes, and develop payment reform options to ensure access to care for vulnerable populations and address payment vulnerabilities in the current payment system. Given the statutory mandate that the rebasing adjustments must be implemented starting at the beginning of CY 2014, we are required to implement the reductions before the study findings will be finalized. However, we will continue to assess the case-mix system and improve the case-mix system as necessary.

Final Decision: We appreciate the comments on the home health study and will take the comments into consideration for the follow-on work under the new contract.

H. Cost Allocation of Survey Expenses

In the CY 2013 HH PPS proposed rule (77 FR 41548), we proposed to amend § 431.610(g), Relations with standard-setting and survey agencies, to require that Medicaid state plans explicitly include Medicaid's appropriate contribution to the cost of HH surveys. We proposed to add a reference to HHAs, along with NFs and ICFs/IIDs at § 431.610(g).

Surveys are required for determining a provider's or supplier's compliance with program participation requirements and the HHA surveys benefit both Medicare and Medicaid programs where the HHAs seek such dual certification. Thus, in accordance with OMB Circular A–87, the costs for surveys of HHAs that are certified for both Medicare and Medicaid should be shared between Medicare, Medicaid and state-only programs in proportion to the benefits received. However, to provide more time for dialogue with states and for any necessary adjustments to state Medicaid programs, we removed the proposed provision at § 431.610(g) in the CY 2013 HH PPS final rule (77 FR 67068). In the CY 2014 HH PPS proposed rule we again proposed to amend § 431.610(g) with additional explanation of our proposal and with updated cost information.

We noted that a state Medicaid program must provide that, in certifying

HHAs, the state's designated survey agency must carry out certain other responsibilities that already apply to surveys of nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF–IID), including sharing in the cost of HHA surveys. Section 431.610(g) provides for the availability of federal financial participation (FFP) in the cost of such surveys, except for expenditures that the survey agency makes that are attributable to the state's overall responsibilities under state law and regulations. We believe that the principles articulated in OMB Circular A–87 require that HHA survey costs be allocated to Medicaid, Medicare and state-only programs in proportion to the benefits received. However, we also explained that the proposed amendment to § 431.610(g) would add clarity, and that the proposed rule would offer states and the public additional opportunity to comment or pose questions that will further aid adherence to the appropriate cost allocation principles. We further invited public comment on our proposed methods to ensure compliance with these requirements. Specifically, we proposed to review each state's allocation of costs for HHA surveys for adherence to OMB Circular A–87 principles and the statutes with the goal of ensuring full adherence by each state no later than July 2014. For that portion of costs attributable to Medicare and Medicaid, we proposed to assign 50 percent to Medicare and 50 percent to Medicaid. This is the standard 50/50 method that CMS and states have used effectively for many years in the allocation of expenses related to surveys of SNF/NF nursing homes, an approach we consider to be more straight-forward and economical compared with calculation of unique percentages that vary state-to-state and year-by-year. Most importantly, we explained that a 50/50 method best reflects the reality that Medicare and Medicaid requirements for home health agencies are generally the same and each program benefits from the regulations.

An alternative to the proposed 50/50 method for allocating each state's Medicare/Medicaid HHA survey costs would be to fix each state's Medicaid share each year based on the proportion of Medicaid funding for HH services in the state compared to the combined Medicare and Medicaid total funding in the most recent years for which the data are reasonably complete. This is the method adopted for the disbursement of civil monetary penalties (CMPs) in the CY 2013 HH PPS final rule (77 FR 67078). However, the effective date of HHA CMPs is not until July 1, 2014. Our preparations for imposing such CMPs in 2014 indicate that the annual data collection and calculations necessary for that methodology are (a) more complicated and burdensome than necessary, (b) involve an inherent data lag that could create uncertainty for states and CMS in preparing state survey agency budgets, (c) sufficiently variable from year to year to create further uncertainty for states, (d) unable to anticipate the effects of substantial expansion of Medicaid under the Affordable Care Act (which could increasingly enlarge the state Medicaid share) and (e) will not recognize that both Medicare and Medicaid programs benefit from the regulations. Therefore, we expressed our belief that the more efficient and advantageous method, for both CMS and states, would be the 50/50 allocation method that has been used successfully for many years in the allocation of survey costs for SNF and NF. We invited comment not only on the 50/50 allocation method for the costs of HHA survey expenses, but on whether the method of distribution for CMP receipts back to states and to the U.S. Treasury should be changed to the same 50/50 methodology.

Based on such a 50/50 ratio for each state, and based upon the projected national HHA survey budget for FY 2014 of $37.2 million, if implemented in the beginning of FY 2014, the anticipated aggregate share for Medicaid would amount to $18.6 million. The cost of surveys is treated as a Medicaid administrative cost, reimbursable at the professional staff rate of 75 percent. Therefore, the state Medicaid share would be approximately $4.65 million on an annualized basis. The $4.65 million cost would be spread out over the 53 states/jurisdictions that currently conduct surveys under section 1864 of the Act. However, the adherence date of July FY 2014 would reduce the Medicaid aggregate share to approximately $4.65 million (for 3 months of the annual $18.6 million aggregate cost) and the state Medicaid share to approximately $1.16 million (25 percent of expenses for the last quarter of FY 2014).

We received a total of 7 pertinent comments from 5 organizations regarding the Cost Allocation of Survey Expenses proposal. The following is a summary of the comments we received.

Comment: Two organizations supported the proposed cost allocation and the proposed 50/50 split between Medicare and Medicaid for that proportion of the overall expense attributed to those programs. The commenters noted that the 50/50 split has been in long-standing use for the allocation of survey costs for skilled nursing facilities that are dually certified for Medicare and Medicaid.

Response: These comments reflect the allocation methodology proposed in the notice of proposed rule-making. We concur with the comments.

Comment: Another commenter agreed with the preamble statement that costs should be allocated in proportion to benefits received, but disputed that the costs should be split 50/50 between Medicare and Medicaid. The commenter expressed the belief that Medicaid receives less than 50 percent of the benefit on the grounds that (a) OASIS (Outcome and Assessment Information Set) drives much of S&C activity, and no State uses OASIS in rate setting; (b) Medicare requires that beneficiaries be homebound, in contrast to Medicaid home health policy mandates; (c) Medicare and its survey activities are focused on a medical model in contrast to Medicaid's focus on support for activities of daily living and heavy reliance on home health aides rather than skilled nurses; and (d) about 77 percent of the commenter's state Medicaid home health beneficiaries are under age 65, with children representing 34 percent of those beneficiaries receiving Medicaid home health services.

Response: We appreciate the distinctions between Medicare and Medicaid that the commenter makes, but do not agree that these distinctions are particularly relevant to the issue of survey expenses. Medicare and Medicaid pay for survey expenses to assess a provider's compliance with Conditions of Participation (CoPs). HHAs providing services under Medicaid's home health benefit must meet the CoPs for Medicare, as specified at § 440.70(d). As articulated in the State Operations Manual at 2202.3E, if home care is provided by an entity required to meet the Medicare CoPs for any reason, then the entity must apply all the requirements of the CoPs, including the comprehensive assessment and OASIS data reporting requirements, to all patients of the agency, including patients treated under a Medicaid waiver or state plan, as applicable, with certain minor exceptions.

In short, the CoPs expressed in 42 CFR part 484 benefit both Medicare and Medicaid patients. For example, the regulations begin with a focus on proper organization of the HHA and qualifications of personnel. The first full CoP delineates patient rights that apply equally to Medicare and Medicaid patients, such as informing patients of their rights in advance, the right to file

a grievance and to have a grievance investigated, the right to be informed and participate in planning care and treatment, the right to have medical records held confidentially, and the right to have his or her property treated with respect. An entire CoP (§ 484.36) is dedicated to home health aides, an area that the commenter observes is particularly important for Medicaid. Similarly, § 484.55 obliges HHAs to conduct a timely and comprehensive assessment of the care and support needs of each individual. This is a basic expectation regardless of whether it is viewed through the lens of a medical model or daily living and support model.

With regard to OASIS, some states do indeed use OASIS in their HHA rate-setting methodology, but such use is immaterial to the question at hand, since the survey process is concerned with application of the CoPs and quality of care, not enforcement of payment policy or the calculation of payment rates. Further, OASIS is an integral part of the comprehensive assessment process required at § 484.55. The comprehensive assessment regulation requires that HHAs use a standard core data set, that is, OASIS, when evaluating adult, non-maternity Medicare and Medicaid patients (except those receiving exclusively homemaker or chore services). OASIS data must be collected and reported for Medicaid as well as Medicare beneficiaries in accordance with § 484.20.

Because the focus of the survey process is on compliance with the CoPs, and the CoPs apply to all patients served by the HHA, it is largely immaterial whether the majority of the work for either Medicare or Medicaid is done by registered nurses or home health aides, whether a medical model or daily living and support model predominates, or whether the majority of the clientele is under or over the age of 65.

It is arguably the case that certain specific standards tend to apply to some groups more than to others. For example, § 484.55(c) requiring drug regimen review may most benefit those patients taking many medications, while § 484.34 governing medical social work may most benefit individuals who face challenging social and emotional factors related to health problems. However, the preponderance of standards benefits almost all patients regardless of payment source. This is particularly true of the most common area identified for deficiency citations by surveyors as a result of the onsite survey process. In FY 2012, for example, the most frequently-cited deficiencies were for failure to ensure that a written plan of care was established and periodically reviewed (8.6 percent of all agencies surveyed), the assessment included a review of all medications (6.1 percent), the plan of care covered applicable diagnoses and required services and visits (6.0 percent), a record of past and current findings was maintained (5.2 percent), and that care was provided in accordance with commonly-accepted professional standards (3.9 percent). Therefore, while there are differences between Medicare and Medicaid coverage, we do not agree that such differences materially affect the extent to which the CoPs benefit Medicare compared to Medicaid beneficiaries when the regulations are taken as a whole.

Comment: Another commenter stated that the proposed rule would result in a loss of federal funds for the state and comes at a very inconvenient time, since the state survey agency's state funding in the past 3 years has been level-funded in the state budget while the survey agency's responsibilities have grown, the Medicare portion of survey agency funding has been reduced considerably, and the proposed rule would require changes in the state accounting system, which would add costs that should be recognized by CMS.

Response: We very much appreciate the extraordinary fiscal constraints under which most states have recently labored. We also acknowledge that federal budget sequestration resulted in a decrease in federal funding for the Medicare portion of state survey agency responsibilities. Neither observation, however, directly affects the question of whether Medicare and Medicaid should both contribute to the cost of surveys, in accordance with the accounting principles articulated in OMB Circular A–87. We appreciate that there is some fiscal impact for states, but note that the Medicaid impact is mitigated by two major factors. First, Medicaid's share is treated as a Medicaid administrative cost, reimbursable at the professional staff rate of 75 percent. This means that the state Medicaid cost is limited to 25 percent of the Medicaid share. Second, we sought to provide states with considerable preparatory time. As discussed in the preamble, we first published a notice of proposed rule-making on this topic in 2012 (CY 2013 HH PPS proposed rule (77 FR 41548)), but postponed action on a final rule in order to provide more time for states. Further, in our latest proposal we delayed the proposed enforcement date until July 1, 2014 to offer even more preparatory time for states. In various national calls and meetings with state survey agencies over the past two years, we also communicated our intent to issue and finalize the proposal to ensure that Medicaid contributes its fair share of the cost of HHA surveys. The combined effect has been to provide states with almost 2 years advance notice of CMS enforcement. We believe that the FY 2013 reduction in Medicare funding for state survey work reinforces the need to ensure that all appropriate payment sources are contributing their fair share of survey expenses, rather than expecting Medicare to shoulder a disproportionate share.

We appreciate that some states may need to make minor accounting system changes and will work with such states to accomplish the changes expeditiously. We expect that arrangements for Medicaid fair share contributions to the cost of the HHA surveys can easily be built on the procedures and requirements that are already in place for states to receive Medicaid federal financial participation for certain existing activities, such as the cost of surveys in nursing facilities. States already track the survey hours and costs associated with home health surveys. The 50/50 methodology specified in this rule for allocating expenses between Medicare and Medicaid simplifies the cost accounting. Further, states are already required under § 431.610(h)(2) to remove from federal reimbursement claims the costs of surveying for HHA compliance with state-only laws and regulations. We therefore expect that there already exists the appropriate infrastructure for proper cost accounting, but that some states may need to establish additional, internal cost accounting codes. We plan to work with states to make any accounting system changes in state cost accounting systems that are necessary to ensure there are proper audit trails and data to support claims for federal reimbursement.

Comment: Another commenter observed that there was a number of different methods that CMS could use to arrive at an appropriate split between Medicare and Medicaid contributions, such as the proportion of aggregate Medicare or Medicaid spending to the combined total spending of the two programs. The commenter also stated that the volume of survey activity in a state should inform the cost-share assigned to a state.

Response: We discussed the aggregate spending method in our notice of proposed rule-making, and explained that we were proposing the 50/50 split as an administratively simpler and appropriate alternative that has been in long-standing use with respect to

surveys of SNF and NF. The commenter did not recommend the aggregate method, nor did any other commenter, but simply expressed the aggregate method as an acceptable alternative. We are therefore retaining the proposed 50/50 cost-allocation methodology. With regard to the comment that survey activity in a state should inform the cost-share assigned to a state, our methodology would incorporate that principle. The amount of Medicaid funding for HHA surveys in each state would be based on 50 percent of the total cost of surveys in the particular state in question that is attributable to the Medicare and Medicaid share of total cost (exclusive of any state-only cost attributable to state licensure requirements).

Response Based on No Comments: CMS received no comments on whether the method of distribution for CMP receipts back to the states and to the U.S. Treasury should be changed to the same
50/50 methodology. If CMS does propose a change in the CMP receipt distribution methodology, we will propose the change in the CY 2015 HH PPS proposed rule.

Final Decision: After careful consideration of the comments, we conclude that it is appropriate and warranted to publish in this final rule the regulatory changes we proposed to ensure that state Medicaid programs include explicit provision to contribute to the cost of HHA surveys in accordance with OMB Circular A–87, with the costs that are attributable to Medicare and Medicaid shared on a 50/50 basis between the two programs.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Unless otherwise noted, to derive average costs we used data from the U.S. Bureau of Labor Statistics for all salary estimates. The salary estimates include the cost of fringe benefits, calculated at 35 percent of salary, which is based on the March 2011 Employer Costs for Employee Compensation report by the Bureau.

In the July 3, 2013, proposed rule we solicited public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs). A summary of the public comments we received, and our responses, can be found in sections IV.E.2 and IV.H of this preamble. This final rule does not revise any of the proposed rule's PRA-related requirements or burden estimates, except to clarify that existing state plan provisions already address Medicaid coverage for state survey costs and states will not have the burden of submitting a State Plan Amendment (SPA) when they ensure that Medicaid contributes its fair share to the cost of HHA surveys (described below in V.B).

A. ICRs Regarding OASIS

The information collection requirements and burden estimates associated with OASIS have been approved by OMB under OCN 0938–0760. While OASIS is discussed in preamble section IV.E.2.a, this rule does not revise any of its information collection requirements or burden estimates and, therefore, does not require additional OMB review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

B. Cost Allocation of Home Health Agency (HHA) Survey Expenses (§ 431.610)

In § 431.610(g), HHAs have been added to the survey agency provision concerning state Medicaid programs. Since CMS already requires that state survey agencies have qualified personnel perform onsite inspections as appropriate, we believe that the requirement to use qualified staff is met in the current state Medicaid plans. As explained in the preamble (*see* section IV.H, Cost Allocation of Survey Expenses, of this final rule) and in the CY 2014 HH PPS proposed rule (78 FR 40302), we also expect that state Medicaid programs will provide for the appropriate Medicaid share of expenses for the conduct of HHA surveys. This is a budgeting and accounting task. Since state Medicaid plans already provide for the necessary relations with state survey agencies, we do not believe it will be necessary for states to submit a state plan amendment. We believe the responsibilities for Medicaid home health survey costs may be met through appropriate budgeting and accounting adjustments within the context of each state's current Medicaid plan. This rule will not revise any budget-related recordkeeping or reporting requirements or estimates for state Medicaid agencies and, therefore, does not require additional OMB review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

C. ICRs Regarding Home Health Care CAHPS® (HHCAHPS®) Survey

In the proposed rule, CMS proposed to add the OMB number to the HHCAHPS Participation Exemption Request Form. CMS did not receive any comments about the proposed change, and CMS is moving forward with adding the OMB number to the Participation Exemption Request Form. This is discussed in the preamble in the section about the Home Health CAHPS (HHCAHPS) survey in the Quality Reporting Requirement section at IV.E.2.e. CMS implements the HHCAHPS® Survey to measure and to publicly report patients' experiences with home health care they receive from Medicare-certified agencies. Section 484.250, Patient Assessment Data, requires that HHAs submit to CMS, HHCAHPS® data in order to administer the payment rate methodologies described in §§ 484.215, 484.230, and 484.235. The burden associated with this is the time and effort put forth by the HHAs to submit the HHCAHPS® data, the patients' burden to respond to the HHCAHPS® survey, and the cost to the HHAs to pay for the HHCAHPS® survey vendors to collect the data on their behalf. This burden is currently accounted for under OCN 0938–1066 (CMS–10275).

CMS allows Medicare-certified home health agencies that serve 59 or fewer HHCAHPS® eligible patients, to request an exemption from participating in the HHCAHPS® survey. Currently, we have posted the HHCAHPS® Participation Exemption Request (PER) Form for the CY 2015 Annual Payment Update on *https://homehealthcahps.org*. The form is only to be used if home health agencies have 59 or fewer HHCAHPS® eligible patients in the count period that is referenced for a given calendar year. For the CY 2015 annual payment update, home health agencies with 59 or fewer HHCAHPS® patients in the period of April 2012 through March 2013 are exempt from participation in the HHCAHPS® Survey from April 2013

through March 2014, if they complete the HHCAHPS Participation Exemption Request Form for the CY 2015 Annual Payment Update, and the counts are verified in the CMS database for the same period. While the HHCAHPS® Participation Exemption Request Form is in use without an OMB control number, we are revising OCN 0938–1066 by adding the form and our estimated burden to that the control number.

The HHCAHPS® PER Form for the CY 2015 Annual Payment Update is a one-page form. We estimate that it will take 15 minutes to complete the form since it only has a few items to complete including one item concerning the count of HHCAHPS® eligible patients in an annual period. We believe that it will take an additional 20 minutes to count the patients and to verify the count. The annualized aggregated total burden to completion of the form is 1,170 hr ((15 min + 20 min)/60 × 2,000 Medicare-certified home health agencies) at a total estimated cost of $36,400 for 2,000 home health agencies.

In deriving these figures, we used the following hourly labor rates and time to complete each task: $36.27/hr and 20 min (.33 hr) for a home health care agency director to check the work on the Participation Exemption Request Form and $24.92/hr and 15 min (.25 hr) for an executive assistant to perform the patient count and to complete the form. This amounts to $18.20 per respondent ($11.97 + $6.23) or $36,400 ($18.20 × 2,000) total.

D. Submission of PRA-Related Comments

We have submitted a copy of this rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

To obtain copies of the supporting statement and any related forms for the paperwork collections referenced above, access CMS' Web site at *www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/*, or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these information collection requirements. If you comment on these information collection and recordkeeping requirements, please submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, (CMS–1450–F) Fax: (202) 395–6974; or Email: *OIRA_submission@omb.eop.gov*.

PRA-specific comments must be received on/by January 2, 2014.

VI. Waiver of Delay in Effective Date

In the absence of an appropriation for FY 2014 or a Continuing Resolution, the federal government shut down on October 1, 2013. During the funding lapse, which lasted from October 1, 2013 through October 16, 2013, only excepted operations continued, which largely excluded work on this final rule. Accordingly, most of the work on this final rule was not completed in accordance with our usual schedule for final calendar-year-based payment rules, which aims for an issuance date of November 1 followed by an effective date of January 1 to ensure that the policies are effective at the start of the calendar year to which they apply. We ordinarily provide a 60-day delay in the effective date of final rules after the date they are issued. The 60-day delay in effective date can be waived, however, if the agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued. We believe it would be contrary to the public interest to delay the effective date of the HH PPS, HH PPS Grouper refinements, rebasing, and quality reporting portions of this final rule. The HH PPS is a calendar-year payment system, and we typically issue the final rule by November 1 of each year to ensure that the payment policies for the system, associated HH PPS Grouper, and quality reporting requirements are effective on January 1, the first day of the calendar year to which the policies are intended to apply. Likewise, the HH PPS rebasing is required by section 3131(a) of the Affordable Care Act to be effective for the entirety of calendar year 2014. If the effective date of this final rule were to be delayed by 60 days, the policies adopted in this final rule would not be effective until January 21, 2014. This would be contrary to the public's interest in ensuring that home health agencies and state survey agencies receive appropriate payments in a timely manner. For these reasons we find that the delayed effective date is both impracticable and contrary to the public interest, and we are waiving such delay in the effective date of this final rule.

VII. Regulatory Impact Analysis

A. Introduction

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 Act, section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA, March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

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). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This final rule has been designated as economically significant, under section 3(f)(1) of Executive Order 12866, and thus is a major rule under the Congressional Review Act. Accordingly, we have prepared a regulatory impact analysis (RIA) that to the best of our ability presents the costs and benefits of the rulemaking. Also, the rule has been reviewed by OMB.

B. Statement of Need

Section 1895(b)(1) of the Act requires the Secretary to establish a HH PPS for all costs of HH services paid under Medicare. In addition, section 1895(b)(3)(A) of the Act requires (1) the computation of a standard prospective payment amount include all costs for HH services covered and paid for on a reasonable cost basis and that such amounts be initially based on the most recent audited cost report data available to the Secretary, and (2) the standardized prospective payment amount be adjusted to account for the effects of case-mix and wage levels among HHAs. Section 1895(b)(3)(B) of the Act addresses the annual update to the standard prospective payment amounts by the HH applicable percentage increase. Section 1895(b)(4) of the Act governs the payment computation. Sections 1895(b)(4)(A)(i) and (b)(4)(A)(ii) of the Act require the standard prospective payment amount to be adjusted for case-mix and geographic differences in wage levels. Section 1895(b)(4)(B) of the Act requires the establishment of appropriate case-mix adjustment factors for significant variation in costs among different units of services. Lastly, section 1895(b)(4)(C)

of the Act requires the establishment of wage adjustment factors that reflect the relative level of wages, and wage-related costs applicable to HH services furnished in a geographic area compared to the applicable national average level.

Section 1895(b)(5) of the Act gives the Secretary the option to make changes to the payment amount otherwise paid in the case of outliers because of unusual variations in the type or amount of medically necessary care. Section 1895(b)(3)(B)(v) of the Act requires HHAs to submit data for purposes of measuring health care quality, and links the quality data submission to the annual applicable percentage increase. Also, section 1886(d)(2)(D) of the Act requires that HH services furnished in a rural area for episodes and visits ending on or after April 1, 2010, and before January 1, 2016, receive an increase of 3 percent the payment amount otherwise made under section 1895 of the Act.

Section 3131(a) of the Affordable Care Act mandates that starting in CY 2014, the Secretary must apply an adjustment to the national, standardized 60-day episode payment rate and other amounts applicable under section 1895(b)(3)(A)(i)(III) of the Act to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. In addition, section 3131(a) of the Affordable Care Act mandates that rebasing must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts) as of the date of enactment (2010) under section 1895(b)(3)(A)(i)(III) of the Act, and be fully implemented in CY 2017.

C. Overall Impact

The update set forth in this rule applies to Medicare payments under HH PPS in CY 2014. Accordingly, the following analysis describes the impact in CY 2014 only. We estimate that the net impact of the proposals in this rule is approximately $200 million in decreased payments to HHAs in CY 2014. The impact of the 2014 wage index would be a decrease of $50 million. However, we applied a standardization factor to the rates as discussed earlier. Therefore, the net effect of the 2014 wage index is zero dollars. The −$200 million impact reflects the distributional effects of the 2.3 percent HH payment update percentage ($440 million increase), the effects of the rebasing adjustments to the national, standardized 60-day episode payment amount, the national per-visit payment rates, and the NRS conversion factor for an impact of −2.73 percent ($520 million decrease), and the effects of the ICD–9–CM HH PPS Grouper refinements of −0.62 percent ($120 million decrease). The $200 million in decreased payments is reflected in the last column of the first row in Table 33 as a 1.05 percent decrease in expenditures when comparing CY 2013 payments to estimated CY 2014 payments.

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 $7.0 million to $34.5 million in any 1 year. For the purposes of the RFA, we estimate that almost all HHAs are small entities as that term is used in the RFA. Individuals and states are not included in the definition of a small entity. The economic impact assessment is based on estimated Medicare payments (revenues) and HHS's practice in interpreting the RFA is to consider effects economically ''significant'' only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. As we discussed in the preamble of this final rule in response to comments (section IV.D), the majority of HHAs' visits are Medicare-paid visits and therefore the majority of HHAs' revenue consists of Medicare payments. Based on our analysis, we conclude that the policies finalized in this rule will not result in an estimated total impact of 3 to 5 percent or more on Medicare revenue for greater than 5 percent of HHAs. Therefore, the Secretary has determined that this final rule will not have a significant economic impact on a substantial number of small entities. Further detail is presented in Table 33 below, by HHA type and area.

Executive Order 13563 specifies, to the extent practicable, agencies should assess the costs of cumulative regulations. However, given potential utilization pattern changes, wage index changes, changes to the market basket forecasts, and unknowns regarding future policy changes, we believe it is neither practicable nor appropriate to forecast the cumulative impact of the rebasing adjustments on Medicare payments to HHAs for future years at this time. Changes to the Medicare program may continue to be made as a result of the Affordable Care Act, or new statutory provisions. Although these changes may not be specific to the HH PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes would make it difficult to predict accurately the full scope of the impact upon HHAs for future years beyond CY 2014. We note that the rebasing adjustments to the national, standardized 60-day episode payment rate and the national per-visit rates are capped at the statutory limit of 3.5 percent of the CY 2010 amounts (as described in the preamble in section IV.D) for each year, 2014 through 2017. The NRS rebasing adjustment will be −2.82 percent in each year, 2014 through 2017. As described in section IV.D of the preamble, the −2.82 percent rebasing adjustment will not exceed the statutory limit in CY 2014 and there is a very low likelihood that future adjustments of −2.82 percent in CY 2015 through 2017 would exceed the statutory limit.

In addition, section 1102(b) of the 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 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 final rule applies to HHAs. Therefore, the Secretary has determined that this rule will not have a significant economic impact on the operations 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 2013, that threshold is approximately $141 million. This final rule is not anticipated to have an effect on state, local, or tribal governments in the aggregate, or by the private sector, of $141 million or more in CY 2014.

D. Detailed Economic Analysis

This final rule sets forth updates to the HH PPS rates contained in the CY 2013 HH PPS final rule. The impact analysis of this rule presents the estimated expenditure effects of policy changes in this rule. We use the latest data and best analysis available, but we do not make adjustments for future

changes in such variables as number of visits or case-mix.

This analysis incorporates the latest estimates of growth in service use and payments under the Medicare HH benefit, based primarily on Medicare claims from 2012. We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to errors resulting from other changes in the impact time period assessed. Some examples of such possible events are newly-legislated general Medicare program funding changes made by the Congress, or changes specifically related to HHAs. In addition, changes to the Medicare program may continue to be made as a result of the Affordable Care Act, or new statutory provisions. Although these changes may not be specific to the HH PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon HHAs.

Table 33 represents how HHA Medicare revenues are likely to be affected by the policy changes in this rule. For this analysis, we used linked CY 2012 HH claims and OASIS assessments; the claims are for dates of service that ended in CY 2012. The first column of Table 33 classifies HHAs according to a number of characteristics including provider type, geographic region, and urban and rural locations. The second column shows the payment effects of the wage index. The third column shows the effects of the standardization factor. The forth column shows the effects of the ICD–9–CM Grouper scoring changes. The fifth column displays the effects of the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and NRS conversion factor as well as the effects of the LUPA add-on factors. The sixth column shows the effects of the market basket increase. The seventh column shows the payment effects of all the finalized policies.

Overall, HHAs are anticipated to experience a 1.05 percent decrease in payment in CY 2014, with freestanding HHAs anticipated to experience a 1.10 percent decrease in payments while facility-based HHAs and non-profit HHAs are anticipated to experience a 0.58 percent and a 0.49 percent decrease in payments, respectively. Government-owned HHAs are anticipated to experience a 0.92 percent decrease in payments and proprietary HHAs are anticipated to experience a 1.27 percent decrease in payments. Rural HHAs are anticipated to experience a decrease in estimated payments ranging from 0.45 percent for facility-based non-profit HHAs to 1.08 for freestanding government-owned HHAs. Urban HHAs are anticipated to experience a decrease in estimated payments, ranging from 0.47 percent for freestanding non-profit HHAs to 1.29 percent for freestanding proprietary HHAs. The overall impact in the South is estimated to be a 1.56 percent decrease in payments whereas the overall impact to the ''Other'' category (for example, Puerto Rico, Guam, U.S. Virgin Islands), is estimated at 0.14 percent increase in payments. The Pacific census region is estimated to receive a 0.34 percent increase in payments for CY 2014; however, in contrast, the West South Central census region is estimated to receive a 1.74 percent decrease in payments for CY 2014. Finally, HHAs with less than 100 first episodes are anticipated to experience a 1.27 percent decrease in payments compared to a 0.90 percent decrease in payments in CY 2014 for HHAs with 1,000 or more first episodes. A substantial amount of the variation in the estimated impacts of the proposals in this final rule in different areas of the country can be attributed to variations in the CY 2014 wage index used to adjust payments under the HH PPS. Instances where the impact, due to the rebasing adjustments, is less than others can be attributed to differences in the incidence of outlier payments and LUPA episodes, which are paid using the national per-visit payment rates that are subject to payment increases due to the rebasing adjustments. We note that some individual HHAs within the same group may experience different impacts on payments than others due to the distributional impact of the CY 2014 wage index, the extent to which HHAs utilized the 170 ICD–9–CM codes that will be removed from scoring points in the HH PPS Grouper as of January 1, 2014, and the degree of Medicare utilization.

TABLE 33—HOME HEALTH AGENCY POLICY IMPACTS FOR CY 2014, BY FACILITY TYPE AND AREA OF THE COUNTRY

	Number of agencies	CY 2014 Wage index (%)	Standardization (%)	ICD–9–CM Grouper scoring changes (%)	Rebasing [1] (%)	CY 2014 HH Payment update percentage (%)	Impact of all CY 2014 policies (%)
All Agencies	11,620	−0.25	0.25	−0.62	−2.73	2.30	−1.05
Facility Type and Control							
Free-Standing/Other Vol/NP	1,057	0.10	0.22	−0.40	−2.71	2.30	−0.49
Free-Standing/Other Proprietary	8,967	−0.37	0.25	−0.71	−2.74	2.30	−1.27
Free-Standing/Other Government	421	−0.24	0.25	−0.50	−2.73	2.30	−0.92
Facility-Based Vol/NP	813	0.01	0.24	−0.33	−2.72	2.30	−0.50
Facility-Based Proprietary	117	−0.17	0.25	−0.52	−2.77	2.30	−0.91
Facility-Based Government	245	−0.34	0.25	−0.39	−2.75	2.30	−0.93
Subtotal: Free-standing	10,445	−0.27	0.25	−0.65	−2.73	2.30	−1.10
Subtotal: Facility-based	1,175	−0.04	0.24	−0.35	−2.73	2.30	−0.58
Subtotal: Vol/NP	1,870	0.07	0.23	−0.38	−2.71	2.30	−0.49
Subtotal: Proprietary	9,084	−0.37	0.25	−0.71	−2.74	2.30	−1.27

TABLE 33—HOME HEALTH AGENCY POLICY IMPACTS FOR CY 2014, BY FACILITY TYPE AND AREA OF THE COUNTRY—Continued

	Number of agencies	CY 2014 Wage index (%)	Standardization (%)	ICD–9–CM Grouper scoring changes (%)	Rebasing [1] (%)	CY 2014 HH Payment update percentage (%)	Impact of all CY 2014 policies (%)
Subtotal: Government	666	−0.28	0.25	−0.45	−2.74	2.30	−-0.92
Facility Type and Control: Rural							
Free-Standing/Other Vol/NP	205	−0.01	0.25	−0.31	−2.75	2.30	−0.52
Free-Standing/Other Proprietary	142	−0.12	0.25	−0.43	−2.77	2.30	−0.77
Free-Standing/Other Government	468	−0.29	0.26	−0.58	−2.77	2.30	−1.08
Facility-Based Vol/NP	262	0.10	0.24	−0.34	−2.75	2.30	−0.45
Facility-Based Proprietary	35	0.18	0.24	−0.53	−2.77	2.30	−0.58
Facility-Based Government	153	−0.21	0.26	−0.34	−2.77	2.30	−0.76
Facility Type and Control: Urban							
Free-Standing/Other Vol/NP	915	0.11	0.22	−0.40	−2.70	2.30	−0.47
Free-Standing/Other Proprietary	8,652	−0.38	0.25	−0.72	−2.74	2.30	−1.29
Free-Standing/Other Government	170	−0.32	0.26	−0.54	−2.74	2.30	−1.04
Facility-Based Vol/NP	551	−0.01	0.24	−0.33	−2.72	2.30	−0.52
Facility-Based Proprietary	82	−0.25	0.26	−0.51	−2.77	2.30	−0.97
Facility-Based Government	92	−0.40	0.25	−0.42	−2.73	2.30	−1.00
Facility Location: Urban or Rural							
Rural	1,158	−0.11	0.25	−0.46	−2.76	2.30	−0.78
Urban	10,462	−0.26	0.25	−0.62	−2.73	2.30	−1.06
Facility Location: Region of the Country							
North	874	0.47	0.20	−0.36	−2.70	2.30	−0.09
Midwest	3,107	−0.52	0.25	−0.53	−2.76	2.30	−1.26
South	5,727	−0.61	0.26	−0.77	−2.74	2.30	−1.56
West	1,862	0.62	0.23	−0.46	−2.69	2.30	0.00
Other	50	0.64	0.23	−0.22	−2.81	2.30	0.14
Facility Location: Region of the Country (Census Region)							
New England	334	0.12	0.23	−0.41	−2.72	2.30	−0.48
Mid Atlantic	540	0.68	0.18	−0.33	−2.69	2.30	0.14
East North Central	2,343	−0.54	0.25	−0.56	−2.76	2.30	−1.31
West North Central	764	−0.44	0.25	−0.43	−2.75	2.30	−1.07
South Atlantic	2,122	−0.71	0.27	−0.63	−2.73	2.30	−1.50
East South Central	440	−0.41	0.26	−0.57	−2.78	2.30	−1.20
West South Central	3,165	−0.58	0.26	−0.99	−2.73	2.30	−1.74
Mountain	672	−0.30	0.26	−0.45	−2.71	2.30	−0.90
Pacific	1,190	0.98	0.21	−0.47	−2.68	2.30	0.34
Facility Size (Number of 1st Episodes)							
<100 episodes	2,881	−0.33	0.25	−0.72	−2.77	2.30	−1.27
100 to 249	2,617	−0.41	0.26	−0.78	−2.75	2.30	−1.38
250 to 499	2,577	−0.42	0.26	−0.77	−2.74	2.30	−1.37
500 to 999	1,878	−0.28	0.25	−0.65	−2.73	2.30	−1.11
1,000 or More	1,667	−0.18	0.24	−0.54	−2.72	2.30	−0.90

Source: CY 2012 Medicare claims data for episodes ending on or before December 31, 2012 (as of June 2013) for which we had a linked OASIS assessment.

[1] The impact of rebasing includes the rebasing adjustments to the national, standardized 60-day episode payment rate (−2.81 percent), the national per-visit rates (+3.45 percent), and the NRS conversion factor (−2.82%). It also includes the impact of the LUPA add-on factors. The estimated impact of the NRS conversion factor rebasing adjustment is an overall −0.05 percent decrease in estimated payments to HHAs. The estimated impact of the LUPA add-on factors is an overall 0.01 percent increase in payments to HHAs.

REGION KEY:

New England = Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Middle Atlantic = Pennsylvania, New Jersey, New York; South Atlantic = Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia; East North Central = Illinois, Indiana, Michigan, Ohio, Wisconsin; East South Central = Alabama, Kentucky, Mississippi, Tennessee; West North Central = Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota; West South Central = Arkansas, Louisiana, Oklahoma, Texas; Mountain = Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming; Pacific = Alaska, California, Hawaii, Oregon, Washington; Outlying = Guam, Puerto Rico, Virgin Islands.

E. Alternatives Considered

As described the proposed rule (78 FR 40307), we noted that additional factors were considered, but not incorporated into the methodology for calculating the rebasing adjustments. One such factor was a downward adjustment to the costs per-visit as a result of the findings from the audits of 98 Medicare HH cost reports. The results of the audits showed that agencies over-reported costs by an average of about 8 percent. More information on the analysis of the audit results can be found in the report titled: ''Analyses in Support of Rebasing & Updating the Medicare Home Health Payment Rates—CY 2014 Home Health Prospective Payment System Proposed Rule'' available on the CMS Home Health Agency (HHA) Center Web site at: *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html?redirect=/center/hha.asp*. Given this finding, we considered downward adjusting the costs on the cost report in order to better align payment with the agencies' true costs. We also considered updating costs by the HH payment update percentage (adjusted market basket) rather than the full HH market basket. In 2012 and 2013, HH payments were increased by the HH market basket minus one percentage point, as mandated by the Affordable Care Act. Furthermore, the Affordable Care Act mandates that CMS remove 5 percent of the national, standardized 60-day episode payment rate to fund the 2.5 percent outlier pool. We considered setting our target national, standardized 60-day episode payment rate for rebasing at 5 percent below the estimated cost per episode that we derived from the 2011 cost reports.

We did not incorporate any of the options discussed above as those changes would not impact the final rebasing adjustments to the national, standardized 60-day episode payment rate or national per-visit payment rates as those adjustments are at the statutory limit (no more than 3.5 percent of the CY 2010 payment rates). We note that if we implemented the rebasing adjustments using the methodology described in the CY 2014 HH PPS proposed rule, the effects from the rebasing adjustments would have been a 3.4 percent reduction in payments to HHAs in CY 2014 compared to CY 2013 rather than a 2.7 percent reduction described above. We estimate that a 2.7 percent reduction versus a 3.4 percent reduction in payments results in an increase in payments to HHAs of $140 million for CY 2014 and $1.1 billion through 2017.

In addition to the rebasing adjustments, we considered implementing a prospective reduction for nominal case-mix growth for CY 2014. In the past, various sources have suggested implementing a prospective nominal case-mix growth adjustment, which would attempt to predict the amount of nominal case-mix growth in future years and implement a reduction to prevent possible overpayments due to nominal case-mix growth. To date, we have implemented nominal case-mix growth adjustments retrospectively. That is, we use the most recent, complete data available—typically two to three years prior to the payment year—to identify nominal case-mix growth, and implement a payment reduction to account for the observed growth. The payment reductions to date for nominal case-mix growth do not attempt to re-coup overpayments made in previous years due to nominal case-mix growth. We plan to continue to monitor case-mix growth (both real and nominal case-mix growth) as more data become available.

F. Cost Allocation of Survey Expenses

We project that aggregate Medicare and Medicaid HH survey costs in FY 2014 will be approximately $37.2 million. As these costs will be assigned 50 percent to Medicare and 50 percent to Medicaid for each state, the anticipated aggregate Medicaid share would amount to $18.6 million, if implemented at the beginning of FY2014. However, the enforcement date of July FY 2014 will reduce the Medicaid aggregate share to approximately $4.65 million. The cost of surveys is treated as a Medicaid administrative cost, reimbursable at the professional staff rate of 75 percent. Therefore, the states' portion of the Medicaid HH survey costs incurred in FY 2014, with an adherence date of July FY 2014, will be approximately $1.16 million (25 percent of the aggregate $4. 65 million Medicaid cost for the last quarter of the FY), spread out across all states and two territories. Furthermore, the Federal Medicaid share will reflect the remaining $3.49 million, with an adherence date of July FY 2014. While we regard Medicaid fair share of costs to reflect an existing cost allocation principle, the methods for making the appropriate determinations have not been clear. Therefore, in this rule we delineate those methods and provide that the Medicaid responsibility be reflected in the state Medicaid Program.

G. Accounting Statement and Table

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars_a004_a-4*), in Tables 34 and 35, we have prepared an accounting statement showing the classification of the transfers associated with the provisions of this final rule. Table 34 provides our best estimate of the decrease in Medicare payments under the HH PPS as a result of the changes presented in this final rule.

TABLE 34—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS, FROM THE CY 2013 HH PPS TO THE CY 2014 HH PPS

Category	Transfers
Annualized Monetized Transfers	−$200 million

TABLE 34—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS, FROM THE CY 2013 HH PPS TO THE CY 2014 HH PPS—Continued

Category	Transfers
From Whom to Whom?	Federal Government to HH providers

Table 35 provides our best estimate of the changes in the classification of the cost allocation of survey expenses.

TABLE 35—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS RELATING TO THE MEDICARE AND MEDICAID HOME HEALTH SURVEY AND CERTIFICATION COSTS, FYS 2013 TO 2014

Category	Transfers
Federal Medicaid HH Survey & Certification Costs	
Annualized Monetized Transfers	$3.49 Million*
From Whom to Whom?	Federal Government (Medicaid) to Federal Government (Medicare)
State Medicaid HH Survey & Certification Costs	
Annualized Monetized Transfers	$1.16 Million*
From Whom to Whom?	State Governments (Medicaid) to Federal Government (Medicare)

* HH survey and certification costs reflect an adherence date of July FY 2014.

H. Conclusion

In conclusion, we estimate that the net impact of this rule is approximately $200 million in CY 2014 savings. The −$200 million reflects the distributional effects of an updated wage index ($50 million decrease), a standardization factor to ensure budget neutrality in episode payments using the 2014 wage index ($50 million increase), the 2.3 percent HH payment update percentage ($440 million increase), the rebasing adjustments required by section 3131(a) of the Affordable Care Act of −2.73 percent ($520 million decrease), and the ICD–9–CM HH PPS Grouper refinements of −0.62 percent ($120 million decrease).

VII. Federalism Analysis

Executive Order 13132 on Federalism (August 4, 1999) establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that it will not have substantial direct effects on the rights, roles, and responsibilities of states, local or tribal governments.

List of Subjects in 42 CFR Part 431

Grant programs-health, Health facilities, Medicaid, Privacy, and Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR part 431 as set forth below:

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

■ 1. The authority citation for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

■ 2. Section 431.610 is amended by revising paragraph (g) introductory text to read as follows:

§ 431.610 Relations with standard-setting and survey agencies.

* * * * *

(g) *Responsibilities of survey agency.* The plan must provide that, in certifying NFs, HHAs, and ICF–IIDs, the survey agency designated under paragraph (e) of this section will —

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program).

Dated: November 12, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 18, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2013–28457 Filed 11–22–13; 4:15 pm]

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Part IV

Department of Health and Human Services

45 CFR Parts 144, 147, 153, et al.

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 147, 153, 155, and 156

[CMS–9954–P]

RIN 0938–AR89

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015

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

ACTION: Proposed rule.

SUMMARY: This proposed rule sets forth payment parameters and oversight provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost-sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges. It also proposes additional standards with respect to composite rating, privacy and security of personally identifiable information, the annual open enrollment period for 2015, the actuarial value calculator, the annual limitation in cost sharing for stand-alone dental plans, the meaningful difference standard for qualified health plans offered through a Federally-facilitated Exchange, patient safety standards for issuers of qualified health plans, and the Small Business Health Options Program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on December 26, 2013.

ADDRESSES: In commenting, please refer to file code CMS–9954–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four 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–9954–P, 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–9954–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

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

FOR FURTHER INFORMATION CONTACT: For general information: Sharon Arnold, (301) 492–4286; Laurie McWright, (301) 492–4311; or Jeff Wu, (301) 492–4305.

For matters related to student health insurance coverage and composite rating: Jacob Ackerman, (301) 492–4179.

For matters related to the risk adjustment program generally, the small group counting requirements, the risk adjustment methodology, and the methodology for determining the reinsurance contribution rate and payment parameters: Kelly Horney, (410) 786–0558.

For matters related to reinsurance generally, oversight of the premium stabilization programs, distributed data collection, and administrative appeals: Adrianne Glasgow, (410) 786–0686.

For matters related to reinsurance contributions: Adam Shaw, (410) 786–1019.

For matters related to risk corridors: Jaya Ghildiyal, (301) 492–5149.

For matters related to cost-sharing reductions, the premium adjustment percentage, and Federally-facilitated Exchange user fees: Johanna Lauer, (301) 492–4397.

For matters related to the annual limitation on cost sharing for stand-alone dental plans, privacy and security of personally identifiable information, the annual open enrollment period for the 2015 benefit year, and the meaningful difference standard: Leigha Basini, (301) 492–4380.

For matters related to the Small Business Health Options Program: Scott Dafflitto, (301) 492–4198.

For matters related to the actuarial value calculator: Allison Wiley at (410)786–1740.

For matters related to patient safety standards for issuers of qualified health plans: Nidhi Singh Shah, (301) 492–5110.

For matters related to netting of payments and charges: Pat Meisol, (410) 786–1917.

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 Web site as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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Acronyms

Affordable Care Act—The collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152)
AV—Actuarial Value
CFR—Code of Federal Regulations
CMS—Centers for Medicare & Medicaid Services
EHB—Essential Health Benefits
ERISA—Employee Retirement Income Security Act of 1974 (Pub. L. 93–406)
FFE—Federally-facilitated Exchange
FF–SHOP—Federally-facilitated Small Business Health Options Program
FPL—Federal poverty level
HCC—Hierarchical condition category
HHS—United States Department of Health and Human Services
HIPAA—Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
IRS—Internal Revenue Service
MLR—Medical Loss Ratio
NAIC—National Association of Insurance Commissioners
OMB—Office of Management and Budget
OPM—United States Office of Personnel Management
PHS Act—Public Health Service Act
PII—Personally identifiable information
PSO—Patient Safety Organization
PRA—Paperwork Reduction Act of 1985
PSES—Patient safety evaluation system
QHP—Qualified health plan
SHOP—Small Business Health Options Program
The Code Internal Revenue Code of 1986

I. Executive Summary

Qualified individuals and qualified employers are now able to purchase private health insurance coverage that begins as early as January 1, 2014, through competitive marketplaces called Affordable Insurance Exchanges, or ''Exchanges'' (also called Health Insurance Marketplaces, or ''Marketplaces'').[1] Individuals who enroll in qualified health plans (QHPs) through individual market Exchanges may receive premium tax credits to make health insurance more affordable and financial assistance to reduce cost sharing for health care services. In 2014, HHS will also operationalize the premium stabilization programs established by the Affordable Care Act—the risk adjustment, reinsurance, and risk corridors programs—which are intended to mitigate the impact of possible adverse selection and stabilize the price of health insurance in the individual and small group markets. We believe that these programs, together with other reforms of the Affordable Care Act, will make high-quality health insurance affordable and accessible to millions of Americans.

HHS has previously outlined the major provisions and parameters related to the advance payments of the premium tax credit, cost-sharing reductions, and premium stabilization programs. This proposed rule proposes additional provisions related to the implementation of these programs. Specifically, we propose certain oversight provisions for the premium stabilization programs, as well as key payment parameters for the 2015 benefit year.

The Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 final rule (78 FR 15410) (2014 Payment Notice) finalized the risk adjustment methodology that HHS will use when it operates risk adjustment on behalf of a State. This proposed rule proposes minor updates to this risk adjustment methodology for 2014 to account for certain private market Medicaid expansion plans, and seeks comment on how to adjust the geographic cost factor in the payment transfer formula to account for less populous rating areas in future benefit years. In this proposed rule, we also propose to clarify the counting methods for determining small

[1] The word ''Exchanges'' refers to both State Exchanges, also called State-based Exchanges, and Federally-facilitated Exchanges (FFEs). In this proposed rule, we use the terms ''State Exchange'' or ''FFE'' when we are referring to a particular type of Exchange. When we refer to ''FFEs,'' we are also referring to State Partnership Exchanges, which are a form of FFE.

group size for participation in the risk adjustment and risk corridors programs.

Using the methodology set forth in the 2014 Payment Notice for determining the uniform reinsurance contribution rate and uniform reinsurance payment parameters, we propose in this rule a 2015 uniform reinsurance contribution rate of $44 annually per capita, and the 2015 uniform reinsurance payment parameters—a $70,000 attachment point, a $250,000 reinsurance cap, and a 50 percent coinsurance rate. We also propose to decrease the attachment point for 2014 from $60,000 to $45,000. Additionally, in order to maximize the financial effect of the transitional reinsurance program, we propose that if reinsurance contributions collected for a benefit year exceed the requests for reinsurance payments for the benefit year, we would increase the coinsurance rate on our reinsurance payments, ensuring that all of the contributions collected for a benefit year are expended for claims for that benefit year.

We also propose several provisions related to cost sharing. First, we propose a methodology for estimating average per capita premium and for calculating the premium adjustment percentage for 2015 which is used to set the rate of increase for several parameters detailed in the Affordable Care Act, including the maximum annual limitation on cost sharing and the maximum annual limitation on deductibles for health plans in the small group market for 2015. We also propose to set the same reduced maximum annual limitations on cost sharing for the 2015 benefit year as we established for the 2014 benefit year for cost-sharing reduction plan variations. Additionally, we are proposing certain modifications to the methodology for calculating advance payments for cost-sharing reductions for the 2015 benefit year. We also propose standards for updating the actuarial value (AV) calculator.

This proposed rule provides for a 2015 Federally-facilitated Exchange (FFE) user fee rate of 3.5 percent of premium. Additionally, we propose a user fee adjustment allowance for administrative costs in the 2015 benefit year to reimburse third party administrators that provide payment for contraceptive services for enrollees in certain self-insured group health plans that receive an accommodation from the obligation to cover these services in 2014.

On November 14, 2013, the Federal government announced a policy under which it will not consider certain non-grandfathered health insurance coverage in the individual or small group market renewed between January 1, 2014, and October 1, 2014, under certain conditions to be out of compliance with specified 2014 market rules, and requested that States adopt a similar non-enforcement policy.[2]

Issuers have set their 2014 premiums for individual and small group market plans by estimating the health risk of enrollees across all of their plans in the respective markets, in accordance with the single risk pool requirement at 45 CFR 156.80. These estimates assumed that individuals currently enrolled in the transitional plans described above would participate in the single risk pools applicable to all non-grandfathered individual and small group plans, respectively (or a merged risk pool, if required by the State). Individuals who elect to continue coverage in a transitional plan (forgoing premium tax credits and cost-sharing reductions that might be available through an Exchange plan, and the essential health benefits package offered by plans compliant with the 2014 market rules, and perhaps taking advantage of the underwritten premiums offered by the transitional plan) may have lower health risk, on average, than enrollees in individual and small group plans subject to the 2014 market rules.

If lower health risk individuals remain in a separate risk pool, the transitional policy could increase an issuer's average expected claims cost for plans that comply with the 2014 market rules. Because issuers would have set premiums for QHPs in accordance with 45 CFR 156.80 based on a risk pool assumed to include the potentially lower health risk individuals that enroll in the transitional plans, an increase in expected claims costs could lead to unexpected losses.

To help address the effects of this transitional policy on the risk pool, we are exploring modifications to a number of programs. We have outlined various options under consideration throughout this proposed rule, including adjustments to the reinsurance and risk corridors programs. We are seeking comment on these proposals, as well as soliciting suggestions for alternate proposals. As the impact of the transitional policy becomes clearer, we will determine what, if any, adjustments are appropriate.

The success of the premium stabilization programs depends on a robust oversight program. This proposed rule expands on provisions of the Premium Stabilization Rule (77 FR 17220), the 2014 Payment Notice (78 FR 15410), and the first and second final Program Integrity Rules (78 FR 54070 and 78 FR 65046). In this proposed rule, we propose that HHS may audit State-operated reinsurance programs, contributing entities, and issuers of risk adjustment covered plans and reinsurance eligible-plans. We also clarify participation standards for the risk corridors program, and outline a proposed process for validating risk corridors data submissions and enforcing compliance with the provisions of the risk corridors program.

We also propose several provisions regarding the HHS-operated risk adjustment data validation process. On June 22, 2013, we issued "The Affordable Care Act HHS-operated Risk Adjustment Data Validation Process White Paper"[3] and on June 25, 2013, we held a public meeting to discuss how to best ensure the accuracy and consistency of the data we will use when operating the risk adjustment program on behalf of a State. In this proposed rule, we propose standards for risk adjustment data validation, including a sampling methodology for the initial validation audit and detailed audit standards. These proposed standards would be tested for 2 years before they are used as a basis for payment adjustments. This proposed rule also includes a proposal to implement, over time, the requirements related to patient safety standards that QHP issuers must meet, and proposes reducing the time period for which a State electing to operate an Exchange after 2014 must have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment from at least 12 months to 6.5 months prior to the Exchange's first effective date of coverage. We also propose provisions related to the privacy and security of personally identifiable information (PII), the annual open enrollment period for 2015, the annual limitation on cost sharing for stand-alone dental plans, and the meaningful difference standards for QHPs offered through an FFE. We also propose certain standards for the Small Business Health Options Program (SHOP) and for composite rating in the small group market.

II. Background

A. Legislative and Regulatory Overview

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted

[2] Letter to Insurance Commissioners, Center for Consumer Information and Insurance Oversight, November 14, 2013. *See http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11–14–2013.PDF.*

[3] Available at: *https://www.regtap.info/uploads/library/ACA_HHS_OperatedRADVWhitePaper_062213_5CR_062213.pdf*

on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this proposed rule, we refer to the two statutes collectively as the ''Affordable Care Act.''

Section 1302 of the Affordable Care Act directs the Secretary of Health and Human Services (referred to throughout this rule as the Secretary) to define EHBs and provides for cost-sharing limits and AV requirements. Sections 1302(d)(1) and (d)(2) of the Affordable Care Act describe the determination of the levels of coverage based on AV. Consistent with section 1302(d)(2)(A) of the Affordable Care Act, AV is calculated based on the provision of EHB to a standard population. Section 1302(d)(3) of the Affordable Care Act directs the Secretary to develop guidelines that allow for de minimis variation in AV calculations.

Section 1311(b)(1)(B) of the Affordable Care Act directs that the SHOP assist qualified small employers in facilitating the enrollment of their employees in QHPs offered in the small group market. Under section 1312(f)(2)(B) of the Affordable Care Act, beginning in 2017, States will have the option to allow issuers to offer QHPs in the large group market through the SHOP.

Section 1311(c)(6)(B) of the Affordable Care Act states that the Secretary is to require an Exchange to provide for annual open enrollment periods for calendar years after the initial enrollment period.

Section 1311(h)(1) of the Affordable Care Act specifies that a QHP may contract with health care providers and hospitals with more than 50 beds only if they meet certain patient safety standards, including use of a patient safety evaluation system, a comprehensive hospital discharge program, and implementation of health care quality improvement activities. Section 1311(h)(2) of the Affordable Care Act also provides the Secretary flexibility to establish reasonable exceptions to these patient safety requirements and section 1311(h)(3) of the Affordable Care Act allows the Secretary flexibility to issue regulations to modify the number of beds described in section 1311(h)(1)(A) of the Affordable Care Act.

Section 1313 of the Affordable Care Act, combined with section 1321 of the Affordable Care Act, provides the Secretary with the authority to oversee the financial integrity of State Exchanges, their compliance with HHS standards, and the efficient and non-discriminatory administration of State Exchange activities. Section 1321(a) of the Affordable Care Act provides general authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs, and other components of Title I of the Affordable Care Act.

When operating an FFE under section 1321(c)(1) of the Affordable Care Act, HHS has the authority under sections 1321(c)(1) and 1311(d)(5)(A) of the Affordable Care Act to collect and spend user fees. In addition, 31 U.S.C. 9701 permits a Federal agency to establish a charge for a service provided by the agency. Office of Management and Budget (OMB) Circular A–25 Revised establishes Federal policy regarding user fees and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public.

Section 1341 of the Affordable Care Act requires the establishment of a transitional reinsurance program in each State to help pay the cost of treating high-cost enrollees in the individual market from 2014 through 2016. Section 1342 of the Affordable Care Act directs the Secretary to establish a temporary risk corridors program that provides for the sharing in gains or losses resulting from inaccurate rate setting from 2014 through 2016 between the Federal government and certain participating plans. Section 1343 of the Affordable Care Act establishes a permanent risk adjustment program that is intended to provide increased payments to health insurance issuers that attract higher-risk populations, such as those with chronic conditions, and thereby reduce incentives for issuers to avoid higher-risk enrollees. Sections 1402 and 1412 of the Affordable Care Act establish a program for reducing cost sharing for individuals with lower household income and Indians.

Section 1411(g) of the Affordable Care Act provides that any person who receives information specified in section 1411(b) provided by an applicant or information specified in section 1411(c), (d), or (e) from a Federal agency must use the information only for the purpose of and to the extent necessary to ensure the efficient operation of the Exchange, and may not disclose the information to any other person except as provided in that section. Section 6103(l)(21)(C) of the Code additionally provides that return information disclosed under section 6103(l)(21)(A) or (B) may be used only for the purpose of and to the extent necessary in establishing eligibility for participation in the Exchange, verifying the appropriate amount of any premium tax credit or cost-sharing reduction, or determining eligibility for participation in a health insurance affordability program as described in that section.

1. Premium Stabilization Programs

In the July 15, 2011 **Federal Register** (76 FR 41930), we published a proposed rule outlining the premium stabilization programs. We implemented the premium stabilization programs in a final rule, published in the March 23, 2012 **Federal Register** (77 FR 17220) (Premium Stabilization Rule). In the December 7, 2012 **Federal Register** (77 FR 73118), we published a proposed rule outlining the benefit and payment parameters for 2014 to expand the provisions related to the premium stabilization programs and set forth payment parameters in those programs (proposed 2014 Payment Notice). We published the 2014 Payment Notice in the March 11, 2013 **Federal Register** (78 FR 153410).

As discussed above, we published a white paper on risk adjustment data validation on June 22, 2013, and hosted a public meeting on June 25, 2013, to discuss the white paper.

2. Program Integrity

In the June 19, 2013 **Federal Register** (78 FR 37032), we published a proposed rule that proposed certain program integrity standards related to Exchanges and the premium stabilization programs (proposed Program Integrity Rule). The provisions of that proposed rule were finalized in two rules, the ''first final Program Integrity Rule'' published in the August 30, 2013 **Federal Register** (78 FR 54070) and the ''second final Program Integrity Rule'' published in the October 30, 2013 **Federal Register** (78 FR 65046).

3. Exchanges, Essential Health Benefits, Actuarial Value

A proposed rule relating to EHBs and AV was published in the November 26, 2012 **Federal Register** (77 FR 70644). We proposed standards related to the premium adjustment percentage in the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule, published in the February 25, 2013 **Federal Register** (78 FR 12834) (EHB Rule). We established standards for the administration and payment of cost-sharing reductions and the SHOP in the 2014 Payment Notice and in the Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 interim final rule, published in the

March 11, 2013 **Federal Register** (78 FR 15541). The provisions established in the interim final rule were finalized in the second final Program Integrity Rule.

We set forth standards related to Exchange user fees in the 2014 Payment Notice. We also established an adjustment to the FFE user fee in the Coverage of Certain Preventive Services Under the Affordable Care Act final rule, published in the July 2, 2013 **Federal Register** (78 FR 39870) (Preventive Services Rule).

A Request for Comment relating to Exchanges was published in the August 3, 2010 **Federal Register** (75 FR 45584). An Initial Guidance to States on Exchanges was issued on November 18, 2010. A proposed rule was published in the July 15, 2011 **Federal Register** (76 FR 41866) to implement components of the Exchange. A proposed rule regarding Exchange functions in the individual market, eligibility determinations, and Exchange standards for employers was published in the August 17, 2011 **Federal Register** (76 FR 51202). A final rule implementing components of the Exchanges and setting forth standards for eligibility for Exchanges was published in the March 27, 2012 **Federal Register** (77 FR 18310) (Exchange Establishment Rule).

4. Market Rules

Provisions relating to the 2014 market reforms and rate review were published in Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review proposed rule in the November 26, 2012 **Federal Register** (77 FR 70584). A final rule implementing these provisions was published in the February 27, 2013 **Federal Register** (78 FR 13406) (Market Reform Rule).

5. Medical Loss Ratio

We published a request for comment on PHS Act section 2718 in the April 14, 2010 **Federal Register** (75 FR 19297), and published an interim final rule with a 60-day comment period relating to the medical loss ratio (MLR) program on December 1, 2010 (75 FR 74864). A final rule with a 30-day comment period was published in the December 7, 2011 **Federal Register** (76 FR 76574).

B. Stakeholder Consultation and Input

In addition to seeking advice from the public on risk adjustment data validation, HHS has consulted with stakeholders on policies related to the operation of Exchanges, including the SHOP and the premium stabilization programs. HHS has held a number of listening sessions with consumers, providers, employers, health plans, the actuarial community, and State representatives to gather public input. HHS consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners (NAIC), regular contact with States through the Exchange Establishment grant and Exchange Blueprint approval processes, and meetings with Tribal leaders and representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties. We considered all of the public input as we developed the policies in this proposed rule.

C. Structure of Proposed Rule

The regulations outlined in this proposed rule would be codified in 45 CFR parts 144, 147, 153, 155 and 156. The proposed regulations in parts 144 and 147 propose amendments relating to student health insurance coverage. The proposed regulations in part 147 also outline market-wide provisions regarding composite rating. The proposed regulations in part 153 outline the 2015 uniform contribution rate and uniform reinsurance payment parameters for the 2015 benefit year and oversight provisions related to the premium stabilization programs, such as provisions related to risk adjustment data validation, risk corridors data validation, and HHS's authority to audit entities participating in these programs. The proposed regulations in part 153 propose that excess reinsurance contributions collected for a benefit year be used for claims for that benefit year.

The proposed regulations in part 155 propose to reduce the time that States that elect to establish and operate an Exchange after 2014 must have in effect an approved or conditionally approved Exchange Blueprint and readiness assessment from 12 months to 6.5 months prior to the Exchange's first effective date of coverage. The proposed regulations also include a change to the annual open enrollment period for the 2015 benefit year and certain proposals related to the SHOP Exchanges, which we discuss in greater detail below. We also propose in part 155 to amend § 155.260 to allow the Secretary to determine that additional uses or disclosures of PII not specifically permitted by § 155.260 ensure the efficient operation of the Exchange. In addition, we propose to establish a process under which Exchanges may seek the Secretary's approval for other uses of applicant PII not specifically permitted by § 155.260. We also propose to amend § 155.260 to more specifically define the term ''non-Exchange entity'' and to provide a baseline for the privacy and security standards to which Exchanges must bind non-Exchange entities through written contracts or agreements.

The proposed regulations in part 156 set forth provisions related to cost sharing, including the premium adjustment percentage, the maximum annual limitation on cost sharing, the maximum annual limitation on deductibles for health plans in the small group market, the reductions in the maximum annual limitation for cost sharing plan variations, and the methodology to calculate advance payments of cost-sharing reductions for 2015. They also outline the 2015 FFE user fee rate and propose a user fee adjustment to reimburse third party administrators that pay for contraceptive services for enrollees in certain self-insured group health plans that receive an accommodation from the obligation to cover these services. They also include provisions related to parameters for making updates to the AV calculator in future plan years. The proposed 2015 AV Calculator and a proposed 2015 AV Calculator methodology, which would supersede the 2014 versions of these documents incorporated by reference in the EHB Rule, are being incorporated by reference in this proposed rule. In part 156 we also propose a meaningful difference standard for QHPs offered through an FFE and patient safety standards for issuers of QHPs. Finally, we propose an administrative appeals process applicable to the premium stabilization, cost-sharing reduction, advance payments of the premium tax credit, and FFE user fee programs.

In parts 155 and 156, we also propose the following provisions related to the SHOP:

- We propose to permit all SHOPs performing premium aggregation to establish one or more standard processes for premium calculation, payment, and collection.
- We propose that in the FF–SHOPs, for plan years when premium aggregation is available, employers be required to make premium payments to the FF–SHOP according to a timeline and process established by HHS. We further propose that for plan years beginning on or after January 1, 2015, unless the QHP issuer receives a cancellation notice from the FF–SHOP, the issuer would be required to effectuate coverage.
- We propose a standard premium pro-rating methodology for the FF–SHOPs, for plan years when premium aggregation is available, providing that groups will be charged for the portion

of the month for which an enrollee is enrolled.

- We propose to make explicit our interpretation of current regulations that no SHOPs would be permitted to collect information on a SHOP application unless that information is necessary to determine SHOP eligibility or effectuate enrollment through the SHOP.
- We propose that no SHOPs would be permitted to perform individual market Exchange eligibility determinations or verifications.
- We propose that a qualified employer that becomes a large employer but continues to purchase coverage through a SHOP would continue to be rated as a small employer.
- We propose to limit the employer and employee eligibility adjustment periods to circumstances when the SHOP has an optional verification process, and collects information through that verification process that is inconsistent with the information provided by an employer or employee on a SHOP application.
- We propose for plan years beginning on or after January 1, 2015 to give SHOPs in States that permit this activity under State law, the option of permitting enrollment in a SHOP through the Internet Web site of an agent or broker.
- We propose to limit the availability of composite premiums in the FF–SHOPs after employee choice and premium aggregation become available.
- We propose methods for employers in the FF–SHOPs to offer stand-alone dental coverage after employee choice becomes available in those SHOPs.
- We propose for plan years beginning on or after January 1, 2015 to permit FF–SHOPs to give employers the flexibility to define different premium percentage contributions for full-time employees and non-full-time employees.

We note that nothing in these proposed regulations would limit the authority of the Office of the Inspector General (OIG) as set forth by the Inspector General Act of 1978 or other applicable law.

III. Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2015

A. Part 144—Requirements Relating to Health Insurance Coverage

In § 144.103, the term ''policy year,'' as amended by the second final Program Integrity Rule, is defined as: (1) With respect to a grandfathered health plan offered in the individual health insurance market, the 12-month period that is designated as the policy year in the policy documents of the individual health insurance coverage. If there is no designation of a policy year in the policy document (or no such policy document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year; and (2) with respect to a non-grandfathered health plan offered in the individual health insurance market, or in a market in which the State has merged the individual and small group risk pools (merged market), for coverage issued or renewed beginning January 1, 2014, a calendar year for which health insurance coverage provides coverage for health benefits. Further, § 147.104, as amended by the second final Program Integrity Rule, establishes individual market open enrollment periods based on a calendar policy year and provides that non-grandfathered coverage in the individual or merged markets must be offered on a calendar year basis, with a policy year beginning on January 1 and ending on December 31 of each year.

Under regulations at § 147.145(a), student health insurance coverage is defined as individual health insurance coverage. Section 147.145(b), however, exempts student health insurance coverage from certain PHS Act and Affordable Care Act requirements that apply to individual health insurance coverage, including certain guaranteed availability provisions of section 2702 of the PHS Act, implemented at § 147.104. As discussed below, because student health insurance coverage is traditionally offered on a school year basis (for example, a policy year beginning on September 1 of each year and ending on August 30 of the following year), we are proposing to modify § 147.145 to exempt student health insurance coverage from the requirement under section 2702 to establish open enrollment periods and coverage effective dates that are based on a calendar policy year, including the requirement that non-grandfathered coverage in the individual and merged markets be offered on a calendar year basis. We are also proposing conforming amendments to the definition of ''policy year'' to reflect that student health insurance coverage would not be required to be offered on a calendar year basis. We seek comment on this proposal.

B. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Composite Rating

Section 2701 of the PHS Act, as added by section 1201 of the Affordable Care Act, establishes permissible rating factors that may be used to vary the premium rate charged by a health insurance issuer for non-grandfathered health insurance coverage (including QHPs) in the individual and small group markets beginning in 2014.[4] The factors are: family size, rating area, age, and tobacco use (within limits). Section 2701(a)(4) of the PHS Act provides that with respect to family coverage under a group health plan or health insurance coverage, any rating variation for age or tobacco use must be applied based on the proportion of the premium attributable to each family member covered under the plan or coverage.

In the Market Reform Rule, we applied the per-member rating requirement of PHS Act section 2701(a)(4) in both the individual and small group markets. Thus, at § 147.102(c), we generally directed that issuers calculate a separate premium for each individual covered under the plan or coverage based on allowable rating factors including age and tobacco use, and sum the individual rates to determine the total premium charged by the issuer to a family or to a group health plan.[5]

We recognized that in the small group market it is common industry billing practice to charge an employer a uniform premium for a given family composition by adding the per-member rates and dividing by the total number of employees covered under the employer's health insurance plan. We indicated that nothing prevents an issuer from converting per-member rates into average enrollee premium amounts (calculated composite premiums), provided that the total group premium is the same total amount derived in accordance with the process established by the regulations.

Because calculated composite premiums are average rates for a particular group, changes in employee

[4] Beginning in 2017, States will have the option to allow issuers to offer QHPs in the large group market through the SHOP. If a State elects this option, the rating rules in section 2701 and its implementing regulations will apply to all coverage offered in such State's large group market (except for self-insured group health plans) under to section 2701(a)(5) of the PHS Act.

[5] States that do not permit rating for age or tobacco use may require health insurance issuers in the individual and small group markets to use uniform family tiers and corresponding multipliers established by the State. § 147.102(c)(2).

census would typically cause a change in the average rate. For example, a new average rate per enrollee would typically result from employees adding or dropping coverage during the course of the plan year, causing employer and employee contributions to change as well. We have been asked about such mid-year changes in group composition and how issuers should address the resulting changes in the calculated composite premium for the group.

In this proposed rule, we propose to add a provision at § 147.102(c)(3) clarifying that if an issuer offers a composite premium calculated when the employer obtains or renews coverage, the issuer must ensure that such amount does not vary for any plan participant or beneficiary during the plan year with respect to the particular plan involved. Under this approach, an issuer would be required to accept the group's composite premium, calculated based on applicable employee enrollment at the beginning of the plan year, as the applicable premium rate for any new individual who enrolls in the plan during the plan year.[6] Terminations of coverage during the plan year also would not change the composite premium. At the time of renewal, the issuer would recalculate a group's composite premium based on plan enrollment at that time for subsequent coverage. This will allow calculated composite premiums, and thus employer and employee contributions to coverage, to remain stable during the plan year, regardless of changes in the group's composition.

This proposed policy would generally apply to health insurance issuers offering non-grandfathered health insurance coverage in the small group market, through a SHOP or outside of a SHOP, for plan years beginning on or after January 1, 2015. However, we encourage issuers to voluntarily adopt this approach for plan years beginning in 2014. As discussed in more detail below, we propose a limited exception to this policy in § 155.705(b)(11)(ii)(D) and § 156.285(a)(4)(ii) of this proposed rule, under which composite rating would not be available when an employer participating in a Federally-facilitated SHOP elects to offer its employees all QHPs within a single level of coverage under § 155.705(b)(3)(iv)(A).

We are considering establishing a uniform tiered-composite rating structure that would apply market wide unless a State requires and HHS approves an alternate tiered-composite rating methodology. Under the approach we are considering, a small group market issuer offering composite rating would calculate the composite premium for different tiers of enrollees covered under the employer's plan. For example, in a two-tier structure, one composite premium would be calculated for covered adults (employees and adult dependents) and another composite premium would be calculated for covered children. Alternatively, in a three-tier structure, there would be one composite premium for covered employees, a second composite premium for covered adult dependents, and a third composite premium for covered children. The premium for a given family composition would simply be determined by summing the applicable tiered-composite rates. We believe a tiered-composite approach would promote simplicity for issuers and employers, and ensure that premiums for family coverage appropriately reflect the lower rates for children.

We seek comments on all aspects of this approach to composite rating. We also seek comments on whether to establish a default uniform tiered-composite rating structure, including the appropriate number and types of enrollee tiers (for example, an employee-only tier, an adult dependent tier, and a child dependent tier).

2. Student Health Insurance Coverage

As discussed above, under § 147.145(a), student health insurance coverage is defined as a type of individual health insurance coverage. However, § 147.145(b) provides that for purposes of the guaranteed availability requirements of section 2702 of the PHS Act, a health insurance issuer that offers student health insurance coverage is not required to accept individuals who are not students or dependents of student in such coverage. Because student health insurance coverage is traditionally offered on a school year basis that does not align with the calendar year, we do not believe student health insurance should be required to establish open enrollment periods and coverage effective dates under § 147.104(b)(1) and (2) that are based on a calendar policy year, including the requirement that non-grandfathered coverage in the individual and merged markets be offered on a calendar year basis. Accordingly, we are proposing to amend § 147.145(b)(1)(ii) to exempt student health insurance coverage from these guaranteed availability requirements. We seek comments on this proposal and whether other modifications are necessary for student health insurance coverage.

C. Part 153—Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act

1. Provisions and Parameters for the Permanent Risk Adjustment Program

The risk adjustment program is a permanent program created by section 1343 of the Affordable Care Act that transfers funds from lower risk, non-grandfathered plans to higher risk, non-grandfathered plans in the individual and small group markets, inside and outside the Exchanges. In subparts D and G of the Premium Stabilization Rule, we established standards for the administration of the risk adjustment program. A State that is approved or conditionally approved by the Secretary to operate an Exchange may establish a risk adjustment program, or have HHS do so on its behalf.

a. Risk Adjustment User Fees

If a State is not approved to operate or chooses to forgo operating its own risk adjustment program, HHS will operate risk adjustment on the State's behalf. As described in the 2014 Payment Notice, HHS's operation of risk adjustment on behalf of States is funded through a risk adjustment user fee. Section 153.610(f)(2) provides that an issuer of a risk adjustment covered plan must remit a user fee to HHS for each month equal to the product of its monthly enrollment in the plan and the per-enrollee-per-month risk adjustment user fee specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year.

OMB Circular No. A–25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. The risk adjustment program will provide special benefits as defined in section 6(a)(1)(b) of Circular No. A–25R to an issuer of a risk adjustment covered plan because it will mitigate the financial instability associated with risk selection as other market reforms go into effect. The risk

[6] In cases where the composite premium does not incorporate the age or tobacco use rating factor, an issuer would be required to accept the group's composite premium, calculated based on applicable employee enrollment at the beginning of the plan year, multiplied by any applicable age or tobacco rating factor, as the applicable premium for any new individual who enrolls in the plan during the plan year. Under § 147.102(a)(1)(iv), rating for tobacco use is subject to the nondiscrimination and wellness provisions under section 2705 of the PHS Act and its implementing regulations, regardless of whether the composite premium incorporates the tobacco use rating factor.

adjustment program also will contribute to consumer confidence in the health insurance industry by helping to stabilize premiums across the individual and small group health insurance markets.

In the 2014 Payment Notice, we estimated Federal administrative expenses of operating the risk adjustment program to be $0.96 per enrollee per year, based on our estimated contract costs for risk adjustment operations. For the 2015 benefit year, we propose to use the same methodology to estimate our administrative expenses to operate the program. These contracts cover development of the model and methodology, collections, payments, account management, data collection, data validation, program integrity and audit functions, operational and fraud analytics, stakeholder training, and operational support. We do not propose to set the user fee to cover costs associated with Federal personnel. To calculate the user fee, we would divide HHS's projected total costs for administering the risk adjustment programs on behalf of States by the expected number of enrollees in risk adjustment covered plans (other than plans not subject to market reforms and student health plans, which are not subject to payments and charges under the risk adjustment methodology HHS uses when it operates risk adjustment on behalf of a State) in HHS-operated risk adjustment programs for the benefit year.

We estimate that the total cost for HHS to operate the risk adjustment program on behalf of States for 2015 will be approximately $27.3 million, and that the per capita risk adjustment user fee would be no more than $1.00 per enrollee per year. We seek comment on this proposed assessment of user fees to support HHS-operated risk adjustment programs.

b. HHS Risk Adjustment Methodology Considerations

In the 2014 Payment Notice, we finalized the methodology that HHS will use when operating a risk adjustment program on behalf of a State in 2014. We propose to use the same methodology in 2015. In this proposed rule, we propose to clarify the treatment of premium assistance Medicaid alternative plans in this risk adjustment methodology, and seek comment on potential adjustments to the geographic cost factor in the HHS risk adjustment model for future years.

(i) Incorporation of Premium Assistance Medicaid Alternative Plans in the HHS Risk Adjustment Methodology

Section 1343(c) of the Affordable Care Act provides that risk adjustment applies to non-grandfathered health insurance coverage offered in the individual and small group markets. In some States, expansion of Medicaid benefits under section 2001(a) of the Affordable Care Act may take the form of enrolling newly Medicaid-eligible enrollees into individual market plans. For example, these enrollees could be placed into silver plan variations—either the 94 percent silver plan variation or the zero cost sharing plan variation—with a portion of the premiums and cost sharing paid for by Medicaid on their behalf. Because individuals in these types of Medicaid expansion plans receive significant cost-sharing assistance, they may utilize medical services at a higher rate. To address this induced utilization in the context of cost-sharing reduction plan variations in the HHS risk adjustment methodology, we increase the risk score for individuals in plan variations by a certain factor. We propose to use the same factor for individuals enrolled in the corresponding Medicaid expansion plan variations. Table 1 shows the cost-sharing adjustments for both 94 percent silver plan variation enrollees and zero cost-sharing plan variation enrollees for silver QHPs as finalized in the 2014 Payment Notice. We propose to implement these adjustments for 2014. We plan to evaluate these adjustments in the future, after data from the initial years of risk adjustment is available. We seek comment on this approach.

TABLE 1—COST-SHARING REDUCTION ADJUSTMENTS

Plan variation	Induced utilization factor
94 percent Plan Variation	1.12
Zero Cost-Sharing Plan Variation of Silver QHP	1.12

(ii) Adjustment to the Geographic Cost Factor

As finalized in the 2014 Payment Notice, the geographic cost factor is an adjustment in the payment transfer formula to account for plan costs such as input prices that vary geographically and are likely to affect plan premiums. For the metal-level risk pool, it is calculated based on the observed average silver plan premium in a geographic area relative to the statewide average silver plan premium. It is separately calculated for catastrophic plans in a geographic area relative to the statewide catastrophic pool. However, several States have defined a large number of rating areas. Less populous rating areas raise concerns about the accuracy and stability of the calculation of the geographic cost factor because in less populous rating areas the geographic cost factor might be calculated based on a small number of plans. Inaccurate or unstable geographic cost factors could distort premiums and the stability of the risk adjustment model.

We seek comment on how to best adjust the geographic cost factors or geographic rating areas in future years to address these potential premium distortions. We also seek comments on how this adjustment should be implemented for a separately risk adjusted pool of catastrophic plans. We do not intend to make this adjustment for 2014.

c. Small Group Determination for Risk Adjustment

For a plan to be subject to risk adjustment, according to section 1343(c) of the Affordable Care Act and the definition of a ''risk adjustment covered plan'' in § 153.20, a plan must be offered in the ''individual or small group market.'' The definition of small group market in § 153.20 references the definition at section 1304(a)(3) of the Affordable Care Act.

Section 1304(a)(3) of the Affordable Care Act, in defining ''small group market,'' references the definition of a ''small employer'' in section 1304(b)(2) of the Affordable Care Act. That definition provides that an employer with an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year will be considered a ''small employer.'' However, section 1304(b)(3) of the Affordable Care Act provides that, for plan years beginning before January 1, 2016, a State may elect to limit ''small employer'' to mean an employer with at least 1 but not more than 50 employees.

In the 2014 Payment Notice, we stated that we believe that the Affordable Care Act requires the use of a counting method that accounts for part-time employees, and that the full-time equivalent method described in section 4980H(c)(2)(E) of the Code is a reasonable method to apply. Thus, we believe that the risk adjustment program must also use a counting method that takes employees that are not full-time into account when determining whether

a group health plan must participate in that program.

However, we also recognize that, because risk adjustment is intended to stabilize premiums by mitigating the effects of the rating rules, it is important that the program be available to plans that are subject to the rating rules, to the extent permissible under the Affordable Care Act. We recognize that a number of States, which have primary enforcement jurisdiction over the market rules, may use counting methods that do not take non-full-time employees into account.

Thus, we propose to clarify that in determining which group health plans participate as small group plans in the risk adjustment program, we would apply the applicable State counting method, unless the State counting method does not take into account employees that are not full-time. In that circumstance, we would apply the full-time equivalent method described in section 4980H(c)(2)(E) of the Code.[7] We believe that this approach defers to State counting methods and aligns with State enforcement of rating rules, within the bounds of what is permissible under the Affordable Care Act. We seek comment on our interpretation of the permissible counting rules for purposes of risk adjustment, the approach described above, and on alternate counting methods that may be preferable. We also seek comment on whether we should codify these risk adjustment counting rules in regulation text.

d. Risk Adjustment Data Validation

The 2014 Payment Notice established a risk adjustment data validation program that HHS will use when operating risk adjustment on behalf of a State. In the 2014 Payment Notice, we specified a framework for this program that includes six stages: (1) Sample selection; (2) initial validation audit; (3) second validation audit; (4) error estimation; (5) appeals; and (6) payment adjustments.

To develop the details of the program, we sought the input of issuers, consumer advocates, providers, and other stakeholders. We issued the ''Affordable Care Act HHS-Operated Risk Adjustment Data Validation Process White Paper'' on June 22, 2013. That white paper discussed and sought comments on a number of potential considerations for the development of the risk adjustment data validation methodology. On June 25, 2013, we held a public meeting to discuss the topics considered in the white paper. We received submissions from 53 commenters, including issuers, issuer trade groups, advocacy groups, and consultants. As we noted in the white paper, our overall goals are to promote consistency and a level playing field by establishing uniform audit requirements, and to protect private information by limiting data transfers during the data validation process.

In this proposed rule, we propose provisions for the risk adjustment data validation process and methodology that reflect our analysis of the white paper comments and our discussions with stakeholders. We note that a State operating a risk adjustment program is not required to adopt these standards. These proposed rules are consistent with the white paper and lessons drawn from our experience with Medicare Advantage risk adjustment data validation and thus should be familiar to issuers.

(i) Sample Selection

The first stage in the HHS-operated risk adjustment data validation process is the selection of a sample of an issuer's enrollees whose risk adjustment data will be validated. In the proposed 2014 Payment Notice, we stated that HHS would choose a sample size of enrollees such that the estimated risk score errors would be statistically sound and the enrollee-level risk score distributions would reflect enrollee characteristics for each issuer. We stated that in determining the appropriate sample size for data validation, we recognized the importance of striking a balance between ensuring statistical soundness of the sample and minimizing the operational burden on issuers, providers, and HHS. Additionally, we stated that we would ensure that the sample would cover critical subpopulations of enrollees for each risk adjustment covered plan, such as enrollees with and without hierarchical condition categories (HCCs). To develop a proposed sample size for the first year of the HHS risk adjustment data validation program, we propose to use the methodology outlined in the white paper. Our goal in determining the enrollee sample size for the initial 2 years of risk adjustment data validation is to propose a statistically valid sample large enough to inform us to the dynamics of the risk adjustment data validation process in operation and estimation of risk score accuracy. As we established in the 2014 Payment Notice, for HHS to observe and optimize the risk adjustment data validation process, no payment adjustments will be made based on the risk adjustment data validation process for the initial 2 years of HHS-operated risk adjustment.

In general, we propose to select the initial validation audit sample for a given benefit year by dividing the relevant population into a number of ''strata,'' representing different demographic and risk score bands. We are proposing that, for the initial 2 years of the risk adjustment data validation program, the initial validation audit sample will consist of 200 enrollees from each issuer. We stated in the 2014 Payment Notice that the overall sample will reflect a disproportionate selection of enrollees with HCCs. Here, we discuss in detail our proposed sampling methodology, including our proposal to group enrollees to account for age characteristics and health status. Some commenters on the white paper suggested that we also consider sampling based on plan types and other characteristics. We will consider other sampling strategies in the future, but believe that we do not yet have enough experience with the risk adjustment process to determine the most appropriate sampling groups at this time.

Therefore, we are proposing a simple age and risk score stratification for at least the initial 2 years of the program. Following the division of the relevant population into strata, we propose to use the following formulas to calculate a proposed sample size for the initial validation audit each year. In general, the proposed formula for the overall sample size for an issuer (n) is:

[7] We note that the IRS has published a proposed regulation that contains further details that would apply to this calculation (54.4980H–2(c)).

$$n = \frac{\left(\sum_{h=1}^{H} N_h S_h\right)^2}{\sum_{h=1}^{H} N_h S_h^{\ 2} + \left(\frac{Prec \times Y}{z - value}\right)^2}$$

Where:

H is the number of strata;

N_h is the population size of the *hth* stratum;

Y is the average risk score of the population, adjusted based upon the estimated risk score error;

S_h represents the standard deviation of risk score error for the *hth* stratum;

Prec represents the desired precision level (for example, 10 percent, meaning a 10 percent margin of error in the estimated risk score); and

z-value is the z-value associated with the desired confidence level (for example, 1.96 for a two-sided 95 percent confidence level).

As noted above, we propose a sample size of 200 enrollees from each issuer for the initial 2 years of the program. The formula above would be used after this initial 2-year period to calculate a more precise, issuer-specific sample size for each issuer.

The proposed formula for calculating the sample size for each stratum is:

$$n_h = n \times \frac{N_h S_h}{\sum_{h=1}^{H} N_h S_h}$$

Where:

N_h is the population size of the hth stratum;

n is the overall sample size; and

S_h represents the standard deviation of risk score error for the hth stratum.

For the 2014 benefit year, the parameters listed above were developed using data from two principal sources: Medicare Advantage risk adjustment data validation net error rates and variances; and expenditures data from the Truven Health Analytics 2010 MarketScan® Commercial Claims and Encounters database (MarketScan®). We chose to use Medicare Advantage error rates because Medicare Advantage utilizes an HCC-based methodology similar to the one used for HHS risk adjustment, and because it uses a similar risk adjustment data validation process to determine payment error rates.

We also chose to use the MarketScan® expenditure database because of the comprehensiveness of the database, which was the primary source for calibration for the HHS risk adjustment models. The database contains enrollee-specific claims utilization, expenditures, and enrollment across inpatient, outpatient, and prescription drug services from a selection of large employers and health plans. The database includes de-identified data from approximately 100 payers, and contains more than 500 million claims from insured employees, spouses, and dependents.

We used enrollee predicted expenditure results from our risk adjustment model calibration, which was based on the MarketScan® data, to stratify the population (by age group for enrollees with HCCs, and within a single group for enrollees with no HCCs), then calculated risk scores for the predicted expenditures to relate them to the average expenditures. To estimate a sample size for each issuer, an average issuer size was estimated based on the total expected insured population and the total expected number of issuers. The average issuer population containing enrollees with and without HCCs was assumed to be split 20 percent with HCCs and 80 percent without HCCs, consistent with the MarketScan® data.

We propose to group each issuer's enrollee population into 10 strata based on age group, risk level, and presence of HCCs, as follows:

- Strata 1–3 would include low, medium, and high risk adults with the presence of at least one HCC.
- Strata 4–6 would include low, medium, and high risk children with the presence of at least one HCC.
- Strata 7–9 would include low, medium, and high risk infants with the presence of at least one HCC.
- Stratum 10 will include the No-HCC population, which will not be further stratified by age or risk level, because we assume this stratum has a uniformly low error rate.

We calculated a predicted risk score for each individual in each stratum by dividing the predicted expenditures for that individual by the average predicted expenditures for the entire population. Using these individual predicted risk scores, we calculated the overall average risk score for all individuals in each risk-based stratum. This calculation was performed nine times for the HCC population—once for each of the three risk-based strata within each of the three age groups. We set the minimum risk score for enrollees without HCCs in the tenth stratum.

This method of stratification is similar to that used in the Medicare Advantage risk adjustment data validation program. That program divides enrollees into three strata, representing low, medium, and high risk expenditures. Error rates and variances are calculated for each of these strata. In the initial year, before error rate and standard deviation data for the population subject to the HHS-operated risk adjustment program are available, we propose to use the Medicare Advantage error rates and variances to calculate sample sizes. After the initial year, we will evaluate whether sufficient HHS-operated risk adjustment error rate and standard deviation data are available to calculate sample sizes.

We propose to use the lowest error rate across all HCC strata as the error rate for the stratum of enrollees without HCCs, and we propose to use the variance associated with that error rate to calculate the standard deviation of the error for the stratum of enrollees without HCCs. If error rates and variances are smaller than assumed for this stratum, the resulting sampling precision may increase.

Because the Medicare Advantage error rates and variances are not calculated for different age bands, and therefore are available only for three risk-score differentiated subgroups, we used the same risk score error rates and standard

deviation for the age bands for a risk category. Thus, we used the same risk score error rate and standard deviation assumptions for the adult, child, and infant strata associated with each risk score band. We do not anticipate the expected risk score error rate and variance to be uniform for all age groups; however, in the absence of data, we made this simplifying assumption. In general, we believe the Medicare Advantage error rates and variances likely overstate the corresponding error rates and assumptions for the HHS risk adjusted population, and therefore, the estimated precision of our error estimates may be understated.

The formulas identified above require data on error rates and standard deviations for the strata, and also a target confidence interval and sampling precision level (or margin of error). For the initial year, we propose to use a 10 percent relative sampling precision at a two-sided 95 percent confidence level. That is, we wish to obtain a sample size such that 1.96 [8] multiplied by the standard error, divided by the estimated adjusted risk score, equals 10 percent or less. After actual data are collected from the initial year, we will test and evaluate the data for use in determining the sample size in future years.

Once the proposed overall sample size is calculated, the enrollee count will be distributed among the population based on the second formula above for calculating the sample size of each stratum. Because strata with enrollees with HCCs have a higher standard deviation of risk score error, the overall sample will be disproportionately allocated to enrollees with HCCs (Strata 1–9), helping to ensure adequate coverage of the higher risk portion of the enrollee population.

In the proposed rule for the 2014 Payment Notice, we suggested that an issuer's initial validation audit sample for risk adjustment data validation would consist of approximately 300 enrollees. After conducting the calculations described above, we believe that we can achieve acceptable sampling precision with a sample size of 200 enrollees for the initial years of HHS-operated risk adjustment data validation. Therefore, we are proposing a sample size of 200 enrollees in the initial 2 years of the program. As noted above, we may provide for different, or issuer-specific, sample sizes in future years.

When data becomes available from the program's first year, we expect to examine our sampling assumptions using actual enrollee data. We anticipate that at least in the initial years of the risk adjustment data validation program, the stratification design will remain consistent with the design outlined above—nine HCC strata and one No-HCC stratum. However, the specific size and allocation of the sample to each stratum may be refined based on average issuer enrollee risk score distributions. For example, in future years, we are considering using larger sample sizes for larger issuers or issuers with higher variability in their enrollee risk scores, and smaller sample sizes for smaller issuers or issuers with lower variability in their enrollee risk scores. The sampling design may also consist of a minimum and maximum sample size per stratum for each average issuer (large, medium, small) to follow when selecting the sample.

We seek comments on this approach, including our proposed sample size of 200 enrollees for the initial 2 years of HHS-operated risk adjustment data validation.

(ii) Initial Validation Audit

The second stage of the HHS-operated risk adjustment data validation process is the initial validation audit. In § 153.630(b)(1), we require an issuer of a risk adjustment covered plan to engage one or more independent auditors to perform an initial validation audit of a sample of its risk adjustment data selected by HHS, which will include individually identifiable health information subject to HIPAA.[9] In this section of this proposed rule, we discuss proposed standards and guidelines regarding the qualifications of the initial validation auditor, including conflict of interest standards, standards for the initial validation audit, rater consistency and reliability, and confirmation of risk adjustment errors. As discussed in the white paper, we considered existing best practices and standards for independent auditors, such as those of Medicare Quality Improvement Organizations and the National Committee for Quality Assurance, when establishing our standards for initial validation auditors.

(1) Initial Validation Auditor

The 2014 Payment Notice established certain standards for the initial validation auditor. In § 153.630(b)(2) and (b)(3), we direct the issuer to ensure that the initial validation auditor is reasonably capable of performing an initial validation audit, and is reasonably free of conflicts of interest, such that it is able to conduct the initial validation audit in an impartial manner with its impartiality not reasonably open to question.

In the white paper, we elaborated on options for ensuring that an initial validation auditor meets these criteria, including standardized auditor certification processes and promulgation of best practices. Many commenters sought additional information and guidance regarding initial validation auditor selection and requested that HHS define conflicts of interest between an issuer and the initial validation auditor. We propose certain guidance on these topics here.

We are considering the following criteria for assessing conflicts of interest between the issuer and the initial validation auditor:

- Neither the issuer nor any member of its management team (or any member of the immediate family of such a member) may have any material financial or ownership interest in the initial validation auditor, such that the financial success of the initial validation auditor could be seen as materially affecting the financial success of the issuer or management team member (or immediate family member) and the impartiality of the initial validation audit process could reasonably be called into question, or such that the issuer or management team member (or immediate family member) could be reasonably seen as having the ability to influence the decision-making of the initial validation auditor;
- Neither the initial validation auditor nor any member of its management team or data validation audit team (or any member of the immediate family of such a member) may have any material financial or ownership interest in the issuer, such that the financial success of the issuer could be reasonably seen as materially affecting the financial success of the initial validation auditor or management team or audit team member (or immediate family member) and the impartiality of the initial validation audit process could reasonably be called into question, or such that the initial validation auditor or management or audit team member (or immediate family member) could be seen as having the ability to influence the decision-making of the issuer;
- Owners, directors and officers of the issuer may not be owners, directors

[8] Critical value for the two-sided 95 percent confidence level.

[9] Whether any given organization is a HIPAA business associate is a fact-specific inquiry. We expect that most independent auditors operating on behalf of an issuer of a health plan would be performing activities that would render them a business associate of the covered plan, and would be required to enter into and maintain a business associate agreement with the health plan.

or officers of the initial validation auditor, and vice versa;

• Members of the data validation audit team of the initial validation auditor may not be married to, in a domestic partnership with, or otherwise be in the same immediate family as an owner, director, officer, or employee of the issuer; and

• The initial validation auditor may not have had a role in establishing any relevant internal controls of the issuer related to the risk adjustment data validation process when HHS is operating risk adjustment on behalf of a State, or serve in any capacity as an advisor to the issuer regarding the initial validation audit. In addition, we are considering standards under which issuers would verify that no key individuals involved in supervising or performing the initial validation audit have been excluded from working with either the Medicare or Medicaid program, are on the Office of the Inspector General exclusion list, or are under investigation with respect to any HHS programs.

We note that we intend to review the initial validation auditor's qualifications and relationship to the issuer to verify that the initial validation auditor is qualified to perform the audit, and that the issuer and initial validation auditor are free of actual or apparent conflicts of interest, including those stated above. We note that HHS could gather information through external reporting to support that review. Although we are confident that most issuers will exercise diligence in selecting an initial validation auditor that will be able to comply with HHS audit standards, we intend to monitor the performance of initial validation auditors to determine whether certification or additional safeguards are necessary.

We propose to amend § 153.630(b)(1) to specify that the issuer of a risk adjustment covered plan must provide HHS with the identity of the initial validation auditor, and must attest to the absence of conflicts of interest between the initial validation auditor (or the members of its audit team, owners, directors, officers, or employees) and the issuer (or its owners, directors, officers, or employees). We propose to consider any individual with a significant ownership stake in an entity such that the individual could reasonably be seen to have the ability to influence the decision making of the entity to be an ''owner,'' and propose to consider any individual that serves on the governing board of an entity to be a director of the entity. We are contemplating beginning the initial validation process at the end of the first quarter of the year following the benefit year, with the issuer's submission of the initial validation auditor's identity. We expect to identify the enrollee sample for the initial validation audit in the summer of the year following the benefit year. We are contemplating requiring delivery of the initial validation audit findings to HHS in the fourth quarter of that year. We include a proposed schedule of the risk adjustment data validation process at the end of this section.

Once the audit sample is selected by HHS, we expect issuers would ensure that the initial validation audit is conducted in the following manner:

• The issuer would provide the initial validation auditor with source enrollment and source medical record documentation to validate issuer-submitted risk adjustment data for each sampled enrollee;

• The issuer and initial validation auditor would determine a timeline and information-transfer methodology that satisfies data security and privacy requirements, including the applicable provisions of HIPAA, and enables the initial validation auditor to meet HHS established timelines;

• The initial validation auditor would analyze the enrollment and medical record data to validate the demographic information, plan or plan variation enrollment, and health status of each enrollee in the sample in accordance with the standards established by HHS; and

• The initial validation auditor would provide HHS with the final results from the initial validation audit and all requested information for the second validation audit.

We note that § 153.630(f)(2) is not changed by this proposal, and that the issuer would be required to ensure that its initial validation auditor comply with the security standards described at 45 CFR 164.308, 164.310, and 164.312 in connection with the initial validation audit. We seek comments on these proposals.

(2) Standards for the Initial Validation Audit

We propose to add a new paragraph (b)(5) to § 153.630, in which we propose that an initial validation audit review of enrollee health status be conducted by medical coders certified after examination by a nationally recognized accrediting agency for medical coding, such as the American Health Information Management Association (AHIMA) or the American Academy of Professional Coders (AAPC). We seek comment on other nationally recognized accrediting agencies that may be appropriate to certify medical coders who are performing the initial validation audit review of enrollee health status.

(3) Validation of Enrollees' Risk Scores

An enrollee's risk score is derived from demographic and health status factors, which requires the use of enrollee identifiable information. Thus, we propose to add paragraph (b)(6) to § 153.630, to require an issuer to provide the initial validation auditor and the second validation auditor with all relevant information on each sampled enrollee, including source enrollment documentation, claims and encounter data, and medical record documentation (defined below) from providers of services to enrollees in the applicable sample without unreasonable delay and in a manner that reasonably assures confidentiality and security of data in transmission (''data in transit''). We note that existing privacy and security standards, such as standards under HIPAA and those detailed at § 153.630(f)(2), would apply. This information will be used to validate the enrollment, demographic, and health status data of each enrollee. Only source documentation for encounters with dates of services within the applicable benefit year would be considered relevant. This would require issuers to collect the appropriate enrollment and claims information from their own systems, as well as from all relevant providers (particularly with respect to medical record documentation). We note that only a very small percentage of an issuer's records containing personally identifiable information would be made available to auditors as part of the risk adjustment data validation process, and that similar transmissions are required today for data validation for the Medicare Advantage program. As we describe in this section at (viii), regarding data security standards, we are seeking comment on the applicability and effectiveness of current standards, as well as what other standards HHS should promulgate to ensure data security and privacy protections.

We also propose to add paragraph (b)(7) to § 153.630 to describe the standards for validating each factor of an enrollee's risk score. In paragraph (b)(7)(i), we propose that the initial validation auditor must validate demographic data and enrollment information by reviewing plan source enrollment documentation, such as the

834 transaction,[10] which is the HIPAA-standard form used for plan benefit enrollment and maintenance transactions. These enrollment transactions reflect the data the issuer captured for an enrollee's age, name, sex, plan of enrollment, and enrollment periods in the plan. We note that certain identifying information from these enrollment transactions, such as the enrollee's name, would be used to ensure that the appropriate medical documentation has been provided.

The sample audit pool will consist of enrollees with and without risk adjustment-eligible diagnoses within eligible dates of service. For each enrollee in the sample with risk adjustment HCC scores, the initial validation auditor would validate diagnoses through a review of the relevant risk adjustment-eligible medical records. We consider medical record documentation generated with respect to dates of service that occurred during the benefit year at issue to be relevant for these purposes. For enrollees without risk adjustment HCCs for whom the issuer has submitted a risk adjustment-eligible claim or encounter, we would require the initial validation auditor to review all medical record documentation for those risk adjustment-eligible claims or encounters, as provided by the issuer, to determine if HCC diagnoses should be assigned for risk score calculation, provided that the documentation meets the requirements for the risk adjustment data validation audits. Documents used to validate all components of the risk score must reflect dates of service during the applicable benefit year. In the initial years of the data validation program, we plan to accept certain supplemental documentation, such as health assessments, to support the risk adjustment diagnosis. We expect to provide additional details on acceptable supplemental documentation in future guidance.[11]

Therefore, in § 153.630(b)(7)(ii), we propose that the validation of enrollee health status (that is, the medical diagnoses) occur through medical record review, that the validation of medical records include a check that the records originate from the provider of the medical services, that they align with the dates of service for the medical diagnosis, and that they reflect permitted providers and services. In this paragraph, we also propose, for purposes of § 153.630, that ''medical record documentation'' mean: ''clinical documentation of hospital inpatient or outpatient treatment or professional medical treatment from which enrollee health status is documented and related to accepted risk adjustment services that occurred during a specified period of time.'' Medical record documentation must be generated in the course of a face-to-face or telehealth visit documented and authenticated by a permitted provider. We expect to provide additional guidance on telehealth services in future guidance.

In § 153.630(b)(7)(iii), we propose that medical record review and abstraction be performed in accordance with industry standards for coding and reporting. Current industry standards are set forth in the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD–9–CM), or the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, 4th Edition* (ICD–10–CM) guidelines for coding and reporting.

(4) Confirmation of Risk Adjustment Errors

We note that the data validation audit processes may identify various discrepancies, many of which will have no impact on an enrollee's risk score. For example, if a medical diagnosis underlying an enrollee's HCC was present on a claim but was not supported by medical record documentation, but the same HCC was supported by the medical record for a different diagnosis, we propose that no risk adjustment error be assessed for the enrollee's HCC. However, if none of the medical record documentation supports a particular HCC diagnosis for an enrollee, we propose that a risk adjustment error be assessed.

We consider a risk adjustment error to occur when a discrepancy uncovered in the data validation audit process results in a change to the enrollee's risk score. A risk adjustment error may result from incorrect demographic data, an unsupported HCC diagnosis, or a new HCC diagnosis identified during the medical record review. An unsupported HCC diagnosis could be the result of missing medical record documentation, medical record documentation that does not reflect the diagnosis, or invalid medical record documentation (such as an unauthenticated record or a record that does not meet risk adjustment data collection standards for the applicable benefit year).

We propose in § 153.630(b)(7)(iv) that a senior reviewer must confirm any finding of a risk adjustment error. We believe that a senior reviewer is a reviewer with substantial expertise in medical record coding such that the initial validation auditor would consider the senior reviewer to be the standard against which to measure inter-rater reliability and coding consistency. As such, we propose to define a senior reviewer as a medical coder certified by a nationally recognized accrediting agency who possesses at least 5 years of experience in medical coding. We seek comment on the credentials and expertise that should be required of a senior reviewer.

(5) Review Consistency and Reliability

Validation audits typically include methods of evaluating review consistency and reliability. We believe such processes help to ensure the integrity of the data validation process and strengthen the validity of audit results. In § 153.630(b)(8), we propose that the initial validation auditor measure and report to the issuer and HHS its inter-rater reliability rates among its reviewers. Such processes measure the degree of agreement among reviewers. We propose to set the threshold for the acceptable level of consistency among reviewers at 95 percent for both demographic and enrollment data review, and health status data review outcome. Reviews should be performed using rater-to-standard procedures whereby reviews conducted by reviewers with extensive qualifications and credentials are used to establish testing thresholds or standards for consistency.

(iii) Second Validation Audit

The initial validation audit will be followed by a second validation audit, which will be conducted by an auditor retained by HHS to verify the accuracy of the findings of the initial validation audit.

We propose to select a subsample of the initial validation audit sample enrollees for review by the second validation auditor. The second validation auditor would perform the data validation audit of the enrollee subsample, adhering to the same audit standards applicable to the initial validation audit described above, but would only review enrollee information that was originally presented during the initial validation audit. In § 153.630(c),

[10] Issuers and State Exchanges use the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Benefit Enrollment and Maintenance (834), August 2006, ASC X12N/005010X220, as referenced in § 162.1502, or ''834 form'' to transmit and update enrollment and eligibility to HHS as often as daily but at least monthly. In Federal operations, HHS and the issuer exchange and update data via this same form.

[11] *See* ''HHS-Operated Data Collection Policy FAQ'' for a discussion of chart review as an acceptable source of supplemental diagnosis codes. Additional detail will be provided in future guidance. *https://www.regtap.info/uploads/library/HHS_OperatedDataCollectionPolicyFAQs_062613.*

we established standards for issuers of risk adjustment covered plans related to HHS's second validation audit. In § 153.630(b)(4), we established that issuers must submit (or ensure that their initial validation auditor submits) data validation information, as specified by HHS, from their initial validation audit for each enrollee included in the initial validation sample. Issuers must transmit all information to HHS or its second validation auditor in a timeframe and manner to be determined by HHS. The second validation auditor would inform the issuer of error findings based on its review of enrollees in the second validation audit subsample. We will provide additional guidance on the manner and timeframe of these submissions in the future.

As discussed in the white paper, we are considering selecting the second validation audit subsample using a sampling methodology that will allow for pair-wise means testing to establish statistical difference between the initial and second validation audit results. If the pair-wise means test results suggest that the difference in enrollee results between the initial validation audit and second validation audit is not statistically significant, the initial validation audit error results would be used for error estimation and calculation of adjustments for plan average risk score. If the test results suggest a statistical difference, the second validation auditor would perform another validation audit on a larger subsample of the enrollees previously subject to the initial validation audit. The results from the second validation audit of the larger subsample would again be compared to the results of the initial validation audit using the pair-wise means test. Again, if no statistical difference is found between the initial validation audit and the second validation audit conducted on the larger subsample, HHS would apply the initial validation audit error results for error estimation using all enrollees selected for the initial validation audit sample. However, if a statistical difference is found based on the second validation audit on the larger subsample, HHS would apply the second validation audit error results to modify the risk scores of the issuer's enrollees, as discussed below. We are considering using a 95 percent confidence interval, but seek comment on the appropriate confidence interval to use with respect to these pair-wise means tests.

As discussed in the white paper, we are considering a number of ways to expedite the second validation audit and the subsequent appeals processes. One possibility would be to begin the second validation audit on those enrollees for which the initial validation audit is complete, even if the entire initial validation audit has not been completed. For example, an issuer could allow its initial validation auditor to submit data validation documentation and results a number of months in advance of the HHS established deadline for submission of initial validation audit results. The second validation auditor would thus be able to begin its review earlier, permitting more time to provide feedback to the issuer on the results of that review and allowing for more opportunity for discussion prior to finalizing the second validation audit findings. Prior to finalizing the risk score adjustment based on the second validation audit findings, the second validation auditor may request discussions with the initial validation auditor to identify the source of the differences, or may review the initial validation auditor's processes. If the initial validation audits are substantiated, the second validation auditor may adjust its risk scores accordingly. This process would not allow for any additional documentation to be submitted on those enrollees for which the second validation audit began early. The appeals decision from the expedited, concurrent process would be final and binding, but would provide issuers the opportunity to begin the process earlier. If HHS establishes a concurrent second validation audit and appeals process, we would need to develop intermediate timelines for initial validation auditor submission of audit documentation and data to the second validation auditor. We seek comments on this approach for establishing a concurrent second validation audit and appeals process.

(iv) Error Estimation

The fourth stage in the HHS risk adjustment data validation process is error estimation. Upon completion of the initial and second validation audits, HHS will derive an issuer-level risk score adjustment and confidence interval. This adjustment would be used to adjust the average risk score for each risk adjustment eligible plan offered by the issuer. HHS intends to provide each issuer with enrollee-level audit results and the error estimates.

We are proposing a two-phase procedure to accept or correct the results of the initial validation audit based on the results of the second validation audit. In phase one, as described above, we conduct a pair-wise statistical test for consistency between the initial validation and second validation audit results (as described above for second validation audits). In phase two, if we determine that the results of the two audits are inconsistent, we would adjust the initial validation audit results based on the second validation audit results. For phase two, we describe two options for using second validation audit results to derive an estimate of an overall corrected risk score for each issuer.

Phase One: Consistency Test between Initial and Second Validation Audit

In phase one, a pair-wise statistical test would be performed to determine if the initial validation audit sample results should be adjusted using the results of the second validation audit. To illustrate the underlying statistical test, consider the following notations:

$\tilde{x}_i$ is the ith initial validation audit risk score observation in the second validation audit sample of n observations;

$\tilde{y}_i$ is the ith second validation audit risk score observation in the second validation audit sample of n observations;

d_i is the difference between $\tilde{y}_i$ and $\tilde{x}_i$ within the second validation audit sample;

$\bar{d}$ is the mean of all d_i observations within the second validation audit sample; and

S_x is standard deviation of all d_i observations within the second validation audit sample.

Assume an issuer submits enrollment and claims data to its dedicated distributed data environment that are used to compute a set of ''original'' risk scores. As required by the risk adjustment data validation process, the issuer engages an independent validation auditor, who reviews N enrollee records, as sampled by HHS, and validates the original enrollee risk scores.

From the N enrollees in the initial validation audit sample, HHS selects a smaller second validation audit subsample of n enrollees. For each second validation audit selected record, HHS calculates the difference, $d_i = \tilde{y}_i - \tilde{x}_i$. HHS then conducts a pair-wise means test to determine whether the mean difference, $\bar{d}$, is statistically significant (that is, unlikely to be zero). Specifically, HHS would conduct a statistical test to determine if zero (0) is contained within the range,

$$\bar{d} \pm 1.96\left(\frac{S_d}{\sqrt{n}}\right).$$

If so, HHS would conclude that there is no statistically significant difference between risk scores determined by the initial and second validation audit

processes, and would accept the results of the initial validation audit.

However, if zero (0) is not contained within this range (that is, the difference between $\bar{d}$ and zero is statistically significant), HHS would expand the second validation audit subsample to select a larger subset of *N*, have the second validation auditor review the enrollee files, and again conduct a pair-wise means test using this larger subsample. If the statistical test shows no statistically significant difference, HHS would accept the results of the initial validation audit. If the statistical test shows a statistically significant difference between the initial and larger subsample second validation audit findings, HHS would conduct phase two to adjust the full initial validation audit sample based on the larger subsample second validation audit findings.

Phase Two: Adjustment to the Initial Validation Audit Sample

In phase two, we propose that if the difference between the initial and second validation audits is found to be statistically significant, then HHS would utilize the risk score error rate calculated from the larger second validation audit subsample to adjust the full initial validation audit sample, which could in turn be used to adjust the average risk scores for each plan. This approach would adjust the entire initial validation audit sample using a one-for-one replacement for the enrollees reviewed by the second validation audit, and a uniform adjustment for the enrollees that were not. We also considered another option, as discussed in the white paper and below. Under this alternate approach, we would use the error rate from the larger second validation audit subsample directly in our determination of whether and by how much to adjust the risk scores of all enrollees in the issuer's risk adjustment covered plans. This approach would disregard all enrollees in the initial validation audit sample that were not reviewed as part of the larger second validation audit subsample.

To illustrate these two options under the phase two adjustment process, consider the following notations:

M is the total number of enrollees in the risk adjustment covered plan;

N is the initial validation audit sample size;

n is the size of the larger second validation audit subsample;

$\bar{y}_N$ is the mean of the initial validation audit-adjusted risk scores in the initial validation audit sample *N;*

$\bar{y}_n$ is the mean of the second validation audit-adjusted risk scores in the second validation audit sample *n;*

$\bar{x}_N$ is the mean of the original risk scores in the initial validation audit sample *N;*

$\bar{x}_n$ is the mean of the original risk scores in the second validation audit sample *n;*

$\bar{X}_M$ is the original risk score total across all *M* records;

$\hat{Y}_N$ is the projected correct risk score across all *M* records using the initial validation error rate; and

$$\hat{Y}_N = \frac{\bar{y}_N}{\bar{x}_N} X_M$$

$\hat{y}_n$ is the projected correct risk score across all *M* records using the error rate from the larger second validation audit subsample.

$$\hat{Y}_n = \frac{\bar{y}_n}{\bar{x}_n} X_M$$

Under this proposed approach, we would undertake the following steps to adjust the risk scores in the initial validation audit samples:

(1) Replace the initial validation audit-adjusted risk scores with the second validation audit-adjusted risk scores in the *n* records that were sampled from *N* (one-for-one risk score adjustment).

(2) Apply a uniform adjustment factor,

$$\frac{\hat{Y}_n}{\hat{Y}_N}$$

to the initial validation audit-adjusted risk scores in the (*N*-*n*) records not reviewed by the second validation audit.

Under the alternate approach, the second validation audit-adjusted risk scores in the *n* records in the larger second validation audit subsample would be used as the basis for adjustment of plan-level average risk scores.

Considering the comments in response to the white paper, and in order to estimate error using a narrower confidence interval, we are proposing to use the larger second validation audit subsample to adjust the initial validation audit sample (by direct replacement for enrollees reviewed by the second validation audit, and by proportional adjustment for the other enrollees), whose adjusted error rate could be used as a basis to adjust plan average risk scores for all risk adjustment covered plans of the issuer. We seek comment on our proposed approach.

Adjusted Risk Score Projections

Based on the proposals described above, the results of the initial or second validation audits could be used as the basis for projecting a corrected risk score for each issuer's population. The projections described above would be performed on a stratum-by-stratum level and weighted accordingly to achieve an estimate of the corrected risk score for each issuer. As described in the white paper, a stratified separate ratio estimator [12] would be used to estimate the corrected average risk score for each issuer. To compute the stratified separate ratio estimator, HHS would first extrapolate the total correct risk score within each stratum, then sum the stratum-specific projected correct risk scores for all strata, with the total sum divided by the total enrollee count to arrive at the corrected average risk score. The projected risk score error could then be calculated as the difference between the recorded average risk score across the entire population and the point estimate.

The stratified separate ratio estimator of the total correct risk score is calculated using the following equation:

$$\hat{Y}_R = \sum_{h=1}^{H} \frac{\bar{y}_h}{\bar{x}_h} X_h$$

Where:

$\hat{Y}_R$ is used to estimate the correct risk score;

$\bar{y}_h$ is the sample mean of the correct risk score in stratum *h;*

$\bar{x}_h$ is the sample mean of the original risk score in stratum *h;*

X_h is the total sum of the original risk score in stratum *h;* and

H is the total number of strata.

$\hat{Y}_R$ would then be normalized by the enrollment count to derive a corrected average risk score for the issuer.

To estimate the variance of the point estimate, HHS will first estimate the variance within each stratum and then sum the stratum-specific variances for all strata. The estimated variance of the stratified separate ratio estimate for the correct risk score is calculated as follows:

[12] For a discussion of stratified separate ratio estimators, *see* Cochran, William G., *Sampling Techniques,* third edition, John Wiley & Sons, 1977, at 164.

$$\text{Variance } (\hat{Y}_R) = \sum_{h=1}^{H} \left[\frac{N_h^2 \left(1 - \frac{n_h}{N_h}\right)}{n_h (n_h - 1)} \left(\sum_{i=1}^{n_h} y_{ih}^2 + \hat{R}_h^2 \sum_{i=1}^{n_h} x_{ih}^2 - 2\hat{R}_h \sum_{i=1}^{n_h} y_{ih} x_{ih} \right) \right]$$

Where:

n_h is the number of enrollees sampled in stratum h;

N_h is the population frequency in stratum h;

y_{ih} is the corrected risk score for the ith sampled enrollee in stratum h;

x_{ih} is the original risk score for the ith sampled enrollee in stratum h; and

$$\hat{R}_h = \frac{\sum_{i=1}^{n_h} y_{ih}}{\sum_{i=1}^{n_h} x_{ih}}$$

The square root of the estimated variance is the standard error (SE).

We are proposing to use the issuer's corrected average risk score to compute an adjustment factor, based on the ratio between the corrected average risk score and the original average risk score that could be applied to adjust plan average risk for all risk adjustment eligible plans within the issuer. We are considering two options for applying the adjustment factor. Under the first option, we are considering directly applying an adjustment factor to all of the issuer's risk adjustment covered plans. Under the second option, we are considering applying this adjustment only if the corrected average risk score and the recorded average risk score are statistically different.

Were we to implement the second option, a critical parameter of the statistical test would be the target confidence interval, which would determine the stringency of the test. For example, we could perform the statistical test at the 90, 95, or 99 percent confidence interval. We note that the HHS Office of the Inspector General performs certain similar data validation tests using a 90 percent confidence interval, while the Medicare Advantage risk adjustment data validation program uses a 99 percent confidence interval. We also note that even if the statistical test finds the two risk scores to be statistically different, we could apply the adjustment factor to adjust plan average risk scores based upon using the point estimate of the adjusted average risk score, or some other value within an interval around the point estimate, such as the upper or lower bound of a 95 percent confidence interval around the point estimate.

The choice among these options poses a tradeoff between reducing issuers' incentives to aggressively report or code diagnoses, and increasing the variability of issuers' risk adjustment payments. Under the first option, an issuer that reports data that systematically overstates its risk score would, on average, assuming the corrected risk scores are unbiased estimates of the true risk scores, receive a downward adjustment to its reported risk score equal in magnitude to the degree of overstatement. As a result, this option could eliminate an issuer's incentive to overstate its risk score. On the other hand, due to sampling variation, the first option would routinely introduce significant variability in issuers' risk scores (both up and down), even if the issuer was making no attempt to manipulate its risk scores. While these adjustments would make such an issuer's risk adjustment payments less predictable in any given year, they would not introduce systematic bias in risk scores (assuming the corrected risk scores are unbiased estimates of the true risk scores).

The second option, in contrast, would only adjust an issuer's risk scores when it is very likely that the reported risk scores deviated from the true values, so issuers' risk adjustment payments would be more predictable. However, particularly if the confidence level of the statistical test were set at a high threshold, this approach would often fail to make adjustments when an issuer does in fact overstate its risk score.

Based on commenters' feedback on the white paper, we are proposing to use the second approach described above—we would adjust the plan average risk scores of an issuer based upon the ratio between the correct average risk score estimate and recorded average risk score only if the difference between the estimated and recorded average risk scores were determined to be statistically significant. We are proposing to use a 95 percent confidence interval to determine if the adjusted average risk score and the recorded average risk score are statistically different. Nevertheless, we welcome comments on both options discussed above and on the appropriate tradeoff between reducing issuers' incentive to aggressively report or code diagnoses and increasing the variability of issuers' risk adjustment payments. In addition, regarding the proposed approach in particular, we seek comments on the appropriate confidence interval to apply when determining whether an adjustment to an issuer's plan average risk score is necessary.

Error Estimation Example

To illustrate the corrected average risk score and error estimation process described above, assume that a sample of 200 enrollees is selected for initial validation audit review for a particular issuer. From this sample, assume that a subsample of 20 enrollees is selected for second validation audit review. Assume the issuer's average recorded population risk score is 1.60 and the projected correct population risk score from the sample of 200 is 1.40, with a two-sided 95 percent confidence interval of 1.30 to 1.50.

The first step in the error estimation process will determine if the initial validation audit results should be corrected based on the second validation audit review or accepted without adjustment. We would perform a pair-wise means test to compare the projected risk scores for the sample of 200 enrollees and the subsample of 20 enrollees.

For this example, assume that the statistical test fails (that is, there is a statistically significant difference between the projected risk scores in the sample of 200 and the subsample of 20).[13] We would then select an expanded subsample from the original sample of 200 enrollees. Assume that the larger sample is a sample of 100 enrollees. Following completion of the larger second validation audit, we would perform the pair-wise means test again. Assume the test fails again (that is, there is a statistically significant difference in the projected risk scores between the sample of 200 and the larger subsample of 100). We would conclude that the risk scores in the sample of 200 enrollees need to be adjusted.

[13] If the test passes, then no adjustments would be made to the sample of 200 and the projected results from this sample would be used to adjust average plan liability risk scores.

In the second step of error estimation, HHS would adjust the risk scores in the sample of 200 using a one-for-one replacement for the risk scores of the enrollees reviewed by the second validation auditor, and a uniform adjustment for the other enrollees in the initial validation audit sample. The one-for-one replacement will replace the risk scores calculated based on initial validation audit findings, with the risk scores calculated based on the second validation audit findings for the larger subsample of 100. The remaining 100 enrollees that were not included in the second validation audit subsample would be adjusted based on the ratio of two projections: (1) the projected correct population risk score using the second validation audit findings in the subsample of 100 (assume this projected risk score is 1.50, with a two-sided 95 percent confidence interval of 1.30 to 1.70); divided by (2) the projected correct population risk score using the initial validation audit findings in the sample of 200 (equal to 1.40 based on the assumption noted above). The adjustment ratio is equal to 1.07 = 1.50/1.40. Therefore, the risk scores of the remaining 100 enrollees not included in the second validation audit subsample would be increased by 7 percent.

The projected correct population risk score from the revised sample of 200 would therefore be 1.45, with a two-sided 95 percent confidence interval of 1.35 to 1.55.

(v) Appeals

We anticipate that the risk adjustment data validation appeals process would occur annually, beginning in the spring of the year in which the error rate will be applied to adjust risk scores and affect risk adjustment payments and charges. Because we are not applying error rates to adjust payments and charges for the initial 2 years of the risk adjustment program, the first year for which payments and charges would apply would be 2016. Risk scores and initial payments and charges would be calculated in the spring of 2017 for that payment cycle. We anticipate the appeals process will begin in the spring of 2018, prior to the 2017 payment transfers. We will provide additional guidance on the appeals process and schedule in future rulemaking.

(vi) Payment Transfer Adjustments

Risk adjustment payment transfer amounts will be based on adjusted plan average risk scores. The data validation audits would be used to develop a risk score error adjustment for each issuer, as described above. Each issuer's risk score adjustment would be applied to adjust the plan average risk score for each of the issuer's risk adjustment covered plans. This adjustment would be applied on a prospective basis beginning with the risk adjustment data for benefit year 2016 (that is, the adjustments would take effect in 2018, during payment transfers for 2017). Because an issuer's adjusted plan average risk score is normalized as part of the risk adjustment payment calculation, the effect of an issuer's risk score error adjustment will depend upon its magnitude and direction compared to the average risk score error adjustment and direction for the entire market.

We are considering reporting the following summary findings to issuers for the initial 2 years of the program:

- State- or market-wide error rates.
- Issuer error rates.
- Initial validation audit or error rates.
- Projected financial impact of the proposed risk adjustments, as determined by the initial and second validation auditors.
- The 2-year interval before risk adjustment data validation adjustments are applied to risk scores and affect payments and charges will provide initial validation auditors and issuers the opportunity to reform existing processes prior to the implementation of HHS payment transfer adjustments for the 2016 benefit year. We believe that the reports described above will help issuers and initial validation auditors better understand the likely effects of the risk adjustment data validation program in States where HHS operates risk adjustment. We seek comment on considerations for reporting error rates and any additional information that could improve transparency in the markets.

(vii) Oversight

The second final Program Integrity Rule outlined selected oversight provisions related to the premium stabilization programs, such as maintenance of records, sanctions for failing to establish a dedicated distributed data environment, and the application of a default risk adjustment charge to issuers in the individual and small group market that fail to provide data necessary for risk adjustment. We are proposing to expand on these provisions to include oversight related to risk adjustment data validation when HHS operates risk adjustment on behalf of a State.

Section 153.620 provides that an issuer that offers risk adjustment covered plans must comply with any data validation requests by the State or HHS on behalf of the State, and that an issuer that offers risk adjustment covered plans must also maintain documents and records, whether paper, electronic, or in other media, sufficient to enable the evaluation of the issuer's compliance with applicable risk adjustment standards, and must make that evidence available upon request to HHS, OIG, the Comptroller General, or their designee, or in a State where the State is operating risk adjustment, the State or its designee to any such entity.

Based on our authority under section 1321(c)(2) of the Affordable Care Act, we are proposing in § 153.630(b)(9) that, when HHS operates risk adjustment on behalf of a State, an issuer of a risk adjustment covered plan that does not engage an initial validation auditor within the timeframe specified by HHS of the year following the benefit year, or that otherwise does not arrange for a risk adjustment initial validation audit that complies with applicable regulations, may be subject to civil money penalties. We note that we intend to apply the proposed sanction so that the level of the enforcement action would be proportional to the level of the violation. While we would reserve the right to impose penalties up to the maximum amounts proposed in § 156.805(c), as a general principle, we intend to work collaboratively with issuers to address problems in conducting the risk adjustment data validation process. In our application of the proposed sanction, we would take into account the totality of the issuer's circumstances, including such factors as an issuer's previous record (if any), the frequency and level of the violation, and any aggravating or mitigating circumstances. Our intent is to encourage issuers to address non-compliance and not to severely affect their business, especially where the issuer demonstrates good faith in monitoring compliance with applicable standards, identifies any suspected occurrences of non-compliance, and attempts to remedy any non-compliance.

We also note that HHS will not perform the initial validation audit for an issuer that does not hire an initial validation auditor or otherwise does not submit initial validation audit results that comply with the regulations in subpart G and subpart H of part 153. For these issuers, we propose in § 153.630(b)(10) to assign a default risk adjustment charge. We are considering whether this charge should be the same charge as contemplated in § 153.740(b), should be based on a default error rate, or should be calculated based on some other methodology. We will propose a

methodology for computing the default error rate or default charge in future rulemaking.

Issuers may request technical assistance from HHS at any stage of the risk adjustment data validation process. HHS may also offer such assistance directly if we become aware of technical issues arising at any time during the risk adjustment data validation process. We plan to provide further assistance and clarification around the risk adjustment data validation process through a range of vehicles, including additional guidance, training materials, webinars, and user group calls. We welcome comment on these proposals.

(viii) Data Security

We recognize that the risk adjustment data validation process outlined here will require the transmission of sensitive data and documents between the issuer and the initial and second validation auditors. HHS takes seriously the importance of safeguarding protected health information and personally identifiable information. As outlined in the white paper, we believe that it will be necessary to specify standards for safeguarding this information through proper information storage and transmission methods.

We note that § 153.630(f)(2) requires issuers to ensure that it and its initial validation auditor comply with the security standards described at 45 CFR 164.308, 164.310, and 164.312 in connection with the initial validation audit, the second validation audit, and any appeal. In addition to these requirements, we are considering defining standards and expectations that would apply to issuers and initial and second validation auditors pertaining to data security, management, and transmission. These standards could require systems to safeguard and encrypt data ''at rest'' and ''in transit,'' and to authenticate identities of users. They could also prohibit the auditors from using or disclosing the information they receive for any purpose other than the audit and oversight. Similar standards have been implemented under the Medicare Advantage risk adjustment data validation process. We intend to address these issues and the treatment of initial and second validation auditors under HIPAA in future rulemaking or guidance, and seek comment on the applicability and effectiveness of current standards, as well as what other standards HHS should promulgate to ensure data security and privacy protections.

(ix) Implementation Timeline

For the 2014 benefit year, we expect to implement risk adjustment data validation activities in early 2015. Implementation activities would begin with issuers submitting the identity of their initial validation auditor to HHS in accordance with § 153.630(b)(1). In the spring of 2015, we would utilize the data submitted by issuers for risk adjustment payments and charges and apply the sampling methodology described above to select the audit sample for each issuer for the initial validation audit. During the same timeframe, we would train issuers and initial validation auditors on the risk adjustment data validation process and the applicable standards for performing the initial validation audit, which would begin in the summer of 2015. Once the initial validation audit has concluded in the fall of 2015, HHS would begin the second validation audit process, which would continue into 2016. Risk adjustment data validation implementation activities for the 2014 benefit year data would conclude in 2016 after distribution of HHS findings to issuers, processing of appeals, and estimation and reporting of final risk scores. Since the 2014 benefit year is the first year of implementation of risk adjustment data validation, we expect to report on lessons learned from these activities, and to use this information to improve the risk adjustment data validation process.

We expect that the risk adjustment data validation implementation activities would follow a similar schedule for each subsequent benefit year. The 2016 benefit year would be the first year when payments and charges are adjusted. Those adjustments would occur after the conclusion of risk adjustment data validation activities for the 2016 benefit year, in the summer of 2018.

e. HHS Audits of Issuers of Risk Adjustment Covered Plans

In order to safeguard Federal funds, we propose in § 153.620(c) that HHS or its designee may audit an issuer of a risk adjustment covered plan, when HHS operates risk adjustment on behalf of a State, to assess the issuer's compliance with the requirements of subparts G and H of 45 CFR part 153. The issuer must also ensure that its relevant contractors, subcontractors, or agents cooperate with the audit. We anticipate conducting targeted audits of issuers of risk adjustment covered plans informed by, among other criteria and sources, the data provided to HHS through the dedicated distributed data environment and any previous history of noncompliance with these standards. We will provide further details on this audit program, including timelines, procedures, and substantive requirements, in future rulemaking and guidance. This audit will focus on those aspects of the risk adjustment program that are not validated through the risk adjustment data validation program, described above in this proposed rule. In particular, we anticipate that the audit will focus on records documenting that the plan was a risk adjustment covered plan. For example, the audit might seek to review records evidencing the type of plan at issue (for example, an individual market metal level plan versus a catastrophic plan), the plan renewal date (to ensure the plan was subject to the market reform rules during the time periods for which data was submitted to the dedicated distributed data environment), and, in the case of an insured group health plan, the plan size (to ensure the plan was a small employer plan).

We also propose that if an audit results in a finding of material weakness or significant deficiency (as these terms are defined in GAAS issued by the American Institute of Certified Public Accountants, and Government Auditing Standards issued by the Government Accountability Office (GAO) [14]) for compliance with any requirement of subpart G or H of 45 CFR part 153, the issuer: (i) Within 30 calendar days of the issuance of the final audit report, must provide a written corrective action plan to HHS for approval; (ii) implement that corrective action plan; and (iii) provide to HHS written documentation of the corrective actions once taken. If HHS determines as the result of an audit that the issuer of the risk adjustment covered plan was required to pay additional risk adjustment charges or has received risk adjustment payments to which it was not entitled, it may require the issuer to pay such amounts to the Federal government.

To reduce the burden on issuers and HHS, to the extent practical, we intend to coordinate any audits of issuers of risk adjustment covered plans with related audits of Exchange financial programs and premium stabilization programs, such as reinsurance. We seek comment on this proposal, including

[14] *See* Government Auditing Standards (2011 Revision), available at: *http://www.gao.gov/yellowbook*. For public companies, the Public Company Accounting Oversight Board (PCAOB) sets audit standards. *See http://pcaobus.org/Standards/Auditing/Pages/default.aspx*. For non-public companies, the AICPA sets audit standards. *See http://www.aicpa.org/Research/Standards/AuditAttest/Pages/SAS.aspx*.

the standards that should govern these audits.

2. Provisions and Parameters for the Transitional Reinsurance Program

The Affordable Care Act directs that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016. In the 2014 Payment Notice, we expanded on the standards set forth in subparts C and E of the Premium Stabilization Rule and established the reinsurance payment parameters and uniform reinsurance contribution rate for the 2014 benefit year. In this proposed rule, we propose the reinsurance payment parameters and uniform reinsurance contribution rate for the 2015 benefit year and certain oversight provisions related to the operation of the reinsurance program.

a. Major Medical Coverage

Section 1341(b)(3)(B)(i) of the Affordable Care Act states that ''the contribution amount for each issuer [must] proportionally reflect each issuer's fully insured commercial book of business for all major medical products . . .'' In the preamble to the 2014 Payment Notice (78 FR 15456), we included a general description of major medical coverage for reinsurance purposes based on the comprehensiveness of the coverage provided (for example, a range of medical, surgical, and preventive services) and the settings in which the coverage is provided (for example, inpatient and outpatient settings). Commenters requested that HHS codify a definition of major medical coverage for purposes of reinsurance contributions in regulation text.

Codification in regulation text of a more specific definition of major medical coverage for reinsurance contributions purposes would provide additional clarification for some contributing entities. Therefore, we propose to add a definition of major medical coverage in § 153.20 to mean health coverage for a broad range of services and treatments provided in various settings that provides minimum value in accordance with § 156.145.

We believe that because minimum value is calculated on a broad set of services—comparable to the essential health benefits applicable to individual and small group coverage—it is a reasonable measure of comprehensiveness of coverage. Minimum essential coverage under an employer-sponsored plan generally will provide minimum value if the plan's share of total allowed costs of benefits provided under the plan exceeds 60 percent of such costs (see section 36B(c)(2)(C)(II) of the Code). The minimum value standards established under § 156.145 also deem coverage that meets any of the levels of coverage requirements described in § 156.140 to satisfy this requirement. Because the calculation of minimum value is an objective process, we believe that the use of the concept of minimum value is a reasonable way to clarify the definition of major medical coverage and reduce uncertainty as to whether reinsurance contributions are required of certain unique plan arrangements. In addition, we believe that the concept of minimum value will be familiar to stakeholders, and will not add undue burden to the determination of whether a plan offers major medical coverage for reinsurance purposes. It is important to note that this definition of major medical coverage only applies for determining reinsurance contributions under section 1341 of the Affordable Care Act. We seek comment on this proposed definition.

b. Self-insured Plans Without Third Party Administrators

Section 1341(b)(1)(A) of the Affordable Care Act provides that ''health insurance issuers and third party administrators on behalf of group health plans'' must make reinsurance contributions. We recognize that some self-insured group health plans self-administer the benefits and services provided under the plan, and do not use the services of a third party administrator. We believe that section 1341(b)(1)(A) of the Affordable Care Act clearly applies to both issuers of insured plans as well as to self-insured plans that use third party administrators. However, our continued study of this issue leads us to believe that this provision may reasonably be interpreted in one of two ways—it may be interpreted to mean that self-insured, self-administered plans must make reinsurance contributions, or it may be interpreted to mean that such plans are excluded from the obligation to make reinsurance contributions. For the reasons discussed below, we propose to modify the definition of a ''contributing entity'' for the 2015 and 2016 benefit years to exclude self-insured group health plans that do not use a third party administrator in connection with claims processing or adjudication (including the management of appeals) or plan enrollment.

Following consideration of the comments submitted with respect to the 2014 Payment Notice and the proposed Program Integrity Rule, we propose that for the 2015 and 2016 benefit years, the phrase ''third party administrators on behalf of group health plans'' not include self-insured, self-administered group health plans. An insured plan and a self-insured plan administered by a third party administrator are similar in that each arrangement involves an employer and an outside commercial entity—an issuer or a third party administrator (which is often an insurance company or an affiliate)—for the administration of the core health insurance functions of claims processing and plan enrollment. We note that under section 1341(b)(3)(B) of the Affordable Care Act and § 153.400(a)(1)(ii), reinsurance contribution amounts are to reflect a ''commercial book of business.'' Our consideration of these comments leads us to believe that a group health plan administered by a third party administrator would normally be viewed as part of the third party administrator's ''commercial book of business,'' but that a self-insured, self-administered plan would not normally be viewed as part of any entity's ''commercial book of business.''

Therefore, we propose that for the 2015 and 2016 benefit years, a ''contributing entity'' would mean: (a) A health insurance issuer; or (b) a self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage) that uses a third party administrator in connection with claims processing or adjudication (including the management of appeals) or plan enrollment. The proposed modification for the 2015 and 2016 benefit years would exclude from the obligation to make reinsurance contributions those self-insured plans that do not use a third party administrator for their core administrative processing functions—adjudicating, adjusting, and settling claims (including the management of appeals), and processing and communicating enrollment information to plan participants and beneficiaries. This proposed amendment would recognize that some self-insured group health plans, which we believe would generally not be considered to be using the core services of a third party administrator, may use third parties for ancillary administrative support, and we would consider these plans to be self-administered for purposes of the reinsurance program.

For purposes of the definition of ''contributing entity,'' we propose to consider a third party administrator to be, with respect to a self-insured group

health plan, an entity that is not under common ownership or control with the self-insured group health plan or its sponsor that provides administrative services to the self-insured group health plan in connection with claims processing or adjudication (including the management of appeals) or plan enrollment. We seek comment on this definition, and whether certain types of service providers, such as an attorney providing legal advice in connection with claims adjudication, or an issuer administering an insured component of a group health plan that is partially self-insured and partially insured should be considered a third party administrator for these purposes.

In addition, we seek comment on whether the core administrative functions that we have described above—claims processing or adjudication (including the management of appeals) and plan enrollment—are the appropriate criteria for this revised definition, and what other administrative functions, such as medical management services, provider network development, or other support tasks, should be considered in determining whether a self-insured group health plan uses a third party administrator. We also seek comment on whether a self-insured plan must perform these core administrative functions for all healthcare benefits and services provided to enrollees under the plan in order not to be considered to be using a third party administrator, or whether certain benefits or services, such as pharmaceutical benefits or behavioral health benefits, or a de minimis or small percentage of all benefits and services may be performed by an unaffiliated service provider. If so, we seek comment on which benefits or services should be excluded from this criterion, or how such a de minimis amount or small percentage should be measured.

While, upon further consideration of the issue, we believe the statutory language can reasonably be read to support the proposition that self-insured group health plans that do not use third party administrators for the functions described above should not be obligated to make reinsurance contributions, we also recognize, as a public policy matter, that it would be disruptive to plans and issuers to modify the definition of ''contributing entity'' for the 2014 benefit year at this late date. Health insurance issuers have already set premiums and developed operational processes based on the definition of ''contributing entity'' that was previously finalized in the 2014 Payment Notice. To prevent lower reinsurance payments, the contribution rate would have to be raised for other contributing entities, many of whom have already set their 2014 premiums based on the contribution rate finalized in March 2013. Excluding self-insured, self-administered group health plans from the set of entities that must provide reinsurance contributions for the 2014 benefit year, without raising the rate on other entities, would decrease the funds available for reinsurance payments for that benefit year, and thus upset settled estimates with respect to expected reinsurance payments that were used to establish premiums.

Therefore, we do not propose to change the definition of a ''contributing entity'' for the 2014 benefit year. That definition will remain as provided for in the second final Program Integrity Rule—a health insurance issuer or a self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage), regardless of whether the group health plan uses a third party administrator. The modification to the definition of ''contributing entity'' described above would be effective only for the 2015 and 2016 benefit years.

Finally, we note that our proposed change to the definition of a contributing entity may have implications for our plan aggregation rules at § 153.405(g), and seek comment on whether a plan sponsor that maintains two or more group health plans covering the same covered lives, where one or more group health plans are insured and one or more are self-insured and do not use a third party administrator for core administrative functions, should be required to treat the multiple plans as a single group health plan for purposes of calculating any reinsurance contribution amount due.

c. Uniform Reinsurance Contribution Rate

(i) Uniform Reinsurance Contribution Rate for the 2015 Benefit Year

Section 153.220(c) provides that HHS is to publish in the annual HHS notice of benefit and payment parameters the uniform reinsurance contribution rate for the upcoming benefit year. Section 1341(b)(3)(B)(iii) of the Affordable Care Act specifies that $10 billion for reinsurance contributions are to be collected from contributing entities in 2014 (the reinsurance payment pool), $6 billion in 2015, and $4 billion in 2016. Additionally, sections 1341(b)(3)(B)(iv) and 1341(b)(4) of the Affordable Care Act direct that $2 billion in funds are to be collected for contribution to the U.S. Treasury in 2014, $2 billion in 2015, and $1 billion in 2016. Finally, section 1341(b)(3)(B)(ii) of the Affordable Care Act allows for the collection of additional amounts for administrative expenses. Taken together, these three components make up the total dollar amount to be collected from contributing entities for each of the 3 years of the reinsurance program under the uniform reinsurance contribution rate.

As discussed in the 2014 Payment Notice, each year, the uniform reinsurance contribution rate will be calculated by dividing the sum of the three amounts (the reinsurance payment pool, the U.S. Treasury contribution, and administrative costs) by the estimated number of enrollees in plans that must make reinsurance contributions:

$$\textit{Uniform Reinsurance Contribution Rate} = \frac{\textit{Reinsurance payment pool} + \textit{Treasury contribution} + \textit{Administrative costs}}{\textit{Estimate of enrollees in plans required to make reinsurance contributions}}$$

As discussed in greater detail below, we are proposing to collect $25.4 million for administrative expenses for the 2015 benefit year (or 0.4 percent of the $6 billion to be dispersed). Therefore, the total amount to be collected would be approximately $8.025 billion. Our estimate of the number of enrollees in plans that must make reinsurance contributions yields an annual per capita contribution rate of $44 for the 2015 benefit year.

(ii) Timing of Collection of Reinsurance Contributions

As set forth in the 2014 Payment Notice, under § 153.405(b), no later than November 15 of the 2014, 2015, and 2016 benefit years, as applicable, a contributing entity must submit an annual enrollment count of the number of covered lives of reinsurance contribution enrollees for the applicable benefit year to HHS. Under § 153.405(c)(1), HHS is to notify the contributing entity of the reinsurance contribution amount to be paid for the applicable benefit year within 30 days of the submission of the annual enrollment count, or by December 15 of the applicable benefit year. Under § 153.405(c)(2), a contributing entity is to remit reinsurance contributions to HHS within 30 days after the date of the notification.

We recognize that the reinsurance collections provided for in the Affordable Care Act—$12 billion for 2014, $8 billion for 2015, and $5 billion for 2016—will result in substantial up-front payments from contributing entities for the reinsurance program. Therefore, we are proposing to modify our collection schedule for the program, so that we would collect the reinsurance contribution amounts for reinsurance payments and for administrative expenses earlier in the calendar year following the applicable benefit year, approximately in accordance with the schedule currently described in § 153.405(c), but collect the reinsurance contribution amounts for payments to the U.S. Treasury in the last quarter of the calendar year following the applicable benefit year. Therefore, we propose to modify § 153.405(c) so that a contributing entity would make reinsurance contributions in two installments to HHS—one at the beginning of the calendar year following the applicable benefit year, and one at the end. As noted in the second final Program Integrity Rule, the proposed policy is designed to alleviate the upfront burden of the reinsurance contribution, allowing contributing entities additional time to make the payment. We note that the proposed change in the collection schedule would not affect the amount of funds collected for reinsurance payments. Additionally, the amounts allocated to reinsurance payments and administrative expenses are needed to operate the reinsurance program, while the amounts allocated for payments to the U.S. Treasury are not needed for the operation of the transitional reinsurance program. Therefore, collecting the amounts allocated to payments to the U.S. Treasury later in the calendar year following the applicable benefit year will not affect the reinsurance program, and will alleviate a contributing entity's upfront financial burden.

Under this proposal, the first of the two installments each year would include the reinsurance contribution amounts allocated to reinsurance payments and administrative expenses. We propose in § 153.405(c)(1) that following submission of the annual enrollment count, HHS would notify a contributing entity of the reinsurance contribution amount allocated to reinsurance payments and administrative expenses to be paid for the applicable benefit year. If the enrollment count is timely submitted, HHS intends to notify the contributing entity by December of benefit year 2014, 2015, or 2016, as applicable. We note that, due to our desire to align the notification of reinsurance contributions due with our monthly payment and collections cycle, this schedule differs slightly from the schedule currently set forth in § 153.405(c)(3), which provides for notification by the later of 30 days of the submission of the annual enrollment count or by December 15. We propose in § 153.405(c)(3) that the contributing entity remit this amount within 30 days after the date of the first notification.

The second installment would cover the portion of the reinsurance contribution amount allocated to the payments for the U.S. Treasury to be paid for a benefit year. We propose in § 153.405(c)(2), that in the fourth quarter of the calendar year following the applicable benefit year, HHS would notify the contributing entity of the portion of the reinsurance contribution amount allocated for payments to the U.S. Treasury for the applicable benefit year. Again, under proposed § 153.405(c)(3), a contributing entity would remit this amount within 30 days after the date of this second notification. We note that the contributing entity would be required to submit an annual enrollment count only once for each benefit year under § 153.405(b).

For example, for the 2014 benefit year, of the $63.00 annual per capita contribution rate, $52.50 would be allocated towards reinsurance payments and administrative expenses, and $10.50 towards payments to the U.S. Treasury. Thus, we contemplate that if a contributing entity submits its enrollment count for the 2014 benefit year in a timely manner (by November 15, 2014), a reinsurance contribution payment of $52.50 per covered life would be invoiced in December 2014, and payable in January, 2015. Another reinsurance contribution payment of $10.50 per covered life would be invoiced in the fourth quarter of 2015, and payable late in the fourth quarter of 2015.

We propose that for the 2015 benefit year, the proposed $44 annual per capita contribution rate be allocated $33 towards reinsurance payments and administrative expenses, and $11 towards payments to the U.S. Treasury. These amounts would similarly be payable in January 2016 and late in the fourth quarter of 2016, respectively.

We plan to establish the uniform reinsurance contribution rate for the 2016 benefit year in the HHS notice of benefit and payment parameters for 2016.

We seek comment on this proposal. We note that we are considering a variation of this proposal under which contributing entities would be provided the option of paying the entire reinsurance contribution amount with the first installment, at the beginning of the calendar year following the applicable benefit year. We also clarify that the two installment payments (or one, should a contributing entity be permitted and elect to make the entire payment with the first installment) would be reported with 2014 data for purposes of the risk corridors and MLR calculations due July 31, 2015, despite the fact that the later installment would not have been paid at that time. This has the effect of leaving the MLR and risk corridors calculations unchanged.

(iii) Allocation of Uniform Reinsurance Contribution Rate

Section 153.220(c) provides that HHS is to set in the annual HHS notice of benefit and payment parameters for the applicable benefit year the proportion of contributions collected under the uniform reinsurance contribution rate to be allocated to reinsurance payments, payments to the U.S. Treasury, and administrative expenses. In the 2014 Payment Notice, we stated that reinsurance contributions collected for 2014 will be allocated pro rata to the reinsurance pool, administrative expenses, and the U.S. Treasury, up to $12.02 billion. In Table 2, we specify these proportions (or amounts, as applicable):

TABLE 2—PROPORTION OF REINSURANCE CONTRIBUTIONS COLLECTED UNDER THE UNIFORM REINSURANCE CONTRIBUTION RATE FOR THE 2015 BENEFIT YEAR FOR REINSURANCE PAYMENTS, PAYMENTS TO THE U.S. TREASURY, AND ADMINISTRATIVE EXPENSES

Proportion or amount for:	If total contribution collections under the uniform reinsurance contribution rate are less than or equal to $8.025 billion.	If total contribution collections under the uniform reinsurance contribution rate are more than $8.025 billion.
Reinsurance payments	74.8 percent ($6 billion/$8.025 billion)	The difference between total collections and those contributions allocated to the U.S. Treasury and administrative expenses.
Payments to the U.S. Treasury	24.9 percent ($2 billion/$8.025 billion)	$2 billion.
Administrative expenses	0.3 percent ($25.4 million/$8.025 billion)	$25.4 million.

As shown in Table 2, if the total amount of contributions collected is less than or equal to $8.025 billion, we propose to allocate approximately 74.8 percent of the reinsurance contributions collected to reinsurance payments, 24.9 percent of the reinsurance contributions collected to the U.S. Treasury, and 0.3 percent of the reinsurance contributions collected to administrative expenses. We note that the proposed method of collection would not affect the allocation to reinsurance payments, administrative expenses, and payments to the U.S. Treasury.

To provide that all reinsurance contributions collected for a benefit year are paid out for claims for that benefit year, we propose to amend § 153.230(d) to provide that if HHS determines that the amount of all reinsurance payments requested under the national payment parameters from all reinsurance-eligible plans in all States for a benefit year will not be equal to the amount of all reinsurance contributions collected for reinsurance payments under the national contribution rate in all States for an applicable benefit year, HHS will determine a uniform pro rata adjustment (up or down) to be applied to all such requests for reinsurance payments for all States. We propose that each applicable reinsurance entity, or HHS on behalf of a State, must reduce or increase the reinsurance payment amounts for the applicable benefit year by any adjustment required under that paragraph.

For example, for 2014, if HHS collects $9 billion for the reinsurance payments pool and $10 billion in reinsurance payments are requested, HHS and each applicable reinsurance entity would reduce all reinsurance payments by 10 percent (effectively decreasing the coinsurance rate). If HHS collects $11 billion for the reinsurance payments pool and $10 billion in reinsurance payments are requested, HHS and each applicable reinsurance entity would increase all reinsurance payments by 10 percent (effectively increasing the coinsurance rate).

We seek comment on this payment proposal, including on whether any excess collections should be allocated to increasing coinsurance rates above 100 percent, or whether such funds should be used instead to change other reinsurance parameters or used for future benefit years.

Because our proposal above would provide that all reinsurance contributions collected for a benefit year are paid out for claims for that benefit year, we propose to delete and reserve § 153.235(b), which currently provides that any excess reinsurance contributions collected from contributing entities for any benefit year but unused for the applicable benefit year *must* be used for reinsurance payments in subsequent benefit years. For years beyond the 2014 benefit year (for which we propose to pay out all reinsurance contributions collected, as described above), we seek comment on whether we should have the flexibility to use excess contributions collected in the applicable benefit year for that benefit year or in a subsequent benefit year.

(iv) Administrative Expenses

In the 2014 Payment Notice, we estimated that the Federal administrative expenses of operating the reinsurance program would be $20.3 million, based on our estimated contract and operational costs. We propose to use the same methodology to estimate the administrative expenses for the 2015 benefit year. These estimated costs would cover the costs related to contracts for developing the uniform reinsurance payment parameters and the uniform reinsurance contribution rate, collecting reinsurance contributions, making reinsurance payments, and conducting account management, data collection, program integrity and audit functions, operational and fraud analytics, training for entities involved in the reinsurance program, and general operational support. We propose to exclude from these administrative expenses the costs associated with work performed by Federal personnel. To calculate our proposed reinsurance administrative expenses for 2015, we divided HHS's projected total costs for administering the reinsurance programs on behalf of States by the expected number of enrollees in reinsurance-eligible plans for the benefit year.

We estimate this amount to be approximately $25.4 million for the 2015 benefit year. This estimate has increased for the 2015 benefit year because we will be making reinsurance payments in the 2015 benefit year for the 2014 benefit year, and as discussed below, will engage in program integrity and audit-related activity in 2015 to oversee the reinsurance program. We believe that this figure reflects the Federal government's significant economies of scale, which helps to decrease the costs associated with operating the reinsurance program. Based on our estimate of covered lives for which reinsurance contributions are to be made for 2015, we are proposing a uniform reinsurance contribution rate of $0.14 annually per capita for HHS administrative expenses. We provide details below on the methodology we used to develop the 2015 enrollment estimates.

For the 2014 benefit year, we allocated the administrative expenses equally between contribution and payment-related activities. Because we anticipate that our additional activities in the 2015 benefit year, including our program integrity and audit activities, will also be divided approximately equally between contribution and payment-related activities, we again propose to allocate the total administrative expenses equally between these two functions. Therefore, as shown in Table 3, we expect to apportion the annual per capita amount of $0.14 of administrative expenses as follows: (a) $0.07 of the total amount collected per capita for administrative expenses for the collection of contributions from health insurance issuers and group health plans; and (b) $0.07 of the total amount collected per capita for administrative expenses for

reinsurance payment activities, supporting the administration of payments to issuers of reinsurance-eligible plans.

TABLE 3—BREAKDOWN OF ADMINISTRATIVE EXPENSES (ANNUAL, PER CAPITA)

Activities	Estimated expenses
Collecting reinsurance contributions from health insurance issuers and group health plans	$0.07
Calculation and disbursement of reinsurance payments	0.07
Total annual per capita expenses for HHS to perform all reinsurance functions	0.14

If HHS operates the reinsurance program on behalf of a State, HHS would retain the annual per capita fee to fund HHS's performance of all reinsurance functions, which would be $0.14. If a State establishes its own reinsurance program, HHS would transfer $0.07 of the per capita administrative fee to the State for purposes of administrative expenses incurred in making reinsurance payments, and retain the remaining $0.07 to offset the costs of collecting contributions. We note that the administrative expenses for reinsurance payments will be distributed to those States that operate their own reinsurance program in proportion to the State-by-State total requests for reinsurance payments made under the uniform reinsurance payment parameters.

d. Uniform Reinsurance Payment Parameters

Our goal in setting the reinsurance payment parameters is to achieve the greatest impact on rate setting, and therefore premiums, through reductions in plan risk, while complementing the current commercial reinsurance market. Section 1341(b)(2)(B) of the Affordable Care Act directs the Secretary, in establishing standards for the transitional reinsurance program, to include a formula for determining the amount of reinsurance payments to be made to issuers for high-risk individuals that provides for the equitable allocation of funds. In the Premium Stabilization Rule, we provided that reinsurance payments to eligible issuers will be made for a portion of an enrollee's claims costs paid by the issuer (the coinsurance rate, meant to reimburse a proportion of claims while giving issuers an incentive to contain costs) that exceeds an attachment point (when reinsurance would begin), subject to a reinsurance cap (when the reinsurance program stops paying claims for a high-cost individual). The coinsurance rate, attachment point, and reinsurance cap together constitute the uniform reinsurance payment parameters.

Given the smaller pool of reinsurance contributions to be collected for the 2015 benefit year, we are proposing that the uniform reinsurance payment parameters for the 2015 benefit year be established at an attachment point of $70,000, a reinsurance cap of $250,000, and a coinsurance rate of 50 percent. We estimate that these uniform reinsurance payment parameters will result in total requests for reinsurance payments of approximately $6 billion for the 2015 benefit year. We believe setting the coinsurance rate at 50 percent and increasing the attachment point allows for the reinsurance program to help pay for nearly the same group of high-cost enrollees as was the case for the 2014 benefit year, while still encouraging issuers to contain costs. We believe that maintaining the reinsurance cap for the 2015 benefit year while ensuring that the coinsurance rate sufficiently compensates issuers for high risk individuals will make it easier for issuers to estimate the effects of reinsurance. We believe that these uniform reinsurance payment parameters will support the reinsurance program's goals of promoting nationwide premium stabilization and market stability while providing issuers incentives to continue to effectively manage enrollee costs. We intend to continue to monitor individual market enrollment and claims patterns to appropriately disburse reinsurance payments throughout each of the benefit years of the transitional reinsurance program.

As discussed in the 2014 Payment Notice, to assist with the development of the uniform reinsurance payment parameters and the premium adjustment percentage index, HHS developed the Affordable Care Act Health Insurance Model (ACAHIM). The ACAHIM estimates market enrollment, incorporating the effects of State and Federal policy choices, and accounting for the behavior of individuals and employers. The outputs of the ACAHIM, especially the estimated enrollment and expenditure distributions, were used to analyze a number of policy choices relating to the uniform reinsurance contribution rate and uniform reinsurance payment parameters proposed in this rule.

The ACAHIM generates a range of national and State-level outputs for 2015, including the level and composition of enrollment across markets given the eligible population in each State. The ACAHIM is described below in two sections: (1) the approach for estimating 2015 enrollment; and (2) the approach for estimating 2015 expenditures. The ACAHIM uses recent Current Population Survey (CPS) data adjusted for small populations at the State level, exclusion of undocumented immigrants, and population growth in 2015 to assign individuals to the various coverage markets.

Specifically, the ACAHIM assigns each individual to a single health insurance market as his or her baseline (pre-Affordable Care Act) insurance status. In addition to assuming that individuals currently in Medicare, TRICARE, or Medicaid will remain in such coverage, the ACAHIM takes into account the probability that a firm will offer employment-based coverage based on the CPS distribution of coverage offers for firms of a similar size and industry. Generally, to determine the predicted insurance enrollment status for an individual or family (the ''health insurance unit'' or ''HIU''), the ACAHIM calculates the probability that the firm will offer insurance, then models Medicaid eligibility, and finally models eligibility for advance payments of the premium tax credit and cost-sharing reductions under the Exchange. Whenever a transition to another coverage market is possible, the ACAHIM takes into account the costs and benefits of the decision for the HIU and assigns a higher probability of transition to those with the greatest benefit. The ACAHIM assumptions of the rate at which uninsured individuals will take up individual market coverage are based on current take-up rates of insurance across States, varied by demographics and incomes and adjusted for post-Affordable Care Act provisions, such as advance payments of the premium tax credit and cost-sharing reductions.

Estimated expenditure distributions from the ACAHIM are used to set the uniform reinsurance payment parameters so that estimated contributions from all contributing entities equal estimated payments for all reinsurance-eligible plans. The ACAHIM uses the Health Intelligence Company, LLC (HIC) database from calendar year 2010, with the claims data trended to 2015 to estimate total medical expenditures per enrollee by age, gender, and area of residence. The expenditure distributions are further adjusted to take into account plan benefit design, or ''metal'' level (that is, ''level of coverage,'' as defined in

§ 156.20) and other characteristics of individual insurance coverage in an Exchange. To describe a State's coverage market, the ACAHIM computes the pattern of enrollment using the model's predicted number and composition of participants in a coverage market. These estimated expenditure distributions were the basis for the uniform reinsurance payment parameters.

e. Adjustment Options

In the 2014 Payment Notice, we finalized the following uniform reinsurance payment parameters for the 2014 benefit year—a $60,000 attachment point, a $250,000 reinsurance cap, and an 80 percent coinsurance rate. However, updated information, including the actual premiums for reinsurance-eligible plans, as well as recent policy changes, suggest that our prior estimates of the payment parameters may overestimate the total covered claims costs of individuals enrolled in reinsurance-eligible plans in 2014. To account for this, we propose to decrease the 2014 attachment point to $45,000. We seek comment on this proposal.

f. Deducting Cost-Sharing Reduction Amounts From Reinsurance Payments

Subpart H of 45 CFR part 153 governs the submission of reinsurance claims to an issuer's dedicated distributed data environment. Under § 156.410, if an individual is determined eligible to enroll in a QHP in the individual market offered through an Exchange and elects to do so, the QHP issuer must assign the individual to a standard plan or cost-sharing plan variation based on the enrollment and eligibility information submitted by the Exchange. Issuers of QHPs offered in an individual market through an Exchange will receive cost-sharing reduction payments for enrollees in their plan variations. Therefore, in the 2014 Payment Notice (78 FR 15499), we stated that the enrollee-level data submitted by an issuer of a reinsurance-eligible plan must include claims data and data related to determining cost-sharing reductions provided through a cost-sharing plan variation, to permit HHS to calculate an issuer's plan paid amounts on behalf of an enrollee. Here, we propose to explain the methodology HHS would use to deduct the amount of cost-sharing reductions paid on behalf of an enrollee enrolled in a QHP in an individual market through an Exchange. In this section, we first set forth a methodology for policies that cover only one enrollee, then policies with more than one enrollee, such as family plans, and finally, for policies under a limited cost sharing plan variation.

As specified in § 153.230, HHS will calculate reinsurance payments by applying the uniform reinsurance payment parameters for the applicable benefit year to the issuer's plan paid amounts on behalf of each enrollee in a reinsurance-eligible plan for the benefit year. However, this calculation may not always account for the cost-sharing reduction payments the QHP issuer receives for an enrollee, resulting in an issuer receiving payments twice for the same enrollee's total costs. We believe that the cost-sharing amounts provided by HHS to a QHP issuer for an enrollee in a plan variation should be deducted from the total plan paid amounts to avoid ''double payment'' [15] to the QHP issuer of the reinsurance-eligible plan because the QHP issuer is already being reimbursed for the value of the cost-sharing reductions provided.

Under the Secretary's authority under section 1341(b)(2)(B) of the Affordable Care Act to establish a payment formula for the reinsurance program, we propose a method through which HHS intends to account for cost-sharing reduction payments when calculating reinsurance payments for QHP issuers for reinsurance-eligible plans offered in an individual market. We seek to avoid requiring QHP issuers to engage in a complicated re-adjudication of claims to determine cost-sharing reduction amounts multiple times throughout the year. We believe that the proposed methodology set forth below will accurately estimate those cost-sharing reduction payments while also alleviating the burden on both QHP issuers and HHS.

We propose that for each enrollee enrolled in a QHP plan variation, we will subtract from the QHP issuer's total plan paid amounts for the enrollee in a reinsurance-eligible plan the difference between the annual limitation on cost sharing for the standard plan and the annual limitation on cost sharing for the plan variation. Because reinsurance payments are made for enrollees only when the issuer's total plan paid amounts exceeds the attachment point (for example, $60,000 in the 2014 benefit year), we believe that it is highly unlikely that an enrollee for which a QHP issuer is eligible for reinsurance payments will not have reached the annual limitation on cost sharing. Therefore, the difference between the two annual limitations on cost sharing is likely to be an accurate estimate of cost-sharing reduction payments provided by HHS to the QHP issuer.[16] We propose to apply this approach to calculating the amounts of cost-sharing reductions provided for an enrollee in a silver plan variation or a zero cost sharing plan variation.

For policies with multiple enrollees, such as family policies, we propose to allocate the difference in annual limitation in cost sharing across all enrollees covered by the family policy in proportion to the enrollees' QHP issuer total plan paid amounts. We believe that such an approach is intuitive and will be easy to operationalize. We considered an alternative approach that would allocate the difference in annual limitation in cost sharing equally across all enrollees in a family policy, with any difference in annual limitations on cost sharing that exceeds the total plan paid amounts for a particular enrollee to be reallocated equally across the other enrollees. That approach would tend to result in a higher allocation of cost sharing on low-claims-cost individuals, which we believe is unrealistic.

In contrast, we propose not to reduce the QHP issuer's plan paid amounts for purposes of calculating reinsurance payments for an Indian in a limited cost sharing plan variation. We note that such enrollees will have the same annual limitation on cost sharing as individuals enrolled in standard plans, and thus, an approach that calculates the difference in annual limitations on cost sharing would yield estimated cost-sharing reductions of zero. We believe that this result is reasonable for individuals with plan paid amounts greater than the attachment point because those individuals are likely to have incurred significant claims costs with providers for which cost sharing is not reduced—that is, providers other

[15] We note an increase in reinsurance claims spread evenly across the individual market may not necessarily result in higher reinsurance payments to all issuers in aggregate. However, increased requests for reinsurance payments may result in a higher pro rata reduction to be applied to all reinsurance payments because total reinsurance payments for a benefit year cannot exceed the reinsurance contributions collected for reinsurance payments (*see* 45 CFR 153.230(d)).

[16] We note that because the annual limitation on cost sharing applies only to in-network services, it is possible that an enrollee could incur additional cost-sharing reductions on out-of-network services. However, except in the case of zero cost sharing plan variations, an issuer is not required to reduce cost sharing out-of-network, and we believe that an issuer will rarely choose to do so because the AV calculator does not recognize any change in AV due to a reduction in out-of-network cost sharing. Although it is possible that an enrollee in a zero cost sharing plan variation could incur significant out-of-network cost-sharing reductions beyond the standard plan's annual limitation on cost sharing, we believe such a circumstance will be relatively rare because of the substantial out-of-pocket costs an enrollee would likely incur in the form of balance billing.

than the Indian Health Service and facilities operated by an Indian Tribe, Tribal Organization, or Urban Indian Organization. Thus, we believe that these individuals are likely to have reached the full annual limitation on cost sharing for the standard plan.

We also considered an alternative approach that would require issuers to re-adjudicate claims periodically throughout the year to calculate cost-sharing reductions provided to date for an Indian enrolled in a limited cost sharing plan, but believe that such an approach would be burdensome to QHP issuers and only slightly improve the accuracy of cost-sharing reduction estimates. Finally, we considered an approach under which QHP issuers would submit an estimate of the effective annual limitation on cost sharing for limited cost sharing plans. However, we believe that this will be difficult for a QHP issuer to estimate due to the lack of cost-sharing reduction data for the early years of the Exchanges.

g. Audits

(i) HHS Audits of State-Operated Reinsurance Programs

To safeguard the use of Federal funds in the transitional reinsurance program, we propose in § 153.270(a) that HHS or its designee may conduct a financial and programmatic audit of a State-operated reinsurance program to assess compliance with the requirements of subparts B and C of 45 CFR part 153. A State that establishes a reinsurance program must ensure that its applicable reinsurance entity and any relevant contractors, subcontractors, or agents cooperate with an audit of its reinsurance program by HHS or its designee.

Under the proposed rule, HHS may conduct targeted audits of State-operated reinsurance programs based on the State summary report provided to HHS for each benefit year described in § 153.260(b), the results of the independent external audit conducted for each benefit year under § 153.260(c), and issuer input, among other factors. Such audits may, for example, examine the receipt and expenditure of reinsurance funds, as well as funds received from HHS for administrative expenses. The audits may also examine the reinsurance program's compliance with the requirements for the State and the program under subparts B and C of 45 CFR part 153. We will provide further details on our audit program, including timelines, procedures, and substantive requirements, in future rulemaking and guidance.

We propose in § 153.270(b) that if an audit by HHS results in a finding of material weakness or significant deficiency (as these terms are defined in GAAS issued by the American Institute of Certified Public Accountants, and Government Auditing Standards issued by the Government Accountability Office (GAO) [17]) with respect to the State-operated reinsurance program's compliance with any requirement of subparts B or C of 45 CFR part 153, the State must ensure that its applicable reinsurance entity provide a written corrective action plan to HHS for approval within 60 calendar days of the issuance of the final audit report. The applicable reinsurance entity must implement the plan and provide to HHS written documentation of the corrective actions once taken. We seek comment on this proposal, including the standards that should govern these audits.

(ii) HHS Audits of Contributing Entities

We propose in § 153.405(i) that HHS or its designee may audit a contributing entity to assess its compliance with the requirements of subpart E of 45 CFR part 153. We anticipate conducting targeted audits of contributing entities based on, among other criteria and sources, data provided to HHS through the annual enrollment count submitted under § 153.405(b) and any previous history of noncompliance with these standards. We will provide further details on this audit program, including timelines, procedures, and substantive requirements, in future rulemaking and guidance. We anticipate that these audits will focus on records relating to the enrollment of the applicable self-insured or insured plan, to confirm that the number of covered lives was correctly counted and that the correct amount of reinsurance contributions was paid. Audits may also identify entities that were required to but did not make reinsurance contributions. If HHS determines as the result of an audit that a contributing entity was required to pay additional reinsurance contributions, it may require the contributing entity to pay such amounts to the Federal government. If the contributing entity is an issuer subject to an audit for other Exchange financial programs or premium stabilization programs, such as risk adjustment, we intend to coordinate these audits, to the extent practical, to reduce the burden on both the contributing entity and HHS.

We seek comment on this proposal, including the standards that should govern these audits.

(iii) HHS Audits of Issuers of Reinsurance-Eligible Plans

We propose in § 153.410(d) that HHS or its designee may audit an issuer of a reinsurance-eligible plan to assess its compliance with the requirements of subparts E and H of 45 CFR part 153, and that if an audit results in a finding of material weakness or significant deficiency, the issuer must:

- Within 30 calendar days of the issuance of the final audit report, provide a written corrective action plan to HHS for approval;
- Implement that corrective action plan; and
- Provide to HHS written documentation of the corrective actions once taken.

If HHS determines as the result of an audit that the issuer of a reinsurance-eligible plan has received reinsurance payments to which it was not entitled, it may require the issuer to pay such amounts back to the Federal government.

We anticipate conducting targeted audits of issuers of reinsurance-eligible plans based on, among other criteria and sources, the data provided to HHS through the dedicated distributed data environment and any previous history of noncompliance with these standards. We will provide further details on this audit program, including timelines, procedures, and substantive requirements, in future rulemaking and guidance. We anticipate that this audit will focus on claims records validating the requests for reinsurance payments submitted to the dedicated distributed data environments, as well as records indicating the plan was a reinsurance-eligible plan. To reduce the burden on issuers and HHS, to the extent practical, we intend to coordinate any audits of issuers of reinsurance-eligible plans with related audits of Exchange financial programs and premium stabilization programs, such as risk adjustment.

We seek comment on this proposal, including the standards that should govern these audits.

h. Same Covered Life

In the second final Program Integrity Rule (78 FR 65057), we stated that it is our intent not to require payment of reinsurance contributions more than once for the same covered life. We

[17] *See* Government Auditing Standards (2011 Revision), available at: *http://www.gao.gov/yellowbook*. For public companies, the Public Company Accounting Oversight Board (PCAOB) sets audit standards. *See http://pcaobus.org/Standards/Auditing/Pages/default.aspx*. For non-public companies, the AICPA sets audit standards. *See http://www.aicpa.org/Research/Standards/AuditAttest/Pages/SAS.aspx*.

stated that we recognize that certain complex group health plan arrangements can lead to situations in which lives are covered by multiple arrangements, where it is unclear whether more than one health plan or issuer must make reinsurance contributions, and that we intended to provide clarity on the matter in future rulemaking.

Therefore, we propose to make two changes to § 153.400. In § 153.400(a)(1), we propose to clarify the general principle that reinsurance contributions are required for major medical coverage that is considered to be part of a commercial book of business, but are not required to be paid more than once with respect to the same covered life.

In addition, we propose to add paragraph (vi) to § 153.400(a)(1), which would provide that no reinsurance contributions would be required in the case of employer-provided group health coverage where (A) such coverage applies to individuals who are also enrolled in individual market health insurance coverage for which reinsurance contributions are required; or (B) such coverage is supplemental or secondary to group health coverage for which reinsurance contributions must be made for the same covered lives. This language would address situations in which a person covered under a group health plan also obtains individual market coverage, and in which multiple group health plans cover the same lives, such as if a union offers a plan that supplements a group health plan offered by the employer. It would also address a situation in which two spouses are each covered as dependents by the respective group health plans offered by their two independent employers.

If it is not clear from the terms of the health plans which group health plan is supplemental, we propose, in keeping with § 153.400(a)(3), that the group health plan that offers the greater portion of inpatient hospitalization benefits be deemed the primary health plan. If it is not clear from the terms of the health plans which group health plan is primary and which is secondary, we propose to defer to the arrangements on primary and secondary liability worked out by the respective plan sponsors, in accordance with applicable State coordination of benefit laws and regulations. In such a situation, we would hold a plan sponsor harmless from non-compliance actions for failure to pay reinsurance contributions to the extent the sponsor relied in good faith upon a written representation by the other sponsor that the other sponsor's coverage has primary liability for claims for particular covered lives.

We seek comment on these proposals, including which entity should be responsible for the reinsurance contributions, how that responsibility should be determined, and what arrangements should be required between the entities to assure efficient coordination of the responsibility for the reinsurance contributions, and what other situations we should address in which reinsurance contributions might be required to achieve the goal of preventing more than one contribution per covered life.

i. Reinsurance Contributions and Enrollees Residing in the Territories

Section 1323(a)(1) of the Affordable Care Act provides that a U.S. territory may establish an Exchange, and any territory that elects to establish an Exchange will be ''treated as a State'' for purposes of the Exchange standards in sections 1311 through 1313 of the Affordable Care Act. In a letter dated December 10, 2012 to the governors of the U.S. territories (Territories Letter), HHS stated that ''if a territory establishes an approved Exchange, it may elect to establish a transitional reinsurance program . . . consistent with the provisions in section 1341 . . . of the Affordable Care Act.'' The Territories Letter further stated that if a territory does not establish a transitional reinsurance program, HHS would not do so on the territory's behalf, and that in order to operate a reinsurance program for the 2014 benefit year, the territory was required to notify HHS of its intention to do so by March 1, 2013. No territory has notified HHS of an intention to operate a reinsurance program.

In this proposed rule, we propose that a contributing entity is not required to make reinsurance contributions on behalf of enrollees who reside in a territory that does not operate a reinsurance program. We propose to add in § 153.400(a)(1)(v) an exception for when a contributing entity must make reinsurance contributions for its self-insured group health plans and health insurance coverage. To the extent that the coverage applies to enrollees with primary residence in a territory when that territory does not operate a reinsurance program, a contributing entity would not be required to make reinsurance contributions for those enrollees. We believe that this proposal aligns with the goals of the reinsurance program because reinsurance contributions would only be required with respect to those jurisdictions that benefit from the premium stabilization effects of the reinsurance program.

We propose that a contributing entity may use any reasonable method to determine the primary residence of an enrollee, including using the last-known mailing address of the principal subscriber on the enrollee's policy. We seek comment on other methods that would be acceptable for determining the primary residence of an enrollee, including the principal work location of the principal subscriber on the enrollee's policy.

We note that a contributing entity is required to allocate its covered lives by primary residence between the territories, on the one hand, and the 50 States and the District of Columbia, on the other hand, only if it wishes to exclude covered lives from reinsurance contributions under proposed § 153.400(a)(1)(v).

j. Form 5500 Counting Method

In the 2014 Payment Notice (78 FR 15463), we established counting methods for calculating the annual enrollment for determining reinsurance contributions for self-insured group health plans, fully insured health plans, and plans that are partially insured and partially self-insured. One of the allowable methods for a self-insured group health plan is the Form 5500 counting method in § 153.405(e)(3). In this proposed rule, we seek to clarify § 153.405(e)(3), by changing the references from ''benefit year'' to ''plan year'' [18] to clarify that a self-insured group health plan may use the enrollment set forth in the Form 5500 even if the group health plan is based on a plan year other than the benefit year, which is defined in § 153.20 and § 155.20 as a calendar year for which a health plan provides coverage for health benefits. Therefore, a self-insured group health plan that chooses to use the Form 5500 counting method and offers self-only coverage would calculate the number of lives covered by adding the total participants covered at the beginning and end of the most current plan year, as reported on the Form 5500, then dividing by two. A self-insured group health plan that offers both self-only coverage and coverage other than self-only coverage would calculate the number of lives covered by adding the total participants covered at the beginning and the end of the most current plan year, as reported on the Form 5500.

[18] Plan year as defined in 45 CFR 155.20 as a consecutive 12 month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year or otherwise.

3. Provisions for the Temporary Risk Corridors Program

a. Definitions

In the first final Program Integrity Rule, we provided that, in 45 CFR part 153, subpart F, regarding risk corridors, any reference to a ''qualified health plan'' or ''QHP'' includes plans that are the ''same'' as a QHP or ''substantially the same'' as a QHP. We noted that plans that are substantially the same as a QHP will continue to be considered substantially the same even if they differ in terms of benefits, premium, provider network or cost-sharing structure, provided that the differences are tied directly and exclusively to Federal or State requirements or prohibitions on the coverage of benefits that apply differently to plans depending on whether they are offered through an Exchange or outside of an Exchange.

In the first final Program Integrity Rule, we recognized that OPM might issue additional standards for multi-State plan (MSP) issuers in the future (for example, standards related to provider networks) that could create situations analogous to the ones we discuss above. We are considering whether a plan that differs from a QHP (as defined at § 155.20) based on these standards would be considered to be ''substantially the same'' as a QHP for the purposes of participating in the risk corridors program, and are considering amending the definition of a QHP at § 153.500 in response. We seek comment on this approach.

b. Compliance With Risk Corridors Standards

The risk corridors program requires the Federal government and participating plans to share in profits or losses resulting from inaccurate rate setting for benefit years 2014 through 2016. A robust oversight process is critical for this program because risk corridors payments are Federal funds. In this proposed rule, we outline our proposed process for validating risk corridors data submissions and enforcing compliance with the risk corridors requirements in subpart F of 45 CFR part 153. Because the MLR program and the risk corridors program will require similar data, we propose to closely align the data submission, data validation, audit provisions, and sanctions for the two programs. We note that the risk corridors oversight provisions will apply to all plans, including QHPs and plans that are substantially the same as QHPs (as defined in the first final Program Integrity Rule) that are subject to the risk corridors program, whether these plans are offered through the Exchange or outside of the Exchange.

For the 2014 benefit year, we propose to collect risk corridors data through the same form used for MLR data collection, at the same time (July 31 of the year following the applicable benefit year). We note that we would modify the collection instrument and adjust the operational aspects of data submission as necessary to ensure that the data collection process adheres to the requirements for both programs. We would leverage data validation procedures that are used by the MLR program to uncover data inconsistencies, and would add additional validation steps that would allow us to identify QHP issuers and verify QHP-specific premium information. In addition, we are considering conducting an internal quality check of risk corridors data to ensure that the information submitted is consistent with information submitted for other programs (for example, premiums and claims reported in the dedicated distributed data environment). Similar to the MLR process, we anticipate requiring issuers to resubmit corrected data after risk corridors data errors are identified. We request comment on this approach.

To ensure the integrity of risk corridors data reporting, we propose in § 153.540(a) to establish HHS authority to conduct post-payment audits of QHP issuers. Because similar data is used in the risk corridors and MLR calculations, we are considering conducting the risk corridors audits using the existing MLR auditing process set forth at § 158.402 to reduce the time and expense (for both HHS and issuers) of conducting multiple audits on similar data. We are further contemplating conducting risk corridors audits under an overall issuer audit program so that we may simultaneously obtain the financial information necessary to determine compliance with other programs, such as the risk adjustment and reinsurance programs. We believe that this may further reduce the overall audit burden on issuers. Some States already review data and audit issuer information related to MLR reporting and rebate obligations; HHS does not intend to review information that would be duplicative of a review that has been completed by a State. However, because States may not examine all data required to be examined for the risk corridors program, HHS could audit a QHP issuer's risk corridors data to the extent not examined by the State. We request comments on all aspects of this approach, including appropriate criteria for identifying issuers for audit in any particular benefit year.

The second final Program Integrity Rule provides that a QHP issuer on an FFE that fails to comply with the risk corridors provisions may be subject to decertification or civil money penalties (CMPs), but does not extend this remedy to a QHP issuer on a State Exchange. State Exchange issuers that fail to submit risk corridors charges, and consequently owe HHS money, would be subject to the Federal debt collection processes; however, without risk corridors data, HHS will be unable to determine whether a debt is owed or the amount of a debt. Therefore, in § 153.540(b) we propose to extend our CMP authority under sections 1321(a)(1) and (c)(2) of the Affordable Care Act to all QHP issuers that fail to provide timely, accurate, and complete data necessary for risk corridors calculations, or that otherwise do not comply with the standards in subpart F of 45 CFR part 153. We propose to assess CMPs on QHP issuers in State Exchanges in accordance with the same enforcement and sanction procedures that apply to QHP issuers on FFEs, under § 156.805. For purposes of calculating the maximum CMP amount, we may consider using enrollment information acquired from other internal sources (for example, risk adjustment and reinsurance enrollment data from the dedicated distributed data environment). Under this approach, we would either use enrollment information from all of an issuer's non-grandfathered plans within a State market, or would limit calculation of the CMP amount to the number of enrollees in an issuer's QHPs (including enrollees in plans that are substantially the same as a QHP). We note that, consistent with our general approach relating to the application of sanctions, we would take various factors into account when determining the amount of a CMP, including an issuer's record of prior compliance with risk corridors requirements, the gravity and the frequency of the violation, and the issuer's demonstrated success in correcting violations that HHS has identified (for example, errors identified in corrective action plans).[19] We request comments on all aspects of this approach, particularly for the methodology that we should use to determine a CMP amount for a QHP

[19] We note that the good faith provision at § 156.800(c) will not be applicable in this context because risk corridors activities, such as data submission and payment, occur beginning in 2015.

issuer that does not comply with risk corridors data requirements.

c. Participation in the Risk Corridors Program

Because the premium stabilization programs, including the risk corridors program, are intended to mitigate pricing uncertainty associated with the 2014 market reforms, particularly the rating rules at section 2701 of the PHS Act and § 147.102, we believe that the protections of these programs should be for plans that are subject to the premium rating rules. Therefore, in the 2014 Payment Notice, we clarified that under the methodology HHS will use when operating risk adjustment on behalf of a State, a plan that is not subject to the market reform rules, including the premium rating rules, is not a risk adjustment covered plan. In the second final Program Integrity Rule, we further clarified that stand-alone dental plans would not be subject to the risk corridors program because they are not subject to the premium rating rules, and therefore do not require the protections of the risk corridors program. In this proposed rule, we are similarly proposing to amend the risk corridors rules to provide that a plan that is not subject to the market reform rules and premium rating rules would not participate in the risk corridors program. We propose to add a paragraph (f) to § 153.510 to provide that the risk corridors program would apply only to qualified health plans, as defined in § 153.500, including all plans offered through the individual market Exchange or SHOP, regardless of employer size, that are subject to the following provisions within title 45 of the CFR:

- § 147.102 (fair health insurance premiums).
- § 147.104 (guaranteed availability of coverage).
- § 147.106 (guaranteed renewability of coverage).
- § 147.150 (essential health benefits).
- § 156.80 (single risk pool) and subpart B of 45 CFR part 156 (essential health benefits package).

We believe that this approach is consistent with how QHPs have determined their pricing for the 2014 benefit year. We note that a QHP that must adhere to the premium rating rules as a condition of participation on the SHOP is a plan that is ''subject to the rating rules'' for the purposes of this policy.

We are also proposing that the employee counting method applicable under State law would determine whether a plan is considered to be offered in the small group market for purposes of the risk corridors program even if the State definition does not take non-full-time employees into account, and thus could include some employers as small employers that would be large employers under the Federal definition. Given our broad authority to establish the risk corridors program, we believe that we have the discretion to include such employers in the program even if they do not meet the Federal definition of small employer that would apply for other purposes. We believe that the inclusion of such employers in the definition of small employers for purposes of the risk corridors program would maintain consistency between the risk corridors calculation and implementation of the single risk pool provision, which is generally enforced by the State. We further believe that clearly specifying the employee counting method that is specific to the risk corridors program would provide clarity for QHP issuers with plans that could either be excluded from or subject to the risk corridors program, depending on the employee counting method used. We note that permitting the use of a State employee counting method that is inconsistent with Federal law for purposes of the risk corridors program differs from the approach taken under the MLR program and the proposed counting method for the risk adjustment program that is described elsewhere in this proposed rule. Under these programs, non-full-time employees must be counted. We note that the State's employee counting method would also be used to determine whether a plan that is not a QHP is part of the non-grandfathered individual or small group market within a State, and would, therefore, be part of a QHP issuer's risk corridors data submission under § 153.530. We also note that the State's employee counting method would determine whether any plan offered outside of an Exchange that is the ''same'' as or ''substantially similar'' to an Exchange QHP (under the definition set forth in § 153.500) would be part of the individual or small group market for purposes of the risk corridors program, and, therefore whether it is eligible to receive or make risk corridors payments. This proposed approach would serve to align the market-wide rating rules with the protections of the premium stabilization programs. However, the approach could likely lead to a more complex data submission for risk corridors and MLR, because we may not be able to align the market definitions between the two programs.

We seek comment on our proposal that a QHP must be subject to the market reform rules in order to participate in the risk corridors program. We also seek comment on our proposal to use the State employee counting method to define plans in the small group market for purposes of determining which plans participate in the risk corridors program, even where that would include employers that would be large employers under the Federal definition, or whether we should instead use the counting method used for the MLR program and proposed for risk adjustment purposes. We also seek comments on whether we should explicitly codify the applicable counting rules for each program in regulations text.

d. Adjustment Options for Transitional Policy

As discussed earlier, on November 14, 2013, the Federal government announced a policy under which it will not consider certain health insurance coverage in the individual or small group market between January 1, 2014, and October 1, 2014, under certain conditions to be out of compliance with specified 2014 market rules, and requested that States adopt a similar non-enforcement policy.[20] CMS noted in a letter to the insurance commissioners of the 50 States and the District of Columbia that while this transitional policy would not have been anticipated by issuers in setting rates for 2014, the risk corridors program should ameliorate the effect of this policy. We also stated that we intended to explore ways to modify the risk corridors program to address any unanticipated effects of this policy.

Therefore, for the 2014 benefit year, we are considering whether we should make an adjustment to the risk corridors formula that would help to further mitigate any unexpected losses for issuers of plans subject to risk corridors that are attributable to the effects of the transition policy. One potential option we are considering would be to implement an adjustment to the risk corridors formula set forth in subpart F of part 153 for each of the individual and small group markets by increasing the profit margin floor (from 3 percent of after-tax profits) and the allowable administrative costs ceiling (from 20 percent of after-tax profits) in an amount sufficient to offset the effects of the transitional policy upon the claims costs of a model plan (that is, a plan with an 80 percent allowable costs-to-premium ratio). This adjustment could serve to

[20] Letter to Insurance Commissioners, Center for Consumer Information and Insurance Oversight, November 14, 2013. *See http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.*

increase a QHP issuer's risk corridors ratio and its risk corridors payment amount to help offset the loss in premium revenue and profit that might occur under the transitional policy as a result of predicted increased claims costs that were not accounted for when setting 2014 premiums. We are considering applying this adjustment only to plans whose allowable costs (as defined at 45 CFR 153.500) are at least 80 percent of their after-tax premiums, because issuers under this threshold would generally be required to pay out rebates to consumers. We note that for plans whose ratio of allowable costs to after-tax premium are below 80 percent, the 3 percent risk corridors profit margin and 20 percent allowable administrative cost ceiling would continue to apply for these plans.

The effect on the risk pool of plans compliant with the 2014 market rules may vary significantly from State to State, depending upon the extent to which each State elects not to enforce the 2014 market rules, as recommended under the transition policy, and upon the market dynamics of the health insurance market within the State. We believe that the State-wide effect on this risk pool will increase with the increase in the percentage enrollment in transitional plans in the State, and so we are considering having the State-specific percentage adjustment to the risk corridors formula also vary with the percentage enrollment in these transitional plans in the State.

We are considering calculating the State-specific percentage adjustment by analyzing the effects of the transitional policy upon a plan with specified characteristics. For example, our actuaries believe the following are reasonable plan assumptions: allowable costs (including claims) equal to 80 percent of premiums, federal income taxes equal to 35 percent of pre-tax profits, other tax liability equal to 7.5 percent of premiums, and other administrative costs equal to 8 percent of premiums.

We are considering calculating the State-specific percentage adjustment to the risk corridors profit margin floor and allowable administrative costs ceiling in a manner that would help to offset the effects of the transitional policy upon the model plan's claims costs.

We propose to estimate the effect of the transitional policy upon the model plan's claims costs by assuming that allowable costs (including claims) among the transitional plans are 80 percent of the allowable costs that would have resulted from the broad risk pool, in the absence of the transitional policy. After consulting our actuaries, we believe that this assumption is a reasonable reflection of the effects of underwriting on the transitional plans. To estimate this State-specific effect of the transitional policy on average claims costs, we propose to require all issuers participating in the individual and small group markets in a State to submit to HHS a member-month enrollment count for transitional plans and non-transitional plans in the individual and small group markets. This submission would occur in 2015 prior to the risk corridors submission. HHS would analyze that data, and publish the State-specific adjustments that issuers would use in the risk corridors calculations for the 2014 benefit year.

We have proposed a State-wide adjustment for reasons of administrative simplicity and due to the analytical difficulty in estimating this effect on an issuer-by-issuer basis. Although the adjustment that we are considering would affect each issuer differently, depending on its particular claims experience and administrative cost rate, we believe that, on average, the adjustment would suitably offset the losses that a standard issuer might experience as a result of the transitional policy. We also note that, because the risk corridors program applies only to certain plans defined to be qualified health plans at 45 CFR 153.500, the extent to which an issuer may receive the full effect of this adjustment would depend upon the portion of an issuer's individual and small group enrollees in plans subject to risk corridors.

Another option we are considering would be to make a similar modification to the medical loss ratio formula. We would use our authority under section 2718(c) of the Public Health Service Act to ''take into account . . . special circumstances of different types of plans'' to ensure that the proposed adjustment to the risk corridor program does not distort the implementation of MLR requirements, so that the rebates that would be owed absent the transitional policy and this adjustment would not substantially change. We seek comment on the best way to make such a modification, and whether such a modification is required.

We request comment on all aspects of these potential approaches to help mitigate any potential impact of the transitional policy. As we continue to analyze its potential impacts, we will determine whether such approaches and modifications are warranted. We seek comment on alternate ways of implementing adjustments to current risk corridors and reinsurance program policy that would help offset issuers for any unexpected losses that might be incurred as a result of the transitional policy. In particular, we seek comment on whether this risk corridors adjustment should depend upon State-wide market characteristics, as we have proposed, or whether it should be national, tailored to each issuer, or based upon different State-wide characteristics.

We also seek comment on whether the characteristics of the standard plan we have outlined above are the appropriate characteristics to use for our modeling. We seek comment on the data that we should collect to measure the key characteristics for this adjustment, and who we should collect that data from. We seek comment on whether particular ceilings and floors should be placed upon the amount of the adjustment. We also seek comment on whether the adjustment should apply to QHP issuers with allowable costs that are below 80 percent of after-tax premiums.

4. Distributed Data Collection for the HHS-operated Risk Adjustment and Reinsurance Programs

a. Discrepancy Resolution Process

(i) Confirmation of HHS Dedicated Distributed Data Environment Reports

Because the accuracy of the data on an issuer's dedicated distributed data environment is critical to the accuracy of the HHS-operated risk adjustment and reinsurance calculations, we are proposing an iterative discrepancy reporting process that would allow an issuer of a risk adjustment covered plan or a reinsurance-eligible plan to notify HHS in a timely fashion of data and calculation discrepancies related to the data the issuer uploaded to its dedicated distributed data environment. We anticipate that this process would allow HHS and issuers sufficient time to resolve discrepancies, prior to HHS notifying issuers of final risk adjustment payments and charges and reinsurance payments. This process would also enable HHS to identify and address issues that affect multiple issuers throughout the benefit year.

Interim dedicated distributed data environment reports: Beginning in 2014, HHS anticipates sending interim dedicated distributed data environment reports to issuers of risk adjustment covered plans and reinsurance-eligible plans that have loaded data onto their dedicated distributed data environments. (We also intend to issue these interim reports to issuers of risk adjustment covered plans and reinsurance-eligible plans that do not load data, to verify this result.) We anticipate that issuers of risk adjustment covered plans would receive interim

reports that include preliminary risk scores based on this data. We anticipate that issuers of reinsurance-eligible plans would receive interim reports that include an estimate of the issuer's aggregated total claims eligible for reinsurance payments based on this data. Therefore, we propose in § 153.710(d) that within 30 calendar days of the receipt of an interim dedicated distributed data environment report from HHS, the issuer must either confirm to HHS that the information in the interim report accurately reflects the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with § 153.700(a) for the timeframe specified in the report, or else must describe to HHS any discrepancy it identifies in the interim report. Following the identification of a discrepancy in an interim dedicated distributed data environment report, HHS would review the evidence submitted by the issuer, along with any other relevant data, and would determine if the preliminary risk score or estimated payment amount at issue was properly calculated using the applicable data. We believe that the 30-calendar-day timeframe would provide sufficient opportunity for an issuer to verify the preliminary risk scores and estimated reinsurance payment amounts, but note that an issuer may notify HHS of a newly discovered discrepancy in connection with responses to later interim or final dedicated distributed environment reports until 15 calendar days after the final dedicated distributed data environment report is issued, as discussed below. We anticipate that the interim dedicated distributed data environment reports would allow issuers to proactively address any data discrepancies regarding the data the issuer made accessible to HHS on the dedicated distributed data environment and HHS's analysis of the data.

We note that under § 153.700(a), an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State where HHS operates the risk adjustment or reinsurance program on behalf of the State, must establish a dedicated distributed data environment and provide data access to HHS, in a manner and timeframe specified by HHS, for any HHS-operated risk adjustment or reinsurance program. For the issuer and HHS to effectively address and resolve discrepancies through the proposed interim reporting process, we propose that once an issuer's dedicated distributed data environment is established, the issuer would be required, on a quarterly basis, to make a complete and current enrollment file accessible to HHS through the dedicated distributed data environment, and would be required to make good faith efforts to make accurate and current claims files accessible to HHS through the dedicated distributed data environment. An issuer may later (up until April 30 of the year after the benefit year, as provided for in § 153.730) adjust these files with the most current information to account for changing enrollments or more current adjudications of claims in later periods. However, we believe it is critical for issuers to provide quarterly uploads of enrollment and claims files to permit issuers and HHS to monitor data collection.

We note that, as part of the process for making these files available to HHS on a dedicated distributed data environment, we anticipate providing an issuer a transactional process report that will identify data that has been attempted to be uploaded, but that has been rejected. To fulfill its obligation to make these files available to HHS, an issuer would be required to either correct or accept the rejection of this data for the submission process to be considered complete.

Final dedicated distributed data environment report: We propose that HHS would provide issuers with a final dedicated distributed data environment report following the applicable benefit year, after the April 30 data submission deadline. The final dedicated distributed data environment report would include final risk scores and claims amounts eligible for reinsurance payments, each calculated from the issuer's data that was timely loaded onto the dedicated distributed data environment. As with the interim reports discussed above, we propose in § 153.710(e) that the issuer be required, within 15 calendar days of receipt of the final report, to either confirm to HHS that the information in the final dedicated distributed data environment report accurately reflects the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with § 153.700(a) for the benefit year specified in the report, or to describe to HHS any discrepancy it identifies in the final dedicated distributed data environment report. The shorter 15-calendar-day reporting timeframe for the final dedicated distributed data environment report is necessary so that HHS can notify issuers of their final risk adjustment payments and charges and final reinsurance payments by June 30 of the year following the applicable benefit year, as required under § 153.310(e) and § 153.240(b)(1)(ii). We seek comment on these proposals.

Notification of payments and charges: Last, as required under § 153.310(e) and § 153.240(b)(1)(ii), HHS will provide issuers a report detailing their final risk adjustment payments and charges and reinsurance payments for the applicable benefit year by June 30 of the year following the applicable benefit year. We also anticipate providing a report on cost-sharing reduction reconciliation payments and charges for that benefit year in the same timeframe. Although we anticipate that the interim and final dedicated distributed data environment reports would permit HHS and issuers to resolve most data and payment discrepancies for risk adjustment and reinsurance before the June 30 report is issued, we recognize that some discrepancies might remain unresolved. Therefore, we propose in § 153.710(f) that if a discrepancy that is first identified in an interim or final dedicated distributed data environment report in accordance with proposed § 153.710(d)(2) or § 153.710(e)(2) remains unresolved after issuance of the June 30 report, an issuer of a risk adjustment covered plan or reinsurance-eligible plan may make a request for reconsideration using the process proposed in § 156.1220(a). To promote the goals of the premium stabilization programs and to ensure that risk adjustment and reinsurance payments are provided to an issuer of a risk adjustment covered plan or reinsurance-eligible plan in a timely fashion, HHS would assess charges and make payments based on the amounts listed in the June 30 report, whether or not the issuer had submitted a request for reconsideration under proposed § 156.1220(a), and would later correct any charges or payments determined to be inaccurate under the reconsideration or administrative appeals process.

(ii) Reporting of Payments and Charges Under Reconsideration

Because risk adjustment payment and charge amounts and reinsurance payment amounts are factors in an issuer's risk corridors and MLR calculations, a delay in resolving final risk adjustment payments and charges and reinsurance payments could make it difficult for issuers to comply with reporting requirements under the risk corridors and MLR programs. Therefore, to clarify how issuers are to comply with these reporting requirements, we propose in § 153.710(g)(1) that, notwithstanding any discrepancy report made under paragraph § 153.710(d)(2) or (e)(2), or any request for

reconsideration under § 156.1220(a), unless the dispute has been resolved, an issuer must report, as applicable, for purposes of the risk corridors and the MLR program, the risk adjustment or reinsurance payment to be made to the Federal government, or the risk adjustment charge assessed by the Federal government, as reflected in the June 30 report.

If the amount of cost-sharing reductions a QHP issuer has provided is at issue because the issuer requested reconsideration of a cost-sharing reduction reconciliation payment or charge under the process proposed in § 156.1220(a), we propose that for the purposes of the risk corridors and the MLR program, a QHP issuer would be required to report a cost-sharing reduction amount equal to the amount of the advance payments of cost-sharing reductions paid to the issuer by HHS for the benefit year as reflected in the HHS report on cost-sharing reduction reconciliation payments and charges. Additionally, if a QHP issuer requests reconsideration of risk corridors payments or charges under the process proposed in § 156.1220(a), then for purposes of MLR reporting, the QHP issuer would be required to report the risk corridors payment to be made to the Federal government or charge assessed by the Federal government as reflected in the notification provided under § 153.510(d).

Finally, we propose in § 153.710(g)(2) that an issuer must report any adjustment made following any discrepancy report made under paragraph (d)(2) or (e)(2), or any request for reconsideration under § 156.1220(a) with respect to any risk adjustment payment or charge, including an assessment of risk adjustment user fees, reinsurance payment, cost-sharing reconciliation payment or charge, or risk corridors payment or charge, or following any audit, where the adjustment has not been accounted for in a prior risk corridors or medical loss ratio report, in the next following risk corridors and medical loss ratio report.

We seek comment on these proposals.

b. Default Risk Adjustment Charge

As described in the second final Program Integrity Rule, if an issuer does not establish a dedicated distributed data environment or submits inadequate risk adjustment data, HHS would not have the required risk adjustment data from the issuer to calculate risk scores or payment transfers for the issuer. As a result, HHS would not be able to properly calculate risk adjustment payments and charges for the entire applicable market for the State. Under § 153.740(b), if an issuer of a risk adjustment covered plan fails to establish a dedicated distributed data environment or fails to provide HHS with access to risk adjustment data in such environment by April 30 of the year following the applicable benefit year in accordance with §§ 153.610(a), 153.700, 153,710, or 153.730, such that HHS cannot apply its Federally certified risk adjustment methodology to calculate the plan's risk adjustment payment transfer amount in a timely fashion, HHS will assess a default risk adjustment charge.

As described in the second final Program Integrity Rule, the total risk adjustment default charge for a risk adjustment covered plan would equal a per member per month (PMPM) amount multiplied by the plan's enrollment.

$T_n = C_n \times E_n$

Where:

T_n = total default risk adjustment charge for a plan *n;*

C_n = the PMPM amount for plan n; and

E_n = the total enrollment (total billable member months) for plan *n.*

In the second final Program Integrity Rule, we provided that E_n could be calculated using an enrollment count provided by the issuer, using enrollment data from the issuer's MLR and risk corridors filings for the applicable benefit year, or using other reliable data sources.

We are considering several methods to calculate C_n—the PMPM amount for a plan. As discussed in the proposed Program Integrity Rule, one method would be to set a PMPM amount that is equal to the highest PMPM transfer charge that HHS calculates based on risk adjustment data submitted by risk adjustment covered plans in the applicable risk pool in the applicable market in the State. Such a method could yield a PMPM amount that would reflect a PMPM charge that reflects the high end of the PMPM distribution in certain States. However, in a situation in which the risk adjustment covered plans that provide the necessary risk adjustment data have very similar risk scores, a PMPM amount calculated under this method may yield a relatively low risk adjustment charge, and fail to provide adequate incentive for prompt establishment of a compliant distributed data system.

A second option would be to assess a PMPM amount based on the standard deviation of the PMPM charge among all risk adjustment covered plans in the applicable risk pool in the applicable market in the State. The PMPM amount used to calculate the default risk adjustment charge would be an amount equal to the mean PMPM amount plus two such standard deviations. Such an approach could also yield a PMPM amount that is high but reflects the PMPM distribution in certain situations, but, again, low in others. The amount might also be quite unpredictable *ex ante.*

A third option would be to assess a charge equal to a fixed percentage of the State-wide weighted average premium, which would be calculated as the enrollment-weighted mean of all plan average premiums of risk adjustment covered plans in the applicable risk pool in the applicable market in the State. This option might be relatively straightforward to implement, but would yield a charge that is not linked to the distribution of PMPM amounts within the relevant risk pool in the market in the State.

We note the many possible variations of these methods. For example, instead of the highest PMPM amount in the risk pool in the market in the State, the PMPM amount could be a fixed percentile along the distribution of PMPM charges for the risk pool in the market in the State—thus, we could use the 75th percentile or an amount equal to 10 percent above the 100th percentile, for example. Instead of the amount based on the mean PMPM amount and two standard deviations, a different number of standard deviations could be used. Also, instead of using a fixed percentage of the State-wide weighted average premium, a fixed percentage of the plan's premium, or a fixed percentage of the average premium of a subpopulation of risk adjustment covered plans in the State, such as those plans in the applicable risk pool, or those plans paying risk adjustment charges, could be used.

Commenters to the proposed Program Integrity Rule also suggested an approach under which the PMPM amount would be the highest amount calculated under each of the three methods described above. Finally, to ensure that a total default charge is not excessive for a particular plan, we are considering setting an upper limit on the total default charge for a plan based on a percentage of the plan's own total premiums. We seek comment on these methods, or other appropriate methods for calculating a default risk adjustment charge.

D. Part 155—Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

1. Election to Operate an Exchange After 2014

HHS has learned through the process of approving or conditionally approving

the first generation of State Exchanges that it is challenging to make an accurate assessment of a State's progress and ability to complete an Exchange build 10 months prior to open enrollment and a year prior to the first date that coverage would become effective. We are therefore proposing to reduce the time that the State must have in effect an approved or conditionally approved Exchange Blueprint and readiness assessment from 12 months to 6.5 months prior to the Exchange's first effective date of coverage. We propose to amend § 155.106(a)(2) by moving the deadline for the approval of the Exchange Blueprint for States electing to establish and operate an Exchange after 2014 to June 15th of the previous plan year rather than January 1st of the previous plan year. We believe that this proposal will give States more time prior to approval of the Blueprint to prepare for the transition from an FFE or State Partnership Exchange to a State Exchange. It will also enable HHS to gauge the State's actual technical, business and operational progress as more indicative milestones should be reached by June 15th. It should be noted that § 155.106(a)(2) sets the date by which a State electing to operate an Exchange after 2014 must ''[h]ave in effect'' an ''approved, or conditionally approved, Exchange Blueprint and operational readiness assessment'' and that the rule is silent about the date by which such a State must submit the Exchange Blueprint. HHS, therefore, proposes to extend the date by which a State must submit the Exchange Blueprint from November 15th to June 1st.

2. Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs

In § 155.220, we propose to add new paragraph (i) to provide that current paragraph (c)(3), which addresses enrollment through an Internet Web site of an agent or broker, and currently applies only to the individual market Exchanges, would apply to the SHOPs for plan years beginning on or after January 1, 2015. Agents and brokers have traditionally assisted employers in the small group market, and many of them use Internet Web sites to assist employers. Permitting an employer to complete QHP selection through the Internet Web site of an agent or broker would provide an additional potential SHOP enrollment option for small employers. Under this proposal, employers that have not traditionally worked with agents and brokers but have, in the past, utilized Internet Web sites of agents and brokers for purchasing insurance would have another option to learn about and participate in the SHOPs, in a manner similar to that already available in the current market. We propose to allow SHOPs, in States that allow this activity under State law, to permit enrollment in a SHOP QHP through an Internet Web site of an agent or broker under the standards outlined in § 155.220(c)(3) if a State SHOP or the FF–SHOP has the technical capability to make this possible. We invite comment on this proposal.

3. Privacy and Security of Personally Identifiable Information

Section 1411(g)(2)(A) of the Affordable Care Act provides that Exchanges may use information provided by an applicant ''. . . only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange . . .'' Section 155.260(a)(1) provides the specific circumstances under which an Exchange may use or disclose PII the Exchange creates or collects for the purposes of determining eligibility for enrollment in a QHP; determining eligibility for other insurance affordability programs as defined at § 155.20; or determining eligibility for exemptions from the individual responsibility provisions in section 5000A of the Code (collectively referred to as ''eligibility and enrollment PII''). We believe, based on considerations that have been brought to our attention by States as we work together to implement the Exchanges, that § 155.260(a)(1) unduly limits the ability of an Exchange to ensure its efficient operation. We therefore propose to amend § 155.260(a)(1) to permit an Exchange to use or disclose eligibility and enrollment PII to ensure the efficient operation of an Exchange through uses or disclosures that may not be directly connected to the Exchange minimum functions described at § 155.200, subject to privacy and security standards.

We anticipate that there may be uses or disclosures of eligibility and enrollment PII that present additional opportunities to ensure the efficient operation of the Exchange, consistent with the strict protections of section 1411(g)(2)(A) of the Affordable Care Act. Therefore, we propose in § 155.260(a)(1)(ii) that the Secretary may approve other uses and disclosures of eligibility and enrollment PII, provided that HHS determines that the information will be used only for the purposes of and to the extent necessary in ensuring the efficient operation of the Exchange consistent with section 1411(g)(2)(A) of the Affordable Care Act and determines that the use or disclosure is appropriate and permissible under relevant law and policy. In addition, prior to an Exchange using eligibility and enrollment PII for such an approved function, the individual would need to provide consent before his or her eligibility and enrollment PII could be used or disclosed for this additional function. We anticipate providing additional information in future guidance about uses or disclosures determined by the Secretary that ensure the efficient operation of the Exchange while maintaining information privacy and security, and we seek comment on such uses and disclosures.

Further, in § 155.260(a)(1)(iii) we propose a process under which Exchanges may seek approval from the Secretary for uses or disclosures of eligibility and enrollment PII not explicitly described in § 155.260(a)(1)(i) or (ii). Requestors must show that the proposed use or disclosure will ensure the efficient operation of the Exchanges consistent with section 1411(g)(2)(A) of the Affordable Care Act and describe how the information to be used or disclosed will be protected by privacy and security standards that are compliant with § 155.260. In addition, any time an Exchange is using eligibility and enrollment PII for such an approved function, the individual would need to provide consent before his or her eligibility and enrollment PII could be used or disclosed. We anticipate providing additional information in future guidance about this process and about the facts and circumstances that will be considered in determining whether a proposed use or disclosure will ensure the efficient operation of an Exchange while maintaining information privacy and security and is also an appropriate and permissible use or disclosure under relevant law and policy. We seek comment on this proposed process, as well as other factors or information that should be considered when determining whether a proposed use or disclosure should be approved pursuant to this proposed process.

We further recognize the imperative to maintain safeguards for eligibility and enrollment PII when it is used or disclosed to support functions beyond those described in § 155.200. Exchanges would be required to limit the disclosure of eligibility and enrollment PII to the extent necessary to accomplish the proposed function and obtain an individual's consent. The proposed use and disclosure would be

subject to privacy and security standards that § 155.260 requires Exchanges to establish in relation to non-Exchange entities.

In light of the proposed amendments to § 155.260(a)(1), we further propose to amend § 155.260(a)(2) to delete the specific reference to § 155.200 minimum functions and to indicate that all permitted uses under § 155.260(a)(1) must be consistent with § 155.260.

Section 155.260(a)(3) provides that Exchanges must establish and implement privacy and security standards consistent with the eight principles in § 155.260(a)(3)(i) through (a)(3)(viii). Section 155.260(b) addresses situations in which Exchanges share PII with ''non-Exchange entities,'' including ''. . . individuals or entities, such as Navigators, agents, and brokers.'' Through public comment to the Program Integrity Proposed Rule, we received requests for clarification on the definition of ''non-Exchange entities'' and also received questions asking if the regulatory language ''individuals or entities, such as Navigators, agents, and brokers,'' was meant to be an exhaustive list. In the preamble to the first final Program Integrity Rule (78 FR 54082), we stated that we would issue further guidance on this topic. We now propose to amend the regulation text to address these questions.

In § 155.260(b)(1), we propose that any individual or entity that gains access to PII submitted to an Exchange or collects, uses or discloses PII gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing the functions agreed to with the Exchange, be considered a non-Exchange entity, such that a non-Exchange entity is defined based on access to PII and not based on a representative or exhaustive list of entities. As clarification, we believe that entities that would qualify as ''non-Exchange entities'' based on this proposed definition include, but are not limited to, Medicaid agencies; CHIP agencies; Certified Application Counselors; in person assisters; agents and brokers, including Web-brokers; QHP issuers; Navigators; and other third party contractors. We feel very strongly about the importance of requiring privacy and security standards and believe that this proposed definition of non-Exchange entity makes even more clear which entities are subject to these standards.

At § 155.260(b)(2), we propose to maintain the existing requirement for Exchanges to enter into a contract or agreement with non-Exchange entities, while providing more details regarding the required elements of these contracts and agreements. We propose that the contract or agreement between an Exchange and a non-Exchange entity must include at least five elements. First, we believe it is important to define in this contract or agreement the functions that the non-Exchange entity will perform so that both parties agree to the circumstances and tasks during which the privacy and security standards will be applicable, and propose to include this requirement in § 155.260(b)(2)(i). This requirement already exists in § 155.260(b)(2), where reference is made to a non-Exchange entity performing the functions outlined in the agreement with the Exchange. Second, we propose in § 155.260(b)(2)(ii) that in the required contract or agreement, the Exchange must impose a requirement for compliance with privacy and security standards and specifically list or incorporate by reference the privacy and security standards and obligations with which the non-Exchange entity must comply. A similar requirement also already exists in the current text of § 155.260(b), where an Exchange must require the same or more stringent privacy and security standards as a condition of contract or agreement with the non-Exchange entity. The nature of these standards will be discussed in greater detail in the next paragraph. Third, we propose in § 155.260(b)(2)(iii) that in the contract or agreement, the Exchange must require the non-Exchange entity to monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with § 155.260(a)(5). It is assumed that the Exchange would expect this type of assessment to occur any time the non-Exchange entity has a major change in the operational or technical environment employed to meet the duties outlined in their contracts or agreements with the Exchange, and at the time of renewal of the contract or agreement. Fourth, we propose in § 155.260(b)(2)(iv) that in the contract or agreement, the Exchange must require the non-Exchange entity to inform the Exchange of any change in its administrative, technical, or operational environment defined within the contract that would require an alteration of the standards within the contract or agreement. The intent of this requirement is to provide an opportunity to assess and revise standards to ensure that the standards remain relevant. We seek comment on other mechanisms that could be more effective in keeping standards aligned with operating environments. Fifth, we propose in § 155.260(b)(2)(iv) that the contract or agreement include a requirement that the non-Exchange entity, in a written contract or agreement, must require any downstream entities that also meet the definition established in § 155.260(b)(1) to comply with the same privacy and security standards with which the non-Exchange entity agrees to comply under its contract or agreement with the Exchange. We feel it is important that the privacy and security standards continue to apply to PII as it moves to additional downstream entities.

Currently, § 155.260(b) states that an Exchange must require the same or more stringent privacy and security standards as a condition of contract or agreement with individuals or entities that gain access to PII submitted to an Exchange. In § 155.260(b)(3), we maintain the specification for an Exchange to require privacy and security standards as a condition of contract or agreement with non-Exchange entities and we propose criteria for the establishment of these standards that allow Exchanges flexibility in setting standards for non-Exchange entities that will provide equivalent or more stringent protection while aligning more closely to the functions the non-Exchange entity is performing and the operating environment under which the non-Exchange entity is performing. Because the definition for non-Exchange entities is broad and includes a variety of entities, we recognize that there can be variation between non-Exchange entities.

Different non-Exchange entity functions can result in variation in both the amount and type of access to PII (as an example, a Certified Application Counselor's access to consumer PII is different than the access a consumer's agent or broker would have) and the technical characteristics of the non-Exchange entity's environment (as an example, some non-Exchange entities, such as Medicaid agencies, may have a connection to the Data Services Hub, whereas others, such as Navigators, do not). Additionally, some non-Exchange entities already are required by law to meet other industry-recognized security standards for the environment in which they will perform Exchange-related functions. Currently there is no mechanism within the regulation to take environment variations or already existing security requirements into account, resulting in an operational burden for non-Exchange entities that does not result in additional protections for applicants.

As applied to non-Exchange entity privacy standards, the introduction of this flexibility is not anticipated to result in any weakening of Exchange privacy standards. Variation is not anticipated in the stringency of the particular privacy standard but in how it is implemented. As an example, a written policy and procedure document as required by § 155.260(d) regarding the collection, use, and disclosure of PII may take a different form based on a non-Exchange entity's duties and operations. A non-Exchange entity that is a QHP issuer currently obligated to follow the HIPAA security rule might seek to negotiate a contract with the Exchange under which it is permitted to follow the HIPAA security rules in place of the specific security standards followed by the Exchange. It would then be incumbent upon the Exchange to evaluate whether this arrangement would meet all of the criteria established for privacy and security standards under § 155.260(b)(3). We intend for these standards to provide the same level of protection and safeguards as the current § 155.260(b) affords.

Currently § 155.280 establishes the regulatory authority for oversight and monitoring of Exchanges and non-Exchange entities with regard to privacy and security standards. We anticipate additional proposed rulemaking on oversight, monitoring and enforcement during 2014. We invite comment on alternative ways to address the challenge of implementing effective enforcement while allowing the proposed flexibility.

These proposed requirements in § 155.260(b)(3) are intended to provide a foundation that Exchanges must use to define privacy and security standards for non-Exchange entities that afford a level of protection equal to that provided by the standards the Exchanges adopt for themselves. We have put forth three criteria that must be met by the privacy and security standards to which an Exchange must bind non-Exchange entities, and require that these standards take into specific consideration the environment in which the non-Exchange entity is operating.

The first criterion is set out in § 155.260(b)(3)(i) and requires that any privacy and security standards must be as protective as the standards that the Exchange sets for itself and must be consistent with all of the principles and requirements listed under § 155.260(a). This includes the principles of (a)(3), as well as the requirements established by (a)(1) through (a)(6).

The second criterion proposed in § 155.260(b)(3)(ii) requires that any privacy and security standards must also comply with the requirements for workforce compliance, written policies and procedures, compliance with the IRS code, and the consequences of improper use and disclosure of information established by § 155.260(c), (d), (f) and (g).

The third criterion proposed in § 155.260(b)(3)(iii) requires that the privacy and security standards to which non-Exchange entities are bound take several factors into consideration. Section 155.260(b)(3)(iii)(A) requires that an Exchange take into consideration the operational and technical environment in which the non-Exchange entity is operating. These environments, and the standards themselves, should be assessed in light of the requirement established by § 155.260(a)(5) to monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls. Should the environment change, the standards should change accordingly as required by proposed § 155.260(b)(2)(iii) and § 155.260(b)(2)(iv). We would expect that an Exchange's contracts and agreements with non-Exchange entities provide an opportunity for such changes.

Section 155.260(b)(3)(iii)(B) requires standards be relevant and applicable to the non-Exchange entity's duties and activities in relation to the Exchange. The introduction of the concept of 'relevant and applicable' is intended to address the various responsibilities assumed by non-Exchange entities, and the associated technical infrastructures.

Although the proposed approach affords greater flexibility to Exchanges, this flexibility carries with it an Exchange's responsibility to perform an assessment of the non-Exchange entity's duties, activities, and environment and the standards to which it will bind non-Exchange entities to ensure that the standards satisfy § 155.260 requirements. For example, assuming § 155.260 is finalized as proposed, the FFE will incorporate privacy and security standards into non-Exchange entity contracts and agreements only after determining that the standards satisfy the criteria proposed under § 155.260(b)(3)(i), (ii) and (iii), and thereby meet the requirements of § 155.260 and the Affordable Care Act. We expect to publish guidance to provide additional details regarding the process the FFE will follow to evaluate privacy and security standards to which non-Exchange entities will be bound.

We seek comments on the proposed amendments to § 155.260 and on alternate ways to ensure protection for information while not imposing irrelevant or unnecessarily burdensome requirements on non-Exchange entities.

4. Annual Open Enrollment Period for 2015

In 45 CFR 155.410, as finalized in the Exchange Establishment Rule, we set forth provisions for initial and annual open enrollment periods. We now propose amending § 155.410(e) and (f), which pertain to the annual open enrollment period and effective date for coverage after the annual open enrollment period.

In paragraph (e), we propose adding a paragraph that would change the annual open enrollment period for the 2015 benefit year. We propose that for all Exchanges, annual open enrollment would begin on November 15, 2014 and extend through January 15, 2015. This proposed change would give health insurance issuers an additional month in 2014 before they would need to begin accepting plan selections for the upcoming plan year. It also staggers the start of open enrollment for the Exchange from that for Medicare Advantage. It would give consumers the ability to have coverage starting January 1, 2015, or if they need more time, until January 15, 2015 to shop for, and select a QHP for the 2015 plan year. If finalized, all Exchanges would be expected to delay their QHP certification dates by at least one month. This would give health insurance issuers additional time to monitor 2014 enrollments, prior to submitting their 2015 rates. First-year challenges in enrolling individuals may mean higher than expected enrollment toward the end of the initial open enrollment period which, under the current schedule, coincides with the first day in which applications for 2015 can be submitted to the FFE. This compressed schedule would add uncertainty to setting rates for 2015 and potentially higher premiums without change. This proposed change is applicable for only the 2015 coverage year. We seek comments on this proposed amendment.

In paragraph (f), we propose adding a paragraph to address coverage effective dates for plan selections made during the annual open enrollment period for the 2015 benefit year. We propose that coverage must be effective January 1, 2015, for plan selections received by the Exchange on or before December 15, 2014. We propose that coverage must be effective February 1, 2015, for plan selections received by the Exchange from December 16, 2014 through January 15, 2015. In accordance with 45 CFR 155.335(j), qualified individuals

already enrolled in a QHP through the Exchange in 2014 who maintain the same eligibility would have their coverage continue into 2015, but they would have the ability to change QHPs until January 15, 2015. We seek comments regarding whether issuers should accept payments up until the 31st of a given month, in order to effectuate coverage by the first of the following month. We also seek comment on whether there should be retrospective coverage to January 1, 2015, for any individual who signs up after December 15, 2014 in the open enrollment period to ensure continuity of coverage.

5. Functions of a SHOP

For plan years beginning before January 1, 2015, qualified employers participating in a Federally-facilitated SHOP (''FF–SHOP'') are able to select a single QHP to offer to their employees. For plan years beginning on or after January 1, 2015, employers participating in the FF–SHOPs will also have the option to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, and make all QHPs within that level available to their qualified employees (''employee choice''). Additionally, the FF–SHOPs will begin performing premium aggregation services under § 155.705(b)(4) for plan years beginning on or after January 1, 2015—corresponding with the beginning of employee choice in the FF–SHOPs. Several of the amendments proposed below would take effect when employee choice and premium aggregation become available, including a requirement that employers make premium payments to the FF–SHOPs according to a timeline and process set by HHS, a standard premium pro-rating methodology in the FF–SHOPs providing that groups will be charged for the portion of the month for which an enrollee is enrolled, a prohibition on composite premiums in the FF–SHOPs when an employer utilizes employee choice, methods for employers in the FF–SHOPs to offer stand-alone dental coverage, and flexibility for employers in the FF–SHOPs to define different premium contributions for full-time employees and non-full-time employees.

We propose revising § 155.705(b)(1), which lists the rules regarding eligibility and enrollment to which the SHOP must adhere, to include mention of additional provisions regarding termination of coverage in the SHOPs and SHOP employer and employee eligibility appeals that were finalized in the first final Program Integrity Rule. This provision would become effective when this proposed rule is finalized and becomes effective.

We also propose adding a new paragraph § 155.705(b)(3) to provide qualified employers with options to offer dental coverage after employee choice becomes available in the FF–SHOPs. We propose that for plan years beginning on or after January 1, 2015, a qualified employer participating in an FF–SHOP would have two methods by which to offer stand-alone dental plans (SADPs) to its employees and their dependents. This proposal would provide employers with options for offering SADPs while preserving the flexibility not to contribute to SADP coverage. For example, an employer that elects to offer a single QHP that lacks the pediatric dental benefit may want to ensure that its employees with child dependents have the option to enroll in pediatric dental coverage.

We considered several options for methods by which a qualified employer participating in an FF–SHOP could offer SADPs to its employees and their dependents: the employer could offer a single SADP, the employer could offer all SADPs at a given dental AV level (under 45 CFR 156.150(b)), the employer could offer all SADPs in an FF–SHOP, or the employer could offer a subset of SADPs available in an FF–SHOP. All of these options would allow an employer flexibility to provide its employees and their dependents with standalone dental coverage. The single SADP option would enable an employer to choose the plan offered, and may be more administratively appealing to an employer already used to offering a single plan in the current market. This option would have the benefit of administrative ease for an FF–SHOP and issuer, but it would limit the selection for employees more than other options.

Allowing the option for qualified employers to offer all SADPs at a given dental AV level option would also enable an employer to make decisions about the type of plans offered to employees while retaining some administrative simplicity by only requiring a choice between the two dental AV levels (high and low) that were established for the 2014 benefit year. This option would also help advance the goal of increased choice and competition and is similar to employee choice of QHPs where an employer selects a metal tier and employees may select any QHP within that tier. However, the proposed changes to § 156.150 in this proposed rule would remove the AV standards for stand-alone dental plans; thus, this option would not be possible if § 156.150 is finalized as proposed.

Allowing qualified employers to offer all SADPs available in an FF–SHOP would provide an employer with maximum flexibility to offer its employees and their dependents the ability to choose an SADP that best fits their needs. Additionally, it would allow an employer to make an offer of coverage without needing to compare and select among plans or tiers. This approach would most advance the goals of increased choice and competition within the small group market, but might create concerns among issuers about potential adverse selection arising from higher risk employees electing to enroll in certain SADPs.

Finally, we considered an option that would allow an employer to make an offer to its employees and their dependents from a defined subset of SADPs in an FF–SHOP. In this option, an FF–SHOP would define a subset of SADPs from which an employer could choose. For example, an employer might be allowed to offer any two plans from the same issuer. This option would allow an employer additional flexibility in offering dental plans while maintaining some control over the particular plans offered to its employees and their dependents. Although less administratively simple, this option could provide some increased level of choice for employers and their employees.

After considering the options described above, we are proposing that a qualified employer in an FF–SHOP could offer its employees (and, if desired, their dependents) either a single SADP or a choice of all SADPs available in an FF–SHOP after employee choice becomes available in the FF–SHOPs. We note that an employer could choose either option under this proposal regardless of whether it offers one QHP or all QHPs available in an FF–SHOP to its employees and their dependents under § 155.705(b)(3)(iv). We believe this proposal provides the best balance of advancing the Affordable Care Act's goals of increased choice and competition in the small group market, providing employers with an administratively simple way to offer stand-alone dental coverage, providing employees with increased dental coverage options, and maintaining consistency with employee choice. We seek comment on these options, including on the option of offering all plans at a dental AV level if the proposal to eliminate dental AV levels is not finalized.

We also propose to re-designate § 155.705(b)(4)(ii) as (b)(4)(iii) and to

add new paragraph (b)(4)(ii) to allow all SHOPs, both FF–SHOPs and State SHOPs, to establish one or more standard processes for premium calculation, payment, and collection after the SHOP makes premium aggregation available. Many States do not have standardized prorating, payment, and collection practices, and within a given State, issuers may have varying practices. In this environment, a standard method of handling premiums may be necessary for a SHOP to successfully and efficiently implement and operate the premium aggregation services described in § 155.705(b)(4)(i).

We also propose provisions related to the processes FF–SHOPs would establish for premium calculation, payment, and collection under proposed new § 155.705(b)(4)(ii). Consistent with § 155.720(b), which establishes that all SHOPs must establish a uniform enrollment timeline and process, including establishment of effective dates of employee coverage, for all QHP issuers and qualified employers to follow, and consistent with § 155.720(d), which establishes that all SHOPs must follow the requirements set forth at § 155.705(b)(4), we are proposing at § 155.705(b)(4)(ii)(A) that, after premium aggregation becomes available in the FF–SHOPs, employers in the FF–SHOPs would be required to make all premium payments—initial and subsequent—according to a timeline and process that HHS will establish through guidance. We intend for this proposed timeline and process to include all premium payments and considered whether to include ''all'' in the regulation text, but we decided that including the word ''all'' would be unnecessary. In developing this timeline and process, HHS will consider its interest in operating and administering the FF–SHOPs efficiently, as well as issuers' interests in ensuring timely payment of premiums, and issuers' and employers' interests in establishing a fair and workable premium payment process. We anticipate that this payment timeline would require employers to make an initial premium payment at least two days prior to the employer's desired coverage effectuation date, in order to provide a reasonable window of time for the relevant banks to process the payment transaction. However, we solicit comments about whether such a time frame would be reasonable for employers or issuers, about alternative time frames that might be more appropriate, and about the payment timeline and process for the FF–SHOPs generally, including the considerations HHS should factor into the development of the payment timeline and process. We are also proposing a conforming amendment to § 156.285(c)(7)(iii), discussed in greater detail below, to establish that an FF–SHOP issuer would be required to effectuate coverage unless it has received an enrollment cancellation from the FF–SHOP, and explain in the preamble discussion related to that proposal that if the FF–SHOP has not received an employer's initial premium payment in accordance with the payment timeline and process established under proposed § 155.705(b)(4)(ii)(A), the FF–SHOP will send the issuer an enrollment cancellation.

At proposed § 155.705(b)(4)(ii)(B), we also propose a methodology for prorating premiums in FF–SHOPs after premium aggregation becomes available in those SHOPs in plan years beginning on or after January 1, 2015. Because it would be impractical for FF–SHOPs to accommodate the existing variation in premium methodologies that exists across States and issuers, we propose a standard methodology such that groups will be charged for the portion of the month for which the enrollee is enrolled. We considered several methods for prorating partial month payment in the FF–SHOPs, including not charging for a partial month's coverage, charging a full month's premium if coverage is effective prior to the 15th of the month, or not charging any premium if coverage is effective after the 15th of the month. We propose that in the FF–SHOPs, premiums for coverage of less than 1 month will be prorated by multiplying the number of days of coverage in the partial month by the premium for 1 month divided by the number of days in the month. We believe this approach to be the fairest for both consumers and issuers because the issuer will charge for only the portion of coverage provided for a partial month. We invite comments about this methodology, as well as comments about whether a standardized methodology regarding prorating premiums for partial month enrollment should be adopted across all individual market Exchanges as well.

In the proposed 2014 Payment Notice, we proposed at § 155.705(b)(11)(ii)(D) to permit a qualified employer participating in an FF–SHOP to establish, to the extent allowed by Federal and State law, different premium contribution percentages for different employee categories. In the 2014 Payment Notice, we did not finalize this proposal because we concluded that it would be inconsistent with the uniformity provisions established in Internal Revenue Service Notice 2010–82, which requires employers to contribute a uniform percentage to all employee premiums in order to claim a small business tax credit for health insurance premiums paid.[21] In this proposed rule, we propose at paragraph (b)(11)(ii)(C) to provide FF–SHOPs, in plan years beginning on or after January 1, 2015, with the option of permitting a qualified employer to define a different percentage contribution for full-time employees (as defined in § 155.20 and section 4980H(c)(4) of the Code) from the percentage contribution it defines for employees that are not full-time employees under that definition, to the extent permitted by applicable law. This proposal would also allow a FF–SHOP to permit an employer to define different percentage contributions toward premiums for dependent coverage for full-time and non-full-time employees. We note that, to the extent permitted by applicable law, the percentage contributions established for dependent coverage under this proposal could be different from the premium contribution percentages established for employee-only coverage, consistent with current paragraph (b)(11)(ii)(C). Thus, an FF–SHOP under this proposal could allow an employer to define up to four different contribution levels: full-time employee-only, full-time employee dependent, non-full-time employee-only, and non-full-time employee dependent.

We note that under this proposal, a decision by an employer to define different contribution levels for full-time and non-full-time employees offered coverage through the SHOP may potentially have small business tax credit implications. However, the IRS, not HHS administers the small business tax credit. Therefore, if the proposal is finalized as proposed, employers considering taking this option should consider consulting with the IRS and/or their tax advisors about the implications of such a decision. Even so, we believe that this proposal would provide employers with additional flexibility to choose whether offering different contribution levels would be in the best interest of the business and its employees. Further, this additional flexibility would bring the FF–SHOP more in line with current small group market practices and provide an additional incentive for small employers to participate in the FF–SHOP. Finally, providing for different contribution

[21] *See* 78 FR 15502. IRS recently proposed regulations addressing the uniform premium contribution requirement for 2014 at 78 FR 52719, 52721 (Aug. 26, 2013).

levels based on full-time or non-full-time status may encourage some employers to offer coverage to employees who do not meet the Exchange definition of a ''full-time employee.''

We also propose amending § 155.705(b)(11)(ii)(D). When an employer offering SHOP coverage elects to base premium contributions on a composite premium, that premium is calculated based on the average per-member premiums for the employees who initially enroll in coverage. Under § 155.705(b)(6)(ii), the average employee premium rate is locked in for the entire plan year, regardless of whether any employees enter or leave the group during the plan year. Additionally, as described above, we are proposing in this rulemaking to amend § 147.102(c) to establish that if an issuer offers a composite premium, the premium amount would not be permitted to vary for any participant during the plan year with respect to a particular plan, even if the composition of the group changes. For example, if several older employees joined the group or several employees terminated their coverage, the composite premium would remain the same until renewal. After employee choice becomes effective in the FF–SHOPs, if an employer participating in an FF–SHOP elects to offer employees all plans at a single metal level of coverage, that employer might have employees enrolled in several different plans. In that circumstance, mid-year changes to the group's composition without a corresponding change to the composite rate may adversely affect issuers that gain a significant number of older employees once a plan year has started, without a resulting change in premiums to reflect the potentially higher risk. Because any risk related to a change in the group's composition is divided among issuers in an employee choice environment, they would be taking on proportionately more risk than in a single plan environment where the issuer would be assuming the risk—good and bad—for the entire group. We believe this uncertainty may make issuers more hesitant to offer QHPs in FF–SHOPs after employee choice is available in them—which risks undermining the Affordable Care Act's goals of increased choice and competition in the small group market. Accordingly, we propose a limited scope prohibition on composite rating in the FF–SHOPs when an employer elects to select a level of coverage and make all QHPs within that level available to its employees. We acknowledge that this proposal would create a limited exception to § 147.102(c)(3) and that it would preempt State laws requiring or permitting composite rating in the small group market, but we believe this proposal to be limited in scope and tailored to provide for administrative efficiency and uniformity, system compatibility among the FF–SHOPs, and increased competition and choice in the small group market. Therefore, we propose amending § 155.705(b)(11)(ii)(D) to not allow an employer or State to require that employer premium contributions in an FF–SHOP be based on a calculated composite premium if the employer elects to offer its employees all QHPs within the employer's selected level of coverage under § 155.705(b)(3)(iv)(A), that is, after employee choice is available in the FF–SHOPs and when an employer elects that option. State-based SHOPs may set their own policies. We are considering extending the prohibition on composite rating to SADPs in the FF–SHOPs, and we invite comment on whether such a prohibition should be adopted, how this policy might affect current market practices on composite rating of dental plans, whether a prohibition on composite rating should apply to all SADP offering methods or just when an employer chooses to offer more than a single SADP, and how such a prohibition would affect choice and competition in the small group dental market. Finally, we seek comment on whether the calculation of user fees for the FF–SHOP should be calculated based upon composite premiums or premiums calculated on per-member buildup.

6. Eligibility Determination Process for SHOP

We propose to amend paragraph (c)(4) to replace a reference to sections 1411(b)(2) and (c) of the Affordable Care Act with a reference to Subpart D of 45 CFR part 155, and to add a reference to eligibility verifications as well as to eligibility determinations. The proposed changes would prohibit a SHOP from performing any individual market eligibility determinations or verifications as described in Subpart D, which, for example, includes making eligibility determinations for advance payments of the premium tax credit and cost sharing reductions in the individual market Exchange. HHS already interprets existing regulations at § 155.715(c)(3) and (4) and § 155.730 to prohibit SHOPs from performing these types of determinations or verifications and from collecting through the SHOP application process any information other than what is required to make SHOP eligibility determinations or effectuate enrollment through the SHOP. However, we wish to make the prohibitions explicit in regulation text. We propose this amendment because the SHOPs are designed to assist small employers and employees of small businesses in accessing health insurance coverage, whereas the individual market Exchanges are designed to assist individual consumers. We believe that this proposal would create efficiencies for the SHOP and enable it to focus solely on small businesses. Additionally, we believe the prohibitions in this proposal, in conjunction with the proposed amendments to § 155.730, would help to protect SHOP consumers' privacy. This provision would become effective when this proposed rule is finalized and becomes effective.

We propose amending paragraph (d) to address when SHOP eligibility adjustment periods would be triggered. Under current paragraph (d)(1), an eligibility adjustment period for an employer would be triggered whenever the employer submits information on the SHOP single employer application that is inconsistent with the eligibility standards described in § 155.710, which effectively means that the inconsistency period is triggered whenever an employer would be determined ineligible. Under current paragraph (d)(2), an eligibility adjustment period would be triggered for employees if the SHOP receives information on the employee's application that is inconsistent with the information provided by the employer. We are proposing to provide instead for eligibility adjustment periods for both employers and employees only when there is an inconsistency between information provided by an applicant and information collected through optional verification methods under § 155.715(c)(2).

A SHOP applicant who is determined ineligible could always resolve the reasons for that negative eligibility determination and re-file the application to obtain a favorable eligibility determination. As written, the current eligibility adjustment periods could delay this process in ways that might complicate the enrollment of all employees being offered coverage by an employer, because they could delay the SHOP's final eligibility determination for an employer or for individual employees, in order to give the SHOP time to resolve issues that may be relatively straightforward for employers or employees to address without the SHOP's intervention, in a newly filed application. However, if the SHOP has

opted, under § 155.715(c)(2), to establish additional verification methods, and has, as part of that process, decided to verify SHOP applicant eligibility by checking applicant-provided information against information obtained from a trusted third-party data source (such as quarterly wage report data), the applicant might be denied eligibility because of an inconsistency between the information the SHOP received from that applicant and information contained in a third-party data source. Such inconsistencies might be difficult for applicants to identify and resolve on their own.

Our proposed amendments to the eligibility adjustment periods would eliminate the potential for unnecessary delay created under the current regulation, while providing SHOP applicants with an opportunity to address inconsistencies between a submitted application and trusted third-party data sources that a SHOP might utilize to verify eligibility under the optional verification process established in § 155.715(c)(2). Under the proposal, the applicability of SHOP eligibility adjustment periods would be limited to circumstances where such a discrepancy occurs, and the applicant would be provided an opportunity to submit documentation proving the information submitted on the application is correct without having to initiate a formal eligibility appeal. For example, if an employer provided its commonly used business name on the application but that name varies slightly from the registered business name listed in an unemployment insurance data source used by a SHOP to verify eligibility under § 155.715(c)(2), or if an employee provides a nickname on an application that differs from his or her formal name in quarterly wage report data source used by a SHOP to verify eligibility under § 155.715(c)(2), the applicants would be able to use the adjustment period to address the inconsistencies between their applications and the third-party data sources. If a SHOP does not collect information through optional verification methods under § 155.715(c)(2), the employer and employee would not have to go through the eligibility adjustment period before re-filing their applications, but would still have the right to appeal an adverse eligibility determination under § 155.740. Accordingly, we propose to amend paragraphs (d)(1) and (d)(2) to provide for eligibility adjustment periods when information submitted on an application is inconsistent with information collected through an optional verification process under § 155.715(c)(2). This provision would become effective when this proposed rule is finalized and becomes effective. We seek comments on this proposal, including comments on whether the current eligibility adjustment periods should remain in place.

7. Application Standards for SHOP

HHS already interprets existing regulations at § 155.715(c)(3) and (c)(4) and § 155.730 to prohibit SHOPs from collecting through the SHOP application process any information other than what is required to make SHOP eligibility determinations or effectuate enrollment through the SHOP. We propose amendments to § 155.730 that would expressly state this prohibition in regulation text. Specifically, we propose to re-designate paragraph (g) as paragraph (g)(1) and add new paragraph (g)(2) to provide that a SHOP is not permitted to collect information on the single employer or single employee application that is not necessary to determine SHOP eligibility or effectuate enrollment through the SHOP. In conjunction with the amendments we are proposing to § 155.715(c)(4), which would prohibit a SHOP from performing any individual market eligibility determinations or verifications as described in Subpart D of 45 CFR part 155, this proposal seeks to ensure that SHOPs are not collecting information on the single employer or single employee applications that is not pertinent to a determination of SHOP eligibility or effectuation of enrollment. For example, a SHOP could not request through the single employee application the income information necessary for determining eligibility for advance payments of the premium tax credit in the individual market Exchange. Limiting the information required of an applicant helps to protect privacy and promote efficiency and streamlining of the SHOP application process. This provision would become effective when this proposed rule is finalized and becomes effective.

E. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Provisions Related to Cost Sharing

In this section, we propose several provisions and parameters for the 2015 benefit year related to cost sharing.

a. Premium Adjustment Percentage

Section 1302(c)(4) of the Affordable Care Act directs the Secretary to determine an annual premium adjustment percentage, which is used to set the rate of increase for four parameters detailed in the Affordable Care Act: The maximum annual limitation on cost sharing (defined at § 156.130(a)), the maximum annual limitation on deductibles for plans in the small group market (defined at § 156.130(b)), and the assessable payment amounts under section 4980H(a) and (b) of the Code (proposed at 26 CFR 54.4980H in the ''Shared Responsibility for Employers Regarding Health Coverage,'' published in the January 2, 2013 **Federal Register** (78 FR 218)). Section 156.130(e) provides that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013, and that this percentage will be published annually in the HHS notice of benefit and payment parameters.

We propose to establish a methodology for estimating average per capita premium for purposes of calculating the premium adjustment percentage. In selecting this methodology, we considered the following four criteria:

(1) Comprehensiveness—the premium adjustment percentage should be calculated based on the average per capita premium for health insurance coverage for the entire market, including the individual and group markets, and both fully insured and self-insured group health plans;

(2) Availability—the data underlying the calculation should be available by the summer of the year prior to the calendar year so that the premium adjustment percentage can be published in the annual HHS notice of benefit and payment parameters in time for issuers to develop their plan designs;

(3) Transparency—the methodology for estimating the average premium should be easily understandable and predictable; and

(4) Accuracy—the methodology should have a record of accurately estimating average premiums.

Based on these criteria, we propose that the premium adjustment percentage be calculated based on the projections of average per enrollee private health insurance premiums from the National Health Expenditure Accounts (NHEA), which is calculated by the CMS Office of the Actuary. We considered several other sources of premium data, including the Medical Expenditure Panel Survey (administered by the Agency for Healthcare Research and Quality), the Employer Health Benefits Survey (administered by the Kaiser

Family Foundation and the Health Research and Educational Trust), and the Federal Employees Health Benefits Program. However, we believe the NHEA projections, which are partially based on several of the other data sources that we considered, best meet the selection criteria described above and will provide the most accurate estimate of the average per capita premium for the entire health insurance market. We welcome comment on the criteria for selecting a methodology, any additional sources of premium data that we should consider, and the choice of methodology. As additional data on health insurance premiums become available through the Exchanges and other sources, we plan to review the accuracy of the NHEA projections, and if necessary, propose any changes to the methodology for estimating the average premium through the annual Payment Notice.

To calculate the premium adjustment percentage for the 2015 calendar year, we propose to use the most recent NHEA projections of average per enrollee private health insurance spending for 2013 and 2014 ($5,128 and $5,435, respectively).[22] Therefore, we are proposing that the premium adjustment percentage for 2015 be (5,435–5,128)/5,128, and we propose to round the result of this formula to the nearest decimal point, which, in this case, would be 6.0 percent. We are also proposing the following cost-sharing parameters for calendar year 2015, based on our proposed premium adjustment percentage for 2015.

Maximum Annual Limitation on Cost Sharing for Calendar Year 2015. Under § 156.130(a)(2), for the 2015 calendar year, cost sharing for self-only coverage may not exceed the product of the maximum annual limitation on cost sharing for calendar year 2014 and the premium adjustment percentage for 2015, and for other than self-only coverage, the limit is twice the dollar limit for self-only coverage. Under § 156.130(d), these amounts must be rounded to the next lowest multiple of 50. Using the proposed premium adjustment percentage of 6.0 percent and the 2014 maximum annual limitation on cost sharing of $6,350 for self-only coverage, which was published by the IRS on May 2, 2013,[23] we propose that the 2015 maximum annual limitation on cost sharing be $6,750 for self-only coverage and $13,500 for other than self-only coverage.

Maximum Annual Limitation on Deductibles for Plans in the Small Group Market for Calendar Year 2015. Under § 156.130(b)(2), for the 2015 calendar year, the annual deductible for a health plan in the small group market may not exceed, for self-only coverage, the product of the maximum annual limitation on deductibles for calendar year 2014 and the premium adjustment percentage for 2015, and for other than self-only coverage, the limit is twice the dollar limit for self-only coverage. Under § 156.130(d), these amounts must be rounded to the next lowest multiple of 50. Using the proposed premium adjustment percentage of 6.0 percent and the 2014 maximum annual limitation on deductibles of $2,000 for self-only coverage, as specified in § 156.130(b)(1)(i), we propose that the 2015 maximum annual limitation on deductibles be $2,150 for self-only coverage and $4,300 for other than self-only coverage.

b. Reduced Maximum Annual Limitation on Cost Sharing

Sections 1402(a) through (c) of the Affordable Care Act direct issuers to reduce cost sharing for EHBs for eligible individuals enrolled in a silver level QHP. In the 2014 Payment Notice, we set forth standards related to the provision of these cost-sharing reductions. Specifically, in 45 CFR part 156 subpart E, we specified that QHP issuers must provide cost-sharing reductions by developing plan variations, which are separate cost-sharing structures for each eligibility category that change how the cost sharing required under the QHP is to be shared between the enrollee and the Federal government. At § 156.420(a), we detailed the structure of these plan variations and specified that QHP issuers must ensure that each silver plan variation has an annual limitation on cost sharing no greater than the applicable reduced maximum annual limitation on cost sharing specified in the annual HHS notice of benefit and payment parameters. Although the amount of the reduction in the maximum annual limitation on cost sharing is specified in section 1402(c)(1)(A) of the Affordable Care Act, section 1402(c)(1)(B)(ii) of the statute states that the Secretary may adjust the cost-sharing limits to ensure that the resulting limits do not cause the AVs of the health plans to exceed the levels specified in 1402(c)(1)(B)(i) (that is, 73 percent, 87 percent or 94 percent, depending on the income of the enrollee(s)). Accordingly, in the 2014 Payment Notice, we set forth a process for determining the appropriate reductions in the maximum annual limitation on cost sharing. First, we identified the maximum annual limitation on cost sharing applicable to all plans that will offer the EHB package. As noted above, we propose the 2015 maximum annual limitation on cost sharing be $6,750 for self-only coverage and $13,500 for other than self-only coverage. Second, we analyzed the effect on AV of the reductions in the maximum annual limitation on cost sharing described in the statute. Last, we adjusted the reductions in the maximum annual limitation on cost sharing, if necessary, to ensure that the AV of a silver plan variation will not exceed the AV specified in the statute. Below, we describe our analysis for the 2015 benefit year and our proposed results.

Reduced Maximum Annual Limitation on Cost Sharing for Benefit Year 2015. Consistent with our analysis in the 2014 Payment Notice, we developed three model silver level QHPs and analyzed the impact on their AVs of the reductions described in the Affordable Care Act to the estimated maximum annual limitation on cost sharing for self-only coverage ($6,750). However, using data collected for QHP certification for 2014, we updated the model plan designs to ensure that they continue to represent a range of plan designs that we expect issuers to offer at the silver level of coverage through an Exchange. For 2015, the model silver level QHPs would include a PPO with a typical cost-sharing structure ($6,750 annual limitation on cost sharing, $1,700 deductible, and 20 percent in-network coinsurance rate), a PPO with a lower annual limitation on cost sharing ($4,500 annual limitation on cost sharing, $2,000 deductible, and 20 percent in-network coinsurance rate), and an HMO ($6,750 annual limitation on cost sharing, $2,100 deductible, 20 percent in-network coinsurance rate, and the following services with copays that are not subject to the deductible or coinsurance: $500 inpatient stay per day, $350 emergency department visit, $25 primary care office visit, and $50 specialist office visit). All three model QHPs meet the AV requirements for silver health plans.

We then entered these model plans into the proposed 2015 AV calculator developed by HHS and observed how

[22] *See http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology2012.pdf* and Table 17 in *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2012.pdf* for additional information.

[23] *See http://www.irs.gov/pub/irs-drop/rp-13-25.pdf.*

the reductions in the maximum annual limitation on cost sharing specified in the Affordable Care Act affected the AVs of the plans. We found that the reduction in the maximum annual limitation on cost sharing specified in the Affordable Care Act for enrollees with a household income between 100 and 150 percent of the Federal poverty line (FPL) (2/3 reduction in the maximum annual limitation on cost sharing), and 150 and 200 percent of the FPL (2/3 reduction), would not cause the AV of any of the model QHPs to exceed the statutorily specified AV level (94 and 87 percent, respectively). In contrast, the reduction in the maximum annual limitation on cost sharing specified in the Affordable Care Act for enrollees with a household income between 200 and 250 percent of FPL (1/2 reduction), would cause the AVs of two of the model QHPs to exceed the specified AV level of 73 percent. As a result, we propose that the maximum annual limitation on cost sharing for enrollees in the 2015 benefit year with a household income between 200 and 250 percent of FPL be reduced by approximately 1/5, rather than 1/2. We further propose that the maximum annual limitation on cost sharing for enrollees with a household income between 100 and 200 percent of the FPL be reduced by 2/3, as specified in the statute, and as shown in Table 4. These proposed reductions in the maximum annual limitation on cost sharing align with the 2014 reductions and should adequately account for unique plan designs that may not be captured by our three model QHPs. Applying the same parameters as those specified for 2014 would reduce the administrative burden for issuers related to designing new plans, and provide greater continuity for enrollees. Furthermore, as noted in the preamble to the 2014 Payment Notice, selecting a reduction for the maximum annual limitation on cost sharing that is less than the reduction specified in the statute would not reduce the benefit afforded to enrollees in aggregate because QHP issuers are required to further reduce their annual limitation on cost sharing, or reduce other types of cost sharing, if the required reduction does not cause the AV of the QHP to meet the specified level. We welcome comment on this analysis and the proposed reductions in the maximum annual limitation on cost sharing for 2015. We note that for 2015, as described in § 156.135(d), States are permitted to submit for approval by HHS State-specific data sets for use as the standard population to calculate AV. If States submit such data sets, we intend to analyze their effects on the reductions we propose here, and we will adjust the reductions in the maximum annual limitation on cost sharing if necessary in the final rule.

TABLE 4—REDUCTIONS IN MAXIMUM ANNUAL LIMITATION ON COST SHARING FOR 2015

Eligibility category	Reduced maximum annual limitation on cost sharing for self-only coverage for 2015	Reduced maximum annual limitation on cost sharing for other than self-only coverage for 2015
Individuals eligible for cost-sharing reductions under § 155.305(g)(2)(i) (that is, 100–150 percent of FPL)	$2,250	$4,500
Individuals eligible for cost-sharing reductions under § 155.305(g)(2)(ii) (that is, 150–200 percent of FPL)	$2,250	$4,500
Individuals eligible for cost-sharing reductions under § 155.305(g)(2)(iii) (that is, 200–250 percent of FPL)	$5,200	$10,400

c. Design of Cost-sharing Reduction Plan Variations

In the 2014 Payment Notice, we established standards in § 156.420(c)–(e) to ensure that each cost-sharing reduction plan variation would always provide the most cost savings for which an enrollee is eligible while providing the same benefits and provider network as a plan without cost-sharing reductions. In this proposed rule, we are proposing certain modifications to clarify how these standards would apply to out-of-pocket spending required of an enrollee for benefits other than essential health benefits (EHBs).

Following our implementation of Exchange operations for 2014, we have learned that a number of issuers designed QHPs with cost-sharing parameters that apply to both EHB and benefits that are not EHB. For example, one issuer sought to establish a common deductible across all benefits. For the zero cost sharing plan variation of this QHP, this would result in a substantial deductible being applied entirely to benefits that are not EHB. We are proposing to remove the standards in § 156.420(c) and (d) that require that a QHP and each of its plan variations have the same out-of-pocket spending for benefits other than EHB. Instead, we propose that the standard in § 156.420(e)—that cost sharing for an essential health benefit from a provider (including a provider outside the plan's network) required of an enrollee in a silver plan variation may not exceed the corresponding cost sharing required in the standard silver plan or any other silver plan variation of that plan with a lower AV—would also apply to out-of-pocket spending required of enrollees in silver plan variations for a benefit that is not an EHB. Similarly, we propose in § 156.420(d) that the out-of-pocket spending required of enrollees in the zero cost sharing plan variation of a QHP for a benefit that is not an EHB from a provider (including a provider outside the plan's network) may not exceed the corresponding out-of-pocket spending required in the limited cost sharing plan variation of the QHP, which in turn may not exceed the corresponding out-of-pocket spending required in the QHP with no cost-sharing reductions.

We believe these proposed modifications strike the appropriate balance between protecting consumers and providing QHP issuers with flexibility. Each cost-sharing reduction plan variation would continue to provide the most cost savings for which an enrollee is eligible; however, QHP issuers would be able to reduce out-of-pocket spending for benefits that are not EHB for enrollees in plan variations. We believe some issuers may want to provide such reductions so as to offer a simpler cost-sharing design that is consistent across EHB and benefits that are not EHBs. We note, however, that in accordance with section 1402(d)(4) of the Affordable Care Act, any reductions in out-of-pocket spending for benefits that are not EHB would not be reimbursed by the Federal government because payments for cost-sharing reductions only apply to EHB.

We seek comment on this proposal, including on whether our proposal should offer less flexibility.

d. Advance Payments of Cost-sharing Reductions

Section 1402(c)(3) of the Affordable Care Act directs a QHP issuer to notify the Secretary of cost-sharing reductions made under the statute, and directs the Secretary to make periodic and timely payments to the QHP issuer equal to the value of those reductions. Section 1412(c)(3) of the Affordable Care Act permits advance payments of cost-sharing reduction amounts to QHP issuers based upon amounts specified by the Secretary. Under these authorities, we established a payment approach in the 2014 Payment Notice under which monthly advance payments made to issuers to cover projected cost-sharing reduction amounts are reconciled after the end of the benefit year to the actual cost-sharing reduction amounts.

To implement this approach, we specified in § 156.430(a) that a QHP issuer must provide to the Exchange, for approval by HHS, an estimate of the dollar value of the cost-sharing reductions to be provided over the benefit year, calculated in accordance with the methodology specified by HHS in the annual HHS notice of benefit and payment parameters. In the 2014 Payment Notice, we specified that the estimates of the cost-sharing reductions must be calculated using data that issuers submit under §§ 156.420 and 156.470, including the AV of the standard plan and plan variation, and the EHB portion of expected allowed claims costs. If an issuer seeks advance payments for the cost-sharing reductions provided under the limited cost sharing plan variation of a health plan it offers, we specified that the issuer must submit an estimate of the dollar value of the cost-sharing reductions to be provided. As described in § 156.430(b)(1), HHS uses these estimates to determine the monthly advance payments for cost-sharing reductions.

Based on our experience implementing this process for the 2014 benefit year, we propose certain modifications to §§ 155.1030, 156.430, and 156.470. We believe these modifications will simplify the process and improve the accuracy of the calculations. Specifically, we are proposing to remove the requirement detailed in § 156.430(a) that issuers develop estimates of the dollar value of the cost-sharing reductions to be provided, and instead propose to modify § 155.1030(b)(3) to specify that the Exchange must use the methodology specified in the annual HHS notice of benefit and payment parameters to calculate advance payment amounts for cost-sharing reductions, and must transmit the advance payment amounts to HHS, in accordance with § 156.340(a). We anticipate that this transmission would occur using the 834 enrollment transaction. As proposed in § 156.430(b)(1), HHS will provide periodic advance payments to QHP issuers based on the amounts transmitted by the Exchange.

For the 2015 benefit year, we are proposing that the Exchanges use a methodology for calculating the advance payment amounts that will not require QHP issuers to submit an estimate of the value of cost-sharing reductions to be provided or the EHB portion of expected allowed claims costs, as previously required under § 156.470(a), nor will it require Exchanges to transfer data on advance payment amounts to HHS prior to the start of the benefit year. Specifically, we propose that Exchanges calculate the monthly advance payment amount for a specific policy as the product of (x) the total monthly premium for the specific policy, and (y) a cost-sharing reduction plan variation multiplier. The cost-sharing reduction plan variation multiplier would convert the monthly premium into the appropriate monthly advance payment amount, based on the following formula:

Cost-Sharing Reduction Plan Variation Multiplier = Factor to Remove Administrative Costs * Factor to Convert to Allowed Claims Cost * Induced Utilization Factor * (Plan Variation AV—Standard Plan AV)

Where,

Factor to Remove Administrative Costs = 0.8 for all plan variations, because issuers in the individual market must have a medical loss ratio of at least 80 percent, under § 158.210(c);

Factor to Convert to Allowed Claims Costs = the quotient of 1 and the AV for the standard plan, not accounting for de minimis variation;

Induced Utilization Factor = one of the following factors, depending on the plan variation:

TABLE 5—INDUCED UTILIZATION FACTORS FOR PLAN VARIATIONS

Cost-sharing reduction plan variation	Induced utilization factor
73 percent AV silver plan variation	1.00
87 percent AV silver plan variation	1.12
94 percent AV silver plan variation	1.12
Limited cost sharing plan variation of bronze QHP	1.15
Limited cost sharing plan variation of silver QHP	1.12
Limited cost sharing plan variation of gold QHP	1.07
Limited cost sharing plan variation of platinum QHP	1.00
Zero cost sharing plan variation of bronze QHP	1.15
Zero cost sharing plan variation of silver QHP	1.12
Zero cost sharing plan variation of gold QHP	1.07
Zero cost sharing plan variation of platinum QHP	1.00

Standard Plan AV = the AV specified for each level of coverage at § 156.140(b), not accounting for de minimis variation (that is, 60, 70, 80, or 90 percent for a bronze, silver, gold, or platinum QHP, accordingly); and

Plan Variation AV = one of the following actuarial values, depending on the plan variation, not accounting for de minimis variation:

TABLE 6—ACTUARIAL VALUES FOR PLAN VARIATIONS

Cost-Sharing Reduction Plan Variation	Plan Variation AV
73 percent AV silver plan variation.	73 percent
87 percent AV silver plan variation.	87 percent

TABLE 6—ACTUARIAL VALUES FOR PLAN VARIATIONS—Continued

Cost-Sharing Reduction Plan Variation	Plan Variation AV
94 percent AV silver plan variation.	94 percent
Limited cost sharing plan variation of bronze QHP.	87 percent

TABLE 6—ACTUARIAL VALUES FOR PLAN VARIATIONS—Continued

Cost-Sharing Reduction Plan Variation	Plan Variation AV
Limited cost sharing plan variation of silver QHP.	87 percent
Limited cost sharing plan variation of gold QHP.	94 percent
Limited cost sharing plan variation of platinum QHP.	94 percent
Zero cost sharing plan variation of bronze QHP.	100 percent
Zero cost sharing plan variation of silver QHP.	100 percent
Zero cost sharing plan variation of gold QHP.	100 percent
Zero cost sharing plan variation of platinum QHP.	100 percent

The proposed induced utilization factors are consistent with those factors established in the 2014 Payment Notice. For the limited cost sharing plan variations, we derived the induced utilization factors based on the actuarial values proposed above, and the same assumptions used to develop the induced utilization factors for the other plan variations. We will propose updates to the induced utilization factors for all plan variations in future rulemaking as more data becomes available, and at that time will consider applying them to the risk adjustment methodology that HHS will use when operating risk adjustment on behalf of a State. We welcome comment on these induced utilization factors.

The proposed methodology also utilizes the actuarial values of the standard plans and plan variations, not accounting for de minimis variation. Although this may slightly reduce the accuracy of the calculations, we believe it would have little overall impact, and would reduce administrative burden on Exchanges because Exchanges will not need to develop specific multipliers for each QHP and associated plan variations. However, this approach would require us to estimate an actuarial value for each type of limited cost sharing plan variation. We estimate that on average, the AV of the limited cost sharing plan variations of bronze and silver QHPs will be 87 percent, and the AV of the limited cost sharing plan variations of gold and platinum QHPs will be 94 percent. We developed these estimates based on the data submitted by QHP issuers seeking advance payments for limited cost sharing plan variations that will be offered in benefit year 2014. We welcome comment on these actuarial values.

Overall, we believe this proposed methodology would improve the accuracy of the advance payments because it is based on the total premium for each policy, which in accordance with the rating rules described in §§ 147.102 and 156.80, is based on expected allowed claims costs, adjusted for the plan design and provider network, the number of individuals covered by the policy, rating area, age, and tobacco use. Although we acknowledge that there may be some limitations to the multiplier (for example, the multiplier does not make a plan-specific adjustment for the cost of non-EHB, or account precisely for costs for large families with children not accounted for in the premium), we believe that a very small number of QHPs would be affected by these limitations, and any inaccuracies in the advance payments would be corrected through the cost-sharing reduction reconciliation process. We welcome comment on this proposed methodology for the 2015 benefit year, and suggestions for alternative methodologies, including whether the methodology for the 2014 benefit year would be more appropriate.

We are also proposing conforming modifications to §§ 155.1030(b)(1) and 156.470(a), to delete the obligation for QHP issuers to submit, and Exchanges to review, the EHB allocation of the expected allowed claims costs for the plans, because this data would not be used in the proposed 2015 methodology for calculating cost-sharing reduction advance payments.

Lastly, we are proposing to modify § 155.1030(b)(4) to clarify that in accordance with the proposed paragraph (b)(3), the Exchange would not be required to submit issuers' advance payment estimates to HHS for approval prior to the start of the benefit year. We believe such an approval process would no longer be necessary because under the proposed approach, the advance payments will be calculated based on the cost-sharing reduction plan variation multiplier specified by HHS, and the premium for the policy, which is reviewed by the Exchange, in accordance with § 155.1020. HHS would simply validate that the advance payment amounts were calculated in accordance with the methodology specified by HHS, prior to providing advance payments to QHP issuers. This process will ensure the protection of Federal funds, while also limiting the administrative burden on QHP issuers and Exchanges. We welcome comment on these proposed modifications. In future years, as more data becomes available, we will review the methodology for calculating advance payments of cost-sharing reductions, and will propose additional modifications if necessary.

2. Provisions on FFE User Fees

a. FFE User fee for the 2015 Benefit Year

Section 1311(d)(5)(A) of the Affordable Care Act contemplates an Exchange charging assessments or user fees to participating health insurance issuers to generate funding to support its operations. If a State does not elect to operate an Exchange or does not have an approved Exchange, section 1321(c)(1) of the Affordable Care Act directs HHS to operate an Exchange within the State. In addition, 31 U.S.C. 9701 permits a Federal agency to establish a charge for a service provided by the agency. Accordingly, at § 156.50(c), we specified that a participating issuer offering a plan through an FFE must remit a user fee to HHS each month that is equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through an FFE.

OMB Circular No. A–25R establishes Federal policy regarding user fees, and specifies that a user charge will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. As in benefit year 2014, issuers seeking to participate in an FFE in benefit year 2015 will receive two special benefits not available to the general public: (1) the certification of their plans as QHPs; and (2) the ability to sell health insurance coverage through an FFE to individuals determined eligible for enrollment in a QHP. These special benefits are provided to participating issuers through the following Federal activities in connection with the operation of FFEs:

- Provision of consumer assistance tools.
- Consumer outreach and education.
- Management of a Navigator program.
- Regulation of agents and brokers.
- Eligibility determinations.
- Administration of advance payments of the premium tax credit and cost-sharing reductions.
- Enrollment processes.
- Certification processes for QHPs (including ongoing compliance verification, recertification and decertification).
- Administration of a SHOP Exchange.

Activities performed by the Federal government that do not provide issuers

participating in an FFE with a special benefit will not be covered by this user fee.

OMB Circular No. A–25R further states that user charges should generally be set at a level so that they are sufficient to recover the full cost to the Federal government of providing the service when the government is acting in its capacity as sovereign (as is the case when HHS operates an FFE). Accordingly, we propose to set the 2015 user fee rate for all participating issuers at 3.5 percent. This rate is the same as the 2014 user fee rate.[24] Because we expect enrollment to increase in 2015 as awareness of the Exchanges grows, and costs to decrease as operations become more efficient, we believe this user fee rate may allow HHS to recover the full cost to the Federal government of providing the special benefits to issuers participating in an FFE in 2015.

b. Adjustment of FFE User Fee

Section 2713(a)(4) of the PHS Act, as added by the Affordable Care Act and incorporated into the Employee Retirement Income Security Act (ERISA) and the Code, requires that non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage provide benefits for certain women's preventive health services without cost sharing.[25] The Preventive Services Rule (78 FR 39870, July 2, 2013) established accommodations with respect to the contraceptive coverage requirement for health coverage established or maintained or arranged by eligible organizations.[26]

Each organization seeking to be treated as an eligible organization under the Preventive Services Rule is required to self-certify that it meets the definition of an eligible organization. In the case of an eligible organization with a self-insured plan, the self-certification must be provided to the plan's third party administrator. A third party administrator that receives a copy of the self-certification must provide or arrange for separate payments for certain contraceptive services for participants and beneficiaries in the plan without cost sharing, premium, fee, or other charge to plan participants or beneficiaries, or to the eligible organization or its plan. The third party administrator can provide such payments on its own, or it can arrange for an issuer or other entity to provide such payments. In either case, the third party administrator can make arrangements with an issuer offering coverage through an FFE to obtain reimbursement for its costs (including an allowance for administrative costs and margin) through an adjustment to the FFE user fee paid by the issuer.

At § 156.50(d), we established standards related to the administration of the user fee adjustment. Specifically, in § 156.50(d)(3)(ii), we stated that the user fee adjustment will include an allowance for administrative costs and margin that is no less than 10 percent of the total dollar amount of the payments for contraceptive services, and that HHS would specify the allowance for a particular calendar year in the annual HHS notice of benefit and payment parameters.

For user fee adjustments sought in 2015 for the cost of payments for contraceptive services provided in 2014, we propose an allowance for administrative costs and margin that is equal to 15 percent of the total dollar amount of the payments for contraceptive services defined in § 156.50(d)(3)(i).[27] We propose this allowance based on our analysis of the administrative costs that we expect each entity involved in the arrangement to incur. For example, the third party administrator will likely incur certain variable administrative costs, including the cost of provider and medical management, and the cost of processing payments to providers of the contraceptive services. However, because payments for contraceptive services are not a separate insurance product and because the third party administrator will have an existing arrangement with the self-insured group health plan of the eligible organization, we do not expect any additional costs related to marketing, broker fees, enrollment, or billing. We accounted for the cost of submitting data to HHS under § 156.50(d)(2), and the cost of exchanging data between entities involved in the arrangement. We also added an allowance for margin in proportion to the total costs that we expect each entity to incur. We seek comment on the allowance for administrative costs and margin, including the appropriate percentage and alternative methods for future determinations of the allowance.

3. AV Calculation for Determining Level of Coverage

Section 2707(a) of the PHS Act and Section 1302 of the Affordable Care Act direct non-grandfathered health insurance coverage in the individual and small group markets, including QHPs, to ensure that plans meet a level of coverage specified in section 1302(d)(1) of the Affordable Care Act and codified at § 156.140(b). On February 25, 2013, HHS published the EHB Rule implementing section 1302(d) of the Affordable Care Act, which sets forth the requirement that, to determine the level of coverage for a given metal tier level, the calculation of AV be based upon the provision of EHB to a standard population. Section 156.135(a) establishes that AV is to be calculated using the AV Calculator developed and made available by HHS.

The AV Calculator uses national claims data to reflect plans of various levels of generosity as the underlying standard population. This standard population is represented in the calculator as tables of aggregated data called continuance tables. The AV methodology document that was incorporated by reference in the EHB Rule provides an overview of the development of these continuance tables and the AV Calculator logic.

As stated in the EHB Rule, HHS does not anticipate making annual changes to the AV Calculator logic or the underlying standard population reflected in the continuance tables. However, HHS recognizes that certain routine changes will on occasion need to be made to facilitate the AV Calculator's ongoing operation by ensuring that it can accommodate changes in the marketplace or product design over time and due to the changing cost of providing health care services. Here, we propose to provide for authority to update certain aspects of the AV Calculator on a regular basis, but no more frequently than annually, based on changes to applicable standards or the availability of new data that could

[24] OMB granted HHS an exception to the policy in Circular No. A–25R, allowing HHS to set the user fee rate for 2014 at 3.5 percent, rather than a higher rate which would have allowed HHS to recover full costs. This rate was chosen because we wished to encourage issuers to offer plans on FFEs and to align with the administrative cost structure of State-based Exchanges.

[25] The women's preventive health services referenced by PHS Act section 2713(a)(4) are provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). On August 1, 2011, HRSA adopted and released guidelines for women's preventive health services based on recommendations of the independent Institute of Medicine.

[26] Under the Preventive Services Rule, an eligible organization is an organization that: (1) Opposes providing coverage for some or all of the contraceptive services required to be covered under section 2713 of the PHS Act and the companion provisions of ERISA and the Code on account of religious objections; (2) is organized and operates as a nonprofit entity; (3) holds itself out as a religious organization; and (4) self-certifies that it satisfies the first three criteria.

[27] We note that the submission of the dollar amount of the payments for contraceptive services is subject to the oversight standards detailed at 45 CFR 156.50(d)(7), as well as the False Claims Act, 31 U.S.C. 3729–3733.

make the AV Calculator more accurate. These types of changes include:

(1) *Updating the annual limit on cost sharing and related functions in the calculator:* Section 1302(c) of the Affordable Care Act, codified at § 156.130, imposes an annual limit on cost sharing on non-grandfathered plans in the individual and small group markets. We note that, in accordance with section 1302(c)(4) of the Affordable Care Act and § 156.130(e), starting in 2015, HHS will publish the premium adjustment percentage in the annual HHS notice of benefit and payment parameters for purposes of calculating the required indexing of the annual limit on cost sharing. Because this limit is included in the AV Calculator and impacts the range of the AV Calculator, we propose to update the AV Calculator to include an estimated annual limit on cost sharing. In order to allow issuers the most time possible to develop plans, HHS may make available prior to the annual HHS notice of benefit and payment parameters the AV Calculator that would project an estimated annual limit on cost sharing for the given plan year. Issuers would still be required to adhere to the annual limit on cost sharing that is published in the applicable HHS notice of benefit and payment parameters. The intention in using an estimated annual limit on cost sharing in the AV Calculator is to ensure flexibility of the AV Calculator for issuers. Since we may make the AV Calculator available prior to the finalization of the annual limit on cost sharing for a given plan year, we are proposing to use an estimated annual limit on cost sharing in the AV Calculator, to ensure that the final AV Calculator does not contain an annual limit on cost sharing that is lower than the finalized one. Accordingly, in the proposed 2015 AV Calculator, we propose an estimated annual limit on cost sharing of $6,850, compared to the proposed annual limit for cost sharing for 2015, which is $6,750.

(2) *Updating the continuance tables to reflect more current enrollment data:* Starting in 2016, HHS expects to have sets of actual enrollment data from 2014 and to receive the subsequent year's data on an annual basis thereafter. These data could be used to reweight the standard population in the continuance tables that run the AV Calculator to more accurately reflect true enrollment trends and as a result project claims spending. We anticipate that during the first several years of operation, the demographic mix of the enrolled population will likely change and may need to be reweighted in the AV Calculator annually. After a few years, the population may stabilize and begin matching the claims data to the point where reweighing the AV Calculator may not be necessary on an annual basis.

We propose to analyze the most recently available data on the enrolled population every year, starting in 2016, and in cases where we determine that the enrolled population has materially changed, we propose to reweight the continuance tables in the AV Calculator to continue to accurately reflect enrollment data. We are proposing to consider a material change in gender or age in the enrolled population as more than a 5 percent change. We propose to determine this change based on a combined measurement of the effects of shifts in gender or age statistics. We solicit comment on this 5 percent standard and whether it should be a higher or lower percentage, as well as how this change should be determined. For the proposed 2015 AV Calculator, we did not have actual enrollment data to analyze and therefore, we are not proposing to reweight the calculator based on enrollment data at this time.

(3) *Updating the algorithms behind the AV Calculator to adapt to new industry practices and plan designs:* As discussed in the EHB Rule, because the AV Calculator is intended to account for the vast majority of plan designs in the market, in order to ensure that the AV Calculator will be available to plans and issuers, it will likely need to be periodically adapted. To do this, we are proposing to make technical, non-substantive updates to the AV Calculator algorithms as industry practices change and as technology advances, including adding features to the AV Calculator. For example, for the proposed 2015 AV Calculator, we are able to make improvements to the algorithms to allow for additional functionality to apply the deductible first and then copayments. Adding this feature would allow the calculator to be applicable for more types of plans and would not substantively affect other plan designs using the AV calculator. Such an adaptation of the AV Calculator to allow more types of plan designs to use the calculator without adjustment and to accommodate new types of plan designs in the market would be the basis for making these non-substantive changes. The standard that we propose to apply in making such adaptations would be to have the minimum impact possible on the outcomes produced by the AV Calculator generally while still allowing it to be adaptable to the new types of plan designs and allowing more types of plan designs to use the AV Calculator. We propose to make such adaptations under the provisions of this proposed rule if the adaptations can be based on actuarially sound principles and these adaptions would only involve minor modifications to the AV Calculator that would result in only a limited or no impact on the majority of plan designs that use the AV Calculator. We invite public comment on suggestions for ways in which this standard could best be achieved.

To identify new industry practices and technical advances, we propose to consult annually with the American Academy of Actuaries to determine what new adaptations are needed in the AV Calculator as the basis for those changes. Under § 156.135(b), the American Academy of Actuaries' members play a critical role in determining the AV of plan designs that are not compatible with the AV Calculator and would have insight into adjustments that are needed in the AV Calculator to meet the needs of the involving market and to allow more plan designs to use the AV Calculator. We also propose taking into consideration stakeholder feedback on adjustments to the AV Calculator that are submitted to the CMS Actuarial Value email address at *actuarialvalue@cms.hhs.gov*. To accomplish this goal, we propose aggregating this information annually and assessing which modifications would benefit the most issuers, are feasible in the AV Calculator, and will not substantively impact other functions of the calculator. If an algorithm change meets these criteria, and standards set forth above, we would consider incorporating it into the AV Calculator's algorithms. Changes that are made to the algorithms would be described in the AV Calculator Methodology that would be released with any updated AV Calculator.

(4) *Updating the continuance tables to reflect more current claims data:* HHS is proposing to update the claims data underlying the continuance tables, including refreshing the national claims database data with new data, as well as trending the AV Calculator to account for changes in the unit prices, utilization and intensity of services used. A trending factor could be a historical trend factor making use of actual premiums that reflect utilization and unit price increases, a factor based on emerging trends changing the demographic, or be based on the premiums of the new product designs with unique features. Data on these changes in insurance could be used to develop a trending factor that could be applied to the claims data to make adjustments in the continuance tables of the AV Calculator. For future plan years,

we propose to use two sources of data, one to reflect the individual market and one to reflect the small group market, to develop a single trend factor that could be applied to the AV Calculator. For the individual market, we propose to use the premium rate data and/or the standard population data compared from year to year, and for the small group market, we proposed to use similar premium rate data and/or the standard population data compared from year to year to develop a trending factor that we could apply to the claims data in the AV Calculator, adjusted for key changes, such as the reduction in transitional reinsurance that will occur from 2014 through 2016. In years when we are planning to update the claims data from the national claims database system in the AV Calculator, we are proposing to trend the AV Calculator based on the new claims data with the dataset currently being used in the calculator to ensure that the trend factor and claims data are reconciled.

In considering the factors in adjusting the claims data and trending the calculator, we recognize the importance of market stability for both issuers and consumers from year-to-year. At the same time, we recognize the importance of the AV Calculator reflecting the current market. By pursuing the approach of not updating the claims data every year, we would be providing greater stability in an emerging market. For these reasons, we are proposing to update the baseline claims data no more than every 3 and no less than every 5 years. This proposal of no more than every 3 years reflects the duration of the transitional reinsurance program and the temporary risk corridors program.

We are also proposing to consider trending the AV calculator every year and in cases, where the trend factor is cumulatively more than 5 percent different from the previous time the AV Calculator was updated, we would implement the trend factor. By considering whether to trend the AV Calculator every year, we would be helping to ensure that the AV Calculator more accurately reflects the current market and to avoid having any steep ''cliff'' changes in the AV Calculator every few years. Under the methodology proposed above, we are proposing to trend the AV Calculator on premium data and/or the standard population data in years when the underlying claims data are not being updated in the AV Calculator, and in years where the claims data are being updated, we are proposing to trend the calculator based on the updated claims data. We seek comments on this proposed approach, including our proposed approach to updating the claims data. We are proposing to provide details of our consideration of the trending factor each year in the AV Methodology. For 2015, we do not propose to trend the AV Calculator since the necessary 2 years of data were not available to make the adjustment per our proposed policy.

(5) *Updating the AV Calculator user interface:* HHS is proposing to update the AV Calculator user interface as needed to improve the user's experience. An example of this type of change, which we included in the proposed 2015 AV Calculator, is adding the ability for the user to save AV calculations. The 2014 AV Calculator did not incorporate this function, but based on comments received, we recognized the importance for users to have this feature. In the future, we anticipate that there will be other ways in which we could continue to make improvements to the AV Calculator's user interface to assist users and we anticipate that we will continue to receive feedback from various stakeholders to inform future proposed improvements to the AV Calculator user experience. HHS may consider making changes when an improvement would be useful to a broad group of users of the AV Calculator, would not affect the function of the AV Calculator, and would be technically feasible. These changes would simplify the process for providing users with features that could help save time and improve processes.

When making updates to the AV Calculator in accordance with this proposed rule, we propose to update the AV Calculator through guidance that will be posted on our CCIIO Web site. This guidance will include an updated AV Calculator Methodology to explain the changes that were made to the AV Calculator, along with the updated AV Calculator. We also expect that we would make any updates that will affect the AV Calculator in advance of the benefit year for which issuers are using the AV Calculator, with the intention of making the AV Calculator available no later than the end of the first quarter of the preceding the benefit year.

We are soliciting comments on all of the above types of updates and the accompanying criteria that would be used to identify the need for and to implement these updates. Outside of the above types of updates, we are also soliciting comments on whether other types of updates should be considered routinely for the AV calculator. To clarify, we are proposing that, to comply with § 156.135(a), issuers would be required to use the AV Calculator published by HHS for a given benefit year or, in cases where a State has obtained HHS approval to use State specific data in the AV Calculator, issuers would be required to use that AV Calculator HHS has published for the given benefit year, adjusted to use the State's data (State AV Calculator). The purpose of requiring that the issuers use the AV Calculator of the given benefit year or the State AV Calculator is to ensure that the AV calculation is being more accurately calculated on the most recent data each year and that there is only one AV Calculator (or State AV Calculator) applicable for each benefit year. We are also soliciting comments on the proposed 2015 AV Calculator and AV Calculator methodology that would supersede the 2014 versions of these documents. In accordance with our proposed policy, we provide an explanation of the changes that were made in the proposed 2015 AV Calculator in the proposed 2015 AV Methodology. For the 2015 AV Calculator, HHS is only proposing to make minor changes to the design and inputs into the AV Calculator. While plans' AV calculations may be impacted by the updated AV Calculator, our testing has shown that this impact will be limited for the vast majority of plans and that only in certain cases will plans see a significant change in AV. We encourage stakeholders to test the proposed 2015 AV Calculator and submit technical comments on it during the comment period.

In the preamble to the EHB Rule, we discussed the calculation of AV for health plans with family cost-sharing features. In addition we provided guidance in the ''2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges'' [28] on accounting for family plans for 2014. Since the AV Calculator claims data are based on individual claims data that did not include family cost-sharing information, HHS is seeking the necessary empirical data to develop the code that can incorporate family plans into future versions of the AV Calculator. We are now seeking comment on how to account for these family plan designs and we are particularly interested in information regarding potential data source options.

4. National Annual Limit on Cost Sharing for Stand-Alone Dental Plans in an Exchange

The EHB Rule established an annual limit on cost sharing for the pediatric dental essential health benefit offered by

[28] ''Letter to Issuers on Federally-facilitated and State Partnership Exchanges,'' April 5, 2013, available at: *http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.*

stand-alone dental plans (SADPs) in the Exchanges that is separate from the annual limit on cost sharing that applies to QHPs that offer comprehensive medical benefits. The EHB Rule established that Exchanges should set a ''reasonable'' annual limit on cost sharing for SADPs. The CMS Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, established that CMS's interpretation of a reasonable SADP annual limit on cost sharing for the FFEs is $700 for an SADP with one child enrollee and $1,400 for an SADP with two or more children enrollees.

We propose a revised policy for the 2015 benefit year and beyond in response to significant public interest in establishing a policy that is consistent across Exchanges and that minimizes a consumer's total annual limit on cost sharing. HHS also seeks to minimize the differences between a consumer's total annual limit on cost sharing when purchasing essential health benefits through a QHP that includes coverage of the pediatric dental essential health benefits or through a combination of a QHP and an SADP. Thus, we are proposing in this rule an amendment to § 156.150 that would establish an annual limit on cost sharing for SADPs that would be applicable in all Exchanges. For the 2015 benefit year, the new proposed paragraph (a)(1) would impose an annual limit on cost sharing for the pediatric dental EHB when offered through an SADP of $300 for one covered child and $400 for two or more covered children. We request comment on the proposed annual limits on cost sharing, and specifically whether a higher or lower limit would be appropriate for the pediatric dental EHB. Further, due to the limited variation in cost sharing with a decreased annual limit on cost sharing, we propose removing the actuarial value requirement SADPs offered through the Exchanges by deleting paragraph (b) of § 156.150. We request comment on the removal of the AV standard as well.

We understand that under the current rules, some State Exchanges have interpreted a reasonable annual limit on cost sharing to be higher than what is proposed in this proposed rule. For example, at least two State Exchanges have established an annual limit on cost sharing for SADPs of $1,000 for one covered child and $2,000 for two or more covered children. We therefore request comment on whether the annual limit on cost sharing should be consistent nationally, which would be more straightforward for consumers and issuers, or set by each Exchange, which allows for State flexibility to adjust to specific market standards and whether the limits proposed here are appropriate. As stated above, we propose to establish the $300/$400 annual limit on cost-sharing as a national maximum annual limit on cost sharing applicable in all Exchanges. For those States that currently have annual limits on cost sharing of $1,000/$2,000, we request comment on whether there should be a more gradual decrease in the annual limit in cost sharing that would ultimately reach the national level, but would result in a less significant one-time decrease.

HHS considered several other alternatives to minimize a consumer's total annual limit on cost sharing when purchasing the pediatric dental EHB through a SADP, including: Requiring issuers of SADPs to consider the annual limit on cost sharing to be met once the consumer reaches the annual limit on cost sharing for the QHP; requiring issuers of QHPs without the pediatric dental EHB to reduce the annual limit on cost sharing by the amount of annual limit on cost sharing permitted for SADPs; and, requiring issuers of QHPs and SADPs to track out of pocket costs for a shared consumer and jointly consider a consumer's out of pocket commitments to be met once a total number has been reached. We note that HHS is generally concerned with the administrative costs of implementing a policy that requires coordination of claims to a single annual limit on cost sharing. We seek comments on these alternatives.

5. Additional Standards Specific to SHOP

We propose to add new paragraph (a)(4)(i) to § 156.285 to provide that a qualified employer in the SHOP that becomes a large employer would continue to be rated as a small employer. Under section 1304(b)(4)(D) of the Affordable Care Act, a small employer that ceases to be a small employer by reason of an increase in the number of employees continues to be treated as a small employer for purposes of Subtitle D of Title I of the statute. Included within Subtitle D are the provisions governing the SHOP and the premium stabilization rules. However, the fair health insurance premium provisions at section 2701 are not contained in Title D. To assure consistency of pricing within the SHOP,[29] we propose to require a QHP offered through the SHOP to comply with the rating rules described in § 147.102. We note that nothing in this proposal prevents such an employer from choosing to buy a guaranteed issue new policy (without small group rating rules) in the large group market outside of the SHOP.

We believe that, when employee choice becomes available in FF–SHOPs for plan years beginning on or after January 1, 2015, allowing composite rating when an employer chooses to offer all plans within a metal tier under § 155.705(b)(3)(iv)(A) could result in issuers becoming more hesitant to offer QHPs in an employee choice environment—undermining the ACA's goals of increased choice and competition. As discussed in more detail above with regard to proposed § 155.705(b)(11)(ii)(D), composite rating when an employer takes advantage of employee choice could result in an issuer taking on proportionately more risk from mid-year changes to the employer's roster than in a single plan environment and, therefore, deny an issuer the premiums that would otherwise be due in a per-member premium calculation for the group. We proposed in § 155.705(b)(11)(ii)(D) to prohibit composite rating in the FF–SHOPs when an employer chooses a level of coverage and make all QHPs within that level available to its employees, and we propose in § 156.285(a)(4)(ii) to subject issuers to the same prohibition, to assure that issuers understand that composite billing is not allowed in the FF–SHOPs when employee choice becomes available and an employer selects a level of coverage and not a single plan. As with proposed § 155.705(b)(11)(ii)(D), we are considering extending the prohibition on composite rating to SADPs in the FF–SHOPs, and we invite comment on whether such a prohibition should be adopted, how this policy might affect current market practices on composite rating of dental plans, whether a prohibition on composite rating should apply to all SADP offering methods or just when an employer chooses to offer more than a single SADP, and how such a prohibition would affect choice and competition in the small group dental market. We acknowledge that this proposal provides a limited exception to § 147.102(c)(3) and note that this proposal would preempt State law in

[29] In the 2014 Payment Notice (78 FR 15418), we provided that risk adjustment would not apply to a plan unless it was subject to certain market reform rules, including the rating rules. Elsewhere in this proposed rule, at § 153.510(f), we propose a similar approach with respect to risk corridors. Our proposed approach here for the SHOP would provide that a SHOP QHP that grows into a large group plan would continue to receive the protections of the risk adjustment and risk corridors programs.

this context, but we believe this proposal to be limited in scope and tailored to provide for administrative efficiency and uniformity, system compatibility among the FF–SHOPs, and increased competition and choice in the small group market.

If the proposed amendments to § 155.705(b)(4) summarized above are finalized as proposed, all SHOPs would be permitted to establish standard methods for premium payment under § 155.705(b)(4), as part of carrying out the premium aggregation function, and HHS would establish through guidance a process and timeline for employers to follow when remitting premium payments to the FF–SHOPs once premium aggregation becomes available in the FF–SHOPs. We anticipate that after premium aggregation becomes available in the FF–SHOPs, an FF–SHOP would transmit premium payments—both initial and subsequent—to issuers on a regular schedule and anticipate that this would be no more frequently than once a week. We recognize that under this approach, an issuer might not receive an employer's initial premium payment from the FF–SHOP prior to the coverage effective date even though the employer has remitted payment to the FF–SHOP consistent with the HHS-established timeline. We understand that issuers may be concerned about effectuating coverage prior to receiving payment from a FF–SHOP. To address this concern, if the FF–SHOP has not received the initial premium payment in accordance with the payment timeline and process established in accordance with proposed § 155.705(b)(4)(ii)(A), the FF–SHOP will send an enrollment cancellation transaction to the issuer to ensure that coverage is not effectuated. Accordingly, we propose that if the issuer does not receive an enrollment cancellation transaction, it should effectuate coverage. We considered whether an FF–SHOP could, alternatively, send an issuer a notice confirming that it should effectuate coverage when the FF–SHOP received an employer's initial premium payment but the issuer would not receive that payment prior to the coverage effective date. However, it would be simpler administratively and operationally for issuers to assume they should effectuate coverage and proceed to effectuate coverage unless an FF–SHOP cancels the enrollment. Therefore, we propose adding § 156.285(c)(7)(iii) to establish that a QHP issuer offering a QHP through an FF–SHOP would be required to enroll a qualified employee unless it receives a cancellation notice from the FF–SHOP. We note that this operational scenario would arise only in the case of an employer's initial premium payment. For regular monthly payments from a participating SHOP employer, the requirements of the payment timeline and process established in accordance with proposed § 155.705(b)(4)(ii)(A) and the termination provisions of § 155.735 would apply. We seek through this proposal to balance issuers' concerns about receiving payment with the need for timely FF–SHOP enrollment and operational efficiency. We welcome comment on the proposed approach, as well as on the alternative approach discussed above which we considered but rejected, and encourage commenters to suggest additional alternatives.

6. Meaningful Difference Standard for QHPs in the FFEs

Section 1311(e)(1)(B) of the Affordable Care Act, codified at § 155.1000(c)(2), sets forth the standard that the Exchange may certify a health plan as a QHP if it determines that making the plan available through the Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates. Therefore, as a means of ensuring that all QHPs offered through an FFE are in the interest of qualified individuals and qualified employers, we propose that, to be certified as a QHP in an FFE, a plan must be considered ''meaningfully different'' from all other plans offered by the same issuer through the same Exchange, and we propose a standard for what is meant by the term ''meaningfully different.''

Based on feedback from stakeholders and HHS' experience from administering the Medicare program, HHS believes that it is in the interests of consumers to have an Exchange with meaningfully different plan choices, as meaningful difference has important benefits to consumers, such as ensuring the ability to readily differentiate and compare plan choices, leading to informed decisions.[30] A single issuer offering a number of plans that lack meaningful difference could take virtual ''shelf space'' from other competitors and stifle competition. Therefore, conducting a review for meaningful difference will ensure that consumers are able to make informed selections among an ample—but manageable—number of QHPs, while allowing for plan innovation. The approach outlined below for a meaningful difference requirement would allow time for HHS to see how the market develops, assess the consumer need for a more specific meaningful difference standard, and consider options to meet this potential need. HHS does not intend to set numerical limits on the number of QHPs that may be offered; rather, the proposed approach would serve to avoid having an issuer offering multiple QHPs that appear the same through an Exchange.

In § 156.298(a), we propose that the FFEs and FF–SHOPs will impose a meaningful difference requirement when approving a QHP application for certification of multiple QHPs within a service area and level of coverage in the Exchange from a single issuer. Due to the special characteristics of the stand-alone dental plan market, HHS proposes not to require meaningful difference as a condition for certification among stand-alone dental plans at this time. HHS seeks comment on this approach. We propose, in § 156.298(b), that a plan within a service area and metal tier (bronze, silver, gold, or platinum, and catastrophic coverage) is considered meaningfully different from other plans if a reasonable consumer (the typical consumer buying health insurance coverage) would be able to identify at least two material differences among eight key characteristics between the plan and other plans to be offered by the same issuer. The key characteristics are proposed in paragraphs (b)(1)–(b)(7), and would include (1) Cost sharing; (2) provider networks; (3) covered benefits (including prescription drugs); (4) plan type (for example, HMO or PPO); (5) premiums; (6) health savings account eligibility; and (7) self-only, non-self-only, or child-only coverage offerings. At a minimum, two or more of the characteristics proposed at § 156.298(b) must be different in order to pass the meaningful difference test. Therefore, within a service area and level of coverage in an Exchange, if two plans submitted by a single issuer seeking QHP certification vary among their cost sharing and covered benefits features but have the same premiums, the plans may be deemed as having met the meaningful difference test.

Furthermore, to ensure that consumers have an adequate number of plan options across all metal levels of coverage, we propose at § 156.298(c), that if HHS determines that the plan offerings at a particular metal level (including catastrophic plans) within a county are limited, plans submitted for certification at that level within that county will not be subject to the meaningful difference requirement.

[30] Research suggests that consumers may prefer more limited arrays of choices. *See* Iyengar, S.; Lepper, M. *Journal of Personality and Social Psychology,* Vol. 79(6), Dec 2000, 995–1006.

To provide flexibility for issuers that merge with or acquire another issuer that is a separate legal entity, HHS proposes in § 156.298(d), a 2-year meaningful difference transition period starting from the date on which a QHP issuer (acquiring entity) obtains or merges with another issuer. We propose in paragraph (d) that during the first 2 plan years after a merger or acquisition, the acquiring entity can offer plans that were recently obtained or merged from another issuer that do not meet the meaningful difference standard. After the 2-year transition period, HHS may approve a QHP application for certification that is being offered by the acquiring entity only if HHS finds that the plan's benefit package or costs are meaningfully different from other QHPs offered by the acquiring entity and the plan meets all other certification requirements. We believe that this transition timeframe provides ample time for issuers to ensure that benefit packages being offered are meaningfully different without stifling market transactions.

We seek comment on the proposed approach to reviewing meaningful difference for QHP certification and whether this standard should be expanded to all Exchanges, including State Exchanges. We also seek comment on whether this authority granted to the Exchange by section 1311(e)(1) of the Affordable Care Act, to act in the interests of qualified individuals and qualified employers, should be used by the Secretary, in conjunction with the authority granted by section 1311(e)(2) of the Affordable Care Act, to limit an issuer's participation in the FFEs should there be significantly different rate increases for its QHPs and non-QHPs. While the transitional policy regarding renewals of certain coverage announced in November 2013 and described earlier in this preamble was intended to allow for continuity of coverage, it was not intended to promote adverse selection through significantly higher rates for QHPs.

7. Quality Standards: Establishment of Patient Safety Standards for QHP Issuers

Section 1311(h)(1)(A) of the Affordable Care Act specifies that, beginning on January 1, 2015, a QHP may contract with hospitals with greater than 50 beds only if the hospitals meet certain patient safety standards, including use of a patient safety evaluation system (PSES) as described in part C of Title IX of the PHS Act, and a comprehensive hospital discharge program. A PSES means the collection, management, or analysis of information for reporting to or by a patient safety organization (PSO).[31] Section 1311(h)(1)(B) of the Affordable Care Act specifies that a QHP may contract with health care providers that implement health care quality mechanisms, if any are required by the Secretary in regulations. Section 1311(h)(2) of the Affordable Care Act provides the Secretary with the authority and flexibility to establish reasonable exceptions to these requirements and section 1311(h)(3) of the Affordable Care Act allows the Secretary to issue regulations to modify the number of beds described in section 1311(h)(1)(A).

As discussed in the National Strategy for Quality Improvement in Health Care (National Quality Strategy), HHS seeks to improve the overall quality of health care by making health care more patient-centered, reliable, accessible, and safe.[32] One of the main priorities of the National Quality Strategy is making care safer by reducing harm caused in the delivery of care. In addition, section 1311(h) of the Affordable Care Act aims to strengthen quality improvement and patient safety for consumers in Exchanges. To effectively balance the priorities for making quality health care accessible and safe in the Exchanges, we propose to implement these patient safety standards for QHP issuers over time, under the Secretary's authority in section 1311(h)(2) of the Affordable Care Act. We believe that implementing all of the requirements described in section 1311(h) by January 1, 2015 could result in a shortage of qualified hospitals and providers available for contracting with QHPs.

Currently, there are 79 listed PSOs nationwide operating in 29 States and the District of Columbia.[33] PSOs carry out a variety of patient safety activities with the goal to improve patient safety and the quality of health care delivery. PSOs are able to collect, aggregate, and analyze patient safety events and information that is protected under privilege and confidentiality standards. However, it is not entirely clear that there is sufficient capacity to enable all hospitals subject to this provision to contract with a PSO at this time. HHS recognizes the continuously-growing capacity of the PSO program and the potential to accommodate U.S. hospitals subject to § 156.1110 within the proposed phase-in period. HHS recognizes the significant burden and time constraints for hospitals to enter into agreements with PSOs for appropriate services to improve patient safety, especially for particular hospital settings and populations. HHS also recognizes the significant resources that QHP issuers would need to invest to track such initiatives, such as ensuring that the hospitals and health care providers the QHP issuer contracts with have appropriate agreements with PSOs and adequate hospital discharge planning activities. Consequently, we believe that this proposed rule would provide an opportunity for QHP issuers to meaningfully comply with section 1311(h) of the Affordable Care Act and consider how PSOs will work with their network hospitals and health care providers. This proposal would also provide time for hospitals and healthcare providers to demonstrate to a QHP issuer that they meet the patient safety standards in accordance with section 1311(h). Moreover, we believe that this proposed approach to implementation of section 1311(h) would ensure that QHP issuers have sufficient hospitals and health care providers to contract with, while providing consumers with access to health care that meets adequate safety and quality standards.

In phase one, which would become effective for QHP issuer plan years beginning on or after January 1, 2015, the patient safety standards proposed in § 156.1110 would apply to hospitals, as defined in section 1861(e) of the Social Security Act,[34] that are Medicare-certified, and to Medicaid-only hospitals which have been issued a Medicaid-only CMS Certification Number (CCN). These standards would apply to such hospitals that have been certified for greater than 50 beds. For the reasons described above, HHS is not proposing requirements regarding the patient safety standards described in section 1311(h)(1)(B) at this time. HHS is currently in the process of researching the establishment of appropriate quality and patient safety standards for QHP issuers contracting with health care providers as described in section 1311(h)(1)(B).

In § 156.1110(a), we propose that a QHP issuer may contract with hospitals that have more than 50 beds, only if they are Medicare-certified or have been issued a Medicaid-only CCN, both of which are subject to Medicare Hospital Conditions of Participation (CoPs)

[31] *See http://www.pso.ahrq.gov/regulations/fnlrule01.pdf.*

[32] *See* Report to Congress: National Strategy for Quality Improvement in Health Care available at *http://www.healthcare.gov/law/resources/reports/quality03212011a.html.*

[33] *See http://www.pso.ahrq.gov/listing/geolist.htm.*

[34] Section 1861(e) of the Social Security Act: *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm.*

standards found in 42 CFR part 482.[35] Specifically, such hospitals must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement (QAPI) program, as described in 42 CFR 482.21. In addition, a hospital that is Medicare-certified or participates in the Medicaid program must have in effect a discharge planning process that applies to all patients, as described in 42 CFR 482.43. HHS believes that the standards of QAPI and discharge planning in the Medicare hospital CoPs represent the most efficient way to balance the need to have a sufficient number of hospitals available for QHP issuers to contract with, and the statutory intent of section 1311(h) to provide for adequate patient safety standards. In addition, based on our preliminary research, the vast majority of hospitals with greater than 50 beds are Medicare-certified or are Medicaid-only hospitals and must comply with the health and patient safety standards in the Medicare hospital CoPs. Hospitals may be deemed to meet the CoP standards if accredited per section 1865 of the Social Security Act. Therefore, the proposed approach would not significantly limit hospital participation in QHP networks and would provide consumers access to health care services from an adequate number of hospitals through QHPs in the Exchanges.

In § 156.1110(b), we propose to direct QHP issuers to maintain documentation, including but not limited to the CCN for each hospital. Since both Medicare-certified hospitals and Medicaid-only hospitals are issued CCNs, such documentation would demonstrate that a QHP issuer's contracted hospital is Medicare-certified or has a Medicaid-only CCN and are subject to the Medicare hospital CoP standards as required in paragraph (a). We believe that collecting and maintaining data such as the CCN would not be burdensome for QHP issuers. In § 156.1110(c), we propose that a QHP issuer must make this documentation available to the Exchange, upon request by the Exchange, and in a time and manner specified by the Exchange. We intend to include all Exchange types when referring to the Exchange in § 156.1110, including a State-based Exchange. We anticipate using the data collected as part of information used to evaluate and oversee QHP issuers in FFEs. We note that multi-State plans, as defined in § 155.1000(a), are subject to these provisions. OPM would determine the time and manner for multi-State plans to submit the documentation.

In § 156.1110(d), we propose that a QHP issuer must ensure that each of its QHPs meets the patient safety standards in accordance with paragraph (a) of this section for plan or policy years beginning on or after January 1, 2015. We anticipate that this first phase of implementation of QHP-related quality standards would be for 2 years beginning January 1, 2015 or until we issue further regulations based on a reassessment of the Exchange market, whichever is later.

We seek comment regarding our proposal to apply Medicare hospital CoP standards for implementation of section 1311(h) of the Affordable Care Act. We also request comment on the proposed 2-year time period for the first phase of implementation. Additionally, we propose to maintain the statutory distinction between hospitals with 50 or fewer beds and hospitals with more than 50 beds, but we request comment for phase one implementation on whether HHS should adjust the number of hospital beds to be greater or less than the standard under section 1311(h)(3) of the Affordable Care Act. We also seek comment regarding whether the proposed standards in § 156.1110 should be applicable to hospitals other than Medicare-certified and Medicaid-only hospitals. We further request comment on whether any other documentation would be reasonable to require QHP issuers to collect and maintain to meet the proposed standards described in § 156.1110(c).

For the next phase of implementation, we are considering requiring QHP issuers to ensure that their contracted hospitals have agreements with PSOs and comprehensive hospital discharge programs, and that their health care providers implement health care quality activities. We recognize the various important patient safety initiatives, including discharge planning activities, with which hospitals, health care providers, and issuers are already involved. In future rulemaking, we intend to consider whether and which reasonable exceptions under section 1311(h)(2) of the Affordable Care Act should be made. We seek comment on:

- What core aspects should be included in hospital patient safety programs.
- What a comprehensive hospital discharge planning program should require for each patient.
- What health care quality improvement activities should be implemented by health care providers.

Specifically, we request comment on how QHP issuers could effectively track patient safety information, such as hospital agreements with a PSO, related to their contracted hospitals and provider networks. We also seek comment regarding specific, comparable activities that may be included as reasonable exceptions to the patient safety standards, in accordance with section 1311(h)(2) of the Affordable Care Act.

8. Financial Programs

a. Netting of Payments and Charges

In the 2014 Payment Notice, HHS established a monthly payment and collections cycle for the advance payments of the premium tax credit, cost-sharing reductions, and FFE user fees, and an annual payment and collections cycle for the premium stabilization programs and reconciliation of cost-sharing reductions. For 2014, to streamline our payments and collections process, we propose in § 156.1215(a) that each month we would determine amounts owed to or by a QHP issuer by netting amounts owed by the QHP issuer to the Federal government against payments due to the QHP issuer for advance payments of the premium tax credit, advance payments of cost-sharing reductions, and payment of FFE user fees. In addition to this netting across these programs, as further described below, the monthly calculation of amounts due would also reflect current information related to enrollment for past months, including information related to excess payments previously made. Finally, we propose that amounts owed to or by a QHP issuer would be netted across all entities operating under the same taxpayer identification number (TIN). This process would permit HHS to calculate amounts owed each month, and pay or collect those amounts from issuers more efficiently. When netting occurs, HHS would demand amounts due only when there is a balance due to the Federal government.

In addition to the monthly payment flows under the programs described above, a number of annual payment flows will begin in 2015 for the risk adjustment program, the reinsurance program, the risk corridors program, and cost-sharing reduction reconciliation. To streamline payment and charge flows from all of these programs—advance payments of the premium tax credit, advance payments and reconciliation of cost-sharing reductions, FFE user fees, and the premium stabilization programs—we propose in § 156.1215(b)

[35] Hospital Conditions of Participation: *http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Hospitals.html.*

that HHS may net amounts owed to the Federal government against payments due to an issuer (or an affiliated issuer under the same TIN) under these programs in 2015 and later years. We believe that this process will enable HHS to operate a monthly payment cycle that will be efficient for both issuers and HHS.

In § 156.1215(c), we propose that any amount owed to the Federal government by an issuer and its affiliates for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions after netting be the basis for calculating a debt owed to the Federal government. We propose that payments and collections under all of these programs would occur under an integrated monthly payment and collection cycle.

We seek comment on these proposals, including on the appropriate payment timeframes for these charges so that amounts may be netted and invoiced as part of an orderly, monthly payment cycle.

b. Confirmation of HHS Payment and Collections Reports

As discussed in the preamble to § 156.1210 of the second final Program Integrity Rule, HHS anticipates sending a monthly payment and collections report—the HIX 820—to issuers describing the advance payments of the premium tax credit and advance payments of cost-sharing reductions that an issuer is to receive on behalf of eligible enrollees, and the FFE user fee charges that the issuer must pay. These amounts are based on enrollments previously confirmed by the issuer as part of the enrollment transaction process and the resultant HIX 820 discrepancy reporting process described in § 156.1210. Under § 156.1210 (a), an issuer must respond to the payment and collections report within 15 calendar days of receipt of the report by either confirming the report or notifying HHS if there is a discrepancy between the data provided in the payment and collections report and the data that the issuer has. Under § 156.1210(b), if an issuer reports a discrepancy in a payment and collections report later than 15 calendar days after receipt of the report, HHS will work with the issuer to resolve the discrepancy as long as the late reporting was not due to misconduct on the part of the issuer. As described below, any resolution to such an identified discrepancy would be reflected in a later payment and collections report and the invoice generated under that later report would not affect the debt established by the invoice generated in connection with the earlier report.

We propose that an issuer that notifies HHS of a discrepancy under § 156.1210 will trigger an administrative discrepancy resolution process. Following the end of the benefit year, if the issuer remains dissatisfied with the results of that process, the issuer may make a request for reconsideration as proposed below in § 156.1220(a).

We intend that this discrepancy resolution process would permit HHS to work with issuers to resolve outstanding discrepancies in a cooperative manner. Because of the number and timing of the daily flows of enrollment and premium-related data and confirmations between HHS, the Exchange, and the issuer, we anticipate that there would be frequent adjustments to the enrollment counts and therefore the amounts of the advance payments of the premium tax credit, advance payments of cost-sharing reductions, and FFE user fees. To decrease the administrative burden on issuers, HHS, and the Exchanges, and in recognition of the number and timing of the data flows involved, we propose not to retroactively adjust previous months' payment and collections reports and amounts previously due. Consistent with our approach in the Medicare Advantage program, the invoice for a particular month would be calculated on the monthly payment cycle. We propose that the amount thus invoiced for a particular month, which would reflect netted amounts as described above, constitute an amount owed to the Federal government. As more accurate data become available to HHS, the Exchange, and the issuer, we propose that this later information not reduce or increase the previous determination of an amount owed. Rather, the information would be captured in subsequent months and reflected in subsequent payment cycles, and reflected in later invoices.

Thus, an issuer would be required to pay the full amount of any invoice issued in connection with a payment and collection report for a month even if the issuer notes a discrepancy that may later be resolved as a credit in a later invoice.

Therefore, we propose to add paragraph (c) to § 156.1210 to provide that discrepancies in payment and collections reports identified to HHS under that section would be addressed in subsequent payment and collections reports, and would not be used to change debts determined pursuant to invoices generated under previous payment and collections reports.

We seek comment on this approach.

c. Administrative Appeals

We propose an administrative appeals process designed to address any unresolved discrepancies for advance payments of the premium tax credit, advance payments of cost-sharing reductions, FFE user fee payments, payments and charges for the premium stabilization programs, cost-sharing reduction reconciliation payments and charges, and any assessments under § 153.740(b) of a default risk adjustment charge. This administrative appeals process is similar to that utilized to address payment disputes in the Medicare Part D program, in which an appeal to a CMS hearing officer, and then the Administrator of CMS, if desired, may be filed after a request for reconsideration.

In § 156.1220(a), we propose that an issuer may file a request for reconsideration of what the issuer believes is a processing error by HHS,[36] HHS's incorrect application of the relevant methodology, or HHS's mathematical error only with respect to: (1) Advance payments of the premium tax credit, advance payment of cost-sharing reductions and FFE user fee charges; (2) risk adjustment payments or charges for a benefit year, including an assessment of risk adjustment user fees; (3) reinsurance payments for a benefit year; (4) a risk adjustment default charge for a benefit year; (5) a reconciliation payment or charge for cost-sharing reductions for a benefit year; or (6) risk corridors payments or charges for a benefit year. For a dispute regarding advance payments of the premium tax credit, advance payments of cost-sharing reductions, or FFE user fee amounts for a benefit year, we propose that a request for reconsideration must be filed within 30 calendar days after the issuer receives a final reconsideration notification specifying the aggregate amount of advance payments of the premium tax credit, advance payments of cost-sharing reductions, and FFE user fees for the applicable benefit year. We anticipate that this final reconsideration notification would be provided in the summer of the year following the benefit year. We believe that the constant flow of enrollment data for payments under these programs will lead to difficulty in finalizing a precise, final calculation for a benefit year, and propose to finalize payments under these programs

[36] We note that under proposed § 156.1220(a)(3)(i)–(ii), an issuer may not submit data for consideration in the appeal if the data was not submitted prior to the applicable data submission deadline, but may submit documentary evidence that certain data was timely submitted.

including for purposes of appeal by the late summer of the following year. We are considering permitting reconsideration only for material errors. We seek comment on this proposal, including on the minimum materiality threshold that should be required to seek reconsideration. For example, we are considering a minimum materiality threshold of 1 percent or 5 percent of total payments made to the issuer for the year for advance payments of the premium tax credit, advance payments of cost-sharing reductions, and FFE user fees, or a minimum dollar amount such as $10,000.

For a dispute regarding a risk adjustment payment or charge, including an assessment of risk adjustment user fees, a reinsurance payment, a default risk adjustment charge, a cost-sharing reduction reconciliation payment or charge, or a risk corridors payment or charge, we propose that a request for reconsideration must be filed within 30 calendar days of receipt of the applicable notification of payments and charges provided by HHS. We believe that because the interim and final dedicated distributed data environment reporting process proposed at § 153.710(d) and (e) would permit an issuer an extended period of time in which to review risk adjustment and reinsurance data and because the cost-sharing reduction reconciliation and risk corridors payments or charges are based on data provided by the issuer, 30 calendar days should be sufficient for an issuer to review the notification and make a request for reconsideration. We seek comment on this timeline.

In § 156.1220(a)(3)(i), we propose that the request for reconsideration specify the findings or issues that the issuer challenges and the reasons for the challenge. In § 156.1220(a)(3)(ii), we propose that a reconsideration with respect to a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error may be requested only if, to the extent the issue could have been previously identified by the issuer to HHS under § 153.710(d)(2) or (e)(2), it was so identified and remains unresolved. Similarly, in § 156.1220(a)(3)(iii), we propose that a reconsideration with respect to advance payments of the premium tax credit, advance payments of cost-sharing reductions, and FFE user fees may be requested only if, to the extent the issue could have been previously identified by the issuer to HHS under § 156.1210, it was so identified and remains unresolved. We propose to clarify that an issuer may request reconsideration if it previously identified an issue under § 156.1210 after the 15-calendar-day deadline, but late discovery of the issue was not due to misconduct on the part of the issuer.

In § 156.1220(a)(3)(iv), we propose that the issuer may include in the request for reconsideration additional documentary evidence that HHS should consider. Such documents may not include data that was to have been filed by the applicable data submission deadline, but may include evidence of the timely submission of such documents.

In § 156.1220(a)(4), we propose that in conducting the reconsideration, HHS would review the payment determination, the evidence and findings upon which it was based, and any additional documentary evidence submitted by the issuer. HHS would also have the discretion to review any other evidence it believes is relevant in deciding the reconsideration (and would provide the issuer a reasonable opportunity to review and rebut the evidence), and would then inform the issuer of the final decision in writing. We propose that an issuer would be required to prove its case by a preponderance of the evidence with respect to issues of fact.

In § 156.1220(a)(5), we propose that a reconsideration decision would be final and binding for decisions regarding the advance payments of the premium tax credit, advance payments of cost-sharing reductions, and FFE user fees. A reconsideration with respect to other matters would be subject to the outcome of a request for informal hearing filed in accordance with proposed § 156.1220(b). Because the monthly iterative discrepancy report process is available until the reconsideration notice is sent and because of the simplicity of the calculation of advance payments of the premium tax credit, advance payments of cost-sharing reductions, or FFE user fees, we believe that providing one level of administrative appeal for advance payments of the premium tax credit, advance payments of cost-sharing reductions, and FFE user fees is sufficient. We propose in § 156.1220(b) that an issuer that elects to challenge the reconsideration decision for the final risk adjustment payment or charge, including an assessment of risk adjustment user fees; reinsurance payment; default risk adjustment charge; cost-sharing reduction reconciliation payment or charge; or risk corridors payment or charge for a benefit year provided under paragraph (a) of proposed § 156.1220 would be entitled to an informal hearing before a CMS hearing officer. In § 156.1220(b)(1), we propose that a request for an informal hearing be made in writing and filed with HHS within 15 calendar days of the date the issuer receives the reconsideration decision. In § 156.1220(b)(2), we propose that the request for an informal hearing must include a copy of the reconsideration decision and must specify the findings or issues in the decision that the issuer is challenging and its reasons for the challenge. We also propose that HHS may submit for review by the CMS hearing officer a statement of the reasons supporting the reconsideration decision.

In § 156.1220(b)(3)(i), we propose that the issuer receive a written notice of the time and place of the informal hearing at least 15 calendar days before the scheduled date. In § 156.1220(b)(3)(ii), we propose that the CMS hearing officer would neither receive testimony nor accept any new evidence that was not presented with the reconsideration request or in any statement provided by HHS. We propose that the scope of the CMS hearing officer's review would be limited to the statements provided by the issuer and HHS and the record that was before HHS in making the reconsideration determination. We would require that the issuer prove its case by clear and convincing evidence with respect to issues of fact and would permit the issuer to be represented by counsel in the informal hearing.

In § 156.1220(b)(4), we propose that, following the informal hearing, the CMS hearing officer would send the decision and the reasons for the decision to the issuer. We propose that this decision would be final and binding, but subject to any Administrator's review initiated in accordance with proposed § 156.1220(c).

We propose in § 156.1220(c)(1) that if the CMS hearing officer upholds the reconsideration decision, the issuer may request a review by the Administrator of CMS within 15 calendar days of receipt of the CMS hearing officer's decision. The request for a review by the Administrator of CMS must specify the findings or issues in the decision that the issuer is challenging, and the reasons for the challenge. We propose that HHS may submit for review by the Administrator of CMS a statement supporting the decision of the CMS hearing officer.

In § 156.1220(c)(2), we propose that the Administrator of CMS or a delegate would review the hearing officer's decision, any written documents submitted by HHS or the issuer, as well as any other information included in the record of the CMS hearing officer's

decision, and would determine whether to uphold, reverse, or modify the CMS hearing officer's decision. We propose that the issuer would be required to prove its case by clear and convincing evidence with respect to issues of fact. We propose that the Administrator's determination would be considered final and binding.

We believe that the administrative appeals process outlined above would give issuers reasonable opportunity for reconsideration and review of their payments and charges. Furthermore, building on established procedures utilized by HHS in Medicare Part D will provide a structure for administrative appeals with which issuers are already familiar. We seek comment on the proposed reconsideration and administrative appeals process.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. This proposed rule contains information collection requirements (ICRs) that are subject to review by OMB. A description of these provisions is given in the following paragraphs with an estimate of the annual burden, summarized in Table 6. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this proposed rule that contain ICRs. We generally used data from the Bureau of Labor Statistics to derive average labor costs (including capital costs, overhead, and fringe benefits) for estimating the burden associated with the ICRs.

A. ICRs Related to HHS Audits of State-operated Reinsurance Programs (§ 153.270)

In § 153.270, we propose that HHS or its designee may conduct a financial and programmatic audit of a State-operated reinsurance program to assess compliance with reinsurance program requirements. We also propose that, if an audit results in a finding of material weakness or significant deficiency, a State must ensure that the applicable reinsurance entity provides a written corrective action plan to HHS for approval within 60 calendar days of the issuance of the final audit report. The burden associated with meeting this third party disclosure requirement includes the burden for a State that establishes a reinsurance program to ensure that its applicable reinsurance entity and any relevant contractors, subcontractors, or agents cooperate with and take appropriate actions in connection with any audit, and the burden associated with preparing and submitting a corrective action plan to HHS for approval. Because only two States will operate reinsurance in the 2014 benefit year, this collection is exempt from the PRA under 44 U.S.C. 3502(3)(A)(i), and we are not seeking approval from OMB for this information collection requirement. We discuss the impact associated with HHS audits of State-operated reinsurance programs in the Regulatory Impact Analysis section of this proposed rule.

B. ICRs Regarding Issuer and Entity Administrative Burden Related to Audits for the Premium Stabilization Programs (§ 153.405(i); § 153.540(a); § 153.410(d); § 153.620(c))

We propose that HHS or its designee would have the authority to audit QHP issuers, contributing entities, and issuers of risk adjustment covered plans or reinsurance-eligible plans to assess compliance with the requirements of subparts E, F, G and H of part 153, as applicable. As mentioned earlier in this proposed rule, where possible, we intend to align the risk corridors audit process with the audits conducted for the MLR program. Therefore, we believe that the issuer burden associated with the risk corridors audit is already accounted for as part of the Supporting Statement for the MLR program approved under OMB control number 0938–1164.

For issuers of risk adjustment covered plans and issuers of reinsurance-eligible plans, these provisions would result in a third party disclosure requirement for issuers to prepare and compile the financial and programmatic information necessary to comply with the audit. For each onsite review, we estimate that it will take an average of 40 hours for administrative work to assemble the requested information, 19.5 hours to review the information for completeness, and 30 minutes to submit the information to HHS in preparation for an onsite review. We estimate that an onsite review would require an additional 2 hours to schedule the onsite activities with the compliance reviewer (at an hourly wage rate of $53.75), 4 hours for introductory meeting, 8 hours to tour reviewers onsite, 10 hours of interview time, 2 hours to walk through processes with the reviewer, and 4 hours for concluding meetings, resulting in a total of approximately 60 hours of preparation time and an additional 30 hours of onsite time for each issuer. We estimate that it will take 90 hours at a cost of approximately $4,838 for each issuer to make information available to HHS for an onsite review. Because we have not finalized our audit protocols, it is difficult to accurately estimate an audit rate. However, we believe that it would be reasonable to assume that approximately 120 issuers, representing roughly 5 percent of issuers of risk adjustment covered plans or reinsurance-eligible plans would be audited. Therefore, we estimate an aggregate burden of 10,800 hours and $580,500 for issuers as a result of this requirement.

For contributing entities, we estimate that the disclosure burden would be substantially less because the audit would be simpler. We estimate the burden to be approximately one-quarter of that of an issuer of a risk adjustment covered plan or a reinsurance-eligible plan, or approximately 22.5 hours at a cost of approximately $1,209 for each contributing entity. Similarly, because we have not finalized the audit protocols, it is difficult to accurately estimate an audit rate. However, we estimate that approximately 1 percent of contributing entities would be audited, representing 226 contributing entities. Therefore, we estimate an aggregate burden of 5,085 hours, or $273,319, as a result of this proposed requirement. We will revise the information collection currently approved under OMB Control Number 0938–1155 with an October 31, 2015 expiration date to account for this additional burden.

C. ICRs Regarding Potential Adjustments for Transitional Plans (§ 153.500–§ 153.540)

For the 2014 benefit year, we are considering adjustments to the premium stabilization programs that would help to further mitigate any unexpected losses for QHP issuers with plans that are affected by the transitional policy. To effectuate potential adjustments, we must estimate the State-specific effect on average claims costs. We therefore

propose to require all issuers participating in the individual and small group markets in a State to submit to HHS a member-month enrollment count for transitional plans and non-transitional plans in the individual and small group markets. This submission would occur in 2015 prior to the risk corridors July 31, 2015 data submission deadline. HHS would analyze that enrollment data, and publish the State-specific adjustments that issuers would use in the risk corridors calculations for the 2014 benefit year. To reduce the burden on issuers, we are considering coordinating this data collection with other data collections for the premium stabilization programs. We request comment on data collection methods and the potential effect on issuers' administrative costs.

We estimate that there will be approximately 2,400 issuers in the individual and small group market in the 2014 benefit year, and that it would take an insurance analyst approximately 30 minutes (at an hourly wage rate of $38.49) to estimate enrollment in transitional plans and non-transitional plans and submit this information to HHS. Therefore, we estimate a cost of approximately $19.25 for each issuer, and an aggregate cost of $46,200 for all individual and small group market issuers (though this cost may be lower depending upon the data collection method we adopt). Because we anticipate collecting this information in 2015, and because we expect to issue additional clarifying guidance on this proposed policy, will seek OMB approval and solicit public comment on this information collection requirement at a future date.

D. ICRs Regarding Risk Corridors Data Validation (§ 153.530 and § 153.540)

For the 2014 benefit year, we propose to collect risk corridors data by using the same form as is used for MLR data collection, at the same time (July 31st of the year following the applicable benefit year). We intend to modify the MLR collection form for benefit year 2015, approved under OMB control number 0938–1164, to add reporting elements (for example, QHP-specific premium amounts) that are required under the risk corridors data submission requirements under § 153.530. We intend to include these data elements in an amendment to the information collection approved under OMB control number 0938–1164 for MLR data submission that we will publish for public comment and advance for OMB approval in the future.

Because the MLR program and the risk corridors program will require similar data, we estimate that submitting the data elements required for the risk corridors program will impose limited additional burden on issuers. We estimate that it will take each QHP issuer approximately 1.5 hours, representing 1 hour for an insurance analyst (at an hourly wage rate of $38.49) and 30 minutes for a senior manager (at an hourly wage rate of $77), to input and review data that is specific to the risk corridors program in the MLR and risk corridors reporting form for benefit year 2015. We estimate that 1,200 QHP issuers will submit risk corridors data for the 2014 benefit year in the 2015 risk corridors and MLR reporting cycle. Therefore, we estimate an aggregate burden of 1,800 hours (at a total cost of approximately $92,394) for QHP issuers as a result of this requirement. We will revise the information collection currently approved OMB Control Number 0938–1155 with an October 31, 2015 expiration date to account for this additional burden.

In § 153.540(b), we propose that HHS may impose CMPs on QHP issuers on a State Exchange that do not comply with the risk corridors requirements in Subpart F. We note that we would impose any CMP in accordance with the procedures set forth in 45 CFR156.805. Although the processes set forth in § 156.805 would result in information collection requirements that are subject to PRA, we expect to impose CMPs on fewer than 10 entities in a year. Therefore, we believe that this collection is exempt from the PRA under 44 U.S.C. 3502(3)(A)(i).

E. ICRs Regarding Data Validation Requirements When HHS Operates Risk Adjustment (§ 153.630)

In § 153.630(b)(1), we propose that an issuer of a risk adjustment covered plan must engage one or more independent auditors to perform an initial validation audit of a sample of its risk adjustment data selected by HHS. This provision also proposes that the issuer provide HHS with the identity of the initial validation auditor, and attest to the absence of conflicts of interest between the initial validation auditor (or the members of its audit team, owners, directors, officers, or employees) and the issuer (or its owners, directors, officers, or employees), in a timeframe and manner to be specified by HHS. We previously estimated the cost to issuers to conduct an initial validation audit in the 2014 Payment Notice and the associated information collection request approved under OMB Control Number 0938–1155 with an October 1, 2015 expiration date. Therefore, the burden associated with this reporting requirement is the time and effort necessary to report the auditor's identity to HHS. We estimate it will take an insurance operations analyst (at an hourly wage rate of $38.49) and a senior manager (at an hourly wage rate of $77) each approximately 15 minutes to prepare and send an electronic report to HHS. Therefore, for 2,400 risk adjustment covered issuers, the aggregate burden associated with this requirement is 1,200 hours, at an approximate cost of $69,300.

In § 153.630(b)(8), we propose that the initial validation auditor measure and report to the issuer and HHS, in a manner and timeframe specified by HHS, the inter-rater reliability rates among its reviewers. Also in this provision, we propose that the initial validation auditor to achieve a minimum consistency measure of 95 percent for demographic, enrollment, and health status review outcomes. We believe establishing standards for inter-rater reliability among reviewers is standard practice in the industry and will not result in extra cost for the initial validation auditor. Therefore, the burden associated with this reporting requirement is the time and effort for the initial validation auditor to report the inter-rater reliability rate to the issuer and to HHS. We estimate it will take an insurance operations analyst (at an hourly wage rate of $38.49) and a senior manager (at an hourly wage rate of $77) each approximately 15 minutes to report the inter-rater reliability rate to the issuer and to HHS. Therefore, assuming that 2,400 issuers of risk adjustment covered plans each engage one independent auditor to perform the initial validation audit, the aggregate burden associated with this requirement is 1,200 hours, at an approximate cost of $69,300. We will revise the information collection currently approved under OMB Control Number 0938–1155 with an October 31, 2015 expiration date to account for this additional burden.

F. ICRs Regarding Quarterly Data Submissions (§ 153.700(a))

Section 153.700 provides that issuers of a risk adjustment covered plan or a reinsurance-eligible plan must establish a dedicated distributed data environment and provide data access to HHS, in a manner and timeframe specified by HHS, for any HHS-operated risk adjustment and reinsurance program. In this proposed rule, we clarify this timeframe, proposing that an issuer must make good faith efforts to make complete, current enrollment and claims files accessible through its

dedicated distributed data environments no less frequently than quarterly, once the issuer's dedicated distributed data environment is established.

Based on HHS's most recent estimate of fully insured issuers in the individual and small group markets, we estimate that 2,400 issuers will be subject to the requirement to establish a dedicated data environment to either receive reinsurance payments or make risk adjustment transfers. Although we are clarifying in this proposed rule that issuers must make this data available to HHS on a quarterly basis, the aggregate burden associated with this requirement is already accounted for under the Premium Stabilization Rule Supporting Statement that is approved under OMB control number 0938–1155 with an October 31, 2015 expiration date. We will revise that supporting statement to specify that issuers must comply with this information collection requirement on a quarterly basis.

G. ICRs Related to Confirmation of Dedicated Distributed Data Environment Reports (§ 153.700(d) and (e))

We propose in § 153.710(d) that within 30 calendar days of the date of an interim dedicated distributed data environment report from HHS, an issuer of a reinsurance-eligible or risk adjustment covered plan must either confirm to HHS that the information in the interim reports for the risk adjustment and reinsurance programs accurately reflect the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with § 153.700(a) for the timeframe specified in the report, or describe to HHS any inaccuracy it identifies in the interim report. Similar to the interim report process, we propose in § 153.710(e) that the issuer either confirm to HHS that the information in the final dedicated distributed data environment report accurately reflects the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with § 153.700(a) for the benefit year specified in the report, or describe to HHS any inaccuracy it identifies in the final dedicated distributed data environment report within 15 calendar days of the date of the report.

We estimate that 2,400 issuers of risk adjustment covered plans and reinsurance-eligible plans will be subject to this requirement, and that issuers will compare enrollee condition codes with risk scores and analyze claims costs to confirm information in the interim and final dedicated distributed data environment reports. On average, we estimate that it will take an insurance operations analyst (at an hourly wage rate of $38.49) approximately 2 hours to respond to an interim report and 6 hours to respond to the final dedicated distributed data environment report. Therefore, we estimate an aggregate burden of 19,200 hours and $739,008 for 2,400 issuers as a result of this requirement. We will revise the information collection currently approved under OMB Control Number 0938–1155 with an October 31, 2015 expiration date to account for this additional burden.

H. ICRs Regarding Privacy and Security of Personally Identifiable Information (§ 155.260(a))

In § 155.260(a), we propose that an Exchange may submit to the Secretary a proposed use or disclosure of eligibility and enrollment PII. The Exchange submitting such a request must provide a detailed description of the use or disclosure and how the proposed use or disclosure will ensure the efficient operation of the Exchanges consistent with section 1411(g)(2)(A) of the Affordable Care Act. The requesting Exchange must also describe how the information to be used or disclosed will be protected in compliance with the privacy and security standards established by the Exchange. We estimate fewer than 10 states will submit such proposals on a yearly basis. While this reporting requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.3(c)(4) and 44 U.S.C. 3502(3)(A)(i), since fewer than 10 entities would be affected. Therefore, we are not seeking approval from OMB for these information collection requirements. We seek comment on this estimate from states that are contemplating any uses of eligibility and enrollment PII for which they would submit such a proposal.

I. ICRs Regarding Quality Standards: Establishment of Patient Safety Standards for QHP Issuers (§ 156.1110)

In § 156.1110, we describe the information collection, recordkeeping, and disclosure requirements that a QHP issuer must meet to demonstrate compliance with these proposed patient safety standards. The burden estimate associated with these standards includes the time and effort required for QHPs to maintain and submit hospital CMS Certification Numbers and any other information to the Exchange that demonstrates that each of its contracted hospitals with greater than 50 beds meets the patient safety standards required in § 156.1110(a). In the near future, HHS intends to publish a rule proposing more specific quality standards for Exchanges and QHPs and will solicit public comment. At that time and per requirements outlined in the PRA, we intend to estimate the burden on QHPs to comply with the patient safety provisions of § 156.1110. Until that time, we are soliciting comments on the burden for QHPs to maintain and submit such documentation to demonstrate meeting the patient safety standards proposed here.

J. ICRs Regarding Administrative Appeals (§ 156.1220)

In § 156.1220, we propose an administrative appeals process to address unresolved discrepancies for advance payment of the premium tax credit, advance payment and reconciliation of cost-sharing reductions, FFE user fees, and the premium stabilization programs, as well as any assessment of a default risk adjustment charge under § 153.740(b).

In § 156.1220(a), we propose that an issuer may file a request for reconsideration to contest a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error for the amount of: (1) Advance payment of the premium tax credit, advance payment of cost-sharing reductions or Federally-facilitated user fees charge for a particular month; (2) risk adjustment payments or charges for a benefit year, including an assessment of risk adjustment user fees; (3) reinsurance payments for a benefit year; (4) a risk adjustment default charge for a benefit year; (5) a reconciliation payment or charge for cost-sharing reductions for a benefit year; or (6) risk corridors payments or charges for a benefit year. While the hours involved in a request for reconsideration may vary, for the purpose of this burden estimate we estimate that it will take an insurance operations analyst 1 hour (at an hourly wage rate of $38.49) to make the comparison and submit a request for reconsideration to HHS. We estimate that 24 issuers, representing approximately 1 percent of all issuers that may be eligible for reinsurance payments, risk adjustment payments or charges (including any assessment of risk adjustment user fees or a default risk adjustment charge), advance payment and reconciliation of cost-sharing reductions, advance payment of the premium tax credit, and FFE user fees, will submit a request for reconsideration, resulting in a total aggregate burden of approximately $924.

We will revise the information collection currently approved OMB Control Number 0938–1155 with an October 31, 2015 expiration date to account for this additional burden.

In § 156.1220(b), we propose that an issuer that is dissatisfied with the reconsideration decision regarding: (1) Risk adjustment payments and charges, including an assessment of risk adjustment user fees; (2) reinsurance payments; (3) default risk adjustment charge; (4) reconciled cost-sharing reduction amounts; or (5) risk corridors payments or charges, provided under paragraph (a) of § 156.1220, is entitled to an informal hearing before a CMS hearing officer, if a request is made in writing within 15 calendar days of the date the issuer receives the reconsideration decision. Further review is available from the Administrator of CMS. However, we believe these processes will occur extremely infrequently. Since collections from fewer than 10 entities are exempt from the PRA under 44 U.S.C. 3502(3)(A)(i), we are not seeking PRA approval for this information collection requirement.

TABLE 7—ANNUAL REPORTING, RECORDKEEPING AND DISCLOSURE BURDEN

Regulation Section(s)	Number of respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Hourly labor cost of reporting ($)	Total labor cost of reporting ($)	Total capital/ maintenance costs ($)	Total cost ($)
§ 153.405	226	226	22.50	5,085	53.75	273,319	0	273,319
§ 153.410; § 153.620	120	120	90.00	10,800	53.75	580,500	0	580,500
§ 153.500– § 153.540– ..	2,400	2,400	0.50	1,200	38.49	46,200	.....	46,200
§ 153.540	1,200	1,200	1.50	1,200	51.33	92,394	0	92,394
§ 153.630(b)(1)	2,400	2,400	0.50	1,200	57.75	69,300	0	69,300
§ 153.630(b)(8)	2,400	2,400	0.50	1,200	57.75	69,300	0	69,300
(§ 153.700(d) and (e))	2,400	2,400	8.00	19,200	38.49	739,008	0	739,008
§ 156.1220	24	24	1.00	24	38.49	924	0	924
Total	[a] 3,970	.....	.....	.....	.....	1,870,945	0	1,870,945

[a] ICRs associated with § 153.500, § 153.630(b)(1), § 153.630(b)(8) and § 153.700(d) and (e) apply to the same respondents, so the total number of unique respondents is 3,970.

We have submitted an information collection request to OMB for review and approval of the ICRs contained in this proposed rule. The requirements are not effective until approved by OMB and assigned a valid OMB control number.

To obtain copies of the supporting statement and any related forms for the paperwork collections referenced above, access CMS's Web site at *http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html* or email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*, or call the Reports Clearance Office at 410–786–1326.

If you comment on these information collection requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, CMS–9972–F. Fax: (202) 395–5806; or Email: *OIRA_submission@omb.eop.gov*.

V. 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.

VI. Regulatory Impact Statement (or Analysis)

A. Statement of Need

This proposed rule proposes standards related to the premium stabilization programs (risk adjustment, reinsurance, and risk corridors) that will protect issuers from the potential effects of adverse selection and protect consumers from increases in premiums due to issuer uncertainty. The Premium Stabilization Rule and 2014 Payment Notice provided detail on the implementation of these programs, including the specific parameters applicable to these programs. This proposed rule also proposes additional standards with respect to composite rating, privacy and security of personally identifiable information, the open enrollment period for 2015, the actuarial value calculator, the annual limitation on cost sharing for stand-alone dental plans, the meaningful difference standard for qualified health plans offered through a Federally-facilitated Exchange, patient safety standards for issuers of qualified health plans, the Small Business Health Options Program, cost sharing parameters, cost-sharing reductions, and FFE user fees.

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 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. 804(2)).

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). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects ($100 million or more in any 1 year).

OMB has determined that this proposed rule is ''economically significant'' within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of $100 million in any 1 year. Accordingly, we have prepared a RIA that presents the costs and benefits of this proposed rule.

Although it is difficult to discuss the wide-ranging effects of these provisions in isolation, the overarching goal of the premium stabilization and Exchange-related provisions and policies in the Affordable Care Act is to make affordable health insurance available to individuals who do not have access to affordable employer-sponsored coverage. The provisions within this proposed rule are integral to the goal of expanding coverage. For example, the premium stabilization programs decrease the risk of financial loss that health insurance issuers might otherwise expect in 2015 and the advance payments of the premium tax credit and cost-sharing reduction programs assist low- and moderate-income consumers and Indians in purchasing health insurance. The combined impacts of these provisions affect the private sector, issuers, and consumers, through increased access to health care services including preventive services, decreased uncompensated care, lower premiums, establishment of patient safety standards, and increased plan transparency. Through the reduction in financial uncertainty for issuers and increased affordability for consumers, these provisions are expected to increase access to health coverage.

In this RIA, we discuss the requirements in this proposed rule related to cost sharing and FFE user fees, as well as new oversight provisions for the premium stabilization programs.

C. Impact Estimates of the Payment Notice Provisions and Accounting Table

In accordance with OMB Circular A–4, Table 8 below depicts an accounting statement summarizing HHS's assessment of the benefits, costs, and transfers associated with this regulatory action.

This proposed rule implements standards for programs that will have numerous effects, including providing consumers with affordable health insurance coverage, reducing the impact of adverse selection, and stabilizing premiums in the individual and small group health insurance markets and in an Exchange. We are unable to quantify certain benefits of this proposed rule—such as increased patient safety and improved health and longevity due to increased insurance enrollment—and certain costs—such as the cost of providing additional medical services to newly-enrolled individuals. The effects in Table 8 reflect qualitative impacts and estimated direct monetary costs and transfers resulting from the provisions of this proposed rule for contributing entities, States, Exchanges, and health insurance issuers. The annualized monetized costs described in Table 8 reflect direct administrative costs (including costs associated with labor, capital, overhead, and fringe benefits) to States and health insurance issuers as a result of the proposed provisions, and include administrative costs estimated in the Collection of Information section of this proposed rule. We note estimated transfers in Table 8 do not reflect any user fees paid by insurance issuers for FFEs because we cannot estimate those fee totals. We also note that, while we are proposing a 2015 reinsurance contribution rate that is lower than the 2014 reinsurance contribution rate, total reinsurance administrative expenses, including the reinsurance contribution rate, will increase from 2014 to 2015.

TABLE 8—ACCOUNTING TABLE

Benefits:

Qualitative:

*Increased enrollment in the individual market leading to improved access to health care for the previously uninsured, especially individuals with medical conditions, which will result in improved health and protection from the risk of catastrophic medical expenditures.

*A common marketing standard covering the entire insurance market, reducing adverse selection and increasing competition.

*Robust oversight of programs that use Federal funds to ensure proper use of taxpayer dollars.

*Access to higher quality health care through the establishment of patient safety standards

*Increasing coverage options for small employers and part-time employees while mitigating the effect of adverse selection.

Costs:	Estimate (in millions)	Year dollar	Discount rate (percent)	Period covered
Annualized Monetized ($/year)	1.75	2013	7	2014–2017
	1.82	2013	3	2014–2017

Qualitative:

*Costs incurred by issuers and contributing entities to comply with provisions in the proposed rule.

*Costs incurred by States for complying with audits of State-operated reinsurance programs.

Transfers:	Estimate (in millions)	Year dollar	Discount rate (percent)	Period covered
Annualized Monetized ($/year)	11.59	2013	7	2014–2017
	12.04	2013	3	2014–2017

TABLE 8—ACCOUNTING TABLE—Continued

*Transfers reflect incremental cost increases from 2014–2015 for reinsurance administrative expenses and the risk adjustment user fee, which are transfers from contributing entities and health insurance issuers to the Federal government.
*Unquantified: Lower premium rates in the individual market due to the improved risk profile of the insured, competition, and pooling.

This RIA expands upon the impact analyses of previous rules and utilizes the Congressional Budget Office's (CBO) analysis of the Affordable Care Act's impact on Federal spending, revenue collection, and insurance enrollment. The CBO's estimates remain the most comprehensive for provisions pertaining to the Affordable Care Act, and include Federal budget impact estimates for provisions that HHS has not independently estimated. The CBO's May 2013 baseline projections estimated that 22 million enrollees will enroll in Exchange coverage by 2016, including approximately 18 million Exchange enrollees who will be receiving subsidies.[37] Participation rates among potential enrollees are expected to be lower in the first few years of Exchange availability as employers and individuals adjust to the features of the Exchanges. Table 9 summarizes the effects of the risk adjustment and reinsurance programs on the Federal budget from fiscal years 2014 through 2017, with the additional, societal effects of this proposed rule discussed in this RIA. We do not expect the provisions of this proposed rule to significantly alter CBO's estimates of the budget impact of the risk adjustment and reinsurance programs that are described in Table 9. For this RIA, we are shifting the estimates for the risk adjustment and reinsurance programs to reflect the 4-year period from fiscal years 2014 through 2017, because CBO's scoring of the risk adjustment and reinsurance programs assumed that payments and charges would begin in 2014, when in fact these payments and charges will begin in 2015. CBO did not separately estimate the program costs of risk corridors, but assumed aggregate collections from some issuers would offset payments made to other issuers. We note that transfers associated with the risk adjustment and reinsurance programs were previously estimated in the Premium Stabilization Rule; therefore, to avoid double-counting, we do not include them in the accounting statement for this proposed rule (Table 8).

In addition to utilizing CBO projections, HHS conducted an internal analysis of the effects of its regulations on enrollment and premiums. Based on these internal analyses, we anticipate that the quantitative effects of the provisions proposed in this rule are consistent with our previous estimates in the 2014 Payment Notice for the impacts associated with the cost-sharing reduction program, the advance payments of the premium tax credit program, the premium stabilization programs, and FFE user fee requirements for health insurance issuers.

TABLE 9—ESTIMATED FEDERAL GOVERNMENT OUTLAYS AND RECEIPTS FOR THE RISK ADJUSTMENT AND REINSURANCE PROGRAMS FROM FY 2013–2017, IN BILLIONS OF DOLLARS

Year	2013	2014	2015	2016	2017	2013–2017
Risk Adjustment and Reinsurance Program Payments	—	6	17	18	20	61
Risk Adjustment and Reinsurance Program Collections*	—	13	16	18	18	65

*Risk adjustment program payments and receipts lag by one quarter. Receipt will fully offset payments over time. Source: Congressional Budget Office. 2012. *Letter to Hon. John Boehner.* July 24, 2012.

Risk Adjustment

The risk adjustment program is a permanent program created by the Affordable Care Act that transfers funds from lower risk, non-grandfathered plans to higher risk, non-grandfathered plans in the individual and small group markets, inside and outside the Exchanges. In subparts D and G of the Premium Stabilization Rule and the 2014 Payment Notice, we established standards for the administration of the risk adjustment program.

A State approved or conditionally approved by the Secretary to operate an Exchange may establish a risk adjustment program, or have HHS do so on its behalf. As described in the 2014 Payment Notice, if HHS operates risk adjustment on behalf of a State, it will fund its risk adjustment program operations by assessing a risk adjustment user fee on issuers of risk adjustment covered plans. For the 2015 benefit year, we estimate that the total cost for HHS to operate the risk adjustment program on behalf of States for 2015 will be approximately $27.3 million, and that the per capita risk adjustment user fee would be less than $1.00 per year for HHS to operate the risk adjustment program on behalf of States for 2015.

In this proposed rule, we propose in § 153.620(c) that HHS or its designee may audit an issuer of a risk adjustment covered plan, when HHS operates risk adjustment on behalf of a State, to assess the issuer's compliance with the requirements of subparts G and H of 45 CFR part 153. As discussed above, HHS intends to fund risk adjustment operations (not including Federal personnel costs), including risk adjustment program integrity and audit functions, by collecting a per capita user fee from issuers of risk adjustment covered plans. Therefore, we believe that the costs to the Federal government associated with the risk adjustment audit activities in this proposed rule would be covered through the risk adjustment user fee, and that there would be no impact for the Federal government as a result of the proposed audit provisions. The proposed audit provision would result in additional costs for issuers of risk adjustment covered plans related to gathering information and preparing for an audit. We discuss the administrative costs associated with this proposed requirement for issuers in the Collection of Information section of this proposed rule.

[37] "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," Congressional Budget Office, May 2013.

Although this proposed rule would result in some additional administrative burden for issuers of risk adjustment covered plans as a result of the proposed requirements for risk adjustment data validation and submission of discrepancy reports in response to interim and final dedicated distributed data environment reports, we note that much of the impact associated with establishing a dedicated distributed data environment and a risk adjustment data validation process has previously been estimated in the Premium Stabilization Rule and the 2014 Payment Notice. We do not believe that provisions contained within this proposed rule substantially alter the previous estimates. We describe these administrative costs in the Collection of Information Requirements section of this proposed rule.

Reinsurance

The Affordable Care Act directs that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016. In the 2014 Payment Notice, we expanded upon the standards set forth in subparts C and E of the Premium Stabilization Rule and established the 2014 uniform reinsurance payment parameters and national contribution rate. In this proposed rule, we set forth the 2015 uniform reinsurance payment parameters and contribution rate, and oversight provisions related to the operation of the reinsurance program.

Section 153.220(c) provides that HHS will publish the uniform per capita reinsurance contribution rate for the upcoming benefit year in the annual HHS notice of benefit and payment parameters. Section 1341(b)(3)(B)(iii) of the Affordable Care Act specifies that $10 billion for reinsurance contributions is to be collected from contributing entities in 2014 (the reinsurance payment pool), $6 billion in 2015, and $4 billion in 2016. Additionally, sections 1341(b)(3)(B)(iv) and 1341(b)(4) of the Affordable Care Act direct that $2 billion in funds is to be collected for contribution to the U.S. Treasury in 2014, $2 billion in 2015, and $1 billion in 2016. Finally, section 1341(b)(3)(B)(ii) of the Affordable Care Act allows for the collection of additional amounts for administrative expenses. Taken together, these three components make up the total dollar amount to be collected from contributing entities for each of the 3 years of the reinsurance program under the uniform per capita contribution rate.

If HHS operates the reinsurance program on behalf of a State, HHS would retain $0.14 as an annual per capita fee to fund HHS's performance of all reinsurance functions. If a State establishes its own reinsurance program, HHS would transfer $0.07 of the per capita administrative fee to the State for purposes of administrative expenses incurred in making reinsurance payments, and retain the remaining $0.07 to offset the costs of contribution collection.

To safeguard the use of Federal funds in the transitional reinsurance program, we propose in § 153.270(a) that HHS or its designee may conduct a financial and programmatic audit of a State-operated reinsurance program to assess compliance with the requirements of subparts B and C of 45 CFR part 153. As discussed above, HHS intends to fund reinsurance operations (not including Federal personnel costs), including program integrity and audit functions, by collecting as part of the uniform contribution rate, administrative expenses associated with operating the reinsurance program from all reinsurance contributing entities. Therefore, we believe that the costs to the Federal government associated with the reinsurance audit activities in this proposed rule would be covered through the reinsurance contribution rate, and that there would be no net budget impact for the Federal government as a result of the proposed audit provisions. Because this proposed audit requirement would direct a State that establishes a reinsurance program to ensure that its applicable reinsurance entity and any relevant contractors, subcontractors, or agents cooperate with an audit, and would direct the State to provide to HHS for approval a written corrective action plan; implement the plan; and provide to HHS written documentation of the corrective actions once taken, if the audit resulted in a finding of material weakness or significant deficiency, the proposed requirement would impose a cost on States operating reinsurance. We believe that State-operated reinsurance programs would already electronically maintain the information necessary for an audit as part of their normal business practices and as a result of the maintenance of records requirement set forth in § 153.240(c), no additional time or effort will be necessary to develop and maintain audit information. We estimate that it will take a compliance analyst (at an hourly wage rate of $53.75) 40 hours to gather the necessary information required for an audit, 5 hours to prepare a corrective action plan based on the audit findings and 64 hours to implement and document the corrective actions taken if necessary. We also estimate a senior manager (at an hourly wage rate of $77) will take 5 hours to oversee the transmission of audit information to HHS and to review the corrective action plan prior to submission to HHS, and 16 hours to oversee implementation of any corrective actions taken. Therefore, we estimate a total administrative cost of approximately $7,476 for each State-operated reinsurance program as a result of this proposed audit requirement. For the two States that will operate reinsurance for the 2014 benefit year, we estimate an aggregate burden of approximately $14,952 as a result of this requirement. Although we have estimated the cost of a potential audit in this RIA, we note that we will not audit all State-operated reinsurance programs, and may not audit any of these programs.

In § 153.405(i) and § 153.410(d), we propose that HHS may audit contributing entities and issuers of reinsurance-eligible plans to assess compliance with reinsurance program requirements. We discuss the costs to contributing entities and issuers of reinsurance-eligible plans as a result of this proposed requirement in the Collection of Information section of this proposed rule. We intend to combine issuer audits for the premium stabilization programs whenever practicable to reduce the financial burden of these audits on issuers. Consequently, we anticipate that, because issuers of reinsurance-eligible plans may also be subject to risk adjustment requirements, we would conduct these audits in a manner that avoids overlapping review of information that is required for both programs.

Risk Corridors

The Affordable Care Act creates a temporary risk corridors program for the years 2014, 2015, and 2016 that applies to QHPs, as defined in § 153.500. The risk corridors program creates a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers. The Affordable Care Act establishes the risk corridors program as a Federal program; consequently, HHS will operate the risk corridors program under Federal rules with no State variation. The risk corridors program will help protect against inaccurate rate setting in the early years of the Exchanges by limiting the extent of issuer losses and gains.

As mentioned elsewhere in this proposed rule, for the 2014 benefit year, we are proposing an adjustment to the risk corridors formula that would help

to further mitigate potential QHP issuers' unexpected losses that are attributable to the effects of the transition policy. This proposed adjustment may increase the total amount of risk corridors payments that the Federal government will make to QHP issuers, and reduce the amount of risk corridors receipts; however, we are considering a number of approaches that would limit the impact of the policy on the Federal budget. Because of the difficulty associated with predicting State enforcement of 2014 market rules and estimating the enrollment in transitional plans and in QHPs, we cannot estimate the magnitude of this impact on aggregate risk corridors payments and charges at this time. We also estimate that this proposed adjustment would result in direct administrative costs for individual and small group market issuers that are discussed in the Collection of Information section of this proposed rule.

To ensure the integrity of risk corridors data reporting, we propose in § 153.540(a) to establish HHS authority to conduct post-payment audits of QHP issuers. We are contemplating several ways to reduce issuer burden, such as conducting the risk corridors audits using the existing MLR audit process or conducting risk corridors audits under an overall issuer audit program. Therefore, as described in the Collection of Information section of this proposed rule, we believe that the cost for issuers that would result from this proposed audit requirement is already accounted for as part of the MLR audit process.

We also propose in § 153.540(c) to extend our CMP authority under sections 1321(a)(1) and (c)(2) of the Affordable Care Act to all QHP issuers that fail to provide timely, accurate, and complete data necessary for risk corridors calculations, or that otherwise do not comply with the standards in subpart F of 45 CFR part 153. We propose to assess CMPs on QHP issuers in State Exchanges in accordance with the same enforcement and sanction procedures that apply to QHP issuers on an FFE under § 156.805.

As set forth in § 156.805(c), HHS will impose a maximum penalty amount of $100 per day on a QHP issuer for each violation, for each individual adversely affected by the non-compliance. As noted in the preamble to § 153.540 in this proposed rule, for violations of subpart F where the number of individuals adversely affected by the non-compliance cannot be determined, we propose giving HHS the authority to estimate the number of individuals likely to be adversely affected by the non-compliance. We note that CMPs will be imposed only for serious issues of non-compliance. We expect to provide technical assistance to issuers, as appropriate, to assist them in maintaining compliance with the applicable standards. We also plan to coordinate with States and the MLR program in our oversight and enforcement activities to avoid inappropriately duplicating enforcement efforts. Consequently, we anticipate that CMPs will be rare, and that the impact of this proposed requirement on QHP issuers will be negligible.

Provisions Related to Cost Sharing

The Affordable Care Act provides for the reduction or elimination of cost sharing for certain eligible individuals enrolled in QHPs offered through the Exchanges. This assistance will help many low- and moderate-income individuals and families obtain health insurance—for many people, cost sharing is a barrier to obtaining needed health care.[38]

To support the administration of the cost-sharing reduction program, we set forth in this proposed rule the reductions in the maximum annual limitation on cost sharing for silver plan variations and a modified methodology for calculating advance payments for cost-sharing reductions. For benefit year 2015, we propose to require the same reductions in the maximum annual limitation on cost sharing as were finalized for benefit year 2014. We note that we are proposing certain modifications to the methodology for calculating advance payments for cost-sharing reductions, but we do not believe these changes will result in a significant economic impact. Therefore, we do not believe the provisions related to cost-sharing reductions in this proposed rule will have an impact on the program established by and described in the 2014 Payment Notice.

We also proposed a methodology for estimating average per capita premium, and proposed the premium adjustment percentage for the 2015 benefit year. Section 156.130(e) provides that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013, and that this percentage will be published annually in the HHS notice of benefit and payment parameters. The annual premium adjustment percentage that is issued sets the rate of increase for four parameters detailed in the Affordable Care Act: the annual limitation on cost sharing (defined at § 156.130(a)), the annual limitation on deductibles for plans in the small group (defined at § 156.130(b)), and the section 4980H(a) and section 4980H(b) assessable payment amounts (proposed at 26 CFR 54.4980H in the ''Shared Responsibility for Employers Regarding Health Coverage,'' published in the **Federal Register** January 2, 2013 (78 FR 218)). We believe that the proposed premium adjustment percentage is well within the parameters used in the modeling of the Affordable Care Act, and do not expect that these proposed provisions will alter CBO's May 2013 baseline estimates of the budget impact.

Annual Open Enrollment Period

We propose amendments to § 155.410(e) and (f) to amend the dates for the annual open enrollment period and related coverage effective dates. These proposed amendments would benefit issuers at no additional cost, as Exchanges would delay their QHP certification dates by at least one month, giving issuers additional time. Because open enrollment dates would be moved forward, Exchanges would still have the same amount of time for the QHP certification process, and we do not anticipate that this would come at an additional cost to Exchanges. Consumers would have the benefit of a more beneficial open enrollment period, without any additional demand placed on them.

Calculation of Plan Actuarial Value

Issuers may incur minor administrative costs associated with altering cost-sharing parameters of their plan designs to ensure compliance with AV requirements when utilizing the AV calculator from year-to-year. These requirements are established in the EHB Rule and are in accordance with the proposed provisions in this proposed rule. Since issuers have extensive experience in offering products with various levels of cost sharing and since these modifications are expected to be relatively minor for most issuers, HHS expects that the process for computing AV with the AV Calculator will not demand many additional resources.

[38] Brook, Robert H., John E. Ware, William H. Rogers, Emmett B. Keeler, Allyson Ross Davies, Cathy D. Sherbourne, George A. Goldberg, Kathleen N. Lohr, Patricia Camp and Joseph P. Newhouse. *The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment.* Santa Monica, CA: RAND Corporation, 1984. Available at: *http://www.rand.org/pubs/reports/R3055.*

User Fees

To support the operation of FFEs, we require in § 156.50(c) that a participating issuer offering a plan through an FFE must remit a user fee to HHS each month equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through an FFE. For the 2015 benefit year, we propose a monthly user fee rate equal to 3.5 percent of the monthly premium. We do not have an aggregate estimate of the collections from the user fee at this time because we do not yet have a count of the number of States in which HHS will run an FFE or FF–SHOP in 2015.

SHOP

The SHOPs facilitate the enrollment of eligible employees of small employers into small group health insurance plans. A qualitative analysis of the costs and benefits of establishing a SHOP was included in the RIA published in conjunction with the Exchange Establishment Rule.[39] This RIA addresses the additional costs and benefits of the proposed modifications in this proposed rule to the SHOP sections of the Exchange Establishment Rule.

In this proposed rule, we propose revising paragraph § 155.705(b)(1), which lists the rules regarding eligibility and enrollment to which the SHOPs must adhere, to include mention of additional provisions regarding termination of coverage in SHOPs and SHOP employer and employee eligibility appeals that were finalized in the first final Program Integrity Rule. We propose that an employer in the FF–SHOPs would have the option to offer its employees either a single SADP or a choice of all SADPs available in an FF–SHOP for plan years beginning on or after January 1, 2015. In § 155.705(b)(11)(ii)(D) we propose prohibiting an employer in an FF–SHOP from basing its contribution on composite rates when employee choice becomes available and the employer elects to offer its employees all plans in a metal tier selected by the employer.

We also propose amendments to § 155.705(b)(4) that would allow SHOPs performing premium aggregation to establish a standard method for premium calculation, payment, and collection. We propose that in the FF–SHOPs, after premium aggregation becomes available in plan years beginning on or after January 1, 2015, employers would be required to remit premiums to the FF–SHOP in accordance with a payment timeline and process established by HHS through guidance, and that premiums for coverage of less than 1 month would be prorated by multiplying the number of days of coverage in the partial month by the premium for 1 month divided by the number of days in the month. In developing the premium payment timeline and process, HHS will consider its interest in operating and administering the FF–SHOPs efficiently, as well as issuers' interests in ensuring timely payment of premiums, and issuers' and employers' interests in establishing a fair and workable premium payment process. We believe the proposed approach to prorating to be the fairest for both consumers and issuers because an enrollee will pay for the portion of coverage provided for a partial month.

We also propose amendments to § 155.705(b)(11) that would provide additional flexibility to an employer's ability to define a percentage contribution toward premiums under the employer selected reference plan in the FF–SHOPs. Although we proposed and rejected a similar approach in the 2014 Payment Notice because we concluded it was inconsistent with the uniformity provisions established in Internal Revenue Service Notice 2010–82, which require employers to contribute a uniform percentage to employee premiums in order to claim a small business tax credit, we believe small employers are best able to determine whether offering different contribution levels would be in the best interest of the business and its employees. We believe that this additional flexibility would bring the FF–SHOPs more in line with current small group market practices and provide an additional incentive for small employers to participate in the FF–SHOPs. Additionally, we believe that providing a mechanism that would allow different contribution levels based on full-time or non-full-time status may encourage some employers to offer coverage to non-full-time employees.

In § 155.715, we propose amendments that would provide for SHOP eligibility adjustment periods for both employers and employees only when there is an inconsistency between information provided by an applicant and information collected through optional verification methods under § 155.715(c)(2) rather than when an employer submits information on the SHOP single employer application that is inconsistent with the eligibility standards described in § 155.710 or when the SHOP receives information on the employee's application that is inconsistent with the information provided by the employer, as current paragraph § 155.715(d) provides. We also propose to amend paragraph (c)(4) to replace a reference to sections 1411(b)(2) and (c) of the Affordable Care Act with a reference to Subpart D of 45 CFR part 155, and to add a reference to eligibility verifications as well as to eligibility determinations. The proposed changes would prohibit a SHOP from performing any individual market Exchange eligibility determinations or verifications as described in Subpart D, which, for example, includes making eligibility determinations for advance payments of the premium tax credit and cost sharing reductions in the individual market Exchange.

In § 155.730 we propose to provide that SHOPs are not permitted to collect information from applicants, employers, or employees in the SHOP if that information is not necessary to determine SHOP eligibility or effectuate enrollment through a SHOP. Limiting the information required of an applicant helps to protect consumer privacy and promote efficiency and streamlining of the SHOP application process.

In § 155.220, we propose for plan years beginning on or after January 1, 2015 to allow SHOPs, in States that permit this activity under State law, to permit enrollment in a SHOP QHP through the Internet Web site of an agent or broker under the standards set forth in § 155.220(c)(3). Permitting an employer to complete QHP selection through the Internet Web site of an agent or broker is an additional potential enrollment channel that would provide small employers with another avenue to the SHOPs.

In § 156.285, we propose that when premium aggregation becomes available in FF–SHOPs for plan years beginning on or after January 1, 2015, if an issuer does not receive an enrollment cancellation transaction from the FF–SHOP, it should effectuate coverage even if the issuer would not receive an employer's initial premium payment from the FF–SHOP prior to the coverage effective date. We also propose that a qualified employer in the SHOP that becomes a large employer would continue to be rated as a small employer and propose to prohibit issuers from composite billing in the FF–SHOPs when employee choice becomes available and an employer selects a level of coverage and not a single plan.

We do not expect the proposed policies related to the SHOP to create

[39] Available at: *http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf*

any new significant costs for small businesses, employees, or the FF–SHOPs.

Patient Safety

The proposed patient safety requirements would be implemented in phases, to ensure that QHP issuers contract with hospitals that meet adequate safety and quality standards in their networks. The proposed rule would require QHP issuers to collect and maintain CCNs for each of its contracted hospitals that are certified for more than 50 beds. It also would require that this documentation, if requested by the Exchange, be submitted in a form and manner specified by the Exchange. QHP issuers would already have established procedures and relationships to contract with hospitals including obtaining hospital identification information. Therefore, HHS believes that there would not be a significant additional cost for a QHP issuer to collect and maintain CCNs. QHP issuers would incur costs to submit this information, if requested, to the Exchange. We discuss the burden associated with submitting this information in the Collection of Information section of this proposed rule.

D. Regulatory Alternatives Considered

We considered a number of alternatives to our proposed approach to program integrity for the premium stabilization programs. For example, although we finalized in previous rulemaking our framework for the risk adjustment data validation program to be used when we operate risk adjustment on behalf of a State, the preamble to this proposed rule discusses and seeks comment on a number of alternative approaches to the detailed methodology proposed here. For example, we have suggested a number of options for confidence intervals and whether to use tests of statistical significance in determining plan average risk score adjustments. We have also suggested an expedited second validation audit approach to permit more time for inter-auditor discussions and appeals. We have suggested a number of ways to calculate a default risk adjustment charge for an issuer that fails to provide initial validation audits.

In the preamble discussion of our proposed modifications to the risk adjustment methodology, we considered not providing for an induced demand adjustment for Medicaid expansion plan variations, but we believe that not doing so would underestimate the risk in those plans, potentially leading to higher premiums in those plans.

In § 153.270, we propose that HHS may audit State-operated reinsurance programs to ensure appropriate use of Federal funds. We also considered not proposing that HHS have such authority. However, we believe that because HHS will collect reinsurance contributions and because a State's issuers' reinsurance requests affect the availability of reinsurance funds for issuers in other States, we think it is critical for HHS to have the authority to perform these audits, so that issuers and States are confident that they will receive the correct allocation of the reinsurance payments. We also considered proposing that HHS have the authority to audit a State-operated risk adjustment program. However, we decided not to do so because those programs do not take in Federal funds and those programs have little impact on the health insurance markets in other States.

We considered not proposing that HHS have the authority to assess CMPs on QHP issuers for non-compliance with the risk corridors standards. This would reduce the burden on QHP issuers on State Exchanges and would have reduced Federal oversight costs. However, we determined that similar standards and oversight were appropriate for all issuers of QHPs, regardless of whether the QHPs were offered through FFEs or State Exchanges, in order to ensure compliance with the risk corridors program and the proper use of Federal funds.

In the preamble discussion of the 2015 reinsurance payment parameters, we also considered, when setting forth the proposed 2015 reinsurance payment parameters, a set of uniform reinsurance payment parameters that would have substantially raised the attachment point or lowered the reinsurance cap, but believe those uniform reinsurance payment parameters would have raised the complexity of estimating the effects of reinsurance for issuers.

As detailed in the preamble discussion regarding our proposed approach to estimating cost-sharing reduction amounts in connection with reinsurance calculations, we considered a number of alternative approaches to this estimation. Finally, we considered a number of different approaches to the discrepancy and administrative appeals process proposed in § 153.710 and § 156.1220. Some of these approaches would have provided for lengthier and more formal administrative appeals processes, including for advance payments of the premium tax credit, advance payment for cost-sharing reductions, and FFE user fees in 2014. We did not adopt that approach for these 2014 programs, and instead rely on operational discrepancy reports and one-level of administrative appeals—a request for reconsideration, because we believe that this approach will be simpler and less expensive, and will permit operations specialists, issuers and HHS to resolve most problems more quickly. We considered relying solely on a simpler operational discrepancy report process for the premium stabilization programs and cost-sharing reductions reconciliation in 2015—but decided that due to the complexity of the calculations involved in these programs and the potential magnitude of the payment flows, issuers would prefer that these calculations be subject to more formal administrative processes.

Multiple alternatives were considered to the proposed SHOP approaches and are discussed in detail above.

E. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the proposed rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The RFA generally defines a ''small entity'' as (1) A proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of ''small entity.'' HHS uses a change in revenues of more than 3 to 5 percent as its measure of significant economic impact on a substantial number of small entities.

In this proposed rule, we propose provisions for the risk adjustment, reinsurance, and risk corridors programs, which are intended to stabilize premiums as insurance market reforms are implemented and Exchanges facilitate increased enrollment. Because we believe that insurance firms offering comprehensive health insurance policies generally exceed the size thresholds for ''small entities'' established by the SBA, we do not believe that an initial regulatory flexibility analysis is required for such firms.

For purposes of the RFA, we expect the following types of entities to be affected by this proposed rule:

- Health insurance issuers.

- Group health plans.
- Reinsurance entities.

We believe that health insurance issuers and group health plans would be classified under the North American Industry Classification System (NAICS) code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of $35.5 million or less would be considered small entities for these NAICS codes. Issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be $30 million or less.

In this proposed rule, we proposed requirements on employers that choose to participate in a SHOP Exchange. The SHOPs are limited by statute to employers with at least one but not more than 100 employees. For this reason, we expect that many employers who would be affected by the proposals would meet the SBA standard for small entities. We do not believe that the proposals impose requirements on employers offering health insurance through the SHOP that are more restrictive than the current requirements on small employers offering employer sponsored insurance. Additionally, as discussed in the RIA, we believe the proposed policy will provide greater choice for both employees and employers. We believe the processes that we have established constitute the minimum amount of requirements necessary to implement the SHOP program and accomplish our policy goals, and that no appropriate regulatory alternatives could be developed to further lessen the compliance burden.

We believe that a substantial number of sponsors of self-insured group health plans could qualify as ''small entities.'' This proposed rule provides HHS with the authority to audit these entities. However, we do not believe that the burden of these audits is likely to reflect more than 3 to 5 percent of such an entity's revenues.

F. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a proposed rule that includes any Federal mandate that may result in expenditures in any 1 year by a State, local, or Tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold is approximately $141 million. Although we have not been able to quantify the user fees that will be associated with this proposed rule, the combined administrative cost and user fee impact on State, local, or Tribal governments and the private sector may be above the threshold. Earlier portions of this RIA constitute our UMRA analysis.

G. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications. Because States have flexibility in designing their Exchange and Exchange-related programs, State decisions will ultimately influence both administrative expenses and overall premiums. States are not required to establish an Exchange or risk adjustment or reinsurance program. For States electing to operate an Exchange, risk adjustment or reinsurance program, much of the initial cost of creating these programs will be funded by Exchange Planning and Establishment Grants. After establishment, Exchanges will be financially self-sustaining, with revenue sources at the discretion of the State. Current State Exchanges charge user fees to issuers.

In HHS's view, while this proposed rule did not impose substantial direct requirement costs on State and local governments, this regulation has Federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining standards relating to health insurance that is offered in the individual and small group markets. Each State electing to establish an Exchange must adopt the Federal standards contained in the Affordable Care Act and in this proposed rule, or have in effect a State law or regulation that implements these Federal standards. However, HHS anticipates that the Federalism implications (if any) are substantially mitigated because under the statute, States have choices regarding the structure and governance of their Exchanges and risk adjustment and reinsurance programs. Additionally, the Affordable Care Act does not require States to establish these programs; if a State elects not to establish any of these programs or is not approved to do so, HHS must establish and operate the programs in that State.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy making discretion of the States, HHS has engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with State insurance officials on an individual basis.

Throughout the process of developing this proposed rule, HHS has attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide access to Affordable Insurance Exchanges for consumers in every State. By doing so, it is HHS's view that we have complied with the requirements of Executive Order 13132.

H. Congressional Review Act

This proposed rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

List of Subjects

45 CFR Part 144

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

45 CFR Part 153

Administrative practice and procedure, Adverse selection, Health care, Health insurance, Health records, Organization and functions (Government agencies), Premium stabilization, Reporting and recordkeeping requirements, Reinsurance, Risk adjustment, Risk corridors, Risk mitigation, State and local governments.

45 CFR Part 155

Administrative practice and procedure, Health care access, Health insurance, Reporting and recordkeeping requirements, State and local governments, Cost-sharing reductions, Advance payments of premium tax credit, Administration and calculation of advance payments of the premium tax credit, Plan variations, Actuarial value.

45 CFR Part 156

Administrative appeals, Administrative practice and procedure, Administration and calculation of advance payments of premium tax credit, Advertising, Advisory Committees, Brokers, Conflict of interest, Consumer protection, Cost-sharing reductions, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, American Indian/Alaska Natives, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Payment and collections reports, Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services proposes to amend 45 CFR parts 147, 153, 155, and 156, and proposes to further amend 45 CFR parts 144, 153, and 156, as amended October 30, 2013, at 78 FR 65091, effective December 30, 2013, as set forth below:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ 1. The authority citation for part 144 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

■ 2. Section 144.103 is amended by revising the first sentence in paragraph (1) of the definition of ''Policy year'' to read as follows:

§ 144.103 Definitions.

* * * * *

Policy year * * *

(1) A grandfathered health plan offered in the individual health insurance market and student health insurance coverage, the 12-month period that is designated as the policy year in the policy documents of the individual health insurance coverage. * * *

* * * * *

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 3. The authority citation for part 147 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 4. Section 147.102 is amended by revising paragraph (c)(3) to read as follows:

§ 147.102 Fair health insurance premiums.

* * * * *

(c) * * *

(3) *Application to small group market.* In the case of the small group market, the total premium charged to the group is determined by summing the premiums of covered participants and beneficiaries in accordance with paragraph (c)(1) or (2) of this section, as applicable. Nothing in this section precludes a State from requiring issuers to offer, or an issuer from voluntarily offering, to a group premiums that are based on average enrollee premium amounts, provided that the total group premium is the same total amount derived in accordance with paragraph (c)(1) or (2) of this section, as applicable. In such case, effective for plan years beginning on or after January 1, 2015, an issuer must ensure that average enrollee premium amounts calculated based on applicable employee enrollment at the beginning of the plan year do not vary for any participant or beneficiary during the plan year.

* * * * *

■ 5. Section 147.145 is amended by revising paragraph (b)(1)(ii) to read as follows:

§ 147.145 Student health insurance coverage.

* * * * *

(b) * * *

(1) * * *

(ii) For purposes of section 2702 of the Public Health Service Act, a health insurance issuer that offers student health insurance coverage is not required to accept individuals who are not students or dependents of students in such coverage, and, notwithstanding the requirements of § 147.104(b), is not required to establish open enrollment periods or coverage effective dates that are based on a calendar policy year or to offer policies on a calendar year basis.

* * * * *

PART 153—STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT

■ 6. The authority citation for part 153 continues to read as follows:

Authority: Secs. 1311, 1321, 1341–1343, Pub. L. 111–148, 24 Stat. 119.

■ 7. Section 153.20 is amended by revising the definition of ''contributing entity'' and adding a definition of ''major medical coverage'' to read as follows:

§ 153.20 Definitions.

* * * * *

Contributing entity means—

(1) A health insurance issuer; or

(2) For the 2014 benefit year, a self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage), whether or not it uses a third party administrator; and for the 2015 and 2016 benefit years, a self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the health insurance coverage does not constitute major medical coverage) that uses a third party administrator in connection with claims processing or adjudication (including the management of appeals) or plan enrollment. A self-insured group health plan that is a contributing entity is responsible for the reinsurance contributions, although it may elect to use a third party administrator or administrative services-only contractor for transfer of the reinsurance contributions.

* * * * *

Major medical coverage means, for purposes only of the requirements related to reinsurance contributions under section 1341 of the Affordable Care Act, health coverage for a broad range of services and treatments provided in various settings that provides minimum value in accordance with § 156.145 of this subchapter.

* * * * *

■ 8. Section 153.230 is amended by revising paragraph (d) to read as follows:

§ 153.230 Calculation of reinsurance payments made under the national contribution rate.

* * * * *

(d) *Uniform adjustment to national reinsurance payments.* If HHS determines that all reinsurance payments requested under the national payment parameters from all reinsurance-eligible plans in all States for a benefit year will not be equal to the amount of all reinsurance contributions collected for reinsurance payments under the national contribution rate in all States for an applicable benefit year, HHS will determine a uniform pro rata adjustment to be applied to all such requests for reinsurance payments for all States. Each applicable reinsurance entity, or HHS on behalf of a State, must reduce or increase the reinsurance payment amounts for the applicable

benefit year by any adjustment required under this paragraph (d).

■ 9. Section 153.235 is amended by removing and reserving paragraph (b).

§ 153.235 Allocation and distribution of reinsurance contributions.

* * * * *

(b) [Reserved]

■ 10. Section 153.270 is added to subpart C to read as follows:

§ 153.270 HHS audits of State-operated reinsurance programs.

(a) *Audits.* HHS or its designee may conduct a financial and programmatic audit of a State-operated reinsurance program to assess compliance with the requirements of this subpart or subpart B of this part. A State that establishes a reinsurance program must ensure that its applicable reinsurance entity and any relevant contractors, subcontractors, or agents cooperate with any audit under this section.

(b) *Action on audit findings.* If an audit results in a finding of material weakness or significant deficiency with respect to compliance with any requirement of this subpart or subpart B, the State must ensure that the applicable reinsurance entity:

(1) Within 60 calendar days of the issuance of the final audit report, provides a written corrective action plan to HHS for approval;

(2) Implements that plan; and

(3) Provides to HHS written documentation of the corrective actions once taken.

■ 11. Section 153.400 is amended by revising paragraph (a)(1) introductory text and adding paragraphs (a)(1)(v) and (vi) to read as follows:

§ 153.400 Reinsurance contribution funds.

(a) * * *

(1) In general, reinsurance contributions are required for major medical coverage that is considered to be part of a commercial book of business, but are not required to be paid more than once with respect to the same covered life. In order to effectuate that principle, a contributing entity must make reinsurance contributions for lives covered by its self-insured group health plans and health insurance coverage except to the extent that:

* * * * *

(v) Such plan or coverage applies to individuals with primary residence in a territory that does not operate a reinsurance program.

(vi) In the case of employer-provided group health coverage:

(A) Such coverage applies to individuals with individual market health insurance coverage for which reinsurance contributions are required; or

(B) Such coverage is supplemental or secondary to group health coverage for which reinsurance contributions must be made for the same covered lives.

* * * * *

■ 12. Section 153.405 is amended by revising paragraphs (c) and (e)(3) and adding paragraph (i) to read as follows:

§ 153.405 Calculation of reinsurance contributions.

* * * * *

(c) *Notification and payment.* (1) Following submission of the annual enrollment count described in paragraph (b) of this section, HHS will notify the contributing entity of the reinsurance contribution amount allocated to reinsurance payments and administrative expenses to be paid for the applicable benefit year.

(2) In the fourth quarter of the calendar year following the applicable benefit year, HHS will notify the contributing entity of the portion of the reinsurance contribution amount allocated for payments to the U.S. Treasury for the applicable benefit year.

(3) A contributing entity must remit reinsurance contributions to HHS within 30 days after the date of a notification.

* * * * *

(e) * * *

(3) Using the number of lives covered for the most current plan year calculated based upon the ''Annual Return/Report of Employee Benefit Plan'' filed with the Department of Labor (Form 5500) for the last applicable time period. For purposes of this paragraph (e)(3), the number of lives covered for the plan year for a plan offering only self-only coverage equals the sum of the total participants covered at the beginning and end of the plan year, as reported on the Form 5500, divided by 2, and the number of lives covered for the plan year for a plan offering self-only coverage and coverage other than self-only coverage equals the sum of the total participants covered at the beginning and the end of the plan year, as reported on the Form 5500.

* * * * *

(i) *Audits.* HHS or its designee may audit a contributing entity to assess its compliance with the requirements of this subpart.

■ 13. Section 153.410 is amended by adding paragraph (d) to read as follows:

§ 153.410 Requests for reinsurance payment.

* * * * *

(d) *Audits.* HHS or its designee may audit an issuer of a reinsurance-eligible plan to assess its compliance with the requirements of this subpart and subpart H. The issuer must ensure that its relevant contractors, subcontractors, or agents cooperate with any audit under this section. If an audit results in a finding of material weakness or significant deficiency with respect to compliance with any requirement of this subpart or subpart H, the issuer must complete all of the following:

(1) Within 30 calendar days of the issuance of the final audit report, provide a written corrective action plan to HHS for approval.

(2) Implement that plan.

(3) Provide to HHS written documentation of the corrective actions once taken.

■ 14. Section 153.510 is amended by adding paragraph (f) to read as follows:

§ 153.510 Risk corridors establishment and payment methodology.

* * * * *

(f) *Eligibility under health insurance market rules.* The provisions of this subpart apply only for plans offered by a QHP issuer in the SHOP or the individual or small group market, as determined according to the employee counting method applicable under State law, that are subject to the following provisions: §§ 147.102, 147.104, 147.106, 147.150, 156.80, and subpart B of part 156 of this subchapter.

■ 15. Section 153.540 is added to subpart F to read as follows:

§ 153.540 Compliance with risk corridors standards.

(a) *Audits.* HHS or its designee may audit a QHP issuer to assess its compliance with the requirements of this subpart. HHS will conduct an audit in accordance with the procedures set forth in § 158.402(a) through (e) of this subchapter.

(b) *Enforcement actions.* If an issuer of a QHP on a State-based Exchange fails to comply with the requirements of this subpart, HHS may impose civil money penalties in accordance with the procedures set forth in § 156.805 of this subchapter.

■ 16. Section 153.620 is amended by adding paragraph (c) to read as follows:

§ 153.620 Compliance with risk adjustment standards.

* * * * *

(c) *Audits.* HHS or its designee may audit an issuer of a risk adjustment covered plan to assess its compliance with the requirements of this subpart and subpart H of this part. The issuer must ensure that its relevant contractors, subcontractors, or agents cooperate with any audit under this section. If an audit results in a finding

of material weakness or significant deficiency with respect to compliance with any requirement of this subpart or subpart H of this part, the issuer must complete all of the following:

(1) Within 30 calendar days of the issuance of the final audit report, provide a written corrective action plan to HHS for approval.

(2) Implement that plan.

(3) Provide to HHS written documentation of the corrective actions once taken.

■ 17. Section 153.630 is amended by revising paragraph (b)(1) and adding paragraphs (b)(5) through (10) to read as follows:

§ 153.630 Data validation requirements when HHS operates risk adjustment.

* * * * *

(b) * * *

(1) An issuer of a risk adjustment covered plan must engage one or more independent auditors to perform an initial validation audit of a sample of its risk adjustment data selected by HHS. The issuer must provide HHS with the identity of the initial validation auditor, and must attest to the absence of conflicts of interest between the initial validation auditor (or the members of its audit team, owners, directors, officers, or employees) and the issuer (or its owners, directors, officers, or employees), in a timeframe and manner to be specified by HHS.

* * * * *

(5) An initial validation audit must be conducted by medical coders certified as such and in good standing by a nationally recognized accrediting agency.

(6) An issuer must provide the initial validation auditor and the second validator auditor with all relevant source enrollment documentation, all claims and encounter data, and medical record documentation from providers of services to each enrollee in the applicable sample without unreasonable delay and in a manner that reasonably assures confidentiality and security in transmission.

(7) The risk score of each enrollee in the sample must be validated by—

(i) Validating the enrollee's enrollment data and demographic data through review of source enrollment documentation;

(ii) Validating enrollee health status through review of all relevant medical record documentation. Medical record documentation must originate from the provider of the services and align with dates of service for the medical diagnoses, and reflect permitted providers and services. For purposes of this section, ''medical record documentation'' means clinical documentation of hospital inpatient or outpatient treatment or professional medical treatment from which enrollee health status is documented and related to accepted risk adjustment services that occurred during a specified period of time. Medical record documentation must be generated under a face-to-face or telehealth visit documented and authenticated by a permitted provider of services;

(iii) Validating medical records according to industry standards for coding and reporting; and

(iv) Having a senior reviewer confirm any enrollee risk adjustment error discovered during the initial validation audit. For purposes of this section, a ''senior reviewer'' is a reviewer certified as a medical coder by a nationally recognized accrediting agency who possesses at least 5 years of experience in medical coding.

(8) The initial validation auditor must measure and report to the issuer and HHS, in a manner and timeframe specified by HHS, its inter-rater reliability rates among its reviewers. The initial validation auditor must achieve a consistency measure of at least 95 percent for demographic, enrollment, and health status review outcomes.

(9) Enforcement actions: If an issuer of a risk adjustment covered plan fails to engage an initial validation auditor or to submit the results of an initial validation audit to HHS, HHS may impose civil money penalties in accordance with the procedures set forth in § 156.805 of this subchapter.

(10) Default data validation charge: If an issuer of a risk adjustment covered plan fails to engage an initial validation auditor or to submit the results of an initial validation audit to HHS, HHS will impose a default risk adjustment charge.

* * * * *

■ 18. Section 153.710 is amended by adding paragraphs (d), (e), (f), and (g) to read as follows:

§ 153.710 Data requirements.

* * * * *

(d) *Interim dedicated distributed data environment reports.* Within 30 calendar days of the date of an interim dedicated distributed data environment report from HHS, the issuer must, in a format specified by HHS, either:

(1) Confirm to HHS that the information in the interim report accurately reflects the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with § 153.700(a) for the timeframe specified in the report; or

(2) Describe to HHS any discrepancy it identifies in the interim dedicated distributed data environment report.

(e) *Final dedicated distributed data environment report.* Within 15 calendar days of the date of the final dedicated distributed data environment report from HHS, the issuer must, in a format specified by HHS, either:

(1) Confirm to HHS that the information in the final report accurately reflects the data to which the issuer has provided access to HHS through its dedicated distributed data environment in accordance with § 153.700(a) for the benefit year specified in the report; or

(2) Describe to HHS any discrepancy it identifies in the final dedicated distributed data environment report.

(f) *Unresolved discrepancies.* If a discrepancy first identified in an interim or final dedicated distributed data environment report in accordance with paragraphs (d)(2) or (e)(2) of this section remains unresolved after the issuance of the notification of risk adjustment payments and charges or reinsurance payments under § 153.310(e) or § 153.240(b)(1)(ii), respectively, an issuer of a risk adjustment covered plan or reinsurance-eligible plan may make a request for reconsideration regarding such discrepancy under the process set forth in § 156.1220(a).

(g) *Risk corridors and medical loss ratio reporting.* (1) Notwithstanding any discrepancy report made under paragraph (d)(2) or (e)(2) of this section, or any request for reconsideration under § 156.1220(a) with respect to any risk adjustment payment or charge, including an assessment of risk adjustment user fees; reinsurance payment; cost-sharing reconciliation payment or charge; or risk corridors payment or charge, unless the dispute has been resolved, an issuer must report, for purposes of the risk corridors and medical loss ratio programs:

(i) The risk adjustment payment to be made or charge assessed, including an assessment of risk adjustment user fees, by HHS in the notification provided under § 153.310(e);

(ii) The reinsurance payment to be made by HHS in the notification provided under § 153.240(b)(1)(ii);

(iii) A cost-sharing reduction amount equal to the amount of the advance payments of cost-sharing reductions paid to the issuer by HHS for the benefit year; and

(iv) For medical loss ratio report only, the risk corridors payment to be made or charge assessed by HHS as reflected

in the notification provided under § 153.510(d).

(2) An issuer must report any adjustment made following any discrepancy report made under paragraph (d)(2) or (e)(2) of this section, or any request for reconsideration under § 156.1220(a) with respect to any risk adjustment payment or charge, including an assessment of risk adjustment user fees; reinsurance payment; cost-sharing reconciliation payment or charge; or risk corridors payment or charge; or following any audit, where such adjustment has not be accounted for in a prior risk corridors or medical loss ratio report, in the next following risk corridors or medical loss ratio report.

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

■ 19. Authority citation for part 155 is revised to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1332, 1334, 1402, 1411, 1412, 1413, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083).

■ 20. Section 155.106 is amended by revising paragraph (a)(2) to read as follows:

§ 155.106 Election to operate an Exchange after 2014.

(a) * * *

(2) Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment at least 6.5 months prior to the Exchange's first effective date of coverage; and

* * * * *

■ 21. Section 155.220 is amended by adding paragraph (i) as follows:

§ 155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

* * * * *

(i) For plan years beginning on or after January 1, 2015, in States that permit this activity under state law, a SHOP may permit agents and brokers to use an Internet Web site to assist qualified employers and facilitate enrollment of qualified employees in a QHP through the Exchange, under paragraph (c)(3) of this section.

■ 22. Section 155.260 is amended by revising paragraphs (a)(1), (a)(2) and (b) to read as follows:

§ 155.260 Privacy and security of personally identifiable information.

(a) * * *

(1) Where the Exchange creates or collects personally identifiable information for the purposes of determining eligibility for enrollment in a qualified health plan; determining eligibility for other insurance affordability programs, as defined in § 155.20; or determining eligibility for exemptions from the individual responsibility provisions in section 5000A of the Code, the Exchange may only use or disclose such personally identifiable information to the extent such information is necessary:

(i) For the Exchange to carry out the functions described in § 155.200;

(ii) For the Exchange to carry out other functions not described in paragraph (a)(1)(i) of this section, which the Secretary determines to be in compliance with section 1411(g)(2)(A) of the Affordable Care Act and for which an individual provides consent for his or her information to be used or disclosed; or

(iii) For the Exchange to carry out other functions not described in paragraphs (a)(1)(i) and (ii) of this section, for which an individual provides consent for his or her information to be used or disclosed, and which the Secretary determines are in compliance with section 1411(g)(2)(A) of the Affordable Care Act under the following substantive and procedural requirements:

(A) *Substantive requirements.* The Secretary may approve other uses and disclosures of personally identifiable information created or collected as described in paragraph (a)(1) of this section that are not described in paragraphs (a)(1)(i) or (a)(1)(ii) of this section, provided that HHS determines that the information will be used only for the purposes of and to the extent necessary in ensuring the efficient operation of the Exchange consistent with section 1411(g)(2)(A) of the Affordable Care Act, and that the uses and disclosures are also permissible under relevant law and policy.

(B) *Procedural requirements for approval of a use or disclosure of personally identifiable information.* To seek approval for a use or disclosure of personally identifiable information created or collected as described in paragraph (a)(1) of this section that is not described in paragraphs (a)(1)(i) or (a)(1)(ii), the Exchange must submit the following information to HHS:

(*1*) Identity of the Exchange and appropriate contact persons;

(*2*) Detailed description of the proposed use or disclosure, which must include, but not necessarily be limited to, a listing or description of the specific information to be used or disclosed and an identification of the persons or entities that may access or receive the information;

(*3*) Description of how the use or disclosure will ensure the efficient operation of the Exchange consistent with section 1411(g)(2)(A) of the Affordable Care Act; and

(*4*) Description of how the information to be used or disclosed will be protected in compliance with privacy and security standards that meet the requirements of this section or other relevant law, as applicable.

(2) The Exchange may not create, collect, use, or disclose personally identifiable information unless the creation, collection, use, or disclosure is consistent with this section.

* * * * *

(b) *Application to non-Exchange entities.* (1) *Non-Exchange entities.* A non-Exchange entity is any individual or entity that:

(i) Gains access to personally identifiable information submitted to an Exchange; or

(ii) Collects, uses, or discloses personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing functions agreed to with the Exchange.

(2) Prior to any person or entity becoming a non-Exchange entity, Exchanges must execute with the person or entity a contract or agreement that includes:

(i) A description of the functions to be performed by the non-Exchange entity;

(ii) A provision(s) binding the non-Exchange entity to comply with the privacy and security standards and obligations adopted in accordance with paragraph (b)(3) of this section, and specifically listing or incorporating those privacy and security standards and obligations;

(iii) A provision requiring the non-Exchange entity to monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with paragraph (a)(5) of this section;

(iv) A provision requiring the non-Exchange entity to inform the Exchange of any change in its administrative, technical, or operational environments defined as material within the contract; and

(v) A provision that requires the non-Exchange entity to bind any downstream entities to the same privacy and security standards and obligations

to which the non-Exchange entity has agreed in its contract or agreement with the Exchange.

(3) When collection, use or disclosure is not otherwise required by law, the privacy and security standards to which an Exchange binds non-Exchange entities must:

(i) Be consistent with the principles and requirements listed in paragraphs (a)(1) through (a)(6) of this section, including being at least as protective as the standards the Exchange has established and implemented for itself in compliance with paragraph (a)(3) of this section;

(ii) Comply with the requirements of paragraphs (c), (d), (f) and (g) of this section; and

(iii) Take into specific consideration:

(A) The environment in which the non-Exchange entity is operating;

(B) Whether the standards are relevant and applicable to the non-Exchange entity's duties and activities in connection with the Exchange; and

(C) Any existing legal requirements to which the non-Exchange entity is bound in relation to its administrative, technical, and operational controls and practices, including but not limited to, its existing data handling and information technology processes and protocols.

* * * * *

■ 23. Section 155.410 is amended by revising paragraphs (e) and (f) to read as follows:

§ 155.410 Initial and annual open enrollment periods.

* * * * *

(e) *Annual open enrollment period.* For benefit years beginning—

(1) On January 1, 2015, the annual open enrollment period begins November 15 of 2014, and extends through January 15 of 2015.

(2) On or after January 1, 2016, the annual open enrollment period begins October 15 of the preceding calendar year, and extends through December 7 of the preceding calendar year.

(f) *Effective date for coverage after the annual open enrollment period.* For the benefit years beginning—

(1) On January 1, 2015, the Exchange must ensure coverage is effective—

(i) January 1, 2015, for plan selections received by the Exchange on or before December 15, 2014.

(ii) February 1, 2015, for plan selections received by the Exchange from December 16, 2015 through January 15, 2015.

(2) On or after January 1, 2016, the Exchange must ensure coverage is effective as of the first day of the following benefit year for a qualified individual who has made a QHP selection during the annual open enrollment period.

* * * * *

■ 24. Section 155.705 is amended by:

■ a. Revising paragraph (b)(1);

■ b. Adding paragraph (b)(3)(v);

■ c. Redesignating paragraph (b)(4)(ii) as (b)(4)(iii);

■ d. Adding new paragraph (b)(4)(ii); and

■ e. Revising paragraphs (b)(11)(ii)(C) and (D).

The additions and revisions read as follows:

§ 155.705 Functions of a SHOP.

* * * * *

(b) * * *

(1) Enrollment and eligibility functions. The SHOP must adhere to the requirements outlined in §§ 155.710, 155.715, 155.720, 155.725, 155.730, 155.735, and 155.740.

* * * * *

(3) * * *

(v) For plan years beginning on or after January 1, 2015, a Federally-facilitated SHOP will provide a qualified employer a choice of two methods to make stand-alone dental plans available to qualified employees and their dependents:

(A) The employer may choose to make available a single stand-alone dental plan.

(B) The employer may choose to make available all stand-alone dental plans offered through the Federally-facilitated SHOP.

(4) * * *

(ii) The SHOP may establish one or more standard processes for premium calculation, premium payment, and premium collection.

(A) Qualified employers in a Federally-facilitated SHOP must make premium payments according to a timeline and process established by HHS;

(B) For a Federally-facilitated SHOP, the premium for coverage lasting less than 1 month must equal the product of:

(*1*) The premium for 1 month of coverage divided by the number of days in the month; and

(*2*) The number of days for which coverage is being provided in the month described in paragraph (b)(4)(ii)(B)(*1*) of this section.

* * * * *

(11) * * *

(ii) * * *

(C) The employer will define a percentage contribution toward premiums for employee-only coverage under the reference plan and, if dependent coverage is offered, a percentage contribution toward premiums for dependent coverage under the reference plan. To the extent permitted by other applicable law, for plan years beginning on or after January 1, 2015, the Federally-facilitated SHOP may permit an employer to define a different percentage contribution for full-time employees from the percentage contribution it defines for non-full-time employees, and it may permit an employer to define a different percentage contribution for dependent coverage for full-time employees from the percentage contribution it defines for dependent coverage for non-full-time employees.

(D) In a Federally-facilitated SHOP, for plan years beginning on or after January 1, 2015, if the employer elects to offer coverage to its employees under § 155.705(b)(3)(iv)(A), neither State law nor the employer may require that employer contributions be based on a calculated composite premium for the reference plan for employees, for adult dependents of employees, and for dependents of employees under age 21.

* * * * *

■ 25. Section 155.715 is amended by revising paragraphs (c)(4), (d)(1) introductory text, and (d)(2) introductory text to read as follows:

§ 155.715 Eligibility determination process for SHOP.

* * * * *

(c) * * *

(4) May not perform individual market Exchange eligibility determinations or verifications described in subpart D of this part.

(d) * * *

(1) When the information submitted on the SHOP single employer application is inconsistent with information collected from third-party data sources through the verification process described in § 155.715(c)(2), the SHOP must—

* * * * *

(2) When the information submitted on the SHOP single employee application is inconsistent with information collected from third-party data sources through the verification process described in § 155.715(c)(2), the SHOP must—

* * * * *

■ 26. Section 155.730 is amended by redesignating paragraph (g) as paragraph (g)(1) and by adding paragraph (g)(2) to read as follows:

§ 155.730 Application standards for SHOP.

* * * * *

(g) * * *

(1) * * *

(2) The SHOP is not permitted to collect information on the single employer or single employee application unless that information is necessary to determine SHOP eligibility or effectuate enrollment through the SHOP.

■ 27. Section 155.1030 is amended by revising paragraphs (b)(1), (3), and (4) to read as follows:

§ 155.1030 QHP certification standards related to advance payments of the premium tax credit and cost-sharing reductions.

* * * * *

(b) * * *

(1) The Exchange must collect and review annually the rate allocation and the actuarial memorandum that an issuer submits to the Exchange under § 156.470 of this subchapter, to ensure that the allocation meets the standards set forth in § 156.470(c) and (d).

* * * * *

(3) The Exchange must use the methodology specified in the annual HHS notice of benefit and payment parameters to calculate advance payment amounts for cost-sharing reductions, and must transmit the advance payment amounts to HHS, in accordance with § 156.340(a).

(4) HHS may use the information provided to HHS by the Exchange under this section for oversight of advance payments of cost-sharing reductions and premium tax credits.

* * * * *

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 28. The authority citation for part 156 is revised to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301–1304, 1311–1312, 1321–1322, 1324, 1334, 1342–1343, 1401–1402, and 1412, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

■ 29. Section 156.135 is amended by revising paragraph (a) and adding paragraph (g) to read as follows:

§ 156.135 AV calculation for determining level of coverage.

(a) *Calculation of AV.* Subject to paragraphs (b) and (d) of this section, to calculate the AV of a health plan, the issuer must use the AV Calculator developed and made available by HHS for the given benefit year.

* * * * *

(g) *Updates to the AV calculator.* HHS will update the AV Calculator as follows, HHS will:

(1) Update the annual limit on cost sharing and related functions based on a projected estimate to enable the AV Calculator to comply with § 156.130(a)(2);

(2) Update the continuance tables to reflect more current enrollment data when HHS has determined that the enrolled population has materially changed;

(3) Update the algorithms when HHS has determined the need to adapt the AV Calculator for use by additional plan designs or to allow the AV Calculator to accommodate potential new types of plan designs, where such adaptations can be based on actuarially sound principles and will not have a substantial effect on the AV calculations performed by the then current AV Calculator;

(4) Update the continuance tables to reflect more current claims data no more than every 3 and no less than every 5 years and to annually trend the claims data when the trending factor is more than 5 percent different, calculated on a cumulative basis; and

(5) Update the AV Calculator user interface when a change would be useful to a broad group of users of the AV Calculator, would not affect the function of the AV Calculator, and would be technically feasible.

■ 30. Section 156.150 is revised to read as follows:

§ 156.150 Application to stand-alone dental plans inside the Exchange.

(a) *Annual limitation on cost-sharing.* For a stand-alone dental plan covering the pediatric dental EHB under § 155.1065 of this subchapter in any Exchange, cost sharing may not exceed $300 for one covered child and $400 for two or more covered children.

(b) [Reserved]

■ 31. Section 156.285 is amended by adding paragraph (a)(4) and revising paragraph (c)(7) to read as follows:

§ 156.285 Additional standards specific to SHOP.

(a) * * *

(4)(i) Adhere to the premium rating standards described in § 147.102 regardless of whether the QHP is sold in the small group market or the large group market; and

(ii) Effective in plan years beginning on or after January 1, 2015, a QHP issuer in a Federally-facilitated SHOP may not offer to an employer premiums that are based on average enrollee amounts under § 147.102(c)(3), if the employer elects to offer coverage to its employees under § 155.705(b)(3)(iv)(A).

* * * * *

(c) * * *

(7) A QHP issuer must enroll a qualified employee only if the SHOP—

(i) Notifies the QHP issuer that the employee is a qualified employee;

(ii) Transmits information to the QHP issuer as provided in § 155.400(a) of this subchapter; and

(iii) Effective for QHPs offered through a Federally-facilitated SHOP in plan years beginning on or after January 1, 2015, does not send a cancellation notice to the QHP issuer prior to the effective date of coverage.

* * * * *

■ 32. Section 156.298 is added to subpart C to read as follows:

§ 156.298 Meaningful difference standard for Qualified Health Plans in the Federally-facilitated Exchanges.

(a) *General.* Subject to paragraph (b)(2) of this section, starting in the 2015 coverage year, in order to be certified as a QHP offered through a Federally-facilitated Exchange, a plan must be meaningfully different from all other QHPs offered by the same issuer of that plan within a service area and level of coverage in the Exchange, as defined in paragraph (b) of this section.

(b) *Meaningful difference standard.* A plan is considered meaningfully different from another plan in the same service area and metal tier (including catastrophic plans) if a reasonable consumer would be able to identify two or more material differences among the following characteristics between the plan and other plan offerings:

(1) Cost sharing;

(2) Provider networks;

(3) Covered benefits;

(4) Plan type;

(5) Premiums;

(6) Health Savings Account eligibility; or

(7) Self-only, non-self-only, or child-only coverage offerings.

(c) *Exception for limited plan availability.* If HHS determines that the plan offerings at a particular metal level (including catastrophic plans) within a county are limited, plans submitted for certification in that particular metal level (including catastrophic plans) within that county will not be subject to the meaningful difference requirement set forth in paragraph (b) of this section.

(d) *Two-year transition period for issuers with new acquisitions.* During the first 2 years after a merger or acquisition in which an acquiring issuer obtains or merges with another issuer, the FFEs may certify plans as QHPs that were previously offered by the acquired

or merged issuer without those plans meeting the meaningful difference standard set forth in paragraph (b) of this section.

■ 33. Section 156.420 is amended by revising paragraphs (c), (d), and (e) to read as follows:

§ 156.420 Plan variations.

* * * * *

(c) *Benefit and network equivalence in silver plan variations.* A standard silver plan and each silver plan variation thereof must cover the same benefits and providers. Each silver plan variation is subject to all requirements applicable to the standard silver plan (except for the requirement that the plan have an AV as set forth in § 156.140(b)(2)).

(d) *Benefit and network equivalence in zero and limited cost sharing plan variations.* A QHP and each zero cost sharing plan variation or limited cost sharing plan variation thereof must cover the same benefits and providers. The out-of-pocket spending required of enrollees in the zero cost sharing plan variation of a QHP for a benefit that is not an essential health benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding out-of-pocket spending required in the limited cost sharing plan variation of the QHP, and the out-of-pocket spending required of enrollees in the limited cost sharing plan variation of the QHP for a benefit that is not an essential health benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding out-of-pocket spending required in the QHP with no cost-sharing reductions. A limited cost sharing plan variation must have the same cost sharing for essential health benefits not described in paragraph (b)(2) of this section as the QHP with no cost-sharing reductions. Each zero cost sharing plan variation or limited cost sharing plan variation is subject to all requirements applicable to the QHP (except for the requirement that the plan have an AV as set forth in § 156.140(b)).

(e) *Decreasing cost sharing and out-of-pocket spending in higher AV silver plan variations.* The cost sharing or out-of-pocket spending required of enrollees under any silver plan variation of a standard silver plan for a benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding cost sharing or out-of-pocket spending required in the standard silver plan or any other silver plan variation thereof with a lower AV.

* * * * *

■ 34. Section 156.430 is amended by removing and reserving paragraph (a) and by revising paragraph (b)(1) to read as follows:

§ 156.430 Payment for cost-sharing reductions.

(b) * * *

(1) A QHP issuer will receive periodic advance payments based on the advance payment amounts calculated in accordance with § 155.1030(b)(3).

* * * * *

■ 35. Section 156.470 is amended by revising paragraph (a) to read as follows:

§ 156.470 Allocation of rates for advance payments of the premium tax credit.

(a) *Allocation to additional health benefits for QHPs.* An issuer must provide to the Exchange annually for approval, in the manner and timeframe established by HHS, for each health plan at any level of coverage offered, or intended to be offered, in the individual market on an Exchange, an allocation of the rate for the plan to:

(1) EHB, other than services described in § 156.280(d)(1); and

(2) Any other services or benefits offered by the health plan not described in paragraph (a)(1) of this section.

* * * * *

■ 36. Section 156.1110 is added to Subpart L to read as follows:

§ 156.1110 Establishment of patient safety standards for QHP issuers.

(a) *Patient safety standards.* A QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital, as defined in section 1861(e) of the Social Security Act, is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Condition of Participation requirements for—

(1) A quality assessment and performance improvement program as specified in 42 CFR 482.21; and

(2) Discharge planning as specified in 42 CFR 482.43.

(b) *Documentation.* A QHP issuer must collect, from each of its contracted hospitals with greater than 50 beds, information that demonstrates that those hospitals meet patient safety standards required in paragraph (a) of this section including, but not limited to, the CCN.

(c) *Reporting.* (1) A QHP issuer must make available to the Exchange the documentation referenced in paragraph (b) of this section, upon request by the Exchange, in a time and manner specified by the Exchange.

(2) Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must provide the documentation described in paragraph (b) of this section to the U.S. Office of Personnel Management, in the time and manner specified by the U.S. Office of Personnel Management.

(d) *Effective date.* A QHP issuer must ensure that each QHP meets patient safety standards in accordance with paragraph (a) of this section effective for plan years beginning on or after January 1, 2015.

■ 37. Section 156.1210 is amended by adding paragraph (c) to read as follows:

§ 156.1210 Confirmation of HHS payment and collections reports.

* * * * *

(c) *Discrepancies to be addressed in future reports.* Discrepancies in payment and collections reports identified to HHS under this section will be addressed in subsequent payment and collections reports, and will not be used to change debts determined pursuant to invoices generated under previous payment and collections reports.

■ 38. Section 156.1215 is added to Subpart M to read as follows:

§ 156.1215 Payment and collections processes.

(a) *Netting of payments and charges for 2014.* In 2014, as part of its monthly payment and collections process, HHS will net payments owed to QHP issuers and their affiliates under the same taxpayer identification number against amounts due to the Federal government from the QHP issuers and their affiliates under the same taxpayer identification number for advance payments of the premium tax credit, advance payments of cost-sharing reductions, and payment of Federally-facilitated Exchange user fees.

(b) *Netting of payments and charges for later years.* In 2015 and later years, as part of its payment and collections process, HHS may net payments owed to issuers and their affiliates operating under the same tax identification number against amounts due to the Federal government from the issuers and their affiliates under the same taxpayer identification number for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, payment of Federally-facilitated Exchange user fees, and risk adjustment, reinsurance, and risk corridors payments and charges.

(c) *Determination of debt.* Any amount owed to the Federal government by an issuer and its affiliates for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, Federally-facilitated Exchange user fees, risk adjustment,

reinsurance, and risk corridors, after HHS nets amounts owed by the Federal government under these programs, is a determination of a debt.

■ 39. Section 156.1220 is added to subpart M to read as follows:

§ 156.1220 Administrative appeals.

(a) *Requests for reconsideration.* (1) *Matters for reconsideration.* An issuer may file a request for reconsideration under this section to contest a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error only with respect to the following:

(i) The amount of advance payment of the premium tax credit, advance payment of cost-sharing reductions or Federally-facilitated Exchange user fees charge for a benefit year;

(ii) The amount of a risk adjustment payment or charge for a benefit year, including an assessment of risk adjustment user fees;

(iii) The amount of a reinsurance payment for a benefit year;

(iv) The amount of a risk adjustment default charge for a benefit year;

(v) The amount of a reconciliation payment or charge for cost-sharing reductions for a benefit year; or

(vi) The amount of a risk corridors payment or charge for a benefit year.

(2) *Time for filing a request for reconsideration.* The request for reconsideration must be filed in accordance with the following timeframes:

(i) For advance payments of the premium tax credit, advance payments of cost-sharing reductions, or Federally-facilitated Exchange user fee charges, within 30 calendar days after the issuer receives a final reconsideration notification specifying the aggregate amount of advance payments of the premium tax credit, advance payments of cost-sharing reductions, and Federally-facilitated Exchange user fees for the applicable benefit year;

(ii) For a risk adjustment payment or charge, including an assessment of risk adjustment user fees, within 30 calendar days of receipt of the notification provided by HHS under § 153.310(e);

(iii) For a reinsurance payment, within 30 calendar days of receipt of the notification provided by HHS under § 153.240(b)(1)(ii);

(iv) For a default risk adjustment charge, within 30 calendar days of receipt of the notification of the default risk adjustment charge;

(v) For reconciliation of cost-sharing reductions, within 30 calendar days of receipt of the notification provided by HHS of the cost-sharing reduction reconciliation payment or charge; and

(vi) For a risk corridors payment or charge, within 30 calendar days of receipt of the notification provided by HHS under § 153.510(d).

(3) *Content of request.* (i) The request for reconsideration must specify the findings or issues specified in paragraph (a)(1) of this section that the issuer challenges, and the reasons for the challenge.

(ii) Notwithstanding paragraph (a)(3)(i) of this section, a reconsideration with respect to a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error may be requested only if, to the extent the issue could have been previously identified by the issuer to HHS under § 153.710(d)(2) or (e)(2) of this subchapter, it was so identified and remains unresolved.

(iii) Notwithstanding paragraph (a)(3)(i) of this section, a reconsideration with respect to advance payments of the premium tax credit, advance payments of cost-sharing reductions, and Federally-facilitated Exchange user fees may be requested only if, to extent the issue could have been previously identified by the issuer to HHS under § 156.1210 of this subpart, it was so identified and remains unresolved. An issuer may request reconsideration if it previously identified an issue under § 156.1210 of this subpart after the 15-calendar-day deadline, but late discovery of the issue was not due to misconduct on the part of the issuer.

(iv) The issuer may include in the request for reconsideration additional documentary evidence that HHS should consider. Such documents may not include data that was to have been filed by the applicable data submission deadline, but may include evidence of timely submission.

(4) *Scope of review for reconsideration.* In conducting the reconsideration, HHS will review the appropriate payment and charge determinations, the evidence and findings upon which the determination was based, and any additional documentary evidence submitted by the issuer. HHS may also review any other evidence it believes to be relevant in deciding the reconsideration, which will be provided to the issuer with a reasonable opportunity to review and rebut the evidence. The issuer must prove its case by a preponderance of the evidence with respect to issues of fact.

(5) *Reconsideration decision.* HHS will inform the issuer of the reconsideration decision in writing. A reconsideration decision is final and binding for decisions regarding the advance payments of the premium tax credit, advance payment of cost-sharing reductions, or Federally-facilitated Exchange user fees. A reconsideration decision with respect to other matters is subject to the outcome of a request for informal hearing filed in accordance with paragraph (b) of this section.

(b) *Informal hearing.* An issuer may request an informal hearing before a CMS hearing officer to appeal HHS's reconsideration decision.

(1) *Manner and timing for request.* A request for an informal hearing must be made in writing and filed with HHS within 15 calendar days of the date the issuer receives the reconsideration decision under paragraph (a)(5) of this section.

(2) *Content of request.* The request for informal hearing must include a copy of the reconsideration decision and must specify the findings or issues in the decision that the issuer challenges, and its reasons for the challenge. HHS may submit for review by the CMS hearing officer a statement of its reasons for the reconsideration decision.

(3) *Informal hearing procedures.* (i) The issuer will receive a written notice of the time and place of the informal hearing at least 15 calendar days before the scheduled date.

(ii) The CMS hearing officer will neither receive testimony nor accept any new evidence that was not presented with the reconsideration request and HHS statement under paragraph (b) of this section. The CMS hearing officer will review only the documentary evidence provided by the issuer and HHS, and the record that was before HHS when HHS made its reconsideration determination. The issuer may be represented by counsel in the informal hearing, and must prove its case by clear and convincing evidence with respect to issues of fact.

(4) *Decision of the CMS hearing officer.* The CMS hearing officer will send the informal hearing decision and the reasons for the decision to the issuer. The decision of the CMS hearing officer is final and binding, but is subject to the results of any Administrator's review initiated in accordance with paragraph (c) of this section.

(c) *Review by the Administrator.* (1) If the CMS hearing officer upholds the reconsideration decision, the issuer may request review by the Administrator of CMS within 15 calendar days of receipt of the CMS hearing officer's decision. The request for review must specify the findings or issues that the issuer challenges. HHS may submit for review by the Administrator a statement supporting the decision of the CMS hearing officer.

(2) The Administrator will review the CMS hearing officer's decision, the statements of the issuer and HHS, and any other information included in the record of the CMS hearing officer's decision, and will determine whether to uphold, reverse, or modify the CMS hearing officer's decision. The issuer must provide its case by clear and convincing evidence with respect to issues of fact. The Administrator will send the decision and the reasons for the decisions to the issuer.

(3) The Administrator's determination is final and binding.

Dated: November 21, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 21, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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Part V

Department of the Treasury

Internal Revenue Service

26 CFR Parts 1 and 602

Net Investment Income Tax; Final and Proposed Rules

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1 and 602

[TD 9644]

RIN 1545–BK44

Net Investment Income Tax

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final Regulations.

SUMMARY: This document contains final regulations under section 1411 of the Internal Revenue Code (Code). These regulations provide guidance on the general application of the Net Investment Income Tax and the computation of Net Investment Income. The regulations affect individuals, estates, and trusts whose incomes meet certain income thresholds.

DATES: *Effective Date:* These regulations are effective on December 2, 2013.

Applicability Dates: For dates of applicability, see §§ 1.469–11(b)(3)(iv)(D); 1.1411–1(g); 1.1411–2(e); 1.1411–3(f); 1.1411–4(i); 1.1411–5(d); 1.1411–6(c); 1.1411–8(c); 1.1411–9(d); and 1.1411–10(i).

FOR FURTHER INFORMATION CONTACT: David H. Kirk or Adrienne M. Mikolashek at (202) 622–3060 or (202) 317–6852 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in these regulations has been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507) under control number 1545–2227. The collection of information in these final regulations is in § 1.1411–10(g). The collection of information in § 1.1411–10(g) is necessary for the IRS to determine whether a taxpayer has made an election pursuant to § 1.1411–10(g) and to determine whether the amount of tax has been reported and calculated correctly.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

Background

I. In General

This document contains final amendments to 26 CFR part 1 under sections 469 and 1411 of the Internal Revenue Code (Code). Section 1402(a)(1) of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152, 124 Stat. 1029) (HCERA) added section 1411 to a new chapter 2A of subtitle A (Income Taxes) of the Code effective for taxable years beginning after December 31, 2012.

On December 5, 2012, the Treasury Department and the IRS published a notice of proposed rulemaking in the **Federal Register** (REG–130507–11; 77 FR 72612) relating to the Net Investment Income Tax. On January 31, 2013, corrections to the proposed regulations were published in the **Federal Register** (78 FR 6781). The Treasury Department and the IRS received numerous comments in response to the proposed regulations. All comments are available at *www.regulations.gov* or upon request. The Treasury Department and the IRS held a public hearing on the proposed regulations on April 2, 2013.

In addition to these final regulations, the Treasury Department and the IRS are contemporaneously publishing a notice of proposed rulemaking in the **Federal Register** (REG–130843–13) relating to the Net Investment Income Tax.

Public comments on the 2012 proposed regulations identified two issues that the IRS and the Treasury Department will study further and on which the IRS and the Treasury Department request additional comments. Those issues, the treatment of accumulation distributions from foreign trusts and material participation of estates and trusts, are discussed in parts 4.D and 4.F of this preamble, respectively. Comments on those issues should be submitted in writing by March 3, 2014, and can be mailed to the Office of Associate Chief Counsel (Passthroughs and Special Industries), Re: REG–130507–11—Estates/Trusts, CC:PSI:B02, Room 5011, 1111 Constitution Avenue NW., Washington, DC 20224. All comments received will be available for public inspection at *www.regulations.gov* (IRS REG–130507–11).

II. Statutory Provisions

Section 1402(a)(1) of the HCERA added section 1411 to a new chapter 2A of subtitle A (Income Taxes) of the Code effective for taxable years beginning after December 31, 2012. Section 1411 imposes a 3.8 percent tax on certain individuals, estates, and trusts. See section 1411(a)(1) and (a)(2). The tax does not apply to a nonresident alien or to a trust all of the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B). See section 1411(e).

In the case of an individual, section 1411(a)(1) imposes a tax (in addition to any other tax imposed by subtitle A) for each taxable year equal to 3.8 percent of the lesser of: (A) the individual's net investment income for such taxable year, or (B) the excess (if any) of: (i) the individual's modified adjusted gross income for such taxable year, over (ii) the threshold amount. Section 1411(b) provides that the threshold amount is: (1) in the case of a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), $250,000; (2) in the case of a married taxpayer (as defined in section 7703) filing a separate return, $125,000; and (3) in the case of any other individual, $200,000. Section 1411(d) defines modified adjusted gross income as adjusted gross income increased by the excess of: (1) the amount excluded from gross income under section 911(a)(1), over (2) the amount of any deductions (taken into account in computing adjusted gross income) or exclusions disallowed under section 911(d)(6) with respect to the amount excluded from gross income under section 911(a)(1). Section 1.1411–2 of the final regulations provides guidance on the computation of the net investment income tax for individuals.

In the case of an estate or trust, section 1411(a)(2) imposes a tax (in addition to any other tax imposed by subtitle A) for each taxable year equal to 3.8 percent of the lesser of: (A) the estate's or trust's undistributed net investment income, or (B) the excess (if any) of: (i) the estate's or trust's adjusted gross income (as defined in section 67(e)) for such taxable year, over (ii) the dollar amount at which the highest tax bracket in section 1(e) begins for such taxable year. Section 1.1411–3 of the final regulations provides guidance on the computation of the net investment income tax for estates and trusts.

Section 1411(c)(1) provides that net investment income means the excess (if any) of: (A) the sum of (i) gross income from interest, dividends, annuities, royalties, and rents, other than such income derived in the ordinary course of a trade or business to which the tax does not apply, (ii) other gross income derived from a trade or business to which the tax applies, and (iii) net gain (to the extent taken into account in

computing taxable income) attributable to the disposition of property other than property held in a trade or business to which the tax does not apply; over (B) the deductions allowed by subtitle A that are properly allocable to such gross income or net gain. Sections 1.1411–4 and 1.1411–10 of the final regulations provide guidance on the calculation of net investment income under section 1411(c)(1).

Section 1411(c)(1)(A) defines net investment income, in part, by reference to trades or businesses described in section 1411(c)(2). A trade or business is described in section 1411(c)(2) if such trade or business is: (A) a passive activity (within the meaning of section 469) with respect to the taxpayer, or (B) a trade or business of trading in financial instruments or commodities (as defined in section 475(e)(2)). Section 1.1411–5 of the final regulations provides guidance on the trades or businesses described in section 1411(c)(2).

Section 1411(c)(3) provides that income on the investment of working capital is not treated as derived from a trade or business for purposes of section 1411(c)(1) and is subject to tax under section 1411. Section 1.1411–6 of the final regulations provides guidance on working capital under section 1411(c)(3).

In the case of the disposition of an interest in a partnership or an S corporation, section 1411(c)(4) provides that gain or loss from such disposition is taken into account for purposes of section 1411(c)(1)(A)(iii) only to the extent of the net gain or net loss that would be so taken into account by the transferor if all property of the partnership or S corporation were sold at fair market value immediately before the disposition of such interest. Section 1.1411–7 of the final regulations is reserved for guidance under section 1411(c)(4). However, regulations are being proposed contemporaneously with these final regulations that address the application of section 1411(c)(4) to dispositions of interests in partnerships or S corporations.

Section 1411(c)(5) provides that net investment income does not include distributions from a plan or arrangement described in section 401(a), 403(a), 403(b), 408, 408A, or 457(b). Section 1.1411–8 of the final regulations provides guidance on distributions from qualified plans under section 1411(c)(5).

Section 1411(c)(6) provides that net investment income also does not include any item taken into account in determining self-employment income for a taxable year on which a tax is imposed by section 1401(b). Section 1.1411–9 of the final regulations provides guidance regarding self-employment income under section 1411(c)(6).

Summary of Comments and Explanation of Provisions

The Treasury Department and the IRS received numerous written and electronic comments regarding the proposed regulations. The comments included requests for clarification and recommendations relating to: (1) the calculation of net investment income; (2) the treatment of several special types of trusts; (3) the interaction between various aspects of section 469 and the regulations thereunder with the calculation of net investment income; (4) the method of gain calculation regarding a sale of an interest in a partnership or S corporation; and (5) multiple areas where the proposed regulations could be simplified. After consideration of all of the comments, the proposed regulations are adopted as amended by this Treasury decision. In general, the final regulations follow the approach of the proposed regulations with some modifications in response to comments and questions that have arisen with respect to the application of the proposed regulations. This preamble describes comments received by the Treasury Department and the IRS on the most significant issues.

1. Comments of General Applicability

A. Confirmation in the Regulation Text of Certain Statements Made in the Preamble

The Treasury Department and the IRS received a number of comments noting that some of the rules set forth in the preamble were not contained in the regulation text itself. In response to these comments, the final regulations provide additional guidance within the regulation text. For example, § 1.1411–1(d) of the final regulations contains additional guidance related to various definitions applicable to multiple sections of the regulations, which had appeared only in the preamble to the proposed regulations. In addition, the final regulations contain supplemental clarifications and examples.

In addition, one commentator stated that the preamble to the proposed regulations acknowledges that certain types of income may not be subject to tax under section 1411, even if such income is not explicitly excepted from the tax under section 1411(c)(1)(A)(i) or (c)(1)(A)(iii), or is earned in a trade or business that is not a passive activity or in a trade or business of trading in financial instruments or commodities. Multiple commentators suggested that the final regulations confirm that there are types of income that are not included in net investment income. One commentator suggested the best way to illustrate principles of income that is not net investment income is inclusion of one or more examples of income not subject to tax under section 1411. Another commentator requested that the final regulations include a non-exhaustive list of items of income that are not net investment income.

The final regulations do not provide a list of income or deduction items that are excluded from the calculation of net investment income. However, the final regulations provide, in certain instances, additional guidance on items of income that are or are not included in net investment income. For example, pursuant to one comment asking whether distributions from foreign pension plans are included in net investment income, the definition of ''annuity'' in § 1.1411–1(d) of the final regulations clarifies that the term annuities, as used in section 1411(c) and § 1.1411–4, does not include amounts paid in consideration for services rendered even if such amounts are subject to the rules of section 72. This is consistent with United States income tax treaties that prescribe one set of rules for ''annuities'' that are not paid in exchange for services, but another set of rules for pension distributions paid in the form of an annuity. See, for example, paragraphs 1 and 3 of Article 17 (Pensions, Social Security, Annuities, Alimony, and Child Support) of the 2006 United States Model Income Tax Convention. In addition, the final regulations provide examples of items excluded from net investment income in § 1.1411–1(d)(4).

Furthermore, these final regulations, as with the notice of proposed rulemaking, re-confirm the application of chapter 1 provisions in the absence of special rules for purposes of the net investment income tax. The Treasury Department and the IRS may issue other guidance in the future, as necessary, to address the treatment of particular income items whose treatment is not apparent from the general rules of section 1411 and these final regulations or from chapter 1.

B. Section 1411 and Estimated Taxes

Two commentators stated that, because many investors do not know until the end of the year if a passthrough investment will generate net investment income for that year, the Treasury Department and the IRS should not penalize taxpayers for failure to include net investment income in their

calculation of estimated tax payments. One commentator suggested that the estimated tax calculation fully exempt the tax imposed by section 1411. Another commentator urged the Treasury Department and the IRS to grant penalty relief for failure to pay the appropriate estimated tax payments due to the impact of section 1411.

Section 1402(a)(2) of the HCERA amended section 6654 of the Code to provide that the tax imposed under chapter 2A (which includes section 1411) is subject to the estimated tax provisions. To assist taxpayers with their compliance obligations for taxable years beginning after December 31, 2012, the notice of proposed rulemaking extended reliance upon the proposed regulations for this first taxable year in which section 1411 was in effect. Although the Treasury Department and IRS recognize that the actual tax liability of a taxpayer may not be known at the time that an estimated tax payment is due, a similar issue is present for chapter 1 purposes. Moreover, taxpayers subject to estimated tax payments may not be subject to a penalty under certain circumstances. See section 6654(b). After consideration of these comments, the Treasury Department and IRS decline to extend penalty relief.

C. Availability of Tax Credits To Reduce Section 1411 Tax

The Treasury Department and the IRS received comments asking whether foreign income, war profits, and excess profits taxes (''foreign income taxes'') are allowed under sections 27(a) and 901 as a credit against the section 1411 tax. Under the express language of sections 27(a) and 901(a), foreign income taxes are not creditable against United States taxes other than those imposed by chapter 1 of the Code. Section 1.1411–1(e) of the final regulations clarifies that amounts that are allowed as credits only against the tax imposed by chapter 1 of the Code, including credits for foreign income taxes, may not be credited against the section 1411 tax, which is imposed by chapter 2A of the Code. This limitation is similar to the limitation applicable to a number of other credits that are allowed only against the tax imposed by chapter 1 of the Code. See, for example, section 38.

The Treasury Department and the IRS also received comments asking whether United States income tax treaties may provide an independent basis to credit foreign income taxes against the section 1411 tax. The Treasury Department and the IRS do not believe that these regulations are an appropriate vehicle for guidance with respect to specific treaties. An analysis of each United States income tax treaty would be required to determine whether the United States would have an obligation under that treaty to provide a credit against the section 1411 tax for foreign income taxes paid to the other country. If, however, a United States income tax treaty contains language similar to that in paragraph 2 of Article 23 (Relief from Double Taxation) of the 2006 United States Model Income Tax Convention, which refers to the limitations of United States law (which include sections 27(a) and 901), then such treaty would not provide an independent basis for a credit against the section 1411 tax.

2. Comments Regarding Regrouping Under Section 469

Section 1.469–4(e)(1) provides that, except as provided in §§ 1.469–4(e)(2) and 1.469–11, after a taxpayer has grouped activities, the taxpayer may not regroup those activities in subsequent taxable years. The preamble to the proposed regulations acknowledged that the enactment of section 1411 may cause taxpayers to reconsider their previous grouping determinations.

The proposed regulations provided taxpayers an opportunity to regroup their activities in the first taxable year beginning after December 31, 2012, in which: (1) the taxpayer met the applicable income threshold under section 1411, and (2) had net investment income. The determination in the preceding sentence was to be made without regard to the effect of the regrouping. Pursuant to proposed § 1.469–11(b)(3)(iv)(A), a taxpayer may regroup his or her activities once, and any such regrouping applies to the taxable year for which the regrouping is made and all subsequent years. Furthermore, the disclosure requirements of § 1.469–4(e) and Revenue Procedure 2010–13 (2010–1 CB 329) require taxpayers who regroup their activities pursuant to proposed § 1.469–11(b)(3)(iv) to report their regroupings to the IRS.

The Treasury Department and the IRS received several comments regarding proposed amendments to § 1.469–11(b)(3)(iv). One commentator suggested that all individuals, trusts, and estates—regardless of whether they have net investment income or modified adjusted gross income above the threshold—be permitted a ''fresh start'' with respect to their section 469 groupings. The commentator stated that restricting the fresh start only to taxpayers subject to section 1411 places lower income taxpayers at a disadvantage. In addition, multiple commentators recommended that S corporations and partnerships be permitted to change their groupings in light of the application of section 1411 for any tax year that begins during 2013 or 2014. These commentators acknowledged that section 1411 does not apply to partnerships and S corporations directly, but stated that the Treasury Department and the IRS have regulatory authority to allow these entities to change the groupings reported to their owners and that the disclosure required under Revenue Procedure 2010–13 may operate to improve tax administration in this complex area.

Multiple commentators suggested that, in the case of a failure to make regrouping elections in 2013 or 2014, the final regulations should allow taxpayers to make their regrouping election on an amended return. These commentators noted that denying regrouping on an amended return where there is an adjustment to income after a return has been filed may be unfair.

The final regulations retain the requirement that regrouping under § 1.469–11(b)(3)(iv) may occur only during the first taxable year beginning after December 31, 2012, in which (1) the taxpayer meets the applicable income threshold under section 1411, and (2) has net investment income. The Treasury Department and the IRS believe that the interaction between section 1411 and section 469 justifies the section 1411 regrouping rule, and that, if a taxpayer does not have a section 1411 tax liability, the reason for allowing the regrouping does not apply. The Treasury Department and the IRS acknowledge that, in the case of regrouping elections by partnerships and S corporations, one commentator's implied assertion is correct that imposition of section 1411 on a passthrough entity's owner(s) is the same change in law that precipitated the proposed regulation's allowance of regrouping in the first instance. However, if the Treasury Department and the IRS were to expand the scope of the regulations to allow regrouping by partnerships and S corporations, then taxpayers with no tax liability under section 1411 indirectly would be allowed to regroup. Accordingly, the final regulations do not adopt this suggestion.

However, after considering the comments, the Treasury Department and the IRS agree with the commentators' concerns regarding the potential unfairness to taxpayers who become subject to section 1411 after adjustments to, for example, income or deduction items after an original return has been filed. Therefore, the final regulations allow a taxpayer to regroup

under § 1.469–11(b)(3)(iv) on an amended return, but only if the taxpayer was not subject to section 1411 on his or her original return (or previously amended return), and if, because of a change to the original return, the taxpayer owed tax under section 1411 for that taxable year. This rule applies equally to changes to modified adjusted gross income or net investment income upon an IRS examination. However, if a taxpayer regroups on an original return (or previously amended return) under these rules, and then subsequently determines that the taxpayer is not subject to section 1411 in that year, such regrouping is void in that year and all subsequent years until a valid regrouping is done. The voiding of the regrouping may cause additional changes to the taxpayer's current year return and may warrant corrections to future year returns to restore the taxpayer's original groupings. The final regulations contain two exceptions to such voided elections. First, the final regulations allow a taxpayer to adopt the voided grouping in a subsequent year without filing an amended return if the taxpayer is subject to section 1411 in such year. Second, if the taxpayer is subject to section 1411 in a subsequent year, the taxpayer may file an amended return to regroup in a manner that differs from the previous year's voided regrouping. The final regulations provide four new examples on the amended return regrouping rules. Furthermore, § 1.1411–2(a)(2)(iii) of the final section 1411 regulations also contains a similar rule applicable to section 6013(g) elections.

3. Comments Regarding the Application of Section 1411 to Individuals

Section 1411(a)(1) imposes a tax on individuals, but section 1411(e)(1) provides that section 1411 does not apply to a nonresident alien. The proposed regulations provided that the term *individual* for purposes of section 1411 is any natural person, except for natural persons who are nonresident aliens. The final regulations retain this position.

A. Dual Resident Individuals

During the consideration of comments concerning the application of section 1411 to foreign individuals, the Treasury Department and the IRS considered how section 1411 applies to a dual-resident individual, within the meaning of § 301.7701(b)–7(a)(1), who determines that he or she is a resident of a foreign country for tax purposes pursuant to an income tax treaty between the United States and that foreign country and claims benefits of the treaty as a nonresident of the United States. Consistent with § 301.7701(b)–7(a)(1), which provides that such an individual will be treated as a nonresident alien of the United States for purposes of computing that individual's United States income tax liability, the final regulations provide that the individual is treated as a nonresident for purposes of section 1411.

B. Dual-Status Individuals

The Treasury Department and the IRS also considered how section 1411 should apply to a dual-status individual who is a resident of the United States for part of the year and a nonresident for the other part of the year. The Treasury Department and the IRS believe that a dual-status resident should be subject to section 1411 only with respect to the portion of the year during which the individual is a United States resident, and the final regulations clarify this. However, consistent with the rule for taxable years of less than 12 months in § 1.1411–2(d)(2), the threshold amount under § 1.1411–2(d)(1) is not reduced or prorated for a dual-status resident. The Treasury Department and the IRS may reconsider this rule if taxpayers are applying it inappropriately.

C. Section 6013(h) Elections

During the consideration of comments concerning the application of section 1411 to foreign individuals, the Treasury Department and the IRS considered whether the final regulations should provide an election with respect to section 6013(h) that is similar to the election that § 1.1411–2(a)(2)(i)(B) of the proposed regulations provided for section 6013(g). Section 6013(h) allows a dual-status individual who is a nonresident alien at the beginning of any taxable year but at the close of such taxable year is a United States resident, and who is married to a United States citizen or resident, to make a joint election with his or her spouse to be treated as a United States resident for purposes of chapters 1 and 24 for such taxable year. The Treasury Department and the IRS believe that such an election is appropriate. Accordingly, § 1.1411–2(a)(2)(iv)(B) of the final regulations provides that a dual-status individual who makes a section 6013(h) election with his or her spouse for purposes of chapters 1 and 24 also may make a section 6013(h) election for purposes of chapter 2A. For purposes of calculating the tax imposed under section 1411(a)(1), the effect of such an election is to include the combined income of the United States citizen or resident spouse and the dual-status spouse in the section 1411(a)(1) calculation and subject the income of both spouses to the $250,000 threshold amount in section 1411(b)(1) for taxpayers filing a joint return. Section 1.1411–2(a)(2)(iv)(B)(*2*) of the final regulations provides procedural requirements for making this election.

If the spouses do not make a section 6013(h) election for purposes of chapter 2A (whether or not they make the election for purposes of chapters 1 and 24), the final regulations require each spouse to determine his or her own net investment income and modified adjusted gross income (MAGI), and subjects each spouse to the $125,000 threshold amount for spouses filing separately. Consistent with the rule for taxable years of less than 12 months in § 1.1411–2(d)(2), the threshold amount under § 1.1411–2(d)(1) is not reduced or prorated in the case of the dual-status resident spouse for the portion of the year that he or she is treated as a United States resident. The Treasury Department and the IRS may reconsider this rule if taxpayers are applying it inappropriately.

4. Comments Regarding the Application of Section 1411 to Estates and Trusts

In general, section 1411(a)(2) imposes on estates and trusts a tax of 3.8 percent on the lesser of their undistributed net investment income or the excess of their adjusted gross income (as defined in section 67(e)) over the dollar amount at which the highest tax bracket in section 1(e) begins for such taxable year.

A. Exclusion of Certain Estates and Trusts From the Application of Section 1411

The preamble to the proposed regulations stated that section 1411 applies to ordinary trusts described in § 301.7701–4(a) that are subject to the provisions of part 1 of subchapter J of chapter 1 of subtitle A of the Code, even if the trusts have special computational rules within part 1 of subchapter J. The proposed regulation preamble identified four such trusts to which section 1411 will apply: (1) pooled income funds described in section 642(c)(5), (2) cemetery perpetual care funds described in section 642(i), (3) qualified funeral trusts described in section 685, and (4) Alaska Native settlement trusts described in section 646. The Treasury Department and the IRS requested public comments as to whether there may be administrative reasons to exclude one or more of these types of trusts from section 1411. In response, numerous commentators advocated for exclusion or inclusion of the trusts identified above.

i. Pooled Income Funds (PIFs)

Commentators recommended that the final regulations provide that section 1411 not apply to PIFs because doing so would be tantamount to taxing a charity that ultimately receives the property after the expiration of the income interest. Specifically, only the PIF's undistributed short-term gains are subject to tax under chapter 1, and those gains are held for ultimate distribution to charity. The commentators stated that the provisions of the Code dealing with charitable organizations, and contributions to them, should be broadly construed in favor of charitable organizations and their donors and, thus, section 1411 should not apply to PIFs. Furthermore, one commentator stated that treating PIFs in a manner significantly different from charitable remainder trusts is inequitable. The commentator analogized PIFs, operationally, to charitable remainder trusts. However, the commentator acknowledged that, unlike charitable remainder trusts, PIFs, by being taxable on undistributed short-term capital gains, do not escape all instances of federal income taxation. The commentators recommended that the final regulations either: (1) provide that a PIF's short-term capital gains be excluded from net investment income, or (2) exclude PIFs from the application of section 1411 altogether.

The final regulations do not adopt these suggestions. The Treasury Department and the IRS recognize that imposing tax on the PIF will reduce the amount of property the charitable remainderman will receive after the expiration of the income interest. However, section 1411 limits its exclusion to wholly charitable trusts; this group of trusts does not include either charitable remainder trusts or PIFs. While charitable remainder trusts are excluded from section 1411 by the express language of section 664, there is no comparable provision excluding PIFs.

Another commentator recommended that the final regulations provide that the section 642(c) charitable set-aside deduction that is available for a PIF's long-term capital gains for income tax purposes also reduce a PIF's net investment income. For purposes of taxation under chapter 1 of the Code, the taxable income of the PIF is limited, generally, to the undistributed short-term capital gains because the PIF will receive an income distribution deduction for the income paid to the income beneficiaries and any long-term capital gains will be offset by the section 642(c)(3) charitable set aside deduction. As is generally true throughout these regulations, the final regulations mirror this treatment under chapter 1 for purposes of section 1411.

ii. Cemetery Perpetual Care Funds

One commentator stated that there is no administrative reason why Cemetery Perpetual Care Funds (Cemetery Trusts) should not be treated the same as other trusts for purposes of section 1411, and accordingly recommended taxing such trusts under section 1411.

Two other commentators advocated for the exclusion of Cemetery Trusts from section 1411 because inclusion of such trusts would be inconsistent with the policy behind section 1411. They stated that Cemetery Trusts are established for consumer protection, and also to ensure that cemetery properties are maintained in perpetuity and do not become an obligation of the government. They noted that, as is the case with a qualified funeral trust, a cemetery perpetual care trust is essentially a collection of many small, individual trusts held for the benefit of unrelated gravesite owners whose only common interest is that they are owed the same promise of future services from the funeral provider or cemetery company. Thus, under section 642(i), the only ''beneficiary'' is a taxable cemetery company. Therefore, the commentators stated that the imposition of section 1411 tax on the aggregate income of a perpetual care fund would effectively be a tax on an operating business, which directly conflicts with the terms of section 1411.

The Treasury Department and the IRS agree that cemetery trusts should be excluded from section 1411. By benefitting an operating company, these trusts are similar to the business trusts that are excluded from the operation of section 1411. Accordingly, § 1.1411–3(b)(1) of the final regulations exclude Cemetery Perpetual Care Funds described in section 642(i) from the application of section 1411.

iii. Electing Alaska Native Settlement Trusts (ANSTs)

Several commentators argued that ANSTs should be excepted from the net investment income tax as a matter of statutory construction and as a matter of tax policy.

Some commentators explained that the usual rules regarding the income taxation of trusts and their beneficiaries do not apply to ANSTs and their beneficiaries, and accordingly, ANSTs should not be viewed as trusts for purposes of section 1411. Specifically, section 646 provides special rules for the taxation of ANSTs at the lowest individual tax rate. Furthermore, section 646 treats all distributions, to the extent of the trust's current and accumulated taxable income, as amounts excludable from the gross income of the recipient beneficiaries. Additionally, section 646 prohibits the trust from claiming a distribution deduction, which is a deduction allowed in computing a trust's income under chapter 1 and also a deduction allowable for purposes of section 1411.

Commentators further explained that the statutory framework for the taxation of ANSTs reflects important policy considerations relating to the beneficiaries of ANSTs, which were expressed in the Congressional findings and declaration of policy in the Alaska Native Claims Settlement Act (Public Law 92–203, 85 Stat. 688) (''ANCSA''). See 43 U.S.C. 1601. The commentators said that those policies include the following: Alaska Natives have long been recognized as being among the poorest inhabitants of our nation, with poverty rates significantly higher than the national average; ANSTs are not vehicles wealthy individuals might use to avoid the reach of section 1411 by employing a trust to reinvest investment income rather than making distributions; rather, ANSTs are entities created to provide for ''the real economic and social needs of Natives'' by making distributions and/or reinvesting trust income to grow the trust to better provide for the future needs of its beneficiaries.

The Treasury Department and the IRS agree with the commentators that ANSTs should not be subject to section 1411, and that this exclusion is consistent with the chapter 1 taxation of these entities at the lowest individual tax rate. Therefore, the final regulations modify § 1.1411–3(b)(1) to exclude from section 1411 all ANSTs that have made an election under section 646.

iv. Qualified Funeral Trusts (QFTs) Taxable Under Section 685

One commentator stated that it was illogical for section 1411 to apply to QFTs because Congress intended to impose section 1411 on ''private trusts,'' which high-income individuals often establish as vehicles for the management and intergenerational transfer of wealth. Another commentator stated that there is no administrative reason why QFTs should not be treated the same as other trusts for purposes of section 1411.

Three commentators noted that a QFT's regular tax liability is calculated on a per-contract basis and then consolidated into a single return. Specifically, section 685(c) provides

that the tax imposed on the QFT is calculated by treating each beneficiary's interest in his or her contract as a separate trust. The commentators stated that, because the individual contracts are generally under $10,000, the annual investment income on them likewise is generally well under $10,000. Thus, as a practical matter, the commentators believed that QFTs would not incur this tax (due to the investment income on each contract being below the section 1411(a)(2)(B)(ii) threshold amount).

The final regulations do not exclude QFTs from the application of the net investment income tax. However, the final regulations do confirm that the calculation of the section 1411 tax will be consistent with the taxation of QFTs in chapter 1. As a result, § 1.1411–3(b)(2)(i) of the final regulations provides that the section 1411 is applied to the QFT by treating each beneficiary's interest in that beneficiary's contract as a separate trust.

v. Charitable Purpose Estates

Section 1411(e)(2) and proposed § 1.1411–3(b)(1) exclude from the application of section 1411 a trust all of the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B) (referred to as ''Charitable Purpose Trusts''). The final regulations retain this rule in § 1.1411–3(b)(1).

One commentator pointed out that proposed § 1.1411–3(d) does not have an exclusion comparable to proposed § 1.1411–3(b)(1) to exempt an estate all of the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B) (referred to as ''Charitable Purpose Estates''). The commentator noted that, although Charitable Purpose Trusts are statutorily exempt from the net investment income tax, Charitable Purpose Estates are subject to section 1411 but may achieve the same result through the use of the charitable deduction in section 642(c). Thus, through the operation of provisions outside of section 1411, it is expected that Charitable Purpose Estates typically will not have a section 1411 tax liability.

The commentator also pointed out that a Charitable Purpose Estate's need to rely on the section 642(c) deduction to achieve this result (and thus, this inconsistency between Charitable Purpose Trusts and Charitable Purpose Estates) could have an inadvertent and adverse impact on both Charitable Purpose Estates and Charitable Purpose Trusts for chapter 1 purposes—specifically, on their decision to make an election under section 645 (a ''645 Election''). Section 645 was enacted to eliminate the differences in income tax treatment between the disposition of a decedent's property by will (through an estate) and by a revocable trust (that becomes irrevocable on the decedent's death). See H.R. Rep. No. 148, 105th Cong., 1st Sess. 618 (1997).

Assuming a wholly-charitable disposition by a decedent, the commentator stated that a trustee of the decedent's formerly revocable trust and the executor of the related estate would normally join in a 645 Election to minimize the cost and burden of administration and to achieve consistency in the income tax treatment of the estate and trust. However, unless an estate and trust have the same exemption from section 1411, the trustees of a Charitable Purpose Trust may be reluctant to join in an otherwise useful election.

The Treasury Department and the IRS agree with the commentator's recommendation. Given that, whether under section 1411(e)(2) or section 642(c), no section 1411 tax is imposed on a wholly charitable trust or estate, respectively, the Treasury Department and the IRS believe it is consistent with the Congressional intent of both section 1411 and section 645 to treat both types of entities as exempt from section 1411. Accordingly, § 1.1411–3(b)(1) of the final regulations excludes from the application of section 1411 an estate in which all of the unexpired interests are devoted to one or more of the purposes described in section 170(c)(2)(B).

B. Application of Section 1411 To Electing Small Business Trusts (ESBTs)

The proposed regulations preserved the chapter 1 treatment of the ESBT as two separate trusts for computational purposes but consolidated the ESBT into a single trust for determining the adjusted gross income threshold in section 1411(a)(2)(B)(ii). This is consistent with the chapter 1 treatment of ESBTs, which are entitled to only a single personal exemption, rather than one per ESBT portion, notwithstanding the fact that the income for each portion is computed separately. Moreover, this rule in the proposed regulations put ESBTs on the same footing as other taxable trusts by applying a single section 1(e) threshold to ESBTs similar to other taxable trusts. Proposed § 1.1411–3(c)(1)(ii) described the method to determine the ESBT's section 1411 tax base. First, the ESBT separately calculates the undistributed net investment income of the S portion and non-S portion in accordance with the general rules for trusts under chapter 1, and then combines the undistributed net investment income of the S portion and the non-S portion. Second, the ESBT determines its adjusted gross income, solely for purposes of section 1411, by adding the net income or net loss from the S portion to the adjusted gross income of the non-S portion as a single item of income or loss. Finally, to determine whether the ESBT is subject to section 1411, the ESBT compares the combined undistributed net investment income with the excess of its adjusted gross income over the section 1(e) threshold.

One commentator challenged the authority of the Treasury Department and the IRS to issue regulations that require the use of chapter 1's separate trust treatment of the S portion and non-S portion of an ESBT for purposes of section 1411. The commentator also stated that the lack of any mention of ESBTs in section 1411 or its legislative history means that there is no regulatory authority for the treatment of an ESBT as detailed in the proposed regulations.

The preamble to the proposed regulations stated, in relevant part, that ''[s]ection 1411 (which constitutes chapter 2A of the Code) contains terms commonly used in Federal income taxation and cross-references certain provisions of chapter 1 such as sections 67(e), 469, 401(a), and 475(e)(2).'' However, the preamble also stated that ''there is no indication in the legislative history of section 1411 that Congress intended, in every event, that a term used in section 1411 would have the same meaning ascribed to it for other Federal income tax purposes (such as chapter 1).'' The Treasury Department and the IRS believe that the ESBT regulations under section 1411, which generally conform to the chapter 1 framework but with certain modifications needed for section 1411 compliance purposes, fall well within the general regulatory authority pursuant to section 7805.

Two other commentators addressed the inability to offset net investment income losses (capital, ordinary, and/or passive) from one portion of the ESBT with net investment income from the other portion. The commentators recommended that, if one portion has income or a net capital gain and the other has a net capital loss, the ESBT should be able to offset one against the other in the same manner as a non-ESBT nongrantor trust. Both commentators focused on the annual calculation of net investment income, but neither addressed the potential problems from allowing income and losses to offset: (1) loss duplication in carryover years (because loss would offset gain across portions in year 1 and also be a

carryover to year 2 within the originating portion), or (2) differences in loss carryforwards for purposes of chapters 1 and 2A.

The Treasury Department and the IRS agree with the commentators' observations that the method of consolidation in the proposed regulations, in certain instances, may put ESBTs at a computational disadvantage, from a section 1411 perspective, to similarly situated nongrantor trusts in the case of netting of income and losses. However, this computational disadvantage exists with regard to the tax imposed under chapter 1, and the rules regarding ESBTs (and the final regulations generally) adopt chapter 1 principles. The Treasury Department and the IRS believe a full integration of the S portion and non-S portion into a single trust for purposes of section 1411 is administratively burdensome to both taxpayers and the IRS because it would cause the section 1411 calculations to deviate significantly from the calculations for purposes of chapter 1, resulting in the need for additional rules to address the computational differences and treatment of separate carryover regimes. For example, a full integration of the S and non-S portion would allow passive income and passive losses from each portion to offset each other, which would result in different loss carryforwards for regular tax and section 1411 purposes. A similar outcome would occur if capital gains and losses could offset between the portions in a manner inconsistent with chapter 1. Therefore, the final regulations retain the calculation of an ESBT's undistributed net investment income and modified adjusted gross income without change, but have relocated the operative ESBT rules to § 1.1411–3(c).

One commentator recommended that the final regulations clarify that, when an ESBT disposes of S corporation stock, the rules under §§ 1.641(c)–1(d)(3) and 1.1361–1(m)(5)(ii) that permit the use of the installment method on the sale or disposition of stock in an S corporation by an ESBT, also should apply for purposes of section 1411. The Treasury Department and the IRS believe that the general administrative principles enumerated in § 1.1411–1(a) accomplish this result for section 1411 purposes. Accordingly, a special rule within § 1.1411–3(c) is not necessary to achieve what the commentator requested.

C. Application of Section 1411 to Charitable Remainder Trusts (CRTs)

The proposed regulations provided special computational rules for the classification of the income of and the distributions from charitable remainder trusts, solely for section 1411 purposes. Proposed § 1.1411–3(c)(2)(i) provided that distributions from a CRT to a beneficiary for a taxable year consist of net investment income in an amount equal to the lesser of the total amount of the distributions for that year, or the current and accumulated net investment income of the CRT. Proposed § 1.1411–3(c)(2)(iii) defined the term *accumulated net investment income* (ANII) as the total amount of net investment income received by a CRT for all taxable years beginning after December 31, 2012, less the total amount of net investment income distributed for all prior taxable years beginning after December 31, 2012.

The Treasury Department and the IRS acknowledged in the preamble to the proposed regulations that the classification of income as net investment income or non-net investment income would be separate from, and in addition to, the four tiers under section 664(b), which would continue to apply for chapter 1 purposes. The Treasury Department and the IRS also stated in the preamble that they considered an alternative method for determining the distributed amount of net investment income under which net investment income would be determined on a class-by-class basis within each of the § 1.664–1(d)(1) enumerated categories. The Treasury Department and the IRS acknowledged that, although differentiating between net investment income and non-net investment income within each class and category might be more consistent with the structure created for CRTs by section 664 and the corresponding regulations, the Treasury Department and the IRS were concerned that the apparent recordkeeping and compliance burden on trustees would outweigh the benefits of this alternative.

Multiple commentators asked that the final regulations follow the existing rules under section 664 that create subclasses in each category of income as the tax rates on certain types of income are changed from time to time. They said that CRT trustees are already maintaining the appropriate records and are familiar with the existing rules, so compliance would be less complicated than under the new system described in the proposed regulations. Some of the commentators suggested that the final regulations allow the trustee to elect between the method described in the proposed regulations and the existing rules under section 664.

Section 1.1411–3(d)(2) of the final regulations adopts the commentators' request to categorize and distribute net investment income based on the existing section 664 category and class system. The provisions of § 1.1411–3(d)(2), as discussed in this preamble, will apply to taxable years of CRTs that begin after December 31, 2012, provided however that, for CRTs that relied on the proposed regulations for returns filed before the publication of these final regulations in the **Federal Register**, the CRT and its beneficiary (as applicable) do not have to amend their returns to comply with rules set forth in these final regulations. For such a CRT, when transitioning from the method in the proposed regulations to the method in these final regulations, the CRT may use any reasonable method to allocate the remaining undistributed net investment income for that year to the categories and classes under section 664.

The final regulations retain the concept of ANII. ANII is defined as the total amount of net investment income received by a charitable remainder trust for all taxable years beginning after December 31, 2012, less the total amount of net investment income distributed for all prior taxable years beginning after December 31, 2012. The final regulations apply the section 664 category and class system to ANII by providing that the Federal income tax rate applicable to an item of ANII, for purposes of allocating that item of ANII to the appropriate class within a category of income as described in § 1.664–1(d)(1), is the sum of the income tax rate imposed on that item under chapter 1 and the rate of the tax imposed under section 1411. Thus, if a charitable remainder trust has both excluded income (such as income received by the trust prior to January 1, 2013, or other income received after December 31, 2012, but excluded from net investment income) and ANII in an income category, such excluded income and ANII will constitute separate classes of income for purposes of § 1.664–1(d)(1)(i)(b).

The Treasury Department and the IRS believe special rules are necessary to apply the section 664 category and class system contained in § 1.664–1(d) to certain distributions made to charitable remainder trusts that own interests in CFCs and PFICs not making the § 1.1411–10(g) election to account for the difference between the income inclusion for chapter 1 and for section 1411 purposes. Accordingly, the final regulations reserve paragraph § 1.1411–3(d)(2)(ii) for special rules in this case. The companion notice of proposed rulemaking (REG–130843–13) contains special rules relating to CFCs and PFICs

and are proposed to be effective for tax years beginning after December 31, 2013.

The final regulations reserve paragraph § 1.1411–3(d)(3) for rules allowing the CRT to elect between the simplified method contained in the proposed regulations and the section 664 method contained in these final regulations. The companion notice of proposed rulemaking (REG–130843–13) provides rules to enable a CRT to choose between the simplified method described in the proposed regulations (with the modification noted in the companion notice) and the existing rules under section 664. The rules contained in the companion proposed regulation are proposed to be effective for taxable years beginning after December 31, 2012.

D. Application of Section 1411 to Foreign Estates and Trusts

Section 1411 does not address specifically the treatment of foreign estates and foreign nongrantor trusts. Proposed §§ 1.1411–3(d)(2)(i) and 1.1411–3(b)(6) provided, as a general rule, that foreign estates and foreign trusts are not subject to section 1411.

i. Foreign Estates

The proposed regulations requested comments as to whether section 1411 should apply to foreign estates with United States beneficiaries. The Treasury Department and the IRS received several comments recommending that the section 1411 tax not apply to foreign estates, even those with United States beneficiaries, as there is little potential abuse in this context. Although some commentators recommended providing special rules for foreign estates with United States beneficiaries, the Treasury Department and the IRS continue to believe that section 1411 should not apply to foreign estates that often have little or no connection to the United States. Accordingly, § 1.1411–3(b)(1)(ix) of the final regulations provides that the section 1411 tax does not apply to foreign estates. This rule, however, does not exempt United States beneficiaries of foreign estates from the application of section 1411 to distributions from foreign estates. The taxation under section 1411 of United States beneficiaries receiving distributions of net investment income from a foreign estate will be consistent with the general operation of subparts A through D of part I of subchapter J and will be subject to section 1411. See §§ 1.1411–3(e)(3)(ii) and 1.1411–4(e)(1).

ii. Foreign Trusts

The preamble to proposed § 1.1411–3(c)(3) requested comments on the application of section 1411 to net investment income of foreign trusts that is earned or accumulated for the benefit of United States beneficiaries, including whether section 1411 should apply to the foreign trust, or to the United States beneficiaries upon an accumulation distribution. Commentators recommended that section 1411 should not apply to foreign trusts that accumulate income for the benefit of United States beneficiaries, but rather, that United States beneficiaries should be subject to section 1411 upon the receipt of an accumulation distribution from a foreign trust.

The Treasury Department and the IRS agree that section 1411 should apply to United States beneficiaries that receive distributions of accumulated net investment income from a foreign trust rather than to the foreign trust itself. The Treasury Department and the IRS continue to study how section 1411 should apply to accumulation distributions from foreign trusts to United States beneficiaries and intend to issue subsequent guidance on this issue. Pending the issuance of such guidance, section 1411 will not apply to distributions of accumulated income from a foreign trust to United States beneficiary. Therefore, § 1.1411–4(e)(1)(ii) of the final regulations is reserved.

The Treasury Department and the IRS request additional comments concerning this issue, including recommendations on methods by which to identify accumulation distributions as net investment income. In particular, the Treasury Department and the IRS are interested in possible methods by which to determine the ''additional tax'' imposed under section 667(b) when the distribution is ''thrown back'' to the relevant past tax year, possible methods by which to identify and exclude the ''additional tax'' imposed under section 667(b) from years prior to the effective date of section 1411, whether a default rule similar to that contained in Notice 97–34 may be a viable approach for section 1411 purposes, and other specific technical recommendations (accompanied by numerical examples, if possible) for applying section 1411 to accumulation distributions.

E. Calculation of Undistributed Net Investment Income

The proposed regulations provided that undistributed net investment income of an estate or trust is its net investment income (as determined under proposed § 1.1411–4), reduced by the net investment income included in the distribution to beneficiaries deductible by the estate or trust under section 651 or section 661, and by the net investment income for which the estate or trust was entitled to a section 642(c) deduction, in each case as computed in accordance with § 1.642(c)–2 and the allocation and ordering rules under § 1.662(b)–2. The proposed regulations adopted the class system of income categorization, generally embodied in sections 651 through 663 and the regulations thereunder, to arrive at the trust's net investment income reduction in the case of distributions that are comprised of both net investment income and net excluded income items. Section 1.1411–3(e) of the final regulations retain this approach.

Proposed § 1.1411–3(f) provided examples of the calculation of undistributed net investment income. One commentator noted that *Example 1* and *Example 2* of the proposed regulations contain incorrect computations of distributable net income, which consequently causes an incorrect calculation of undistributed net investment income. The final regulations correct the computational error in these examples.

Some commentators recommended that the final regulations allow fiduciaries to reconsider a previous decision to include capital gains in the distributable net income (DNI) of an estate or trust. Section 1.643(a)–3(b)(1) provides that a fiduciary may allocate capital gains between corpus and DNI as long as such decision is a reasonable and impartial exercise of discretion and part of a consistent practice over time. In general, the commentators noted that, because section 1411 causes many capital gains to be included in net investment income, an estate or trust that does not include capital gains in DNI causes such net investment income to be retained in the estate or trust and thus, because of the low income threshold applicable to estates and trusts, to be subjected to the section 1411 tax more readily than if it had been distributed. The commentators note that, when a fiduciary considers whether capital gains are to be treated as part of DNI pursuant to section 643, as part of its duty to the trust or estate and its beneficiaries, a fiduciary takes into account any tax that would be imposed, including any tax imposed pursuant to section 1411. If the tax imposed by section 1411 had existed in the year that an existing trust or estate had first incurred capital gains, the fiduciary may have exercised its

discretion differently. The commentators request that the final regulations allow a fiduciary a ''fresh start'' to determine whether capital gains are to be treated as part of DNI.

The final regulations do not adopt this suggestion. A fiduciary's decision regarding the inclusion of capital gains in DNI is comparable to other elections under chapter 1 that only indirectly impact the computation of net investment income. In addition, the potential for fluctuations in the effective tax rate on capital gains is a factor that is foreseeable by fiduciaries making these elections.

F. Material Participation of Estates & Trusts

Several commentators noted that the enactment of section 1411 has created an additional and compelling reason for the need to determine how an estate or a trust materially participates in an activity. An estate's or a trust's income or gain from a trade or business activity in which the entity materially participates does not constitute income from a passive activity under section 469 or section 1411. One commentator noted that, in the case of estates or trusts that have not incurred losses from a passive activity, those estates and trusts previously have not had to characterize either losses or income under section 469.

Commentators stated that the legislative history of section 469 suggests that only a fiduciary's participation should control in determining whether an estate or a trust materially participates in a trade or business activity. In certain situations, case law has concluded that the participation of beneficiaries and employees also should be considered. One commentator noted that case law and IRS guidance conflict, leaving taxpayers with uncertainty in determining the material participation of a trust.

A number of commentators requested that the Treasury Department and the IRS provide guidance on material participation of estates and trusts. However, the commentators acknowledged that guidance on material participation would apply under both sections 469 and 1411, and consequently suggested the initiation of a guidance project to propose the rules for which § 1.469–5T(g) has been reserved.

The Treasury Department and the IRS believe that the commentators have raised valid concerns. The Treasury Department and the IRS considered whether the scope of these regulations should be broadened to include guidance on q2material participation of estates and trusts. The Treasury Department and the IRS, however, believe that this guidance would be addressed more appropriately in the section 469 regulations. Further, because the issues inherent in drafting administrable rules under section 469 regarding the material participation of estates and trusts are very complex, the Treasury Department and the IRS believe that addressing material participation of trusts and estates at this time would significantly delay the finalization of these regulations. However, the issue of material participation of estates and trusts is currently under study by the Treasury Department and the IRS and may be addressed in a separate guidance project issued under section 469 at a later date. The Treasury Department and the IRS welcome any comments concerning this issue, including recommendations on the scope of any such guidance and on specific approaches to the issue.

5. Comments Regarding the Calculation of Net Investment Income

Section 1411(c)(1) defines net investment income as the excess (if any) of (A) the sum of: (i) gross income from interest, dividends, annuities, royalties, and rents, other than such income derived in the ordinary course of a trade or business to which the tax does not apply, (ii) other gross income from trades or businesses to which the tax applies, and (iii) net gain (to the extent taken into account in computing taxable income) attributable to the disposition of property other than property held in a trade or business to which the tax does not apply, over (B) deductions allowed by subtitle A that are properly allocable to such gross income or net gain. Section 1.1411–4 of the proposed regulations provided guidance on the calculation of net investment income. The final regulations retain the general structure of proposed § 1.1411–4 with some modifications as discussed in this part.

A. Interaction With Section 469

Section 469 and the regulations thereunder provide several rules that restrict the ability of taxpayers to artificially generate passive income from certain types of passive activities. The preamble to the proposed regulations provided a summary of the section 469 rules applicable for purposes of section 1411. The preamble identified certain aspects of the section 469 regulations that would apply for section 1411 purposes (such as the various types of recharacterization rules), and other areas where certain section 469 rules were not applicable for purposes of section 1411 (for example, the scope of a passive activity under section 469 is broader than the section 1411(c)(2)(A) definition of passive activity).

The preamble to the proposed regulations identified a series of section 469 rules that recharacterize income from a passive activity as income not from a passive activity (income recharacterization rules). Commentators requested the final regulations clarify the interaction between certain aspects of the income recharacterization rules and items of gross income included in section 1411(c)(1)(A). One such income recharacterization involves section 469(e)'s definition of portfolio income versus working capital. The comments regarding portfolio income are discussed in this part of the preamble and comments regarding working capital are discussed in part 7 of this preamble. Part 6 discusses comments regarding the net income recharacterization rules.

B. Gross Income Items Described in Section 1411(c)(1)(a)(i)

i. Portfolio Income

The Treasury Department and the IRS received several comments regarding the interaction between section 1411(c)(1)(A)(i) and the portfolio income items described in section 469(e)(1)(A) and the regulations thereunder. One commentator suggested that the final regulations cross reference the definition of portfolio income so that items included in portfolio income for section 469 purposes are net investment income under section 1411(c)(1)(A)(i).

In general, section 469(e)(1)(A)(i)(I) defines portfolio income as interest, dividends, annuities, or royalties not derived in the ordinary course of a trade or business. The Treasury Department and the IRS recognize that this definition is similar to section 1411(c)(1)(A)(i). However, pursuant to the specific grant of authority to promulgate regulations under section 469 provided to the Treasury Department and the IRS in section 469(l), § 1.469–2T(c)(3) expands the definition of portfolio income to include, for example, income from controlled foreign corporations and qualified electing funds.

Furthermore, § 1.469–1T(d)(1) provides that the characterization of items of income or deduction as passive activity gross income (within the meaning of § 1.469–2T(c)) does not affect the treatment of any item of income or gain under any provision of the Code other than section 469.

Therefore, the characterization of certain types of income, gain, loss, and deduction as portfolio income under § 1.469–2T(c)(3) is expressly limited to the section 469 context. While many of the provisions of section 469 impact the classification of income, gain, loss, and deduction for net investment income purposes within section 1411, such interaction with section 469 is generally limited to the determination of whether those items are attributable to a passive activity within the meaning of section 1411(c)(2)(A). Accordingly, because the scope of portfolio income as defined in the regulations under section 469 does not match the scope of net investment income items in section 1411(c)(1)(A)(i), the final regulations do not adopt this recommendation.

ii. Definition of ''Derived in the Ordinary Course of a Trade or Business''

The preamble to the proposed regulations stated that the ordinary course of a trade or business exception is a two-part test. First, the item must be ''derived in'' a trade or business not described in section 1411(c)(2). Second, such item must be derived in the ''ordinary course'' of such trade or business. The preamble to the proposed regulations provided that a trade or business refers to a trade or business within the meaning of section 162 but the phrase was not defined in the proposed regulations. The proposed regulations did not provide guidance on the meaning of ''ordinary course.''

a. Definition of a Trade or Business

Several commentators requested guidance concerning the meaning of ''trade or business.'' Commentators suggested that the regulations include references to relevant case law and administrative guidance. A commentator requested that the regulations expand upon existing guidance by including bright-line examples of what constitutes a trade or business to aid taxpayers in determining if income is derived in the ordinary course of a trade or business and thus is excluded from net investment income.

As noted in part 6.A. of the preamble to the proposed regulations, the rules under section 162 have long existed as guidance for determining the existence of a trade or business and are applied in many circumstances. Whether an activity constitutes a trade or business for purposes of section 162 is generally a factual question. For example, in *Higgins* v. *Commissioner,* 312 U.S. 212 (1941), the Supreme Court stated that the determination of ''whether the activities of a taxpayer are 'carrying on a trade or business' requires an examination of the facts in each case.'' 312 U.S. at 217. Except for certain clarifications made in response to the proposed regulations, further guidance concerning the definition of trade or business is beyond the scope of these regulations.

In response to these commentators, § 1.1411–1(d) of the final regulations provides that the term *trade or business,* when used in section 1411 and the final regulations, describes a trade or business within the meaning of section 162. The section 162 reference incorporates case law and administrative guidance applicable to section 162.

One commentator noted that determining whether income is earned in a section 162 trade or business under a separate entity approach, as reflected in proposed § 1.1411–4(b), will yield unexpected results that are inconsistent with section 162. For purposes of determining whether income is earned under section 162, the commentator noted that § 1.183–1(d) provides that activities are determined and their section 162 trade or business status is evaluated by aggregating undertakings in any reasonable manner determined by the taxpayer.

The Treasury Department and the IRS do not believe that the determination of a trade or business under section 162 mandates the use of the definition of ''activity'' within the meaning of § 1.183–1(d). Section 183 disallows expenses in excess of income attributable to activities not engaged in for profit. Section 1.183–1(a) provides that section 162 and section 212 activities are not subject to section 183 limitations. The definition of activity within § 1.183–1(d) allows taxpayers latitude to combine different activities into a single activity to establish that the taxpayer is engaged in an activity for profit, and thus is not subject to the section 183 limitation. However, once the taxpayer determines that section 183 is not applicable, the taxpayer then must determine whether the activity is a section 162 trade or business or a section 212 for-profit activity. Furthermore, different definitions of ''activity'' can be found in sections 465 and 469. Therefore, the Treasury Department and the IRS do not believe that determining whether a trade or business exists using the activity determinations of Code provisions unrelated to section 162 is appropriate.

The Treasury Department and the IRS received multiple comments regarding the determination of a trade or business within the context of rental real estate. Specifically, commentators stated that *Example 1* of proposed § 1.1411–5(b)(2) is inconsistent with existing case law regarding the definition of a trade or business of rental real estate. Commentators cited cases such as *Fackler* v. *Commissioner,* 45 BTA 708 (1941), aff'd, 133 F.2d 509 (6th Cir. 1943); *Hazard* v. *Commissioner,* 7 T.C. 372 (1946); and *Lagreide* v. *Commissioner,* 23 T.C. 508 (1954), for the proposition that the activities of a single property can rise to the level of a trade or business.

The Treasury Department and the IRS agree with commentators that, in certain circumstances, the rental of a single property may require regular and continuous involvement such that the rental activity is a trade or business within the meaning of section 162. However, the Treasury Department and the IRS do not believe that the rental of a single piece of property rises to the level of a trade or business in every case as a matter of law. For example, § 1.212–1(h) provides that the rental of real property is an example of a for-profit activity under section 212 and not a trade or business.

Within the scope of a section 162 determination regarding a rental activity, key factual elements that may be relevant include, but are not limited to, the type of property (commercial real property versus a residential condominium versus personal property), the number of properties rented, the day-to-day involvement of the owner or its agent, and the type of rental (for example, a net lease versus a traditional lease, short-term versus long-term lease). Therefore, due to the large number of factual combinations that exist in determining whether a rental activity rises to the level of a section 162 trade or business, bright-line definitions are impractical and would be imprecise. The same is true wherever the section 162 trade or business standard is used and is not unique to section 1411. The Treasury Department and the IRS decline to provide guidance on the meaning of trade or business solely within the context of section 1411. However, the Treasury Department and the IRS have modified *Example 1* in § 1.1411–5(b)(3) to explicitly state that the rental property in question is not a trade or business under applicable section 162 standards.

In cases where other Code provisions use a trade or business standard that is the same or substantially similar to the section 162 standard adopted in these final regulations, the IRS will closely scrutinize situations where taxpayers take the position that an activity is a trade or business for purposes of section 1411, but not a trade or business for

such other provisions. For example, if a taxpayer takes the position that a certain rental activity is a trade or business for purposes of section 1411, the IRS will take into account the facts and circumstances surrounding the taxpayer's determination of a trade or business for other purposes, such as whether the taxpayer complies with any information reporting requirements for the rental activity imposed by section 6041.

b. Definition of ''Derived in the Ordinary Course''

Section 1411 does not define the phrase ''derived in the ordinary course'' within the context of a trade or business. The preamble to the proposed regulations stated that other regulation sections and case law provide guidance on whether an item of gross income is derived in the ordinary course of a trade or business and specifically referenced § 1.469–2T(c)(3)(ii) as an example.

The Treasury Department and the IRS received comments regarding the meaning of the phrase ''derived in the ordinary course'' within the context of section 1411(c)(1)(A)(i) and proposed § 1.1411–4(b).

Within the context of section 469, income from interest, dividends, royalties, and annuities is classified as portfolio income unless such income is derived in the ordinary course of a trade or business. Section 1.469–2T(c)(3)(ii)(A) through (c)(3)(ii)(G), which implements section 469(e)(1)(B), identifies several situations where interest, dividends, royalties, or annuities are derived in the ordinary course of a trade or business, and therefore are not portfolio income. If the interest, dividends, royalties, or annuities do not fall into one of these situations, then they constitute working capital because they are not derived in the ordinary course of a trade or business. If the assets that generate the interest, dividends, royalties, and annuities are not held in a trade or business, however, then the classification of the income as working capital by reference to § 1.469–2T(c)(3)(ii) is irrelevant.

Proposed § 1.1411–6 defined working capital by reference to section 469(e)(1)(B) and § 1.469–2T(c)(3)(ii). The definition of working capital in § 1.1411–6(a) of the final regulations continues to reference § 1.469–2T(c)(3)(ii). If a trade or business receives interest, dividends, royalties, or annuities, and the income is working capital under § 1.1411–6(a), then it is not derived in the ordinary course of a trade or business for purposes of section 1411(c)(1)(A)(i) and § 1.1411–4(b). Conversely, if a trade or business receives interest, dividends, royalties, or annuities, and the income is not working capital under § 1.1411–6(a) because it falls within one of the situations in § 1.469–2T(c)(3)(ii), then such income is derived in the ordinary course of a trade or business for both section 469 and section 1411(c)(1)(A)(i) and § 1.1411–4(b). As a result of the interaction between § 1.1411–6(a) and § 1.469–2T(c)(3)(ii), the Treasury Department and the IRS do not believe that any special rules are necessary within § 1.1411–4(b) defining ''derived in the ordinary course'' or, conversely, ''working capital'' with respect to section 1411(c)(1)(A)(i) income other than rents. In the case of rents, which are not covered by § 1.469–2T(c)(3), case law will provide guidance on whether rents are derived in the ordinary course of a trade or business. Additional public comments pertaining to the definition of working capital are discussed in part 7 of this preamble.

iii. Income From Annuities

The preamble of the proposed regulations provided that gross income from annuities includes the amount received as an annuity under an annuity, endowment, or life insurance contract that is includible in gross income as a result of the application of section 72(a) and section 72(b), and an amount not received as an annuity under an annuity contract that is includible in gross income under section 72(e).

The Code does not define the term *annuity.* Section 72(a) provides that gross income includes any amount received as an annuity under an annuity, endowment, or life insurance contract. Section 72(b), however, excludes from gross income that part of an amount received as annuity that bears the same ratio to that amount as the investment in the contract bears to the expected return under the contract (determined as of the annuity starting date).

Section 72(e) governs the treatment of amounts received under an annuity contract that are not received as an annuity (such as lump sum distributions or surrenders). Section 72(e)(2) provides in general that such amounts received on or after the annuity starting date are included in gross income, and that amounts received before the annuity starting date are included in gross income to the extent allocable to income on the contract on an income-first basis.

The preamble to the proposed regulations provided that gain or loss from the sale of an annuity is treated as net investment income for purposes of section 1411. To the extent the sales price of an annuity does not exceed its surrender value, the gain recognized is treated as gross income described in section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i). If the sales price of the annuity exceeds its surrender value, the seller treats the gain equal to the difference between the basis in the annuity and the surrender value as gross income described in section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i), and treats the excess of the sales price over the surrender value as gain from the disposition of property under section 1411(c)(1)(A)(iii) and § 1.1411–4(a)(1)(iii). The final regulations generally retain this approach.

One commentator stated that the definition of the term ''annuity'' provided in the preamble of the proposed regulations is too expansive. The commentator requested that the final regulations clarify that only items of income for which a taxpayer is liable under section 72(a) are subject to the net investment income tax. The final regulations do not adopt the requested change. The principles and rules under chapter 1 of the Code generally apply, where appropriate, in interpreting the statutory language of section 1411. Section 1411(c)(1)(A)(i) provides that net investment income includes ''gross income from . . . annuities.'' Amounts received as an annuity under an annuity contract are includible in gross income under section 72(a) and section 72(b). However, there are other types of distributions from annuity contracts that are includible in gross income under section 72(e). Such amounts may include, for example, dividends received from an annuity contract. See section 72(e)(1)(B). We believe it is appropriate to apply these same rules in determining what constitutes gross income from annuities for purposes of section 1411. Therefore, amounts received under annuity contracts that are includible in income under section 72(a), (b), and (e) are subject to the net investment income tax.

One commentator requested that the final regulations clarify that net investment income from charitable gift annuities established post-2012 will be spread over the annuitant's life expectancy, similar to other items of income, pursuant to § 1.1011–2(c), Example 8. The commentator also requested that the final regulations clarify that the income recognized and distributed from charitable gift annuities established prior to 2013 is not subject to the net investment income tax. The commentator asked that the final regulation extend the benefit afforded to CRTs with regard to pre-2013 gifts to

pre-2013 funded charitable gift annuities.

Charitable gift annuities, like installment sales and other tax deferral transactions, defer the recognition of income to a future year. Charitable gift annuities share more characteristics with installment sales than with CRTs. In the case of installment sales, amounts received in taxable years beginning after December 31, 2012, on installment sales made prior to the effective date of section 1411 are included in net investment income, unless an exception applies. See § 1.1411–4(d)(4)(i)(C), *Example 2.* A CRT, as defined in section 664, must provide for the distribution of a specified payment, at least annually, to one or more persons (at least one of which is a noncharitable beneficiary). Upon the termination of the noncharitable interest or interests, the remainder must either be held in continuing trust for charitable purposes or be paid to or for the use of one or more organizations described in section 170(c). During its operation, a CRT is a tax-exempt entity. Unlike charitable gift annuities, the Federal income tax character of the income received by a CRT's annuity or unitrust beneficiary is dependant on the Federal income tax character of the income received by the CRT in the year of distribution and, in many cases, income received in year(s) prior to the distribution. In the case of charitable gift annuities, the amount and character of the income paid to the annuity recipient generally is known at the inception of the annuity. Furthermore, the amount and character of the income paid to the annuity recipient is not dependent on the charity's use (or sale) of the property exchanged for the annuity. The section 1411 policy reason behind the exclusion of pre-2013 accumulated income within a CRT from net investment income is that the character is passed through from the CRT to the recipient, and pre-2013 income is not net investment income. Because the character of the distribution to the recipient of a charitable gift annuity is not dependent on its character in the hands of the payor, the final regulations do not adopt the requested change.

B. Gross Income Items Described in Section 1411(c)(1)(a)(ii)

Net investment income also includes other gross income derived from a trade or business described in section 1411(c)(2). For a trade or business described in section 1411(c)(2)(A), that is, a trade or business that is a passive activity with respect to the taxpayer, proposed § 1.1411–4(c) provided that section 1411(c)(1)(A)(ii) includes other gross income that is not included in section 1411(c)(1)(A)(i) or section 1411(c)(1)(A)(iii). For a trade or business described in section 1411(c)(2)(B), that is, a trade or business of trading in financial instruments or commodities (a ''trading business''), proposed § 1.1411–4(c) provided that section 1411(c)(1)(A)(ii) includes all other gross income from such trade or business that is not included in section 1411(c)(1)(A)(i). See part 5.b.ii.a of this preamble for a discussion of the definition of a trade or business for purpose of section 1411.

The Treasury Department and the IRS received a number of comments regarding the proper treatment of gains and losses from a trade or business of trading in financial instruments or commodities described in section 1411(c)(2)(B). For chapter 1 purposes, a taxpayer engaged in a trading business combines gains and losses from trading activities to arrive at a net amount of gain or loss from the trading business. Under proposed § 1.1411–4(c)(2), all gross income from a trading business is included in net investment income under section 1411(c)(1)(A)(ii), except for interest, dividends, rents, royalties, and annuities included in net investment income under section 1411(c)(1)(A)(i). Under proposed § 1.1411–4(f)(4), section 165 losses are taken into account under section 1411(c)(1)(A)(iii) and are subject to a limit on net losses. Commentators interpreted these proposed regulations to mean that all gains from the trading activities of a trading business are included in net investment income under section 1411(c)(1)(A)(ii), while the offsetting trading losses would be under section 1411(c)(1)(A)(iii). As a result, the section 1411(c)(1)(A)(iii) loss limitation would prevent a trading business from netting the gains and losses for purposes of the net investment income tax. Multiple commentators recommended that trading losses generated by a trading business should be allocated to the same category as trading gains. Some commentators recommended that proposed § 1.1411–4(f)(4) not apply to trading gains, which would allow trading losses to offset trading gains under section 1411(c)(1)(A)(ii). Other commentators recommended that trading gains should be included in net investment income under section 1411(c)(1)(A)(iii) rather than under section 1411(c)(1)(A)(ii).

The Treasury Department and the IRS agree that trading gains and losses should be assigned to the same category of net investment income. Because section 1411(c)(2)(B) does not distinguish between a trader who has made a section 475(f) mark-to-market election (a ''section 475 trader'') and a trader who has not made a section 475(f) mark-to-market election (a ''non-section 475 trader''), aligning gains and losses from a trading business requires rules that apply equally to a section 475 trader and to a non-section 475 trader. Chapter 1, however, provides different timing and character rules for the two types of traders. For a section 475 trader, all securities and commodities held in a trading business are marked to market on the last day of the tax year, both realized and mark-to-market gains or losses have ordinary character, and any net trading loss may be used to offset other income under chapter 1. In contrast, a non-section 475 trader generally does not mark securities and commodities to market, gains and losses recognized from trading are capital in character, and any net trading loss would be subject to chapter 1 capital loss limitations. One possible solution is to assign the trading gains and losses from both section 475 traders and non-section 475 traders to section 1411(c)(1)(A)(ii), which would permit a non-section 475 trader to use net trading losses to offset other net investment income. Another possible solution is to assign the trading gains and losses from both section 475 traders and non-section 475 traders to section 1411(c)(1)(A)(iii), thereby making a section 475 trader subject to the loss limitations of that section. Under either scenario, some traders would be treated differently for purposes of section 1411 and chapter 1. This would have required those traders to maintain a separate set of books and records specifically to comply with section 1411.

To minimize the inconsistencies between chapter 1 and section 1411 for traders, the final regulations assign all trading gains and trading losses to section 1411(c)(1)(A)(iii). The final regulations also permit a taxpayer to deduct excess losses from the trading business of a section 475 trader from other categories of income. Part 5.C of this preamble describes the treatment of those excess losses. Section 1.1411–4(c) of the final regulations provides that gross income from a trading business is included in net investment income under section 1411(c)(1)(A)(ii) only to the extent that income is not included in section 1411(c)(1)(A)(i) or (c)(1)(A)(iii). This change aligns the categorization of income between section 1411(c)(1)(A)(i), (c)(1)(A)(ii), and (c)(1)(A)(iii) in a manner consistent with income from a passive activity trade or business described in section

1411(c)(2)(A). As a result, the final regulations now categorize gross gains from the disposition of property associated with a trading business as net investment income under section 1411(c)(1)(A)(iii), which may be offset by losses from trading dispositions. However, see part 5.C of this preamble for a discussion of additional changes relative to section 1411(c)(1)(A)(iii) and section 1411(c)(1)(B) that impact the calculation of net investment income for items of gain and loss attributable to a trading business.

C. Calculation of Net Gain in Section 1411(c)(1)(a)(iii)

The proposed regulations provided that net investment income includes net gain (to the extent taken into account in computing taxable income) attributable to the sale, exchange, transfer, conversion, cash settlement, cancellation, termination, lapse, expiration, or other disposition (collectively, referred to as the disposition) of property other than property held in a trade or business not described in section 1411(c)(2). The proposed regulations provided that, because section 1411(c)(1)(A)(iii) uses the term ''net gain'' and not the term ''net gain or loss,'' the amount of net gain included in net investment income may not be less than zero. However, the proposed regulations also provided that losses allowable under section 1211(b)(1) and (b)(2) are permitted to offset gain from the disposition of assets other than capital assets that are subject to section 1411.

i. Overall Limits on Losses

Several commentators suggested that, instead of limiting net gain to zero, losses in excess of gains should offset other net investment income in order to reflect the true economic net investment income for any given year. One commentator acknowledged that the position taken by the proposed regulations appears consistent with the statutory definition of net investment income because section 1411(c)(1)(A)(iii) appears to preclude the possibility of a net loss. Another commentator observed that the proposed regulations place excessive stress on the word ''gain'' in section 1411(c)(1)(A)(iii), and insufficient stress on the word ''net.'' Stressing the word ''gain'' prevents a taxpayer from deducting a $3,000 capital loss limit against other investment income (such as interest). Another commentator stated that, because chapter 1 imposes significant constraints on deducting capital losses against non-capital income (such as the prohibition on carrybacks of such losses for individuals), and imposes a variety of limitations on deducting ordinary losses under section 165, including losses that become section 165 deductions through the operation of other provisions such as section 475, 988, or 1231, there does not appear to be any reason to impose additional limitations on those deductions for section 1411 purposes. A number of commentators recommended that losses in excess of gains be allowed as a properly allocable deduction that may offset other net investment income from section 1411(c)(1)(A)(i) or (c)(1)(A)(ii). Some commentators suggested that section 1411(c)(1)(B) properly allocable deductions include any capital losses allowed for chapter 1 purposes. Several other commentators suggested that there should be no limit imposed on losses, capital or ordinary.

Section 1.1411–4(d)(2) of the final regulations retains the overall limitation of the proposed regulations on allowable losses that the calculation of net gain within section 1411(c)(1)(A)(iii) cannot be less than zero. The Treasury Department and the IRS believe that provision follows the statutory language of section 1411(c)(1)(A)(iii). However, § 1.1411–4(f)(4) of the final regulations provides that losses described in section 165, whether described in section 62 or section 63(d), are allowed as a properly allocable deduction to the extent such losses exceed the amount of gain described in section 61(a)(3) and are not taken into account in computing net gain by reason of § 1.1411–4(d). Thus, although § 1.1411–4(d)(2) imposes an overall limitation on net gain included in net investment income by reason of section 1411(c)(1)(A)(iii), § 1.1411–4(f)(4) allows losses in excess of gains as a properly allocable deduction to the extent the losses would be allowable in computing taxable income under chapter 1. Losses are first applied to calculate net gain under § 1.1411–4(d), and then § 1.1411–4(f)(4) applies to the excess losses. This ordering rule prevents taxpayers from deducting the same loss twice: first in calculating net gain under § 1.1411–4(d), and then again in § 1.1411–4(f)(4). As a result, final § 1.1411–4(f)(4) allows, as a properly allocable deduction, the $3,000 capital loss ($1,500 in the case of an individual filing as married filing separately) allowed by section 1211(b) in all cases. Furthermore, a taxpayer, such as a section 475 trader, that has ordinary losses in excess of ordinary gains and net capital gains, may claim those excess losses as a § 1.1411–4(f)(4) properly allocable deduction.

Furthermore, the final regulations retain the definition of disposition as the sale, exchange, transfer, conversion, cash settlement, cancellation, termination, lapse, expiration, or other disposition of property.

A commentator suggested that section 1411 does not apply to a deemed sale resulting from section 877A. Section 877A(a)(1) provides, in relevant part, that ''For purposes of this subtitle, all property of a covered expatriate shall be treated as sold on the day before the expatriation date for its fair market value.'' The Treasury Department and the IRS believe that any gain taken into account in computing a covered expatriate's taxable income is also included in net investment income because the operative provision of section 877A(a)(1) treats the property as sold for purposes of subtitle A, which includes section 1411. Accordingly, the final regulations clarify that a deemed sale under section 877A, which applies for purposes of subtitle A, is a disposition of property subject to section 1411.

ii. Treatment of Certain Capital Loss Carryforwards

The proposed regulations provided, and the final regulations retain, the provision that except as otherwise expressly provided in regulations, the income tax gain and loss recognition rules in chapter 1 apply for purposes of determining net gain under section 1411. Losses properly taken into account in determining net gain include all losses deductible under section 165 to the extent they are attributable to property that is either: (1) not held in a trade or business, or (2) held in a trade or business described in proposed § 1.1411–5. Therefore, under the proposed regulations, net gain took into account capital losses carried over from prior years by reason of section 1212(b)(1) (including years preceding the effective date of section 1411). The final regulations retain this position.

The Treasury Department and the IRS received several comments and inquiries regarding the treatment of capital loss carryforwards. The final regulations reserve paragraph § 1.1411–4(d)(4)(iii) for special rules that the Treasury Department and the IRS believe are necessary to properly address capital loss carryforwards. The companion notice of proposed rulemaking (REG–130843–13) contains an explanation of the proposed rule and the proposed regulation text.

D. Properly Allocable Deductions Described in Section 1411(C)(1)(b)

Section 1411(c)(1)(B) provides that net investment income includes deductions allowed by subtitle A that

are properly allocable to gross income or net gain described in section 1411(c)(1)(A). Section 1.1411–4(f)(1)(i) of the proposed regulations provided that ''[u]nless specifically stated otherwise, only properly allocable deductions described in this paragraph (f) may be taken into account in determining net investment income.'' Specifically, proposed § 1.1411–4(f)(3) provided that properly allocable deductions include: (A) investment interest expense, (B) investment expenses described in section 163(d)(4)(C), and (C) state, local, and foreign income taxes described in section 164(a)(3). The Treasury Department and the IRS intend this rule to limit the deductions against net investment income to those specifically enumerated in paragraph (f).

One commentator recommended that the final regulations provide that the phrase ''properly allocable deductions'' comprise all of the chapter 1 deductions that are allowed against chapter 1 gross income from rent, dividends, royalties, annuities and interest, other gross income derived from a trade or business, and net gains attributable to the disposition of property other than property held in a trade or business.

The Treasury Department and the IRS believe the recommended language would permit taxpayers to argue that they can take deductions that have no direct relation to net investment income, and it would lead to uncertainty and to disputes between taxpayers and the IRS over what constitutes properly allocable deductions. However, the Treasury Department and the IRS acknowledge that flexibility is needed within § 1.1411–4(f) so that future changes in law or circumstances can be more easily integrated into the regulations. Although the cross-references in § 1.1411–4(f)(2) to deductions described in section 62(a) provide section 1411(c)(1)(B) flexibility to automatically take into account additions or changes to chapter 1 deductions attributable to trades or business, rents, and royalties, these regulations would have to be amended to expand properly allocable deductions in the event of such changes not captured by section 62(a)(1) or 62(a)(4). To strike a balance between the intent of the proposed rule (to provide a specific list of deductions to limit uncertainty and controversy) and the recognized value of future flexibility inherent in the commentators' recommendation, § 1.1411–4(f)(6) of the final regulations allows the Treasury Department and the IRS to publish additional guidance in the Internal Revenue Bulletin that expands the list of properly allocable deductions.

i. Inclusion of Additional Properly Allocable Deductions

Commentators requested that properly allocable deductions also include amounts described in sections 72(b)(3), 642(h), 691(b), 691(c), 1341, and 7518 (c)(1)(A).

Section 72(b)(3) allows a deduction for unrecovered basis in an annuity when an annuitant dies with unrecovered basis in the annuity contract. Section 72(b)(3) allows the deduction on the decedent's final income tax return. The Treasury Department and the IRS believe that, because an annuity contract would have produced income subject to tax under section 1411 had the annuitant continued living, it is appropriate to allow the deduction under section 72(b)(3) in calculating the net investment income for the decedent's final taxable year. Accordingly, § 1.1411–4(f)(3)(iv) of the final regulations provides that the section 72(b)(3) deduction for unrecovered annuity basis is a properly allocable deduction.

Section 642(h) provides ''[i]f on the termination of an estate or trust, the estate or trust has (1) a net operating loss carryover under section 172 or a capital loss carryover under section 1212, or (2) for the last taxable year of the estate or trust deductions (other than the deductions allowed under subsections (b) or (c)) in excess of gross income for such year, then such carryover or such excess shall be allowed as a deduction . . . to the beneficiaries succeeding to the property of the estate or trust.''

Section 691(b) provides that an estate (or successor to property) may take deductions described in section 162, 163, 164, 212, or 611 in respect of a decedent, which are not properly allowable to the decedent in the taxable period prior to or in which falls the date of the decedent's death (these items are often referred to as Deductions in Respect of a Decedent, or ''DRD''). Section 691(b) is the statutory mechanism that allows a deduction to the estate (or other successor to property) because, under the normal accounting rules, the decedent would have been entitled to the deduction but failed to live long enough to take it. The section 691(b) listing of deductions is an exclusive list. If a deduction is not listed (such as suspended capital losses), then it is not deductible under this provision.

The Treasury Department and the IRS believe that it is appropriate to provide a special rule that allows a beneficiary to succeed to the deductions of a terminating estate or trust in the same fashion as that provided by section 642(h) for chapter 1 purposes. In addition, the Treasury Department and the IRS believe that it is appropriate to provide a special rule that allows for deductions described in section 691(b) to be claimed by an estate or a successor to the estate. However, to limit the deductions to those that would have been deductible had the predecessor been able to deduct the expenses, the scope of allowable deductions under these special rules is limited to only those deductions allowed under § 1.1411–4(f), and only to the extent that the terminating estate or trust has negative net investment income upon termination.

Section 691(c) allows a deduction for estate taxes imposed on items of income that are Income in Respect of a Decedent (IRD) under section 691(a). The section 691(c) deduction allowed for estate tax attributable to IRD that is ordinary income must be claimed as an itemized deduction, and not as a deduction from gross income in arriving at adjusted gross income (AGI), because it is not among the deductions listed in section 62. However, the section 691(c) deduction is not subject to the 2-percent floor under section 67.

In the case of IRD that is capital gain, section 691(c)(4) provides that ''[f]or purposes of section 1(h), 1201, 1202, and 1211, the amount taken into account with respect to any item described in subsection (a)(1) shall be reduced (but not below zero) by the amount of the deduction allowable under paragraph (1) of this subsection with respect to such item.''

Net investment income may include items of IRD (such as annuities and outstanding installment sale payments) that may carry with it a deduction under section 691(c) for chapter 1 purposes. Therefore, the Treasury Department and the IRS believe it is consistent with the general principles of section 691 also to allow the section 691(c) deduction to reduce net investment income. Section 1.1411–4(f)(3)(v) of the final regulations provides that the deduction described in section 691(c) is a properly allocable deduction, except to the extent that the section 691(c) deduction is taken into account in determining net gain (within the meaning of § 1.1411–4(d)) by reason of section 691(c)(4).

Generally, section 1341 applies if: (1) a taxpayer included an item in gross income in a prior taxable year because it appeared that the taxpayer had a claim of right to the item, and (2) a deduction is allowable for the repayment of the item in a later taxable

year under some provision of the Code other than section 1341 because it is established that the taxpayer did not have a right to the item. If section 1341 applies, a taxpayer's tax liability for the year of repayment (or the taxable year in which the obligation to make repayment otherwise gives rise to a deduction) is based on the lesser of: (A) the tax for the taxable year, computed with a deduction of the repayment amount (''section 1341 deduction amount''), or (B) the tax for the year of repayment computed without the repayment deduction, less the decrease in tax imposed by chapter 1 in the prior taxable year(s) that would result solely from the exclusion of the restored item from gross income in the prior taxable year(s) (''section 1341 credit amount''). The section 1341 credit amount is intended to compensate the taxpayer for the tax paid in the year of income inclusion (for example, if the tax rates were higher in the year of inclusion).

One commentator recommended that the final regulations contain certain provisions similar to section 1341 to the extent that section 1341 would apply for chapter 1 in a particular year. The commentator noted that, because some types of income that might be restored under section 1341 might have been subjected to tax under section 1411 when included in a prior year, it would be equitable for the section 1411 regulations to contain a mechanism similar to section 1341 to allow a deduction under section 1411(c)(1)(B) for repayment of the income in a later year.

To the extent that a deduction is allowable under a provision of chapter 1 that specifically is allowed under section 1411(c)(1)(B) and § 1.1411–4(f), that amount also would be a deduction for section 1411 purposes in the year of the repayment (or the taxable year in which the obligation to make repayment otherwise gives rise to a deduction). For example, if the repayment constituted a section 165 loss that was a properly allocable deduction, then that deduction also would be available for section 1411 purposes.

However, if the section 1341 credit amount produces a lower tax for the repayment year when compared to the section 1341 deduction amount, section 1341(b)(3) denies the taxpayer a deduction in the year of repayment in favor of the alternative credit for the tax cost. In this instance, the deduction is not allowed by subtitle A (which includes chapter 1, chapter 2, and chapter 2A) in the recovery year, and therefore would not be a properly allocable deduction under section 1411(c)(1)(B) and § 1.1411–4(f). Therefore, the final regulations do not incorporate this recommendation.

One commentator recommended that the final regulations include amounts deposited in capital construction funds described in section 7518 as a properly allocable deduction under section 1411(c)(1)(B). Section 7518(c)(1)(A), which is in chapter 77 of subtitle F of the Code, provides that taxable income is reduced by certain amounts described in section 7518(a)(1)(A) that a taxpayer deposits into the fund. The final regulations do not adopt this recommendation. Section 1411(c)(1)(B) provides that net investment income includes deductions allowed by subtitle A that are properly allocable to such gross income or net gain described in section 1411(c)(1)(A). The reduction in taxable income provided by section 7518(c)(1)(A) is not a deduction allowed by subtitle A of the Code. Therefore, these deductible amounts are outside of the scope of section 1411(c)(1)(B).

Section 1.1411–4(f) of the final regulations also provides that properly allocable deductions include amounts described in section 212(3). Section 212(3) allows a deduction for all the ordinary and necessary expenses paid or incurred during the taxable year in connection with the determination, collection, or refund of any tax. Section 1.212–1(l) provides, in relevant part, that expenses paid or incurred by a taxpayer for tax counsel or expenses paid or incurred in connection with the preparation of tax returns or in connection with any proceedings involved in determining or contesting a tax liability are deductible. Section 1.1411–4(f)(3)(vi) of the final regulations provides that amounts described in section 212(3) and § 1.212–1(l) that are allocable to net investment income using any reasonable method are properly allocable deductions.

Section 1.1411–4(f) also includes two additional properly allocable deductions attributable to investments in certain types of debt instruments. In the case of a contingent payment debt instrument, the holder may receive a payment that is less than the corresponding projected payment determined under the noncontingent bond method, resulting in a negative adjustment under § 1.1275–4(b)(6). In general, a holder treats a negative adjustment as a reduction in interest income otherwise includible for the taxable year and, if there is any excess, as an ordinary loss for the taxable year to the extent of prior interest inclusions. The loss, in effect, reverses the holder's prior interest over-inclusions on the debt instrument. One commentator recommended that the final regulations provide that a holder's negative adjustment treated as an ordinary loss under § 1.1275–4(b)(6) be a properly allocable deduction. The final regulations adopt this recommendation and treat the loss as a properly allocable deduction because it accurately reflects the taxpayer's economic net investment income attributable to the debt instrument and is otherwise allowed by chapter 1. The final regulations also provide a similar rule for a deflation adjustment on an inflation-indexed debt instrument subject to § 1.1275–7.

If a taxpayer purchases a taxable debt instrument at a premium, the taxpayer can elect under section 171 to amortize the bond premium. In general, the amount of amortizable bond premium for a period offsets the interest income allocable to the period and the taxpayer includes the net amount of interest in taxable income. In certain circumstances, however, the taxpayer is entitled to deduct all or a portion of the bond premium under section 171(a)(1). For example, if an electing taxpayer acquires a Treasury bill at a premium and holds the bill until maturity, the taxpayer can deduct the premium at maturity under section 171(a)(1). See § 1.171–2T(a)(4)(i)(C). In these circumstances, the final regulations provide that a deduction under section 171(a)(1) is a properly allocable deduction.

ii. Deduction for Income Taxes Described in Section 164(a)(3)

The Treasury Department and the IRS received comments on multiple aspects of proposed § 1.1411–4(f)(3)(i)(C), which pertains to itemized deductions for state and local, and foreign income, war profits, and excess profits taxes described in section 164(a)(3) (''section 164(a)(3) taxes''). Proposed § 1.1411–4(f)(3)(i)(C) provided that income taxes imposed on investment income that are described in section 164(a)(3) are deductible in determining net investment income. In the case of taxes imposed on both investment income and non-investment income, the proposed regulations provided that the portion of taxes properly allocable to investment income may be determined by taxpayers using any reasonable method. The proposed regulations further provided that allocating the deduction based on the ratio of investment income to total gross income is an example of a reasonable method.

Commentators recommended that the final regulations provide additional examples of reasonable methods of allocation of taxes between net investment income and non-net investment income. One commentator

recommended that the final regulations provide that state income tax reported on the state income tax return, rather than the actual state income tax payments made during the year, should be used in calculating a trust or estate's deduction under proposed § 1.1411–4(f)(3)(i)(C) for taxes under section 164(a)(3). One commentator requested alignment between the reasonable method of allocating section 164(a)(3) taxes in proposed § 1.1411–4(f)(3)(i)(C) with the existing allocation rules in chapter 1 for estates and trusts. One commentator stated that the proposed method of allocation creates a problem because a trust or estate deducts state and local taxes for DNI purposes in a different manner. Another commentator recommended that the final regulations follow the long-standing state and local tax allocation rules of § 1.652(b)–3(b).

The final regulations generally retain the position of the proposed regulations. Although the regulations provide an example of a reasonable method of allocation, it is not the only reasonable method. The final regulations do not provide other examples of generally applicable reasonable allocation methods because the Treasury Department and the IRS believe that providing multiple examples of reasonable methods may lead to taxpayers to incorrectly conclude that the methods listed are the only acceptable methods. Therefore, the Treasury Department and the IRS believe that the final regulations allow taxpayers flexibility to determine a method of allocation that best applies to their specific facts. The final regulations do provide, however, that for estates and trusts, an allocation between classes of income under § 1.652(b)–3 is a reasonable allocation.

Several commentators suggested that foreign taxes should be a properly allocable deduction under section 1411(c)(1)(B), without reference to any election made by the taxpayer for chapter 1 purposes. Another commentator, however, suggested that the final regulations confirm that foreign taxes included in the foreign tax credit computation are not taxes included in section 164(a)(3) and, therefore, would not be allowed as a deduction allocable to net investment income. Section 1.1411–4(f)(3)(iii) of the final regulations provides that foreign income, war profits, and excess profits taxes may be allowable as deductions in determining net investment income only if the taxpayer does not choose to take any foreign tax credits under section 901 with respect to the same taxable year. This rule is consistent with the limitation in section 275(a)(4) on deductibility of those taxes.

Several commentators requested that the final regulations address the proper treatment of refunds of taxes deductible under section 164(a)(3). In response to this request, § 1.1411–4(g)(2) of the final regulations provides guidance on refunds and recoveries of amounts deducted under section 1411(c)(1)(B) and § 1.1411–4 in prior taxable years. In general, the final regulations provide that the recovery or refund of a previously deducted item shall reduce the total amount of properly allocable deductions in the year of the recovery. The final regulations first determine the recovered amount without regard to the application of the tax benefit rule in section 111 for chapter 1 purposes. For example, if a taxpayer receives a refund of state income taxes from a prior year, such a refund would be included in the taxpayer's gross income. However, if the taxpayer was subject to the alternative minimum tax in the year of the payment, the taxpayer may not have received any tax benefit under chapter 1, and therefore section 111 may exclude some, or all, of the refund from gross income. However, the deductibility of state income taxes for section 1411 purposes is independent of the deductibility of the taxes for alternative minimum tax purposes. Therefore, the applicability of the recovery rule in § 1.1411–4(g)(2) is determined without regard to whether the recovered amount was excluded from gross income by reason of section 111.

The final regulations contain two exceptions to the general rule. The two exceptions apply the tax benefit rule of section 111 within the section 1411 system, and therefore operate independently of the application of section 111 for chapter 1 purposes. First, properly allocable deductions are not reduced in the year of the recovery if the amount deducted in the prior year did not reduce the amount of section 1411 liability. For example, the receipt in 2014 of a refund of income taxes paid in 2012 would not reduce a taxpayer's section 1411(c)(1)(B) deduction because section 1411 was not in effect in 2012 and thus the 2012 taxes were not properly allocable to net investment income. Second, properly allocable deductions are not reduced in the year of the recovery if the amount deducted in the prior year is included in net investment income by reason of section 1411(c)(1)(A). For example, a reimbursement of a deduction from a passive activity trade or business that is gross income for chapter 1 purposes is included as gross income from a passive activity under section 1411(c)(1)(A)(ii). Therefore, the recovery is already reflected in the recovery year's net investment income calculation.

In addition, § 1.1411–4(g)(2) of the final regulations provides a special rule in the case of a recovery of a deduction that was allocated between net investment income and non-net investment income (such as section 164(a)(3) taxes). The final regulations provide that the amount taken into account under the recovery rule is based on the ratio used to allocate the item in the year of the deduction. For example, if a taxpayer allocated 45 percent of its total section 164(a)(3) taxes to net investment income in the year of the deduction, 45 percent of the recovery of such taxes will reduce the total amount of properly allocable deductions in the year of the recovery even though the taxpayer's allocation of section 164(a)(3) taxes to net investment income in the year of recovery may be, for example, 30 percent.

iii. Treatment of Estate and Trust Administration Expenses

Several commentators requested that the final regulations explicitly provide that section 1411(c)(1)(B) properly allocable deductions include fiduciary commissions, legal and accounting fees, and other estate and trust administration expenses. Subject to the limitations pursuant to section 67(e), the final regulations adopt this comment by amending proposed § 1.1411–4(f)(3) to provide that properly allocable deductions include amounts described in § 1.212–1(i) (allowing a deduction for reasonable amounts paid or incurred by the fiduciary of an estate or trust on account of administration expenses, including fiduciaries' fees and expenses of litigation) to the extent they are allocable to net investment income. The final regulations require that estates and trusts apportion any § 1.212–1(i) expenses between net investment income and excluded income using any reasonable method.

iv. Limitations on Properly Allocable Deductions

Under the proposed regulations, properly allocable deductions that are itemized deductions subject to the 2-percent floor on miscellaneous itemized deductions under section 67 or to the overall limitation on itemized deductions under section 68 are deducted in determining net investment income only to the extent that they are deductible for income tax purposes after the application of both limitations. The proposed regulations provided a method for apportioning these limitations to

determine the amount of deductions allowed in computing net investment income after applying sections 67 and 68. This method first applies section 67 to all deductions subject to the 2-percent floor. The disallowance is applied proportionately to each deduction subject to section 67. The proposed regulations then apply a similar process to deductions subject to section 68.

One commentator argued that applying general limitations on deductions under sections 67 and 68 is inconsistent with congressional intent, and that it may cause ''taxable'' net investment income to exceed ''economic'' net investment income. The commentator recommended that the final regulations allow the full amount of properly allocable itemized deductions to offset income items comprising net investment income without regard to the limitations imposed under sections 67 and 68.

Section 1411(c)(1)(B) provides that only those deductions that are allowed under subtitle A and properly allocable to component items of net investment income are deducted in determining net investment income. Sections 67 and 68 limit the amount of certain itemized deductions in determining taxable income for purposes of subtitle A and, therefore, also apply to limit the amount of those itemized deductions in determining net investment income. Accordingly, properly allocable deductions that are subject to section 67 or 68 are deducted in determining net investment income only to the extent that they are deductible after the application of the limitations.

Another commentator agreed that the limitations on itemized deductions under sections 67 and 68 should apply for section 1411 purposes, but suggested that these limitations only reduce the amount of properly allocable itemized deductions if such deductions exceed the aggregate amount of the deductions, whether properly allocable or not, that would be allowed after application of these limitations. In other words, the commentator requested an ordering approach to the section 67 and 68 limitations, instead of the pro-rata approach in the proposed regulations. Both the commentator's recommendation and the proposed regulation method are reasonable interpretations of section 1411(c)(1)(B), accordingly, the final regulations adopt the commentator's recommendation.

Under § 1.1411–4(f)(7) of the final regulations, the amount of miscellaneous itemized deductions allowed under section 67 in determining net investment income (but before the application of section 68) is the lesser of: (1) the amount of miscellaneous itemized deductions before applying section 67 that are properly allocable to net investment income, or (2) the amount of all miscellaneous itemized deductions allowed after the application of section 67. The amount of itemized deductions subject to limitation under section 68 that are deducted in determining net investment income is the lesser of: (1) the amount of such deductions that are properly allocable to net investment income allowed after the application of section 67 but before the application of section 68, or (2) the amount of all deductions allowed after the application of section 68.

v. Treatment of Properly Allocable Deductions in Excess of Investment Income

Proposed § 1.1411–4(f)(1)(ii) provided that any deductions described in § 1.1411–4(f) in excess of gross income and net gain are not taken into account in determining net investment income in any other taxable year, except as allowed under chapter 1. Many commentators recommended that the final regulations provide that negative net investment income (when section 1411(c)(1)(B) deductions exceed section 1411(c)(1)(A) income) be carried over and become a section 1411(c)(1)(B) deduction in the subsequent year.

The final regulations do not adopt this recommendation. Section 1411(c)(1)(B) provides that, in order for a deduction to be allowed, it must be: (1) allowed by subtitle A, and (2) be properly allocable to section 1411(c)(1)(A) income. Section 1411(c)(1)(B) only allows deductions allowed by other Code sections; it does not establish a basis for a deduction that does not exist elsewhere in the Code. However, as discussed in the following part of this preamble, the final regulations do permit deductions of net operating losses otherwise allowed by subtitle A that are properly allocable to section 1411(c)(1)(A) income.

vi. Net Operating Losses as a Properly Allocable Deduction

Proposed § 1.1411–4(f)(1)(ii) provided that, in no event, will a net operating loss (NOL) deduction allowed under section 172 be taken into account in determining net investment income for any taxable year. The proposed regulations requested comments on whether a deduction should be allowed for an NOL in determining net investment income. Several commentators argued that, for purposes of section 1411(c)(1)(B), at least some portion of an NOL deduction should be a deduction properly allocable to gross income included in net investment income and therefore allowed in determining net investment income. Three commentators recommended that taxpayers be allowed to keep track of the portions of an NOL attributable to investment income for the loss year. One commentator recommended that the IRS adopt a simple rule for determining a portion of an NOL that is attributable to a ''net investment loss'' for a loss year (for example, using a ratio of the portion of the loss attributable to ''net investment loss'' to the NOL) and allow taxpayers to take a prorated portion of the NOL deduction into account in determining net investment income for a taxable year to which the NOL is carried.

The final regulations adopt a modified version of the commentator's approach in § 1.1411–4(f)(2)(iv) and (h). Because NOLs are computed and carried over year-by-year, a separate ratio must be determined for each year. Thus, the final regulations provide that taxpayers may deduct a portion of an NOL deduction in determining their net investment income. The portion of an NOL deduction for a taxable year that may be deducted for section 1411 purposes is calculated by first determining the applicable portion of the NOL for each loss year. The applicable portion of the NOL is the lesser of: (1) the amount of the NOL for the loss year that the taxpayer would have incurred if only items of gross income that are used to determine net investment income and only properly allocable deductions were taken into account in determining the NOL in accordance with section 172(c) and (d), or (2) the amount of the taxpayer's NOL for the loss year. Next, the amount of the NOL carried from each loss year and deducted in the taxable year is multiplied by a fraction. The numerator of this fraction is the applicable portion of the NOL for the loss year as determined above. The denominator of the fraction is the total NOL for the loss year. A separate fraction is determined for each loss year. The result of this multiplication is the amount of the NOL deduction from the loss year that is allowed as a section 1411(c)(1)(B) deduction in the taxable year, referred to as the *section 1411 NOL* amount. The sum of the section 1411 NOL amounts for each NOL carried to and deducted in the taxable year, referred to as the total section 1411 NOL amount, is the amount of the NOL deduction for the taxable year that is properly allocable to net investment income.

E. Calculation of Net Investment Income in Special Situations

Section 1411(c)(1)(A)(i) provides that net investment income does not include (among other things) items of interest, dividend, annuity, royalty or rent derived in the ordinary course of a trade or business that is not a passive activity with respect to the taxpayer within the meaning of section 469. Section 1411(c)(1)(A)(iii) provides that net investment income does not include (among other things) gain or loss from the disposition of property used in a trade or business that is not a passive activity of the taxpayer. In general, section 469 and the regulations thereunder provide four ways for an item of income to be nonpassive—grouping, activity recharacterization, income recharacterization, and material participation.

In the case of certain types of net investment income, such as rent and interest, commentators recommended that the final regulations exclude certain nonpassive net income, gain, or loss and self-charged interest from net investment income. Other commentators recommended that the final regulations provide a deduction that offsets the income.

As discussed in part 5.D.v. of this preamble, section 1411(c)(1)(B) only allows deductions allowed by other Code sections; it does not establish a basis for a deduction that does not exist elsewhere in the Code. Therefore, the Treasury Department and the IRS do not adopt the recommendation that the final regulations contain an offsetting deduction (or a reversal of a net loss item) that is subject to section 1411. Nevertheless, the Treasury Department and the IRS recognize that in some cases it is appropriate to exclude certain nonpassive items of income from net investment income. Accordingly, in the limited and specific situations described in this part of the preamble, the final regulations deem a particular item of income to be ''derived in the ordinary course of a trade or business'' for purposes of section 1411(c)(1)(A) and therefore excluded from net investment income. However, the Treasury Department and the IRS emphasize that these specific rules contained in these final regulations are for section 1411 purposes only, and thus taxpayers should not draw any inference regarding the treatment of these items for any purpose other than section 1411. See § 1.1411–1(c).

i. Treatment of Self-Charged Interest

Commentators noted that, under the proposed regulations, a taxpayer who is not engaged in the trade or business of lending would have net investment income when it receives interest income attributable to a loan made to a passthrough entity in which it materially participates because the offsetting interest expense allocable to the taxpayer from the nonpassive activity would not be a properly allocable deduction under section 1411(c)(1)(B) and § 1.1411–4(f). An analogous situation was identified during the 1986 enactment of section 469, which resulted in the promulgation of the self-charged interest rules in § 1.469–7.

In response to these comments, the final regulations include a special rule that addresses self-charged interest. The special rule provides that, in the case of self-charged interest received from a nonpassive entity, the amount of interest income excluded from net investment income will be the taxpayer's allocable share of the nonpassive deduction. The rule cross-references the self charged interest rule of § 1.469–7 for the operative mechanics. The mathematical result of the special rule is to exclude an amount of interest income from net investment income that is equal to the amount of interest income that would have been considered passive income under § 1.469–7 if the nonpassive activity was considered passive activity. However, the special rule contains an exception. The special rule will not apply to a situation where the interest deduction is taken into account in determining self-employment income that is subject to tax under section 1401(b).

ii. Treatment of Certain Nonpassive Rental Activities

With regard to grouping and recharacterizations, commentators recommended that the final regulations clarify that determining whether income is net investment income should be based solely on its recharacterized or grouped status as nonpassive under section 469 and the regulations thereunder. Although the Treasury Department and the IRS recognize the administrative simplicity of this rule, the Treasury Department and the IRS believe that this rule is too broad as it would 'deem' certain items to be derived in a trade or business when it is unlikely that a section 162 trade or business is present. For example, see §§ 1.469–1T(e)(3)(ii)(D) (rental of property incidental to an investment activity) and 1.469–2T(f)(3) (rental of nondepreciable property). Therefore, the final regulations do not adopt this broad approach.

Another option advanced by some commentators is a special rule for self-charged rents similar to § 1.469–7 pertaining to self-charged interest. However, a proposed rule for self-charged rents would be more complex than the rule for self-charged interest because the amount of the net investment income exclusion must take into account the deductions allowed (depreciation, taxes, interest, etc.) that are not present in self-charged interest. A self-charged rent rule would have to exclude from gross income rents in the same way as self-charged interest, and would also exclude a share of the deductions attributable to earning the income. In addition, a rule based on § 1.469–7 would cover only rents within the context of section 1411(c)(1)(A)(i) and would not provide relief from the inclusion of the gain upon the sale of the property from net investment income. Accordingly, the final regulations do not adopt this recommendation.

However, the Treasury Department and the IRS appreciate the concerns raised by the commentators. Therefore, the final regulations provide special rules for self-charged rental income. The final regulations provide that, in the case of rental income that is treated as nonpassive by reason of § 1.469–2(f)(6) (which generally recharacterizes what otherwise would be passive rental income from a taxpayer's property as nonpassive when the taxpayer rents the property for use in an activity in which the taxpayer materially participates) or because the rental activity is properly grouped with a trade or business activity under § 1.469–4(d)(1) and the grouped activity is a nonpassive activity, the gross rental income is deemed to be derived in the ordinary course of a trade or business. Furthermore, in both of these instances, the final regulations provide that any gain or loss from the assets associated with that rental activity that are treated as nonpassive gain or loss will also be treated as gain or loss attributable to the disposition of property held in a nonpassive trade or business.

iii. Treatment of Section 469(c)(7) Real Estate Professionals

With regard to real estate professionals, many commentators recommended that the final regulations provide that, if a real estate professional materially participates in his or her rental real estate activities, then the rental income should be excluded from net investment income. The general theory behind the commentators' recommendation was that such rental income must be derived in the ordinary

course of a trade or business because a taxpayer that qualifies as a real estate professional under section 469 is necessarily engaged in a real property trade or business. In certain situations, the Treasury Department and the IRS agree that some real estate professionals derive rental income in the ordinary course of the real property trade or business. However, for several reasons, the Treasury Department and the IRS do not believe that every real estate professional is necessarily engaged in the trade or business of rental real estate.

Section 469(c)(7)(C) provides 11 types of activities that constitute a real property trade or business. Only a few of the 11 enumerated activities may be relevant in determining whether rents are derived in the ordinary course of a trade or business, such as the activities of ''rental'' and ''leasing.'' Some of the other enumerated items have little, if any, relation to rental activities. For example, an individual engaged in real property construction could satisfy the two tests enumerated in section 469(c)(7)(B) to qualify as a real estate professional, but the construction activities may not have any relation to whether the individual's rental income is derived in the ordinary course of a trade or business. In addition, the scope of activities that a taxpayer may consider in determining whether a real property trade or business exists is broader than the definition of a trade or business for section 1411 purposes. Section 1.469–9(b)(1) states ''[a] trade or business is any trade or business determined by treating the types of activities in § 1.469–4(b)(1) as if they involved the conduct of a trade or business, and any interest in rental real estate, including any interest in rental real estate that gives rise to deductions under section 212.'' Therefore, under § 1.469–9(b)(1), individuals may establish real estate professional status by combining non-trade or business activities (such as multiple section 212 rental activities) for determining a taxpayer's real property trade or business. Because the analysis under section 469(c)(7) and the regulations thereunder to determine whether a taxpayer is a real estate professional differs from the analysis to determine whether rental income is derived in the ordinary course of a trade or business under section 1411(c)(1)(A)(i), the use of a taxpayer's real estate professional status as a proxy to determine whether rental income is derived in the ordinary course of a trade or business is not appropriate.

Once an individual establishes real estate professional status, that status only allows the taxpayer to treat rental real estate activities as nonpassive if the taxpayer satisfies at least one of the tests for material participation in § 1.469–5T in the rental real estate activities. The status as a real estate professional alone does not establish that those rental real estate activities rise to the level of a trade or business within the meaning of section 162. Section 1.469–5T(a) provides seven tests to establish material participation. However, not all of the material participation tests provide conclusive evidence that a taxpayer is regularly, continuously, and substantially involved in a rental trade or business within the meaning of section 162. For example, a real estate broker that satisfies the section 469(c)(7) real estate professional requirements by reason of hours devoted to brokerage could classify his or her real property rental activity as nonpassive by satisfying § 1.469–5T(a)(2). Under this test, the taxpayer needs to establish only that the taxpayer's participation in the activity was substantially all of the activity (taking into account all other persons involved in the activity) to establish material participation. As a result, and similar to the case of establishing real estate trade or business, the Treasury Department and the IRS believe that reliance on the § 1.469–5T material participation tests as a proxy to establish regular, continuous, and substantial activity within the meaning of section 162 for section 1411 purposes is not appropriate.

The final regulations do, however, provide a safe harbor test for certain real estate professionals in § 1.1411–4(g)(7). The safe harbor test provides that, if a real estate professional (within the meaning of section 469(c)(7)) participates in rental real estate activities for more than 500 hours per year, the rental income associated with that activity will be deemed to be derived in the ordinary course of a trade or business. Alternatively, if the taxpayer has participated in rental real estate activities for more than 500 hours per year in five of the last ten taxable years (one or more of which may be taxable years prior to the effective date of section 1411), then the rental income associated with that activity will be deemed to be derived in the ordinary course of a trade or business. The safe harbor test also provides that, if the hour requirements are met, the real property is considered as used in a trade or business for purposes of calculating net gain under section 1411(c)(1)(A)(iii). The Treasury Department and the IRS recognize that some real estate professionals with substantial rental activities may derive such rental income in the ordinary course of a trade or business, even though they fail to satisfy the 500 hour requirement in the safe harbor test. As a result, the final regulations specifically provide that such failure will not preclude a taxpayer from establishing that such gross rental income and gain or loss from the disposition of real property, as applicable, is not included in net investment income.

iv. Treatment of Former Passive Activities

Losses disallowed by section 469 stem from (1) expenses incurred in the passive activity or (2) a sale of a portion of the passive activity or property used in the activity, in excess of passive income from any source. Section 1.469–1T(f)(2)(i) and (ii) require taxpayers to trace disallowed losses back to the activities giving rise to the losses and to further trace the losses allocated to a particular activity back to the deductions from the activity giving rise to the net loss. When a taxpayer disposes of a partial interest in a passive activity or disposes of assets used within a passive activity, any losses realized from the disposition are treated as arising from the passive activity and are allocated to that activity. Sections 469(b), (g), and § 1.469–1(f)(4) provide that, generally, passive losses that are disallowed in the current year carry forward to the succeeding tax year and remain suspended until the taxpayer has sufficient passive income to offset those losses or otherwise disposes of the entire activity in a fully taxable transaction with an unrelated party.

In cases where a taxpayer materially participates in an activity that was formerly a passive activity, the deductions produced by the activity in the current year are not subject to section 469. However, the carryover (or ''suspended'') passive losses incurred in prior years when the activity was a passive activity remain disallowed passive losses subject to carryover. Section 469(f)(1)(A) allows the suspended passive losses when the former passive activity produces current-year net income (even though that income is technically from a nonpassive activity). To the extent the taxpayer has passive losses allocable to a former passive activity in excess of the current year nonpassive income from that activity (the section 469(f)(1)(A) amount), section 469(f)(1)(C) allows excess passive losses to offset net passive income from other passive activities of the taxpayer. Any suspended passive losses not allowed

by section 469(f)(1)(A) or (C) remain suspended and are carried over to the following year.

Section 469 does not alter the character or nature of the items that make up the suspended passive loss. If the suspended losses are attributable to operating deductions in excess of operating income, such suspended losses retain that character as deductions described in section 62(a)(1) or 62(a)(4) when ultimately allowed by section 469. To the extent the suspended losses are comprised of losses originating from the disposition of property (such as ordinary section 1231 losses or capital losses), those losses also retain their character as section 165 losses when they are ultimately allowed by section 469.

If a taxpayer materially participates in a former passive trade or business activity, the gross income produced by that activity (and associated section 1411(c)(1)(B) properly allocable deductions) in the current year generally would not be net investment income because the activity is no longer a trade or business that is a passive activity within the meaning of section 469. However, in the case of rental income not derived in the ordinary course of a trade or business, a classification of the rental income as nonpassive for purposes of section 469 will not result automatically in the exclusion of such rental income and associated deductions from net investment income. Furthermore, it is possible that a section 469 former passive activity may still generate net investment income on its disposition to the extent the gain is included in section 1411(c)(1)(A)(iii) and not entirely excluded by, for example, section 1411(c)(4).

Suspended losses that are allowed by reason of section 469(f)(1)(A) or (C) may constitute properly allocable deductions under section 1411(c)(1)(B) and § 1.1411–4(f)(2) (to the extent those losses would be described in section 62(a)(1) or 62(a)(4)) or may be included within the calculation of net gain in section 1411(c)(1)(A)(iii) and § 1.1411–4(d) (to the extent those losses would be described in section 62(a)(3) in the year they are allowed, depending on the underlying character and origin of such losses). The treatment of excess suspended losses of a former passive activity upon a fully taxable disposition is discussed in the next section of this preamble.

The final regulations clarify, for section 1411 purposes, the treatment of income, deductions, gains, losses, and the use of suspended losses from former passive activities. The Treasury Department and the IRS considered three alternatives. One approach is the complete disallowance of all suspended losses once the activity is no longer a passive activity (in other words, becomes a former passive activity or a nonpassive activity). The rationale behind this approach is that the income from the activity would not be includable in net investment income, thus the suspended losses become irrelevant. Another approach is the unrestricted allowance of all suspended losses in the year in which they are allowed by section 469(f), regardless of whether the nonpassive income is included in net investment income. The rationale behind this approach is that the losses were generated during a period when the activity was a passive activity, and if such losses were allowed in full, they would have potentially reduced net investment income, and therefore the losses should continue to retain their character as net investment income deductions. The third approach is a hybrid approach that allows suspended losses from former passive activities in calculation of net investment income (as properly allocable deductions under section 1411(c)(1)(B) or in section 1411(c)(1)(A)(iii) in the case of losses) but only to the extent of the nonpassive income from such former passive activity that is included in net investment income in that year. The final regulations adopt this hybrid approach.

For example, in the case of a former passive trade or business activity with suspended losses of $10,000 that generates $3,000 of net nonpassive income, section 469(c)(1)(A) allows $3,000 of the $10,000 suspended loss to offset the nonpassive income in the current year. Since the gross nonpassive income is not included in section 1411(c)(1)(A)(ii) (or in section 1411(c)(1)(A)(iii) in the case of gains from the disposition of property in such trade or business), none of the deductions and losses associated with such income are properly allocable deductions under section 1411(c)(1)(B) (or in section 1411(c)(1)(A)(iii) in the case of losses from the disposition of property in such trade or business). Thus, under the facts of this example, the final regulations provide that the $3,000 is not a properly allocable deduction (or a loss included in section 1411(c)(1)(A)(iii)). However, to the extent that the remaining suspended passive loss deduction of $7,000 is allowed by section 469(f)(1)(C) to offset other net passive activity income (which is included in net investment income by reason of section 1411(c)(1)(A) less deductions allowed by section 1411(c)(1)(B)), such amounts are considered properly allocable deductions under section 1411(c)(1)(B), or as a loss included in section 1411(c)(1)(A)(iii), as appropriate.

v. Treatment of Losses and Deductions Described in Section 469(g)(1)

Section 469(g)(1) provides, in relevant part, that if all gain or loss realized on a disposition is recognized, the excess of any loss from that activity for such taxable year (determined after the application of section 469(b)), over any net income or gain for that taxable year from all other passive activities (determined after the application of section 469(b)), shall be treated as a loss which is not from a passive activity. The preamble to the proposed regulations requested comments on ''whether the losses triggered under section 469(g)(1) upon the disposition should be taken into account in determining the taxpayer's net gain on the disposition of the activity under section 1411(c)(1)(A)(iii) or whether the losses should be considered properly allocable deductions to gross income and net gain described in section 1411(c)(1)(A)(i) through (iii).'' Because section 469(g)(1) provides that the allowed loss is treated as a loss ''which is not from a passive activity,'' there is a question whether this language prevents the allowed losses from being treated as ''properly allocable deductions'' from passive activities for purposes of section 1411.

Commentators recommended that losses allowed under section 469(g) be taken into account in computing net gain under section 1411(c)(1)(A)(iii), and that any net loss in section 1411(c)(1)(A)(iii) resulting from the use of such losses should be treated as a properly allocable deduction under section 1411(c)(1)(B). One commentator suggested that, to the extent a taxpayer has a net loss under section 1411(c)(1)(A)(iii) that is attributable to the allowed loss under section 469(g), the excess section 469(g) loss should continue to be suspended and carried forward to offset future gain resulting from the disposition of other passive assets subject to inclusion in section 1411(c)(1)(A)(iii).

The final regulations provide that section 469(g) losses, which are treated as losses from a nonpassive activity, are taken into account for net investment income purposes in the same manner in which they are taken into account for chapter 1 purposes. As discussed in the context of section 469(f), section 469 does not alter the character or nature of the suspended passive loss. If the

suspended losses allowed as a current year deduction by reason of section 469(g)(1) are attributable to operating deductions in excess of operating income, such suspended losses retain that character as, in most cases, deductions described in section 62(a)(1) or 62(a)(4). However, to the extent the suspended losses are comprised of losses originating from the disposition of property (such as ordinary section 1231 losses or capital losses), those losses also retain their character when they are ultimately allowed by section 469. Therefore, losses that are allowed by reason of section 469(g) may constitute properly allocable deductions under section 1411(c)(1)(B) or may be included within the calculation of net gain in section 1411(c)(1)(A)(iii) in the year they are allowed, depending on the underlying character and origin of such losses. The recommendations proposed by the commentators depart from the general operating principles in chapter 1 and add additional complexity. Therefore, the final regulations do not adopt the positions advanced by commentators that section 469(g)(1) suspended losses should offset the gain first, then be allowed as a properly allocable deduction or that it should continue to be suspended and carried forward.

Furthermore, section 469(g)(1) losses that are allowed by reason of a fully taxable disposition of a former passive activity are also fully taken into account for net investment income. As a result of the ordering rules in sections 469(f)(1) and (g)(1), any nonpassive gain realized on the disposition that causes passive losses to be allowed would be excluded from net investment income under the general former passive activity rules discussed in part 5.E.iv of this preamble. However, to the extent that any of the nonpassive gain is included in net investment income (for example, a portion of the gain remaining after the application of section 1411(c)(4)), the final regulations allow the same amount of suspended losses described in section 469(f)(1)(A) to be included in net investment income to offset the gain. The section 469(g)(1) losses allowed by reason of the disposition of the former passive activity are allowed in full because they relate to a period of time when the activity was a passive activity and represent true economic losses from a passive activity that do not materially differ from other section 469(g)(1) losses from non-former passive activities.

F. Other Comments Relating to the Calculation of Net Investment Income

The Treasury Department and the IRS received comments requesting that these final regulations address the treatment for section 1411 purposes of section 707(c) guaranteed payments for capital, section 736 payments to retiring or deceased partners, Real Estate Mortgage Investment Conduits (REMICs), and certain notional principal contracts. After consideration of these comments, the Treasury Department and the IRS believe that it is appropriate to address the treatment of these payments in regulations. However, because such guidance was not included in the proposed regulations, these items are addressed in a companion notice of proposed rulemaking (REG–130843–13) relating to the Net Investment Income Tax.

6. Section 1411 Trades or Businesses

Section 1411(c)(1)(A) defines net investment income, in part, by reference to trades or businesses described in section 1411(c)(2). The trades or businesses described in section 1411(c)(2) are: (A) a passive activity (within the meaning of section 469) with respect to the taxpayer, and (B) trading in financial instruments or commodities (as defined in section 475(e)(2)).

A. Passive Activities

The preamble to the proposed regulations stated that ''the statutory language in sections 1411(c)(1)(A) and 1411(c)(2)(A) is intended to take into account only gross income from and net gain attributable to a passive activity that involves the conduct of a trade or business.'' The preamble to the proposed regulations acknowledged that, due to the differences in the definitions for purposes of section 1411 and section 469, gross income from some activities that are passive activities under section 469 will not be taken into account for purposes of section 1411(c)(1)(A)(ii) because the gross income is derived from an activity that does not rise to the level of a trade or business (within the meaning of section 162). In such cases, the gross income will not be taken into account under section 1411 unless it is taken into account under section 1411(c)(1)(A)(i) or section 1411(c)(1)(A)(iii).

The Treasury Department and the IRS have received several comments and inquiries regarding the consequences of the income recharacterization rules. The regulations under section 469 provide special rules that treat income from certain passive activities as not from a passive activity. See § 1.469–2T(f)(2) (special rule for significant participation); § 1.469–2T(f)(3) (rental of nondepreciable property); § 1.469–2T(f)(4) (net interest income from passive equity-financed lending activity); § 1.469–2(f)(5) (net income from certain property rented incidental to development activity); § 1.469–2(f)(6) (property rented to a nonpassive activity); § 1.469–2T(f)(7) (special rules applicable to the acquisition of an interest in a passthrough entity engaged in the trade or business of licensing intangible property). In addition, the preamble to the proposed regulations highlighted a special gain recharacterization rule in § 1.469–2(c)(2)(iii) applicable to gains attributable to the disposition of substantially appreciated property formerly used in a nonpassive activity.

In order for these section 469 recharacterization rules to apply, the income or gain subject to recharacterization must be passive activity income under the general section 469 operating rules. If the income is nonpassive by reason of some other provision of section 469 (such as a taxpayer materially participating in the activity), the recharacterization rules are not applicable because there is no passive income to recharacterize.

In general, commentators had different opinions regarding the treatment under section 1411(c)(1) of income that is recharacterized under the rules in section 469. In the case of income from a passive activity trade or business, some commentators stated that net investment income does not include any amount of income or gain that is recharacterized as ''not from a passive activity,'' either because it satisfies the ordinary course exception (derived in the ordinary course of a trade or business not described in section 1411(c)(2)) in section 1411(c)(1)(A)(i) or (iii), or because such income is not income within the scope of section 1411(c)(1)(A)(ii). Other commentators stated that such nonpassive income qualifies as net investment income under section 1411(c)(1)(A) because the activity's status as a passive activity trade or business described in section 1411(c)(2)(A) is unchanged, despite section 469's recharacterization of a portion of the income or gain to income ''not from a passive activity.''

Another commentator recommended that the final regulations not apply a single rule to all income recharacterization situations because the underlying section 469 rationale differs for each one. The commentator stated that the various income

recharacterization rules do not recharacterize all the income and gains in the same way. In the case of income recharacterizations covered by §§ 1.469–2T(f)(3), 1.469–2T(f)(4), and 1.469–2T(f)(7), such income is further characterized as portfolio income (within the meaning of section 469(e)(1)(A)) by § 1.469–2T(f)(10). In the case of the recharacterization of gains under § 1.469–2(c)(2)(iii), the characterization of the gain as portfolio income is determined under § 1.469–2(c)(2)(iii)(F) based on whether the property was held in an investment activity before it was used in a passive activity. The commentator recommended that the final regulations distinguish recharacterized income treated as portfolio income from recharacterized income not treated as portfolio income.

Section 1.1411–5(b)(2) of the final regulations provides clarification regarding the interaction between the net income recharacterization rules under section 469 and the section 1411 rules. For purposes of section 1411, the final regulations generally follow the section 469 characterization of the income and gain, particularly the treatment of the items as portfolio income. Section 1.1411–5(b)(2) of the final regulations provides that, to the extent that income or gain from a trade or business is subject to a net income recharacterization rule described in §§ 1.469–2T(f)(2), § 1.469–2(f)(5), or § 1.469–2(f)(6), the gross income or gain treated as ''not from a passive activity'' will not be considered derived from a trade or business described in section 1411(c)(2)(A). In addition, any gain recharacterized as ''not from a passive activity'' by reason of § 1.469–2(c)(2)(iii) is not derived from a trade or business described in section 1411(c)(2)(A) if the gain does not constitute portfolio income under § 1.469–2(c)(2)(iii)(F). In the case of recharacterization rules covered by § 1.469–2T(f)(10) and § 1.469–2(c)(2)(iii)(F), the underlying trade or business remains a passive activity within the meaning of section 1411(c)(1)(A) and § 1.1411–5(a)(1).

B. Trading in Financial Instruments or Commodities

The proposed regulations provided that, for purposes of section 1411(c)(2)(B), to determine whether gross income is derived from a section 162 trade or business of trading in financial instruments or commodities, the gross income must be derived from an activity that would constitute trading for purposes of chapter 1. Section 1.1411–5(c)(1) of the proposed regulations defined the term *financial instrument* to include stocks and other equity interests, evidences of indebtedness, options, forward or futures contracts, notional principal contracts, any other derivatives, or any evidence of an interest in any of the listed items. An evidence of an interest in any of these listed items includes, but is not limited to, short positions or partial units in any of these listed items.

Two comments were received regarding the definition of a financial instrument in the proposed regulations. One commentator asked for explicit language that financial instruments that are used in a trade or business and produce foreign currency gain are exempt from section 1411. The same commentator requested that the proposed definition of a financial instrument be narrowed so that it would exclude ''non-financial instruments,'' such as contracts that reference electricity or weather. Another commentator suggested that the term ''stock'' in the definition of a financial instrument be replaced with the phrase ''security as defined in section 2(a)(1) of the Securities Act of 1933'' to broaden the scope of the definition.

With respect to the first comment, foreign currency gain or loss that otherwise is not subject to the Self-Employment Contribution Act is appropriately treated as net investment income. Regarding the definition of a financial instrument, the Treasury Department and the IRS believe that Congress chose that term to capture a broader class of instruments than the securities described in section 475. The suggestion to limit the definition of a ''financial instrument'' to exclude a derivative that is referenced to non-financial information, such as electricity or weather, would not be consistent with the intention to include in net investment income the income from all types of investment property. With respect to the second comment, there is no indication that Congress intended the definition of the term ''financial instrument'' to be coextensive with the definition of the term ''security'' used by the SEC, as evidenced by the fact that section 1411(c)(2)(B) uses the term ''financial instrument,'' not ''security.'' Accordingly, after consideration of both comments, neither suggestion was adopted in the final regulations.

7. Comments Regarding Working Capital

Section 1411(c)(3) provides that a rule similar to the rule of section 469(e)(1)(B) (the working capital rule) applies for purposes of section 1411. Section 469(e)(1)(B) provides that, for purposes of determining whether income is treated as from a passive activity, any income or gain attributable to an investment of working capital is treated as not derived in the ordinary course of a trade or business. Section 1.469–2T(c)(3)(iii) provides an exception to the portfolio income characterization rule for items that are derived in the ordinary course of a trade or business. Section 1.1411–6(a) of the proposed regulations provided that, for purposes of section 1411(c)(3), working capital and the income generated therefrom will be determined under principles similar to those described in § 1.469–2T(c)(3)(ii).

Several commentators noted that the proposed regulations lack an adequate definition of ''working capital'' for purposes of section 1411. One commentator stated that the application of section 1411 is too restrictive because it taxes all working capital as income not derived in the ordinary course of business. Another commentator noted that the regulations should clearly define what property is considered working capital, particularly where capital is invested in a trade or business that either does not rise to the level of a trade or business under section 1411(c)(2)(A) or a trading business described in section 1411(c)(2)(B) that generates nonpassive income. One commentator noted that the cross-reference to working capital in section 469 does not account for the different purposes of the two statutory schemes. Commentators also stated that, if the final regulations do not elaborate on the definition of working capital, taxpayers must speculate where the dividing line is between active business assets and working capital.

Several commentators requested that the final regulations include a more comprehensive definition of working capital. One commentator recommended that proposed § 1.1411–6 be withdrawn and replaced with industry-specific guidelines for a safe harbor. Another commentator suggested the final regulations exclude income generated from liquid, short-term investments, such as interest-bearing bank accounts, from the definition of working capital and further exclude a reasonable amount of working capital.

The specific cross-reference in section 1411(c)(3) to section 469(e)(1)(B) indicates Congress' intent that the definition of working capital in § 1.1411–6 be consistent with the rules in section 469(e)(1)(B) and § 1.469–2T(c)(3)(ii). Accordingly, the proposed regulations intentionally aligned the section 1411 treatment of working capital with the section 469 rules. In addition, the rule in the proposed

regulations avoids complexity that divergent definitions would have on tax administration and compliance. The Treasury Department and the IRS appreciate that certain businesses require different amounts of working capital based on their industries or general business practices, but the Treasury Department and the IRS do not believe that the promulgation of working capital definitions based on industry-specific characteristics would be administrable. Further, if the rules on working capital were materially different for section 469 and section 1411 purposes, such items would have to be reevaluated annually and would require detailed accounting and reporting burdens for both the IRS and taxpayers. As a result, the final regulations retain the provisions in proposed § 1.1411–6 without change. However, see part 5.A.ii.(b) of this preamble for a discussion of changes to the proposed regulations regarding items derived in the ordinary course of a trade or business.

8. Comments Regarding the Calculation of Gain or Loss Attributable to the Disposition of Interests in Partnerships and S Corporations

The proposed regulations described the method for adjusting a transferor's gain or loss from the disposition of a partnership interest or S corporation stock based on the entity's ownership of assets that are nonpassive with respect to the transferor. Under that method, a transferor first computes its gain (or loss) on disposition of its interest in the entity, and then reduces that gain (or loss) by the amount of nonpassive gain (or loss) that would have been allocated to the transferor upon a hypothetical sale of all of the entity's assets for fair market value immediately before the transfer.

Several commentators questioned the proposed regulations' methodology for adjusting a transferor's gain or loss on the disposition of its partnership interest or S corporation stock. These commentators noted that section 1411(c)(4) requires that gain (or loss) from such dispositions be taken into account under section 1411(c)(1)(A)(iii) ''only to the extent of the net gain [or loss] which would be taken into account by the transferor if all property of the partnership or S corporation were sold for fair market value immediately before the disposition of such interest.'' The commentators suggested that section 1411(c)(4) therefore includes gain/loss from the disposition of a partnership interest or S corporation stock only to the extent of the transferor's share of gain/loss from the entity's passive assets. Thus, under the commentator's approach, the amount of gain or loss included in section 1411(c)(A)(iii) is the lesser of a taxpayer's gain on the disposition of the interest or the taxpayer's share of gain or loss on the deemed sale of the entity's assets that would be included in calculating the taxpayer's net investment income. Commentators also discussed the complexity of the proposed regulations, stating that the regulations imposed a high compliance burden, including requiring a transferor to obtain information from the entity regarding valuation and tax basis.

After considering these comments, the Department of Treasury and the IRS are withdrawing the proposed regulations that address this issue and are issuing new proposed regulations under § 1.1411–7 adopting the commentators' suggestion, which are being published contemporaneously with these final regulations (REG–130843–13).

9. Comments Regarding the Exclusion of Certain Income under Section 1411(c)(5)

Section 1411(c)(5) provides that net investment income does not include any distribution from the following plans or arrangements:

(1) A qualified pension, stock bonus, or profit-sharing plan under section 401(a);

(2) A qualified annuity plan under section 403(a);

(3) A tax-sheltered annuity under section 403(b);

(4) An individual retirement account (IRA) under section 408;

(5) A Roth IRA under section 408A; or

(6) A deferred compensation plan of a State and local government or a tax-exempt organization under section 457(b).

Section 1.1411–8(a) of the proposed regulations provided that, for purposes of section 1411, any amount actually distributed from a qualified plan or arrangement is a distribution within the meaning of section 1411(c)(5), and thus is not included in net investment income. The final regulations generally retain the rules in the proposed regulations relating to whether an amount is a distribution from a plan within the meaning of section 1411(c)(5) and, thus, excluded from net investment income. In addition, the final regulations retain the rule that, for purposes of section 1411, amounts that are deemed distributions under the Code for income tax purposes are distributions for purposes of section 1411(c)(5), even if these distributions are not treated as actual distributions for purposes of the qualification requirements under section 401(a). The final regulations also retain the rule in the proposed regulations that any amount that is not treated as a distribution for purposes of the qualification requirements under the Code, but is otherwise includible in gross income pursuant to a rule relating to amounts held in a qualified plan or arrangement is a distribution within the meaning of section 1411(c)(5), and thus is not included in net investment income.

One commentator asked for clarification on the application of section 1411 to employer securities. The commentator specifically asked for clarification on whether section 1411 applies to dividends on employer securities held by an employee stock ownership plan (as defined in section 4975(e)(7) of the Code) that are paid directly to plan participants. A–3 of § 1.404(k)–1T provides that a deductible dividend under section 404(k) that is paid directly to a plan participant or beneficiary is treated as a distribution under the plan for purposes of sections 72, 401, and 402 of the Code. The final regulations clarify that any dividend that is deductible under section 404(k) and is paid in cash directly to a plan participant or beneficiary is a distribution within the meaning of section 1411(c)(5), and thus is not included in net investment income. This rule does not apply to amounts paid as a dividend after the employer securities have been distributed from a qualified plan. Those amounts paid as dividends are included in net investment income.

The commentator also asked for clarification on whether section 1411 applies to the net unrealized appreciation realized on a disposition of employer securities that occurs after the securities were distributed from a qualified plan. Section 402(e)(4) provides that the net unrealized appreciation in employer securities that are distributed from a qualified plan is excluded from gross income in the year of the distribution in certain circumstances. In the case of a lump-sum distribution (within the meaning of section 402(e)(4)(D)), the net unrealized appreciation in the employer securities distributed is excluded from gross income. In the case of any other distribution (other than a distribution that is not currently taxable under the rollover rules), the net unrealized appreciation in the employer securities distributed is generally excluded from gross income only to the extent that it is attributable to after-tax employee contributions. Net unrealized appreciation is defined in § 1.402(a)–1(b)(2)(i) as the excess of the market

value of employer securities at the time of distribution over the cost or other basis of such securities to the trust. The final regulations clarify that any such net unrealized appreciation in employer securities that is realized in a disposition of those employer securities is a distribution within the meaning of section 1411(c)(5), and thus is not included in net investment income. The regulations also provide that any appreciation in value that occurs subsequent to the distribution of the employer securities from a qualified plan is included in net investment income when realized.

10. Comments Regarding the Interaction between Section 1411 and Self-Employment Tax

Section 1411(c)(6) provides that net investment income does not include items taken into account in determining self-employment income for such taxable year on which a tax is imposed by section 1401(b). Several commentators, in considering the interaction of self-employment tax and section 1411, suggested that the regulations clarify that a taxpayer who is fully employed by a limited liability company (LLC) or a limited liability partnership (LLP) materially participates in that entity, and, therefore, the taxpayer's distributive share of income from the LLC or LLP is self-employment income for which a tax is imposed by section 1401. The final regulations do not adopt this suggestion because the imposition of self-employment taxes on LLC members and partners of an LLP is outside the scope of these regulations.

Proposed § 1.1411–9(b) provided a special rule for traders; specifically that deductions described in proposed § 1.1411–4(f)(2)(ii) that do not reduce a taxpayer's net earnings from self-employment (after aggregating the net earnings from self-employment from all of the taxpayer's trades or business) are not considered taken into account for purposes of section 1411(c)(6) and may be considered in determining the taxpayer's net investment income under section 1411. One commentator suggested that this rule be amended to provide that a taxpayer can elect whether properly allocable deductions related to the taxpayer's trade or business of trading in financial instruments or commodities reduce net earnings from self-employment. The expenses of a trader maintaining a trade or business of trading in financial instruments or commodities are taken into account for purposes of determining self-employment income. Thus, such expenses, but for the special rule in § 1.1411–9(b), could not be used to reduce net investment income. The Treasury Department and the IRS believe that a trader should be able to reduce net investment income by amounts not used to reduce net earnings from self-employment income. Thus, the special rule is an exception under section 1411 for the benefit of taxpayers. The special rule was not intended to alter the result under the self-employment tax provisions. Accordingly, the final regulations do not adopt the commentator's suggestion.

11. Comments Regarding the Section 1411 Treatment of Controlled Foreign Corporations and Passive Foreign Investment Companies

A. Income Derived From a Trade or Business Described in Section 1411(c)(2)

Pursuant to section 1411(c)(1)(A)(ii), gross income derived from a trade or business described in section 1411(c)(2) is net investment income. A trade or business is described in section 1411(c)(2) if it is a passive activity (within the meaning of section 469) with respect to the taxpayer or a trade or business of trading in financial instruments or commodities (as defined in section 475(e)(2)). Proposed § 1.1411–10(b), which applies to certain owners of controlled foreign corporations (CFCs) and passive foreign investment companies (PFICs), provides that the special rules in proposed § 1.1411–10 do not apply to income derived by those taxpayers from a trade or business described in section 1411(c)(2) and § 1.1411–5. Instead, such income is included in net investment income under section 1411(c)(1)(A)(ii) and § 1.1411–4(a)(1)(ii).

A commentator asked if the determination of whether income is ''derived from'' a trade or business described in section 1411(c)(2) for § 1.1411–10(b) purposes is made by reference to the trade or business of the CFC or the PFIC, or the trade or business of the taxpayer (or passthrough entity in which the taxpayer invests) that holds the CFC or PFIC. The commentator noted that the rules in proposed § 1.1411–4(b) provided guidance on determining whether income is derived in a trade or business for purposes of section 1411(c)(1)(A)(ii). However, the commentator stated that the rule in proposed § 1.1411–10(b) may be of limited applicability if the rules in § 1.1411–4(b) apply for purposes of proposed § 1.1411–10(b). Section 1.1411–10(b)(1) of these final regulations clarifies that the trade or business determination for purposes of § 1.1411–10(b) is made pursuant to the rules set forth in § 1.1411–4(b)(2), which provide that the determination is either based on the taxpayer's trade or business or the trade or business of the passthrough entity in which the taxpayer invests.

Commentators also recommended that guidance be provided regarding the application of § 1.1411–10(b) to income derived from a trade or business that is a passive activity within the meaning of section 469 because of a concern that taxpayers may not be treated as engaged in a passive activity with respect to a CFC or qualified electing fund (QEF). Although theoretically the definition of ''passive activity'' under section 469 could include holding an interest in a CFC or PFIC, the commentators pointed out that amounts included in income under sections 951(a) (section 951 inclusions) and 1293(a) (section 1293 inclusions) are excluded from the definition of ''passive income'' for section 469 purposes, and, instead, are treated as portfolio income under § 1.469–2T(c)(3)(i)(A). The commentators stated that the exclusion of these items from ''passive income'' may mean that income derived from CFCs and QEFs would never be treated as income derived from a ''passive activity.'' In such a case, § 1.1411–10(b) would never apply to a section 951 inclusion or section 1293 inclusion even if the inclusion was derived from a CFC or QEF held in a trade or business that is a passive activity. After consideration of the comments, the Treasury Department and the IRS do not believe that the final regulations need to be clarified in order for § 1.1411–10(b) to apply to a taxpayer that holds a CFC or QEF in a trade or business that is a passive activity with respect to the taxpayer. Section 1411(c)(2)(A) and the regulations promulgated thereunder cross-reference section 469 solely for purposes of defining ''passive activity.'' Section 1.1411–10 does not cross-reference the section 469(e) rules, which provide guidance on whether income is treated as income from a passive activity, or the rule in § 1.469–2T(c)(3)(i)(A), which addresses portfolio income. In addition, § 1.469–1T(d)(1) provides that the characterization of items of income as passive activity gross income (within the meaning of § 1.469–2T(c)) applies only for purposes of section 469. The rule in § 1.1411–10(b) does not incorporate the section 469 rules on portfolio income, and, thus, applies to income derived by a taxpayer from a CFC or QEF that is held in a trade or business that is a passive activity within the meaning of section 469.

The Treasury Department and the IRS also received a comment that addressed the application of the rules in § 1.1411–10(b) when a taxpayer holds a CFC or PFIC in connection with a trade or business described in section 1411(c)(2) in some, but not all, years. The commentator explained that the trade or business determination is made on an annual basis, which creates the potential for taxpayers to alternate between being subject to the rules in § 1.1411–10(b) and the other applicable rules in § 1.1411–10 on an annual basis. As a result, when a taxpayer does not make an election under § 1.1411–10(g), a taxpayer could either be subject to double taxation under section 1411, or could avoid tax under section 1411, depending on the facts and circumstances. The commentator suggested that the trade or business determination that was in effect in the year in which the taxpayer acquired an interest in a CFC or PFIC should apply to all years in which the taxpayer holds the CFC or PFIC. Although the Treasury Department and the IRS do not adopt the commentator's suggested approach, the final regulations coordinate the application of the rules in § 1.1411–10 when a taxpayer's trade or business determination, either as a trader or for passive activity purposes, causes the taxpayer to alternate between being subject to § 1.1411–10(b) and the other applicable rules in § 1.1411–10, to eliminate both the possibility of double taxation and the avoidance of taxation.

B. Income derived from CFCs and QEFs

In general, the proposed regulations provided that distributions of previously taxed earnings and profits attributable to section 951 inclusions and section 1293 inclusions are dividends for purposes of section 1411, absent an election under § 1.1411–10(g). If a taxpayer made the § 1.1411–10(g) election, the proposed regulations provided that section 951 inclusions and section 1293 inclusions (rather than the distributions of previously taxed earnings and profits) are treated as dividends for purposes of section 1411.

Commentators recommended that the Treasury Department and the IRS revise the final regulations to treat section 951 inclusions and section 1293 inclusions as dividends for purposes of section 1411 (without regard to any election by the taxpayer), rather than treating the distributions of previously taxed earnings and profits attributable to section 951 inclusions or section 1293 inclusions (that were included in chapter 1 income in a taxable year beginning after December 31, 2012) as dividends. The commentators stated that the rules in the proposed regulations applicable to CFCs and QEFs when an election under § 1.1411–10(g) is not in effect are unduly complicated and impose significant administrative burdens on taxpayers. A commentator also recommended modifying the regulations to generally impose section 1411 when section 951 inclusions and section 1293 inclusions are taxed for purposes of chapter 1, and permit taxpayers to elect to defer such tax until the distribution of the earnings and profits that previously were taxed pursuant to sections 951(a) or 1293(a) (in a taxable year beginning after December 31, 2012).

As set forth in the preamble to the proposed regulations, section 951 inclusions and section 1293 inclusions are not treated as dividends except when expressly provided for in the Code. See *Rodriguez* v. *Commissioner,* 137 T.C. 174 (2011), *aff'd.* 722 F.3d 306 (5th Cir. 2013). Accordingly, the Treasury Department and the IRS do not adopt the commentators' recommendations to treat section 951 inclusions and section 1293 inclusions as dividends for purposes of section 1411. For the same reason, the Treasury Department and the IRS do not adopt the recommendation to provide a default rule that would treat section 951 inclusions and section 1293 inclusions as subject to section 1411 when the inclusions are taken into account for purposes of chapter 1, unless the taxpayer affirmatively elected to defer taxation under section 1411 until the distribution of earnings and profits related to the inclusions.

The Treasury Department and the IRS also received a comment that recommended the application of a look-through approach for determining whether income derived with respect to a CFC or QEF is included in net investment income. Pursuant to a look-through approach, taxpayers would determine whether section 1411 applied to a section 951 inclusion or section 1293 inclusion by analyzing the income earned directly by the CFC or QEF that gave rise to the inclusion. The Treasury Department and the IRS do not adopt this recommendation because the approach raises administrative and compliance concerns, including concerns regarding the ability of QEF shareholders to compel a QEF to provide them with the information necessary to comply with a look-through rule.

A commentator pointed out that the same earnings could be subject to section 1411 tax twice if a taxpayer that made an election under § 1.1411–10(g) subsequently transfers CFC or QEF shares to a taxpayer that does not make the election. The Treasury Department and the IRS agree with the commentator that the earnings and profits of a CFC or QEF should be subject to tax under section 1411 only once. Accordingly, these final regulations provide that if earnings and profits of a CFC or QEF were included in the net investment income of an individual, estate, or trust pursuant to a § 1.1411–10(g) election, then a subsequent distribution of those earnings is excluded from the net investment income of any transferee, provided that the transferee can establish entitlement to the exclusion under rules similar to the rules in § 1.959–1(d) (which establish a successor in interest's ability to exclude from chapter 1 income the previously taxed earnings and profits with respect to an interest in a CFC acquired from another person).

In addition, the commentator noted a separate double counting issue with respect to earnings and profits that are included in income as a dividend under section 1248. For example, a seller would be subject to tax under section 1411 when it includes the earnings and profits in income as a dividend under section 1248, and a purchaser who did not make an election under § 1.1411–10(g) also would be subject to tax under section 1411 on a subsequent distribution of the earnings and profits because the distribution would be treated as a dividend for purposes of section 1411. The Treasury Department and the IRS agree that it is appropriate to prevent double taxation in the section 1248 context, and these final regulations include a rule that prevents double taxation with respect to amounts treated as a dividend under section 1248 for purposes of section 1411.

The final regulations include a new rule that applies when a taxpayer makes an election under § 1.1411–10(g) effective for taxable years beginning after December 31, 2013, but does not make an election under § 1.1411–10(g)(4)(iii) for a taxable year beginning before January 1, 2014 (2013 taxable year), and the taxpayer is subject to section 1411 in the 2013 taxable year. Under the new rule, any distributions of previously taxed earnings and profits during taxable years beginning after December 31, 2013, that are attributable to section 951 and 1293 inclusions in the 2013 taxable year, will be treated as dividends for purposes of section 1411 notwithstanding the election under § 1.1411–10(g). Without this rule, it may be possible to avoid taxation under section 1411 for any section 951 and 1293 inclusions during the 2013 taxable year. This is so because those inclusions

would not be subject to tax under section 1411 during the 2013 taxable year in the absence of an election under § 1.1411–10(g) and, as a result of the election under § 1.1411–10(g) for taxable years beginning after December 31, 2013, distributions of previously taxed earnings and profits accrued in the 2013 taxable year would not be subject to section 1411. In order to simplify taxpayer record-keeping, for purposes of applying this special rule, distributions of previously taxed earnings and profits from the CFC or QEF during taxable years beginning after December 31, 2013, will be deemed to first come out of previously taxed earnings and profits attributable to section 951 and 1293 inclusions in the 2013 taxable year.

The Treasury Department and the IRS received a comment that suggested adding an example to the final regulations to illustrate a situation in which the earnings and profits of a CFC are never subject to section 1411 under section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i). The suggested example would include a fact pattern in which a taxpayer that did not make an election under § 1.1411–10(g) includes a section 951 inclusion in income for chapter 1 purposes. In the next year, and before the distribution of earnings and profits attributable to the section 951 inclusion, the taxpayer sells the CFC shares for no gain or loss (as computed for purposes of section 1411) to a taxpayer that makes an election under § 1.1411–10(g) with respect to the CFC. Under these facts, the earnings and profits related to the section 951 inclusion are never subject to tax under section 1411. The Treasury Department and the IRS believe that the application of § 1.1411–10 to this fact pattern is clear, and that an example is not necessary to illustrate the relevant provisions of § 1.1411–10. The commentator also asked that the final regulations clarify the meaning of the phrase ''with respect to which an election under paragraph (g) of this section is not in effect.'' The final regulations clarify that the references in § 1.1411–10 to an election under paragraph (g) not being in effect refer to the person that is determining the section 1411 consequences with respect to holding a particular CFC or QEF.

The Treasury Department and the IRS requested comments on whether guidance is necessary to determine the deductions that are properly allocable to items of net investment income if the election under § 1.1411–10(g) is not made. One such comment was received regarding the allocation of interest expense under section 163(d)(1). Section 1.1411–4(f)(3)(i) allows interest expense as a deduction against net investment income only to the extent allowed under section 163(d)(1), which limits investment interest expense in part based on a taxpayer's investment income. In the absence of an election under § 1.1411–10(g), differences may occur in the timing of income derived with respect to CFCs and QEFs for chapter 1 and chapter 2A purposes. The commentator suggested that, where differences in timing occur, taxpayers should be allowed to calculate their section 163(d)(1) investment interest expense deduction based on amounts included in income for section 1411 purposes, in determining the amount of investment interest expense allocable to net investment income under section 1411. The Treasury Department and the IRS agree with this comment and these final regulations provide that the section 163(d)(1) investment interest expense deduction related to items of net investment income described in § 1.1411–10(c) may be calculated for purposes of section 1411 by adjusting section 163(d)(1)(B) ''investment income'' for purposes of section 1411 to reflect the inclusions under section 951 and section 1293 that are not included in section 1411 net investment income, and the distributions of previously taxed earnings and profits that are included in section 1411 net investment income. To the extent that the taxpayer chooses to calculate any of these deductions based on the amount of net investment income described in § 1.1411–10(c), that method of calculation must be consistently applied for purposes of section 1411 and may only be changed with the consent of the IRS.

C. CFCs and QEFs Held Through Domestic Partnerships and S Corporations

A comment was received on the conforming basis adjustment rules in § 1.1411–10(d)(2) that apply to a taxpayer that owns an interest in a CFC or QEF through a domestic partnership and that does not make an election under § 1.1411–10(g). The commentator stated that it was unclear whether basis adjustments pass through for both section 951 inclusions and distributions of previously taxed earnings and profits. The Treasury Department and the IRS believe that the rules in § 1.1411–10(d), which apply only for purposes of section 1411, adequately address the basis consequences specific to section 1411 that occur when a domestic partnership receives a distribution of previously taxed earnings and profits. The Treasury Department and the IRS believe that general questions about basis adjustments in the context of CFCs and QEFs held through passthrough entities would be more appropriately addressed in guidance under chapter 1.

The Treasury Department and the IRS received a comment that recommended issuing proposed rules regarding adjustments to basis under section 743 for section 1411 purposes. The commentator requested that the regulations clarify that basis adjustments under section 743 relate solely to the transferee and that transferee partners be permitted to adjust the basis of partnership property for purposes of section 1411 regardless of whether the partnership has elected under section 754 or has a substantial built-in loss. Under these regulations, except as otherwise provided, chapter 1 principles and rules apply in determining the tax under section 1411. Therefore, the Treasury Department and the IRS have determined that it is unnecessary to clarify that basis adjustments under section 743 relate solely to the transferee partner because this result is clear under existing law for purposes of chapter 1. The Treasury Department and the IRS have further determined that allowing a transferee partner to adjust its basis in partnership property when the partnership is not otherwise required to do so could create unnecessary administrative complexity for the partnership. Thus, the Treasury Department and the IRS have decided that additional rules relating to section 743 for section 1411 purposes are not necessary.

A comment was received that recommended that a rule be added to the final regulations to require partnerships to provide their partners with the information needed by the partners to compute their tax under section 1411 with respect to CFCs and PFICs held by the partnerships. The Treasury Department and the IRS do not adopt this recommendation. Rather, the IRS is in the process of revising the relevant IRS forms and instructions (such as Form 1065, ''U.S. Return of Partnership Income,'' and the associated Schedule K–1) to require partnerships and S corporations to provide to their partners and shareholders the information necessary to compute their tax under section 1411 with respect to CFCs and PFICs held by partnerships and S corporations.

A commentator recommended that the final regulations include a rule to treat a section 751(c) amount corresponding to the amount included in income as a dividend under section 1248 for section 1411 purposes as net investment income under section 1411(c)(1)(A)(i) rather than under section 1411(c)(1)(A)(iii). In the

alternative, the commentator requested that an example be added to the final regulations to illustrate the operation of section 751 (taking into account section 1248) when a partner sells an interest in a partnership that holds CFC stock. The Treasury Department and the IRS believe that the section 1411 characterization of the section 751(c) amount that corresponds to a section 1248 dividend should be consistent with the chapter 1 characterization and not treated as a dividend, and thus do not adopt the recommendation to treat the amount as net investment income under section 1411(c)(1)(A)(i) or add an example to the final regulation.

D. Section 1.1411–10(g) Election Applicable to CFCs and QEFs

The proposed regulations permitted individuals, estates, and trusts to make an election pursuant to § 1.1411–10(g) to include section 951 inclusions and section 1293 inclusions in net investment income in the same manner and in the same taxable year as the amounts are included in income for chapter 1 purposes. Under the proposed regulations, the election was required to be made on or before the due date for filing the individual's, estate's, or trust's income tax return for the first taxable year that the individual, estate, or trust holds stock of a CFC or QEF and was subject to tax under section 1411 or would be subject to tax under section 1411 if the election were made. Under the proposed regulations the election, if made, applied to all CFCs and QEFs held directly or indirectly by the individual, estate, or trust, regardless of whether the interest in the CFC or QEF is held in the year the election is made or is acquired subsequently.

Commentators suggested that the § 1.1411–10(g) election should be permitted to be made on an entity-by-entity basis, rather than to all CFCs and QEFs held by the taxpayer, or subsequently acquired. The Treasury Department and the IRS adopt this recommendation, and these final regulations provide that the § 1.1411–10(g) election is made on an entity-by-entity basis.

The Treasury Department and the IRS received comments recommending that domestic partnerships and S corporations be allowed to make the § 1.1411–10(g) election. The commentators stated that the partner (or shareholder) level election would create an administrative burden for the partnership (or S corporation) because it would require the partnership (or S corporation) to maintain two sets of records with respect to its CFC and QEF investments: one for chapter 1 purposes and one for section 1411 purposes. In response to these comments, the final regulations include a rule that allows a domestic partnership, S corporation, or common trust fund to make the election in § 1.1411–10(g) for taxable years that begin after December 31, 2013. In addition, a domestic partnership, S corporation, or common trust fund can make the election in § 1.1411–10(g) for a taxable year beginning before January 1, 2014, if all of the partners, shareholders, or participants (as the case may be) consent to the election. The final regulations also provide that a § 1.1411–10(g) election may be made with respect to interests in CFCs or QEFs held indirectly through certain domestic entities such as domestic partnerships or S corporations if the domestic entity does not make a § 1.1411–10(g) election.

A commentator requested that the rule regarding the time for making an election under § 1.1411–10(g) election be revised so that taxpayers would not have to make an election until the first year in which they have a section 951 inclusion or section 1293 inclusion. The commentator stated that a rule based on ownership of a CFC or QEF, rather than a chapter 1 income inclusion, created a trap for the unwary because taxpayers may not consider the rules in § 1.1411–10 until they have a chapter 1 income inclusion. The Treasury Department and the IRS adopt this comment, and the final regulations revise the rules for making a § 1.1411–10(g) election to provide, in relevant part, that the election must be made no later than the first taxable year beginning after December 31, 2013, in which a person both has a section 951 or section 1293 inclusion under chapter 1 with respect to a CFC or QEF and is subject to section 1411 (or would be subject to tax under section 1411 if the election were made with respect to the CFC or QEF). Therefore, the final regulations permit a taxpayer to make the election in a year before the first year in which there is a chapter 1 inclusion under sections 951 or 1293 and the person is subject to tax under section 1411 (or would be subject to tax under section 1411 if the election were made). In addition, the final regulations provide that individuals, estates and trusts may make the election for a taxable year beginning before January 1, 2014.

A commentator suggested that the regulations be revised to allow taxpayers to make the § 1.1411–10(g) election on an amended return. The Treasury Department and the IRS adopt this suggestion, and these final regulations provide that the initial election can be made on an original or an amended return, provided that the year of the election, and all years affected by the election, are not closed by the period of limitations under section 6501.

The Treasury Department and the IRS also received comments suggesting the addition of certain procedural rules related to making § 1.1411–10(g) elections. A comment requested that the final regulations set forth a procedure for taxpayers to make protective § 1.1411–10(g) elections. In addition, a comment suggested that rules for making untimely § 1.1411–10(g) elections should be added to the final regulations, and recommended that the rules be consistent with the rules for making untimely QEF elections. Moreover, a comment suggested that purging elections, similar to QEF purging elections, should be allowed with respect to § 1.1411–10(g) elections. The Treasury Department and the IRS do not adopt these suggestions because they are not necessary in light of the changes these final regulations provide to increase the opportunities for the election to be made.

The § 1.1411–10(g) election generally will be made by individuals, estates, and trusts on Form 8960, ''Net Investment Income Tax—Individuals, Estates, and Trusts.'' Domestic partnerships, S corporations, and common trust funds will make the election on attachments to their relevant partnership or income tax returns.

12. Taxpayer Reliance on Proposed and Final Regulations

These regulations are effective for taxable years beginning after December 31, 2013, except that § 1.1411–3(d) applies to taxable years beginning after December 31, 2012. Taxpayers are reminded that section 1411 is effective for taxable years beginning after December 31, 2012.

Part 12 of the preamble to the proposed regulations stated that taxpayers may rely on the proposed regulations for purposes of compliance with section 1411 until the effective date of the final regulations. Furthermore, the preamble stated that any election made in reliance on the proposed regulations will be in effect for the year of the election, and will remain in effect for subsequent taxable years. In addition, taxpayers who opt not to make an election in reliance on the proposed regulations are not precluded from making that election pursuant to these final regulations.

For taxable years beginning before January 1, 2014, taxpayers may rely on either the proposed regulations or these final regulations for purposes of

compliance with section 1411. See § 1.1411–1(f). However, to the extent that taxpayers take a position in a taxable year beginning before January 1, 2014 that is inconsistent with these final regulations, and such position affects the treatment of one or more items in a taxable year beginning after December 31, 2013, then such taxpayer must make reasonable adjustments to ensure that their section 1411 tax liability in the taxable years beginning after December 31, 2013, is not inappropriately distorted. For example, reasonable adjustments may be required to ensure that no item of income or deduction is taken into account in computing net investment income more than once, and that carryforwards, basis adjustments, and other similar items are adjusted appropriately.

Effective/Applicability Date

These final regulations apply to taxable years beginning after December 31, 2013, except that § 1.1411–3(d) applies to taxable years beginning after December 31, 2012.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It is hereby certified that the collection of information in § 1.1411–10(g) of these final regulations will not have a significant economic impact on a substantial number of small entities. Although a number of small entities may be subject to the requirements of this rule, any economic impact is minimal. This certification is based on the fact that the time required to secure and maintain the required information is minimal and taxpayers would ordinarily already collect and retain much of this information for other income tax and business purposes. The minimal information should be readily available to the parties and the professional skills that would be necessary to make the election would be the same as those required to prepare a return for the small business. Accordingly, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required.

Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding these regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small businesses, and no comments were received.

Drafting Information

The principal authors of these regulations are David H. Kirk and Adrienne M. Mikolashek of the Office of the Associate Chief Counsel (Passthroughs and Special Industries). However, other personnel from the IRS and the Treasury Department participated in their development.

List of Subjects

26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

26 CFR Part 602

Reporting and recordkeeping requirements.

Adoption of the Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 602 are amended as follows:

PART 1—INCOME TAXES

■ **Paragraph 1.** The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

■ **Par 2.** Section 1.469–0 is amended by adding an entry for paragraph (b)(3)(iv) to the § 1.469–11 the table of contents to read as follows:

§ 1.469–0 Table of contents.

* * * * *

§ 1.469–11 Effective date and transition rules.

* * * * *

(b) * * *

(3) * * *

(iv) Regrouping for taxpayers subject to section 1411.

(A) In general.

(B) Eligibility criteria.

(C) Consequences of amended returns and examination adjustments.

(*1*) Taxpayers first subject to section 1411.

(*2*) Taxpayers ceasing to be subject to section 1411.

(*3*) Examples.

(D) Effective/applicability date.

* * * * *

■ **Par 3.** Section 1.469–11 is amended by adding paragraph (b)(3)(iv) to read as follows:

§ 1.469–11 Effective date and transition rules.

* * * * *

(b) * * *

(3) * * *

(iv) *Regrouping for taxpayers subject to section 1411*—(A) *In general.* If an individual, estate, or trust meets the Eligibility Criteria, as defined in paragraph (b)(3)(iv)(B) of this section, such individual, estate, or trust, in the first taxable year beginning after December 31, 2013, in which section 1411 would apply to such taxpayer, may regroup its activities without regard to the manner in which the activities were grouped in the preceding taxable year. For this purpose, the determination of whether a taxpayer meets the Eligibility Criteria is made without regard to the effect of regrouping. The regrouping must be made in the manner prescribed by forms, instructions, or in other guidance on an original return for the taxable year for which the regrouping is done. A taxpayer that is an individual, estate, or trust may regroup its activities for any taxable year that begins during 2013, if the individual, estate, or trust meets the Eligibility Criteria for such year. A taxpayer may regroup activities only once pursuant to this paragraph (b)(3)(iv), and a regrouping made pursuant to this paragraph (b)(3)(iv) will apply to the taxable year for which the regrouping is done and all subsequent years.

(B) *Eligibility criteria.* The term *Eligibility Criteria* means that an individual, estate, or trust has net investment income (as defined in § 1.1411–4) and such individual's (as defined in § 1.1411–2(a)) modified adjusted gross income (as defined in § 1.1411–2(c)) exceeds the applicable threshold in § 1.1411–2(d) or such estate's or trust's (as defined in § 1.1411–3(a)(1)(i)) adjusted gross income exceeds the amount described in § 1.1411–3(a)(1)(ii)(B)(*2*).

(C) *Consequences of amended returns and examination adjustments*—(*1*) *Taxpayers first subject to section 1411.* An individual, estate, or trust also may regroup activities, in the matter described in paragraph (b)(3)(iv)(A) of this section, on an amended return only if the changes reported on such amended return cause the taxpayer to meet the Eligibility Criteria for the first time beginning in the taxable year for which the amended return is applicable and the taxable year is not closed by the period of limitations on assessments under section 6501. If the amended return is for a tax year that precedes a tax year for which a taxpayer had regrouped its activities pursuant to paragraph (b)(3)(iv)(A) of this section, the regrouping on such amended return must be consistent with the taxpayer's subsequent year's regrouping. If a regrouping on an amended return is inconsistent with a subsequent year's grouping, the subsequent year's grouping is invalid under § 1.469–4(e)(1) unless a material change in facts

and circumstances occurred in the subsequent year such that the subsequent year's grouping constitutes a permissible regrouping under § 1.469–4(e)(2). Similar rules also apply for any taxable year that begins during 2013.

(*2*) *Taxpayers ceasing to be subject to section 1411.* In the event a taxpayer regroups activities pursuant to paragraphs (b)(3)(iv)(A) or (C) of this section and it is subsequently determined that such taxpayer does not meet the Eligibility Criteria for the year of such regrouping, such regrouping will have no effect for that year and all future years. Appropriate adjustments should be made to reflect the voiding of the ineffective regrouping. However, notwithstanding the previous sentence, if an individual, estate, or trust meets the Eligibility Criteria in a subsequent year, such taxpayer is deemed to treat such regrouping as being made in such subsequent year unless the taxpayer either regroups in a different manner (so long as such alternative regrouping is permissible under § 1.469–4) or properly reflects the ineffective regrouping in the previous year. The subsequent year's regrouping may be made on an original or on an amended return for that year. This paragraph (b)(3)(iv)(C)(*2*) shall not apply if a taxpayer does not meet the Eligibility Criteria for the year of such regrouping as a result of the carryback of a net operating loss pursuant to section 172. Similar rules also apply for any taxable year that begins during 2013.

(*3*) *Examples.* The following examples illustrate the principles of paragraph (b)(3)(iv)(C) of this section. In each example, unless otherwise indicated, the taxpayer uses a calendar taxable year, the taxpayer is a United States citizen, and Year 1 is a taxable year in which section 1411 is in effect:

Example 1. In Year 1, X, a single individual, reports modified adjusted gross income (as defined in § 1.1411–2(c)) of $198,000 (including $12,000 of net investment income (as defined in § 1.1411–4)); thus is not subject to 1411. After X filed his original return, X receives a corrected Form 1099–DIV, which increases his modified adjusted gross income (as defined in § 1.1411–2(c)) and his net investment income by $2,500. X files an amended return for Year 1 in Year 2 reporting modified adjusted gross income of $200,500 and net investment income of $14,500. Pursuant to paragraph (b)(3)(iv)(C)(*1*) of this section, X may regroup his passive activities on an amended return, because X now has MAGI above the applicable threshold amount and net investment income.

Example 2. Same facts as *Example 1,* except that the $2,500 increase to modified adjusted gross income and net investment income was a result of an examination of X's Year 1 return. Pursuant to paragraph (b)(3)(iv)(C)(*1*) of this section, X may regroup his passive activities on an amended return.

Example 3. In Year 1, Y, a single individual reported modified adjusted gross income (as defined in § 1.1411–2(c)) of $205,000 and net investment income (as defined in § 1.1411–4) of $500. Pursuant to paragraph (b)(3)(iv)(A) of this section, Y regrouped his four passive activities, A, B, C, and D, into a single activity group. Prior to the Year 1 regrouping, Y had grouped A and B into one group, and treated each of C and D as separate activities. Y did not meet the Eligibly Criteria in any year prior to Year 1 or Year 2. In Year 3, Y's employer issued Y a corrected Year 1 Form W–2, which reduced Y's taxable wages by $6,000. As a result, Y no longer meets the Eligibility Criteria in Year 1 because Y's modified adjusted gross income is now $199,000. Therefore, Y's Year 1 regrouping is no longer effective and the prior groupings are in effect (that is, Activity A and B are one group and Activity C and Activity D separately). Appropriate adjustments should be made to reflect the ineffective regrouping. However, if Y had a material change in facts and circumstances such that Y could regroup in Year 1 or a subsequent year, as applicable, by reason of § 1.469–4(e)(2), then the regrouping will be deemed to occur. Y could designate a different regrouping for the year of the material change in facts and circumstances.

Example 4. Same facts as *Example 3,* except that Y met the Eligibly Criteria in Year 2. In this case, Y's Year 1 regrouping is no longer effective and Y must report his income consistent with the pre-Year 1 groupings. In Year 2, Y has three options. First, without any action by Y, Y's activities are regrouped as originally reported in Year 1. In this case, the regrouping from the Year 1 return is deemed to occur on the Year 2 return. This option is the default option. Second, pursuant to paragraph (b)(3)(iv)(C)(*2*) of this section, Y may file an amended return to report his income consistent with groupings in effect prior to Year 1. Third, Y may file an original or an amended return to regroup in a manner different from groupings in effect prior to Year 1 and different from the Year 1 groupings (for example, Y could choose to group Activity C and D into single activity, thus causing Y to have two groups; Group A–B and Group C–D).

(D) *Effective/applicability date.* This section applies to taxable years beginning after December 31, 2013. However, taxpayers may apply this section to taxable years beginning after December 31, 2012.

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■ **Par. 4.** An undesignated center heading and § 1.1411–0 are added immediately following § 1.1403–1 to read as follows:

Net Investment Income Tax

§ 1.1411–0 Table of contents of provisions applicable to section 1411.

This section lists the table of contents for §§ 1.1411–1 through 1.1411–10.

§ 1.1411–1 General rules.

(a) General rule.
(b) Adjusted gross income.
(c) Effect of section 1411 and the regulations thereunder for other purposes.
(d) Definitions.
(e) Disallowance of certain credits against the section 1411 tax.
(f) Application to taxable years beginning before January 1, 2014.
(1) Retroactive application of regulations.
(2) Reliance and transitional rules.
(g) Effective/applicability date.

§ 1.1411–2 Application to individuals.

(a) Individual to whom tax applies.
(1) In general.
(2) Special rules.
(i) Dual resident individuals treated as residents of a foreign country under an income tax treaty.
(ii) Dual-status resident aliens.
(iii) Joint returns in the case of a nonresident alien individual married to a United States citizen or resident.
(A) Default treatment.
(B) Taxpayer election.
(*1*) Effect of election.
(*2*) Procedural requirements for making election.
(*3*) Ineffective elections.
(iv) Joint returns for a year in which nonresident alien married to a United States citizen or resident becomes a United States resident.
(A) Default treatment.
(B) Taxpayer election.
(*1*) Effect of election.
(*2*) Procedural requirements for making election.
(v) Grantor trusts.
(vi) Bankruptcy estates.
(vii) Bona fide residents of United States territories.
(A) Applicability.
(B) Coordination with exception for nonresident aliens.
(C) Definitions.
(*1*) Bona fide resident.
(*2*) United States territory.
(b) Calculation of tax.
(1) In general.
(2) Example.
(c) Modified adjusted gross income.
(1) General rule.
(2) Rules with respect to CFCs and PFICs.
(d) Threshold amount.
(1) In general.
(2) Taxable year of less than twelve months.
(i) General rule.
(ii) Change of annual accounting period.
(e) Effective/applicability date.

§ 1.1411–3 Application to Estates and Trusts

(a) Estates and trusts to which tax applies.
(1) In general.
(i) General application.
(ii) Calculation of tax.
(2) Taxable year of less than twelve months.
(i) General rule.
(ii) Change of annual accounting period.
(3) Rules with respect to CFCs and PFICs.
(b) Application to certain trusts and estates.

(1) Exception for certain trusts and estates.
(2) Special rules for certain taxable trusts and estates.
(i) Qualified funeral trusts.
(ii) Bankruptcy estates.
(c) Application to electing small business trusts (ESBTs).
(1) General application.
(2) Computation of tax.
(i) Step one.
(ii) Step two.
(ii) Step three.
(3) Example.
(d) Application to charitable remainder trusts (CRTs).
(1) Operational rules.
(i) Treatment of annuity or unitrust distributions.
(ii) Apportionment among multiple beneficiaries.
(iii) Accumulated net investment income.
(2) Application of section 664.
(i) General rule.
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§ 1.1411–4 Definition of Net Investment Income

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§ 1.1411–7 Exception for Dispositions of Certain Active Interests in Partnerships and S Corporations [Reserved]

§ 1.1411–8 Exception for Distributions From Qualified Plans

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§ 1.1411–10 Controlled Foreign Corporations and Passive Foreign Investment Companies

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(1) In general.
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(C) Special rule for certain distributions related to 2013 taxable years.

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(1) Basis adjustments under sections 961 and 1293.

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(2) Special rules for partners that own interests in domestic partnerships that own directly or indirectly stock of CFCs or QEFs.

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(4) Special rules for participants in common trust funds.

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(1) Effect of election.

(2) Years to which election applies.

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(ii) Termination of interest in CFC or QEF.

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(ii) Certain domestic passthrough entities.

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(B) Certain domestic passthrough entities.

(iv) Time for making election.

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(i) Effective/applicability date.

■ **Par. 5.** Sections 1.1411–1 through 1.1411–10 are added to read as follows:

* * * * *

Sec.

1.1411–1 General rules.

1.1411–2 Application to individuals.

1.1411–3 Application to estates and trusts.

1.1411–4 Definition of net investment income.

1.1411–5 Trades or businesses to which tax applies.

1.1411–6 Income on investment of working capital subject to tax.

1.1411–7 [Reserved]

1.1411–8 Exception for distributions from qualified plans.

1.1411–9 Exception for self-employment income.

1.1411–10 Controlled foreign corporations and passive foreign investment companies.

* * * * *

§ 1.1411–1 General rules.

(a) *General rule.* Except as otherwise provided, all Internal Revenue Code (Code) provisions that apply for chapter 1 purposes in determining taxable income (as defined in section 63(a)) of a taxpayer also apply in determining the tax imposed by section 1411.

(b) *Adjusted gross income.* All references to an individual's adjusted gross income are treated as references to adjusted gross income as defined in section 62, and all references to an estate's or trust's adjusted gross income are treated as references to adjusted gross income as defined in section 67(e). However, there may be additional adjustments to adjusted gross income because of investments in controlled foreign corporations (CFCs) or passive foreign investment companies (PFICs). See § 1.1411–10(e).

(c) *Effect of section 1411 and the regulations thereunder for other purposes.* The inclusion or exclusion of items of income, gain, loss, or deduction in determining net investment income for purposes of section 1411, and the assignment of items of income, gain, loss, or deduction to a particular category of net investment income under section 1411(c)(1)(A), does not affect the treatment of any item of income, gain, loss, or deduction under any provision of the Code other than section 1411.

(d) *Definitions.* The following definitions apply for purposes of calculating net investment income under section 1411 and the regulations thereunder—

(1) The term *gross income from annuities* under section 1411(c)(1)(A) includes the amount received as an annuity under an annuity, endowment, or life insurance contract that is includible in gross income as a result of the application of section 72(a) and section 72(b), and an amount not received as an annuity under an annuity contract that is includible in gross income under section 72(e). In the case of a sale of an annuity, to the extent the sales price of the annuity does not exceed its surrender value, the gain recognized would be treated as gross income from an annuity within the meaning of section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i). However, if the sales price of the annuity exceeds its surrender value, the seller would treat the gain equal to the difference between the basis in the annuity and the surrender value as gross income from an annuity described in section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i) and the excess of the sales price over the surrender value as gain from the disposition of property included in section 1411(c)(1)(A)(iii) and § 1.1411–4(a)(1)(iii). The term *gross income from annuities* does not include amounts paid in consideration for services rendered. For example, distributions from a foreign retirement plan that are paid in the form of an annuity and include investment income that was earned by the retirement plan does not constitute income from an annuity within the meaning of section 1411(c)(1)(A)(i).

(2) The term *controlled foreign corporation (CFC)* is as defined in section 953(c)(1)(B) or 957(a).

(3) The term *gross income from dividends* includes any item treated as a dividend for purposes of chapter 1. See also § 1.1411–10 for additional amounts that constitute gross income from dividends. The term *gross income from dividends* includes, but is not limited to, amounts treated as dividends—

(i) Pursuant to subchapter C that are included in gross income (including constructive dividends);

(ii) Pursuant to section 1248(a), other than as provided in § 1.1411–10;

(iii) Pursuant to § 1.367(b)–2(e)(2);

(iv) Pursuant to section 1368(c)(2); and

(v) Substitute dividends that represent payments made to the transferor of a security in a securities lending transaction or a sale-repurchase transaction.

(4) The term *excluded income* means:

(i) Items of income excluded from gross income in chapter 1. For example, interest on state and local bonds excluded from gross income under section 103 and gain from the sale of a

principal residence excluded from gross income under section 121.

(ii) Items of income not included in net investment income, as determined under §§ 1.1411–4 and 1.1411–10. For example, wages, unemployment compensation, Alaska Permanent Fund Dividends, alimony, and Social Security Benefits.

(iii) Items of gross income and net gain specifically excluded by section 1411, the regulations thereunder, or other guidance published in the Internal Revenue Bulletin. For example, gains from the disposition of property used in a trade of business not described in section 1411(c)(2) under § 1.1411–4(d)(4)(i), distributions from certain Qualified Plans described in section 1411(c)(5) and § 1.1411–8, income taken into account in determining self-employment income that is subject to tax under section 1401(b) described in section 1411(c)(6) and § 1.1411–9, and section 951(a) inclusions from a CFC for which a § 1.1411–10(g) election is not in effect.

(5) The term *individual* means any natural person.

(6) The term *gross income from interest* includes any item treated as interest income for purposes of chapter 1 and substitute interest that represents payments made to the transferor of a security in a securities lending transaction or a sale-repurchase transaction.

(7) The term *married* and *married taxpayer* has the same meaning as in section 7703.

(8) The term *net investment income (NII)* means net investment income as defined in section 1411(c) and § 1.1411–4, as adjusted pursuant to the rules described in § 1.1411–10(c).

(9) The term *passive foreign investment company (PFIC)* is as defined in section 1297(a).

(10) The term *gross income from rents* includes amounts paid or to be paid principally for the use of (or the right to use) tangible property.

(11) The term *gross income from royalties* includes amounts received from mineral, oil, and gas royalties, and amounts received for the privilege of using patents, copyrights, secret processes and formulas, goodwill, trademarks, tradebrands, franchises, and other like property.

(12) The term *trade or business* refers to a trade or business within the meaning of section 162.

(13) The term *United States person* is as defined in section 7701(a)(30).

(14) The term *United States shareholder* is as defined in section 951(b).

(e) *Disallowance of certain credits against the section 1411 tax.* Amounts that may be credited against only the tax imposed by chapter 1 of the Code may not be credited against the section 1411 tax imposed by chapter 2A of the Code unless specifically provided in the Code. For example, the foreign income, war profits, and excess profits taxes that are allowed as a foreign tax credit by section 27(a), section 642(a), and section 901, respectively, are not allowed as a credit against the section 1411 tax.

(f) *Application to taxable years beginning before January 1, 2014*—(1) *Retroactive application of regulations.* Taxpayers that are subject to section 1411, and any other taxpayer to which these regulations may apply (such as partnerships and S corporations), may apply §§ 1.1411–1 through 1.1411–10 (including the ability to make any election(s) contained therein) in any taxable year that begins after December 31, 2012, but before January 1, 2014, for which the period of limitation under section 6501 has not expired.

(2) *Reliance and transitional rules.* For taxable years beginning before January 1, 2014, the Internal Revenue Service will not challenge a taxpayer's computation of tax under section 1411 if the taxpayer has made a reasonable, good faith effort to comply with the requirements of section 1411. For example, a taxpayer's compliance with the provisions of the proposed and final regulations under section 1411 (REG–130507–11 or REG–130843–13), generally, will be considered a reasonable, good faith effort to comply with the requirements of section 1411 if reliance on such regulation projects under section 1411 are applied in their entirety, and the taxpayer makes reasonable adjustments to ensure that their section 1411 tax liability in the taxable years beginning after December 31, 2013, is not inappropriately distorted by the positions taken in taxable years beginning after December 31, 2012, but before January 1, 2014. A similar rule applies to any other taxpayer to which these regulations may apply (such as partnerships and S corporations).

(g) *Effective/applicability date.* This section applies to taxable years beginning after December 31, 2013. However, taxpayers may apply this section to taxable years beginning after December 31, 2012, in accordance with paragraph (f) of this section.

§ 1.1411–2 Application to individuals.

(a) *Individual to whom tax applies*—(1) *In general.* Section 1411 applies to an individual who is a citizen or resident of the United States (within the meaning of section 7701(a)(30)(A)). Section 1411 does not apply to nonresident alien individuals (within the meaning of section 7701(b)(1)(B)). See paragraph (a)(2)(vi) of this section for special rules regarding bona fide residents of United States territories.

(2) *Special rules*—(i) *Dual resident individuals treated as residents of a foreign country under an income tax treaty.* A dual resident taxpayer (as defined in § 301.7701(b)–7(a)(1)) who determines that he or she is a resident of a foreign country for treaty purposes pursuant to an income tax treaty between the United States and the foreign country and who claims benefits of the treaty as a nonresident of the United States will be treated as a nonresident alien of the United States for purposes of paragraph (a)(1) of this section.

(ii) *Dual-status resident aliens.* A dual-status individual who is a resident of the United States for a portion of a taxable year and a nonresident alien for the other portion of the taxable year will not be subject to section 1411 with respect to the portion of the year for which that individual is treated as a nonresident alien. The only income the individual must take into account for purposes of section 1411 is the income he or she receives during the portion of the year for which he or she is treated as a resident of the United States. The threshold amount under paragraph (d)(1) of this section applies.

(iii) *Joint returns in the case of a nonresident alien individual married to a United States citizen or resident*—(A) *Default treatment.* In the case of a United States citizen or resident who is married to a nonresident alien individual, the spouses will be treated as married filing separately for purposes of section 1411. For purposes of calculating the tax imposed under section 1411(a)(1), the United States citizen or resident spouse will be subject to the threshold amount for a married taxpayer filing a separate return in paragraph (d)(1)(ii) of this section, and the nonresident alien spouse will not be subject to tax under section 1411. In accordance with the rules for married individuals filing separate returns, the spouse that is a United States citizen or resident must determine his or her own net investment income and modified adjusted gross income.

(B) *Taxpayer election.* Married taxpayers who file a joint Federal income tax return pursuant to a section 6013(g) election for purposes of chapter 1 and chapter 24 also may elect to be treated as making a section 6013(g) election for purposes of chapter 2A

(relating to the tax imposed by section 1411).

(*1*) *Effect of election.* For purposes of calculating the tax imposed under section 1411(a)(1), the effect of an election under section 6013(g) is to include the combined income of the United States citizen or resident spouse and the nonresident spouse in the section 1411(a)(1) calculation and to apply the threshold amount for a taxpayer making a joint return as set out in paragraph (d)(1)(i) of this section.

(*2*) *Procedural requirements for making election.* Taxpayers with a section 6013(g) election in effect for chapter 1 and chapter 24 purposes for any taxable year beginning after December 31, 2012, or taxpayers making a section 6013(g) election for chapter 1 and chapter 24 purposes in any taxable year beginning after December 31, 2012, who want to apply their section 6013(g) election for purposes of chapter 2A must make the election for the first taxable year beginning after December 31, 2013, in which the United States taxpayer is subject to tax under section 1411. The determination of whether the United States taxpayer is subject to tax under section 1411 is made without regard to the effect of the section 6013(g) election described in paragraph (a)(2)(iii)(B) of this section. The election, if made, must be made in the manner prescribed by forms, instructions, or in other guidance on an original or amended return for the taxable year for which the election is made. An election can be made on an amended return only if the taxable year for which the election is made, and all taxable years that are affected by the election, are not closed by the period of limitations on assessments under section 6501. Further, once made, the duration and termination of the section 6013(g) election for chapter 2A is governed by the rules of section 6013(g)(2) through (g)(6) and the regulations thereunder.

(*3*) *Ineffective elections.* In the event a taxpayer makes an election described in paragraph (a)(2)(iii)(B) of this section and subsequently determines that such taxpayer does not meet the criteria for making such election in such tax year described in paragraph (a)(2)(iii)(B)(*2*) of this section, then such original election will have no effect for that year and all future years. In such a case, the taxpayer should make appropriate adjustments to properly reflect the ineffective election. However, notwithstanding the previous sentence, if a taxpayer meets the criteria for the same election in a subsequent year, such taxpayer is deemed to treat such original election as being made in that subsequent year unless the taxpayer files (or amends) the return for such subsequent year to report the taxpayer's net investment income tax without the original election. Furthermore, this paragraph (a)(2)(iii)(B)(*3*) shall not apply if a taxpayer does not meet the criteria described in paragraph (a)(2)(iii)(B)(*2*) of this section for making such election in such tax year solely as a result of the carryback of a net operating loss pursuant to section 172.

(iv) *Joint returns for a year in which nonresident alien married to a United States citizen or resident becomes a United States resident*—(A) *Default treatment.* In the case of a United States citizen or resident who is married to an individual who is a nonresident alien individual at the beginning of any taxable year, but is a United States resident at the close of such taxable year, each spouse will be treated as married filing separately for the entire year for purposes of section 1411. For purposes of calculating the tax imposed under section 1411(a)(1), each spouse will be subject to the threshold amount for a married taxpayer filing a separate return in paragraph (d)(1)(ii) of this section. The spouse who becomes a United States resident during the tax year will be subject to section 1411 only with respect to income received for the portion of the year for which he or she is treated as a United States resident. Each spouse must determine his or her own net investment income and modified adjusted gross income.

(B) *Taxpayer election.* Married taxpayers who file a joint Federal income tax return pursuant to a section 6013(h) election for purposes of chapter 1 and chapter 24 also may elect to be treated as making a section 6013(h) election for purposes of chapter 2A for such tax year.

(*1*) *Effect of election.* For purposes of calculating the tax imposed under section 1411(a)(1), the effect of an election under section 6013(h) is to include the combined income of the United States citizen or resident spouse and the dual-status resident spouse in the section 1411(a)(1) calculation and to apply the threshold amount for a taxpayer making a joint return as set out in paragraph (d)(1)(i) of this section.

(*2*) *Procedural requirements for making election.* Taxpayers who make a section 6013(h) election for purposes of chapter 1 and chapter 24 for any taxable year beginning after December 31, 2012, may elect to have their section 6013(h) election apply for purposes of chapter 2A. The election, if made, must be made in the manner prescribed by forms, instructions, or in other guidance on an original or amended return for the taxable year for which the election is made. An election can be made on an amended return only if the taxable year for which the election is made, and all taxable years that are affected by the election, are not closed by the period of limitations on assessments under section 6501. Further, in all cases, once made, the section 6013(h) election is governed by the rules of section 6013(h)(2) and the regulations thereunder.

(iv) *Grantor trusts.* For rules regarding the treatment of owners of grantor trusts, see § 1.1411–3(b)(1)(v).

(v) *Bankruptcy estates.* A bankruptcy estate administered under chapter 7 (relating to liquidations) or chapter 11 (relating to reorganizations) of the Bankruptcy Code (Title 11 of the United States Code) of a debtor who is an individual is treated as a married taxpayer filing a separate return for purposes of section 1411. See § 1.1411–2(d)(1)(ii).

(vi) *Bona fide residents of United States territories*—(A) *Applicability.* An individual who is a bona fide resident of a United States territory is subject to the tax imposed by section 1411(a)(1) only if the individual is required to file an income tax return with the United States upon application of section 931, 932, 933, or 935 and the regulations thereunder. With respect to an individual described in this paragraph (a)(2)(vi)(A), the amount excluded from gross income under section 931 or 933 and any deduction properly allocable or chargeable against amounts excluded from gross income under section 931 or 933, respectively, is not taken into account in computing modified adjusted gross income under paragraph (c) of this section or net investment income (within the meaning of § 1.1411–1(d)).

(B) *Coordination with exception for nonresident aliens.* An individual who is both a bona fide resident of a United States territory and a nonresident alien individual with respect to the United States is not subject to taxation under section 1411(a)(1).

(C) *Definitions.* For purposes of this section—

(*1*) *Bona fide resident.* The term *bona fide resident* has the meaning provided under section 937(a).

(*2*) *United States territory.* The term *United States territory* means American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, or the United States Virgin Islands.

(b) *Calculation of tax*—(1) *In general.* In the case of an individual described in paragraph (a)(1) of this section, the tax imposed by section 1411(a)(1) for each taxable year is equal to 3.8 percent of the lesser of—

(i) Net investment income for such taxable year; or

(ii) The excess (if any) of—

(A) The modified adjusted gross income (as defined in paragraph (c) of this section) for such taxable year; over

(B) The threshold amount (as defined in paragraph (d) of this section).

(2) *Example.* During Year 1 (at year in which section 1411 is in effect), A, an unmarried United States citizen, has modified adjusted gross income (as defined in paragraph (c) of this section) of $190,000, which includes $50,000 of net investment income. A has a zero tax imposed under section 1411 because the threshold amount for a single individual is $200,000 (as provided in paragraph (d)(1)(iii) of this section). If during Year 2, A has modified adjusted gross income of $220,000, which includes $50,000 of net investment income, then the individual has a section 1411 tax of $760 (3.8% multiplied by $20,000, the lesser of $50,000 net investment income or $20,000 excess of modified adjusted gross income over the threshold amount).

(c) *Modified adjusted gross income*—(1) *General rule.* For purposes of section 1411, the term *modified adjusted gross income* means adjusted gross income increased by the excess of—

(i) The amount excluded from gross income under section 911(a)(1); over

(ii) The amount of any deductions (taken into account in computing adjusted gross income) or exclusions disallowed under section 911(d)(6) with respect to the amounts described in paragraph (c)(1)(i) of this section.

(2) *Rules with respect to CFCs and PFICs.* Additional rules in § 1.1411–10(e)(1) apply to an individual that is a United States shareholder of a controlled foreign corporation (CFC) or that is a United States person that directly or indirectly owns an interest in a passive foreign investment company (PFIC).

(d) *Threshold amount*—(1) *In general.* The term *threshold amount* means—

(i) In the case of a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), $250,000;

(ii) In the case of a married taxpayer filing a separate return, $125,000; and

(iii) In the case of any other individual, $200,000.

(2) *Taxable year of less than twelve months*—(i) *General rule.* In the case of an individual who has a taxable year consisting of less than twelve months (short taxable year), the threshold amount under paragraph (d)(1) of this section is not reduced or prorated. For example, in the case of an unmarried decedent who dies on June 1, the threshold amount is $200,000 for the decedent's short taxable year that begins on January 1 and ends on June 1.

(ii) *Change of annual accounting period.* Notwithstanding paragraph (d)(2)(i) of this section, an individual who has a short taxable year resulting from a change of annual accounting period reduces the threshold amount to an amount that bears the same ratio to the full threshold amount provided under paragraph (d)(1) of this section as the number of months in the short taxable year bears to twelve.

(e) *Effective/applicability date.* This section applies to taxable years beginning after December 31, 2013. However, taxpayers may apply this section to taxable years beginning after December 31, 2012, in accordance with § 1.1411–1(f).

§ 1.1411–3 Application to estates and trusts.

(a) *Estates and trusts to which tax applies*—(1) *In general*—(i) *General application.* Section 1411 and the regulations thereunder apply to all estates and trusts that are subject to the provisions of part I of subchapter J of chapter 1 of subtitle A of the Internal Revenue Code, unless specifically exempted under paragraph (b) of this section.

(ii) *Calculation of tax.* The tax imposed by section 1411(a)(2) for each taxable year is equal to 3.8 percent of the lesser of—

(A) The estate's or trust's undistributed net investment income for such taxable year; or

(B) The excess (if any) of—

(*1*) The estate's or trust's adjusted gross income (as defined in section 67(e) and as adjusted under § 1.1411–10(e)(2), if applicable) for such taxable year; over

(*2*) The dollar amount at which the highest tax bracket in section 1(e) begins for such taxable year.

(2) *Taxable year of less than twelve months*—(i) *General rule.* In the case of an estate or trust that has a taxable year consisting of less than twelve months (short taxable year), the dollar amount described in paragraph (a)(1)(ii)(B)(*2*) of this section is not reduced or prorated.

(ii) *Change of annual accounting period.* Notwithstanding paragraph (a)(2)(i) of this section, an estate or trust that has a short taxable year resulting from a change of annual accounting period (but not from an individual's death) reduces the dollar amount described in paragraph (a)(1)(ii)(B)(*2*) of this section to an amount that bears the same ratio to that dollar amount as the number of months in the short taxable year bears to twelve.

(3) *Rules with respect to CFCs and PFICs.* Additional rules in § 1.1411–10 apply to an estate or trust that holds an interest in a controlled foreign corporation (CFC) or a passive foreign investment company (PFIC).

(b) *Application to certain trusts and estates*—(1) *Exception for certain trusts and estates.* The following trusts are not subject to the tax imposed by section 1411:

(i) A trust or decedent's estate all of the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

(ii) A trust exempt from tax under section 501.

(iii) A charitable remainder trust described in section 664. However, see paragraph (d) of this section for special rules regarding the treatment of annuity or unitrust distributions from such a trust to persons subject to tax under section 1411.

(iv) Any other trust, fund, or account that is statutorily exempt from taxes imposed in subtitle A. For example, see sections 220(e)(1), 223(e)(1), 529(a), and 530(a).

(v) A trust, or a portion thereof, that is treated as a grantor trust under subpart E of part I of subchapter J of chapter 1. However, in the case of any such trust or portion thereof, each item of income or deduction that is included in computing taxable income of a grantor or another person under section 671 is treated as if it had been received by, or paid directly to, the grantor or other person for purposes of calculating such person's net investment income.

(vi) Electing Alaska Native Settlement Trusts subject to taxation under section 646.

(vii) Cemetery Perpetual Care Funds to which section 642(i) applies.

(viii) Foreign trusts (as defined in section 7701(a)(31)(B) and § 301.7701–7(a)(2)) (but see §§ 1.1411–3(e)(3)(ii) and 1.1411–4(e)(1)(ii) for rules related to distributions from foreign trusts to United States beneficiaries).

(ix) Foreign estates (as defined in section 7701(a)(31)(A)) (but see § 1.1411–3(e)(3)(ii) for rules related to distributions from foreign estates to United States beneficiaries).

(2) *Special rules for certain taxable trusts and estates*—(i) *Qualified funeral trusts.* For purposes of the calculation of any tax imposed by section 1411, section 1411 and the regulations thereunder are applied to each qualified funeral trust (within the meaning of section 685) by treating each beneficiary's interest in each such trust as a separate trust.

(ii) *Bankruptcy estates.* A bankruptcy estate in which the debtor is an individual is treated as a married taxpayer filing a separate return for

purposes of section 1411. See § 1.1411–2(a)(2)(v) and (d)(1)(ii).

(c) *Application to electing small business trusts (ESBTs)*—(1) *General application.* The S portion and non-S portion (as defined in § 1.641(c)–1(b)(2) and (3), respectively) of a trust that has made an ESBT election under section 1361(e)(3) and § 1.1361–1(m)(2) are treated as separate trusts for purposes of the computation of undistributed net investment income in the manner described in paragraph (e) of this section, but are treated as a single trust for purposes of determining the amount subject to tax under section 1411. If a grantor or another person is treated as the owner of a portion of the ESBT, the items of income and deduction attributable to the grantor portion (as defined in § 1.641(c)–1(b)(1)) are included in the grantor's calculation of net investment income and are not included in the ESBT's computation of tax described in paragraph (c)(1)(ii) of this section.

(2) *Computation of tax.* This paragraph (c)(2) provides the method for an ESBT to compute the tax under section 1411.

(i) *Step one.* The S portion and non-S portion computes each portion's undistributed net investment income as separate trusts in the manner described in paragraph (e) of this section and then combine these amounts to calculate the ESBT's undistributed net investment income.

(ii) *Step two.* The ESBT calculates its adjusted gross income (as defined in paragraph (a)(1)(ii)(B)(*1*) of this section). The ESBT's adjusted gross income is the adjusted gross income of the non-S portion, increased or decreased by the net income or net loss of the S portion, after taking into account all deductions, carryovers, and loss limitations applicable to the S portion, as a single item of ordinary income (or ordinary loss).

(iii) *Step three.* The ESBT pays tax on the lesser of—

(A) The ESBT's total undistributed net investment income; or

(B) The excess of the ESBT's adjusted gross income (as calculated in paragraph (c)(2)(ii) of this section) over the dollar amount at which the highest tax bracket in section 1(e) begins for the taxable year.

(3) *Example.* (i) In Year 1 (a year that section 1411 is in effect), the non-S portion of Trust, an ESBT, has dividend income of $15,000, interest income of $10,000, and capital loss of $5,000. Trust's S portion has net rental income of $21,000 and a capital gain of $7,000. The Trustee's annual fee of $1,000 is allocated 60% to the non-S portion and 40% to the S portion. Trust makes a distribution from income to a single beneficiary of $9,000.

(ii) *Step one.* (A) Trust must compute the undistributed net investment income for the S portion and non-S portion in the manner described in paragraph (c) of this section.

The undistributed net investment income for the S portion is $20,600 and is determined as follows:

Net Rental Income	$21,000
Capital Gain	7,000
Trustee Annual Fee	(400)
Total S portion undistributed net investment income	27,600

(B) The undistributed net investment income for the non-S portion is $12,400 and is determined as follows:

Dividend Income	$15,000
Interest Income	10,000
Deductible Capital Loss	(3,000)
Trustee Annual Fee	(600)
Distributable net income distribution	(9,000)
Total non-S portion undistributed net investment income	12,400

(C) Trust combines the undistributed net investment income of the S portion and non-S portion from (ii)(A) and (B) to arrive at Trust's combined undistributed net investment income.

S portion's undistributed net investment income	$27,600
Non-S portion's undistributed net investment income	12,400
Combined undistributed net investment income	40,000

(iii) *Step two.* (A) The ESBT calculates its adjusted gross income. Pursuant to paragraph (c)(2)(ii) of this section, the ESBT's adjusted gross income is the non-S portion's adjusted gross income increased or decreased by the net income or net loss of the S portion.

(B) The adjusted gross income for the ESBT is $38,000 and is determined as follows:

Dividend Income	$15,000
Interest Income	10,000
Deductible Capital Loss	(3,000)
Trustee Annual Fee	(600)
Distributable net income distribution	(9,000)
S Portion Income	27,600
Adjusted gross income	40,000

(C) The S portion's single item of ordinary income used in the ESBT's adjusted gross income calculation is $27,600. This item of income is determined by starting with net rental income of $21,000 and capital gain of $7,000 and reducing it by the S portion's $400 share of the annual trustee fee.

(iv) *Step three.* Trust pays tax on the lesser of—

(A) The combined undistributed net investment income ($40,000); or

(B) The excess of adjusted gross income ($40,000) over the dollar amount at which the highest tax bracket in section 1(e) applicable to a trust begins for the taxable year.

(d) *Application to charitable remainder trusts (CRTs)*—(1) *Operational rules*—(i) *Treatment of annuity or unitrust distributions.* If one or more items of net investment income comprise all or part of an annuity or unitrust distribution from a CRT, such items retain their character as net investment income in the hands of the recipient of that annuity or unitrust distribution.

(ii) *Apportionment among multiple beneficiaries.* In the case of a CRT with more than one annuity or unitrust beneficiary, the net investment income is apportioned among such beneficiaries based on their respective shares of the total annuity or unitrust amount paid by the CRT for that taxable year.

(iii) *Accumulated net investment income.* The accumulated net investment income of a CRT is the total amount of net investment income received by a CRT for all taxable years that begin after December 31, 2012, less the total amount of net investment income distributed for all prior taxable years of the trust that begin after December 31, 2012.

(2) *Application of Section 664*—(i) *General rule.* The Federal income tax rate of the item of net investment income, to be used to determine the proper classification of that item within the appropriate income category as described in § 1.664–1(d)(1)(i)(b), is the sum of the income tax rate applicable to that item under chapter 1 and the tax rate under section 1411. Thus, the accumulated net investment income and excluded income (as defined in § 1.1411–1(d)(4)) of a CRT in the same income category constitute separate classes of income within that category as described in § 1.664–1(d)(1)(i)(b).

(ii) *Special rules for CRTs with income from CFCs or PFICs.* [Reserved]

(iii) *Examples.* The following examples illustrate the provisions of this paragraph (d)(2).

Example 1. (i) In 2009, A formed CRT as a charitable remainder annuity trust. The trust document requires an annual annuity payment of $50,000 to A for 15 years. For purposes of this example, assume that CRT is a valid charitable remainder trust under section 664 and has not received any unrelated business taxable income during any taxable year.

(ii) As of January 1, 2013, CRT has the following items of undistributed income within its § 1.664–1(d)(1) categories and classes:

Category	Class	Tax rate (percent)	Amount
Ordinary Income	Interest	39.6	$4,000
	Net Rental Income	39.6	8,000
	Non-Qualified Dividend Income	39.6	2,000
	Qualified Dividend Income	20.0	10,000
Capital Gain	Short-Term	39.6	39,000
	Unrecaptured Section 1250 Gain	25.0	1,000
	Long-Term	20.0	560,000
Other Income			None
Total undistributed income as of January 1, 2013			624,000

Pursuant to § 1.1411–3(d)(1)(iii), none of the $624,000 of undistributed income is accumulated net investment income (ANII) because none of it was received by CRT after December 31, 2012. Thus, the entire $624,000 of undistributed income is excluded income (as defined in § 1.1411–1(d)(4)).

(iii) During 2013, CRT receives $7,000 of interest income, $9,000 of qualified dividend income, $4,000 of short-term capital gain, and $11,000 of long-term capital gain. Prior to the 2013 distribution of $50,000 to A, CRT has the following items of undistributed income within its § 1.664–1(d)(1) categories and classes after the application of paragraph (d)(2) of this section:

Category	Class	Excluded/ANII	Tax rate (percent)	Amount
Ordinary Income	Interest	NII	43.4	$7,000
	Interest	Excluded	39.6	4,000
	Net Rental Income	Excluded	39.6	8,000
	Non-Qualified Dividend Income	Excluded	39.6	2,000
	Qualified Dividend Income	NII	23.8	9,000
	Qualified Dividend Income	Excluded	20.0	10,000
Capital Gain	Short-Term	NII	43.4	4,000
	Short-Term	Excluded	39.6	39,000
	Unrecaptured Section 1250 Gain	Excluded	25.0	1,000
	Long-Term	NII	23.8	11,000
	Long-Term	Excluded	20.0	560,000
Other Income				None

(iv) The $50,000 distribution to A for 2013 will include the following amounts:

Category	Class	Excluded/ANII	Tax rate (percent)	Amount
Ordinary Income	Interest	NII	43.4	$7,000
	Interest	Excluded	39.6	4,000
	Net Rental Income	Excluded	39.6	8,000
	Non-Qualified Dividend Income	Excluded	39.6	2,000
	Qualified Dividend Income	NII	23.8	9,000
	Qualified Dividend Income	Excluded	20.0	10,000
Capital Gain	Short-Term	NII	43.4	4,000
	Short-Term	Excluded	39.6	6,000
	Unrecaptured Section 1250 Gain	Excluded	25.0	None
	Long-Term	NII	23.8	None
	Long-Term	Excluded	20.0	None

The amount included in A's 2013 net investment income is $20,000. This amount is comprised of $7,000 of interest income, $9,000 of qualified dividend income, and $4,000 of short-term capital gain.

(v) As a result, as of January 1, 2014, CRT has the following items of undistributed income within its § 1.664–1(d)(1) categories and classes:

Category	Class	Excluded/ANII	Tax rate (percent)	Amount
Ordinary Income	Interest			None

Category	Class	Excluded/ANII	Tax rate (percent)	Amount
	Net Rental Income			None
	Non-Qualified Dividend Income			None
	Qualified Dividend Income			None
Capital Gain	Short-Term	Excluded	39.6	$33,000
	Unrecaptured Section 1250 Gain	Excluded	25.0	1,000
	Long-Term	ANII	23.8	11,000
	Long-Term	Excluded	20.0	560,000
Other Income				None

Example 2 [Reserved].

(3) *Elective simplified method.* [Reserved]

(e) *Calculation of undistributed net investment income*—(1) *In general.* This paragraph (e) provides special rules for the computation of certain deductions and for the allocation of net investment income between an estate or trust and its beneficiaries. Generally, an estate's or trust's net investment income is calculated in the same manner as that of an individual. See § 1.1411–10(c) for special rules regarding CFCs, PFICs, and estates and trusts holding interests in such entities.

(2) *Undistributed net investment income.* An estate's or trust's undistributed net investment income is the estate's or trust's net investment income reduced by distributions of net investment income to beneficiaries and by deductions under section 642(c) in the manner described in paragraphs (e)(3) and (e)(4) of this section.

(3) *Distributions of net investment income to beneficiaries.* (i) In computing the estate's or trust's undistributed net investment income, net investment income is reduced by distributions of net investment income made to beneficiaries. The deduction allowed under this paragraph (e)(3) is limited to the lesser of the amount deductible to the estate or trust under section 651 or section 661, as applicable, or the net investment income of the estate or trust. In the case of a deduction under section 651 or section 661 that consists of both net investment income and excluded income (as defined in § 1.1411–1(d)(4)), the distribution must be allocated between net investment income and excluded income in a manner similar to § 1.661(b)–1 as if net investment income constituted gross income and excluded income constituted amounts not includible in gross income. See § 1.661(c)–1 and *Example 1* in paragraph (e)(5) of this section.

(ii) If one or more items of net investment income comprise all or part of a distribution for which a deduction is allowed under paragraph (e)(3)(i) of this section, such items retain their character as net investment income under section 652(b) or section 662(b), as applicable, for purposes of computing net investment income of the recipient of the distribution who is subject to tax under section 1411. The provisions of this paragraph (e)(3)(ii) also apply to distributions to United States beneficiaries of current year income described in section 652 or section 662, as applicable, from foreign estates and foreign nongrantor trusts.

(4) *Deduction for amounts paid or permanently set aside for a charitable purpose.* In computing the estate's or trust's undistributed net investment income, the estate or trust is allowed a deduction for amounts of net investment income that are allocated to amounts allowable under section 642(c). In the case of an estate or trust that has items of income consisting of both net investment income and excluded income, the allowable deduction under this paragraph (e)(4) must be allocated between net investment income and excluded income in accordance with § 1.642(c)–2(b) as if net investment income constituted gross income and excluded income constituted amounts not includible in gross income. For an estate or trust with deductions under both sections 642(c) and 661, see § 1.662(b)–2 and *Example 2* in paragraph (e)(5) of this section.

(5) *Examples.* The following examples illustrate the provisions of this paragraph (e). In each example, Year 1 is a year in which section 1411 is in effect and the taxpayer is not a foreign estate or trust:

Example 1. Calculation of undistributed net investment income (with no deduction under section 642(c)). (i) In Year 1, Trust has dividend income of $15,000, interest income of $10,000, capital gain of $5,000, and $75,000 of taxable income relating to a distribution from an individual retirement account (as defined under section 408). Trust has no expenses. Trust distributes $10,000 of its current year trust accounting income to A, a beneficiary of Trust.

(ii) Trust's distributable net income is $100,000 ($15,000 in dividends plus $10,000 in interest plus $75,000 of taxable income from an individual retirement account), from which the $10,000 distribution to A is paid. Trust's deduction under section 661 is $10,000. Under § 1.662(b)–1, the deduction reduces each class of income comprising distributable net income on a proportional basis. The $10,000 distribution equals 10% of distributable net income ($10,000 divided by $100,000). Therefore, the distribution consists of dividend income of $1,500, interest income of $1,000, and ordinary income attributable to the individual retirement account of $7,500. Because the $5,000 of capital gain allocated to principal for trust accounting purposes did not enter into distributable net income, no portion of that amount is included in the $10,000 distribution, nor does it qualify for the deduction under section 661.

(iii) Trust's net investment income is $30,000 ($15,000 in dividends plus $10,000 in interest plus $5,000 in capital gain). Trust's $75,000 of taxable income attributable to the individual retirement account is excluded income under § 1.1411–1(d)(4). Trust's undistributed net investment income under paragraph (e)(2) of this section is $27,500, which is Trust's net investment income ($30,000) less the amount of dividend income ($1,500) and interest income ($1,000) distributed to A. The $27,500 of undistributed net investment income is comprised of the capital gain allocated to principal ($5,000), the remaining undistributed dividend income ($13,500), and the remaining undistributed interest income ($9,000).

(iv) Under paragraph (e)(3) of this section and pursuant to § 1.1411–4(a)(1), A's net investment income includes dividend income of $1,500 and interest income of $1,000, but does not include the $7,500 of ordinary income attributable to the individual retirement account because it is excluded from net investment income under § 1.1411–8.

Example 2. Calculation of undistributed net investment income (with deduction under section 642(c)). (i) Same facts as *Example 1,* except Trust is required to distribute $30,000 to A. In addition, Trust has a $10,000 deduction under section 642(c) (deduction for amounts paid for a charitable purpose). Trust also makes an additional discretionary distribution of $20,000 to B, a beneficiary of Trust. As in *Example 1,* Trust's net investment income is $30,000 ($15,000 in dividends plus $10,000 in interest plus $5,000 in capital gain). In accordance with §§ 1.661(b)–2 and 1.662(b)–2, the items of income must be allocated between the mandatory distribution to A, the discretionary distribution to B, and the $10,000 distribution to a charity.

(ii) For purposes of the mandatory distribution to A, Trust's distributable net

income is $100,000. See § 1.662(b)–2, *Example* 1(b). Trust's deduction under section 661 for the distribution to A is $30,000. Under § 1.662(b)–1, the deduction reduces each class of income comprising distributable net income on a proportional basis. The $30,000 distribution equals 30% of distributable net income ($30,000 divided by $100,000). Therefore, the distribution consists of dividend income of $4,500, interest income of $3,000, and ordinary income attributable to the individual retirement account of $22,500. A's mandatory distribution thus consists of $7,500 of net investment income and $22,500 of excluded income.

(iii) Trust's remaining distributable net income is $70,000. Trust's remaining undistributed net investment income is $22,500. The $10,000 deduction under section 642(c) is allocated in the same manner as the distribution to A, where the $10,000 distribution equals 10% of distributable net income ($10,000 divided by $100,000). For purposes of determining undistributed net investment income, Trust's net investment income is reduced by $2,500 under paragraph (e)(4) of this section (dividend income of $1,500, interest income of $1,000, but with no reduction for amounts attributable to the individual retirement account of $7,500).

(iv) With respect to the discretionary distribution to B, Trust's remaining distributable net income is $60,000. Trust's remaining undistributed net investment income is $20,000. Trust's deduction under section 661 for the distribution to B is $20,000. The $20,000 distribution equals 20% of distributable net income ($20,000 divided by $100,000). Therefore, the distribution consists of dividend income of $3,000, interest income of $2,000, and ordinary income attributable to the individual retirement account of $15,000. B's distribution consists of $5,000 of net investment income and $15,000 of excluded income.

(v) Trust's undistributed net investment income is $15,000 after taking into account distribution deductions and section 642(c) in accordance with paragraphs (e)(3) and (e)(4) of this section, respectively. To arrive at Trust's undistributed net investment income of $15,000, Trust's net investment income of $30,000 is reduced by $7,500 of the mandatory distribution to A, $2,500 of the section 642(c) deduction, and $5,000 of the discretionary distribution to B. The undistributed net investment income consists of the remaining dividend income of $6,000 ($15,000 less $4,500 less $1,500 less $3,000), interest income of $4,000 ($10,000 less $1,000 less $3,000 less $2,000), and the $5,000 of undistributed capital gain.

Example 3. Fiscal Year Estate. (i) D died in 2011. D's estate (Estate) filed its first return that established its fiscal year ending October 31, 2011. During Estate's fiscal year ending October 31, 2013, it earned $10,000 of interest, $1,000 of dividends, and $15,000 of short-term gains. The Estate distributed its interest and dividends to S, D's spouse and sole beneficiary, on a quarterly basis; the last quarter's payment for that taxable year was made to S on December 5, 2013. Pursuant to § 1.662(c)–1, S is deemed to have received the first three payments for that taxable year, regardless of the actual payment dates, on October 31, 2013, the last day of Estate's taxable year. Estate makes a timely section 663(b) election to treat the fourth quarter distribution to S as having been made on October 31, 2013, the last day of Estate's preceding taxable year. Accordingly, S is deemed to have received $10,000 of interest and $1,000 of dividends on October 31, 2013.

(ii) Because Estate's fiscal year ending October 31, 2013, began on November 1, 2012, the Estate is not subject to section 1411 on income received during that taxable year. Therefore, none of the income received by Estate during its fiscal year ending October 31, 2013, is net investment income. Pursuant to paragraph (e)(3)(ii) of this section, because none of the distributed interest or dividend income constituted net investment income to Estate, the $10,000 of interest and $1,000 of dividends that Estate distributed to S does not constitute net investment income to S.

(f) *Effective/applicability date.* This section applies to taxable years beginning after December 31, 2013, except that paragraph (d) of this section applies to taxable years of CRTs that begin after December 31, 2012. However, taxpayers other than CRTs may apply this section to taxable years beginning after December 31, 2012, in accordance with § 1.1411–1(f).

§ 1.1411–4 Definition of net investment income.

(a) *In general.* For purposes of section 1411 and the regulations thereunder, net investment income means the excess (if any) of—

(1) The sum of—

(i) Gross income from interest, dividends, annuities, royalties, and rents, except to the extent excluded by the ordinary course of a trade or business exception described in paragraph (b) of this section;

(ii) Other gross income derived from a trade or business described in § 1.1411–5; and

(iii) Net gain (to the extent taken into account in computing taxable income) attributable to the disposition of property, except to the extent excluded by the exception described in paragraph (d)(4)(i)(A) of this section for gain or loss attributable to property held in a trade or business not described in § 1.1411–5; over

(2) The deductions allowed by subtitle A that are properly allocable to such gross income or net gain (as determined in paragraph (f) of this section).

(b) *Ordinary course of a trade or business exception.* Gross income described in paragraph (a)(1)(i) of this section is excluded from net investment income if it is derived in the ordinary course of a trade or business not described in § 1.1411–5. See § 1.1411–6 for rules regarding working capital. To determine whether gross income described in paragraph (a)(1)(i) of this section is derived in a trade or business, the following rules apply.

(1) In the case of an individual, estate, or trust that owns or engages in a trade or business directly (or indirectly through ownership of an interest in an entity that is disregarded as an entity separate from its owner under § 301.7701–3), the determination of whether gross income described in paragraph (a)(1)(i) of this section is derived in a trade or business is made at the individual, estate, or trust level.

(2) In the case of an individual, estate, or trust that owns an interest in a passthrough entity (for example, a partnership or S corporation), and that entity is engaged in a trade or business, the determination of whether gross income described in paragraph (a)(1)(i) of this section is—

(i) Derived in a trade or business described in § 1.1411–5(a)(1) is made at the owner level; and

(ii) Derived in a trade or business described in § 1.1411–5(a)(2) is made at the entity level.

(3) The following examples illustrate the provisions of this paragraph (b). For purposes of these examples, assume that the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example 1. Multiple passthrough entities. A, an individual, owns an interest in UTP, a partnership, which is engaged in a trade or business. UTP owns an interest in LTP, also a partnership, which is not engaged in a trade or business. LTP receives $10,000 in dividends, $5,000 of which is allocated to A through UTP. The $5,000 of dividends is not derived in a trade or business because LTP is not engaged in a trade or business. This is true even though UTP is engaged in a trade or business. Accordingly, the ordinary course of a trade or business exception described in paragraph (b) of this section does not apply, and A's $5,000 of dividends is net investment income under paragraph (a)(1)(i) of this section.

Example 2. Multiple passthrough entities. B, an individual, owns an interest in UTP2, a partnership, which is not engaged in a trade or business. UTP2 owns an interest in LTP2, also a partnership, which is engaged in a commercial lending trade or business. LTP2 is not engaged in a trade or business described in § 1.1411–5(a)(2). LTP2's trade or business is not a passive activity (within the meaning of section 469) with respect to B. LTP2 earns $10,000 of interest income from its trade or business which is allocated to B through UTP2. Although UTP2 is not engaged in a trade or business, the $10,000 of interest income is derived in the ordinary course of LTP2's lending trade or business. Because LTP2 is not engaged in a trade or

business described in § 1.1411–5(a)(2) and because LTP2's trade or business is not a passive activity with respect to B (as described in § 1.1411–5(a)(1)), the ordinary course of a trade or business exception described in paragraph (b) of this section applies, and B's $10,000 of interest is not included as net investment income under paragraph (a)(1)(i) of this section.

Example 3. Entity engaged in trading in financial instruments. C, an individual, owns an interest in PRS, a partnership, which is engaged in a trade or business of trading in financial instruments (as defined in § 1.1411–5(a)(2)). PRS' trade or business is not a passive activity (within the meaning of section 469) with respect to C. In addition, C is not directly engaged in a trade or business of trading in financial instruments or commodities. PRS earns interest of $50,000, and C's distributive share of the interest is $25,000. Because PRS is engaged in a trade or business described in § 1.1411–5(a)(2), the ordinary course of a trade or business exception described in paragraph (b) of this section does not apply, and C's $25,000 distributive share of the interest is net investment income under paragraph (a)(1)(i) of this section.

Example 4. Application of ordinary course of a trade or business exception. D, an individual, owns stock in S corporation, S. S is engaged in a banking trade or business (that is not a trade or business of trading in financial instruments or commodities), and S's trade or business is not a passive activity (within the meaning of section 469) with respect to D because D materially participates in the activity. S earns $100,000 of interest in the ordinary course of its trade or business, of which $5,000 is D's pro rata share. For purposes of paragraph (b) of this section, the interest income is derived in the ordinary course of S's banking business because it is not working capital under section 1411(c)(3) and § 1.1411–6(a) (because it is considered to be derived in the ordinary course of a trade or business under the principles of § 1.469–2T(c)(3)(ii)(A)). Because S is not engaged in a trade or business described in § 1.1411–5(a)(2) and because S's trade or business is not a passive activity with respect to D (as described in § 1.1411–5(a)(1)), the ordinary course of a trade or business exception described in paragraph (b) of this section applies, and D's $5,000 of interest is not included under paragraph (a)(1)(i) of this section.

(c) *Other gross income from a trade or business described in § 1.1411–5.* For a trade or business described in § 1.1411–5, paragraph (a)(1)(ii) of this section includes all other gross income (within the meaning of section 61) that is not gross income described in paragraph (a)(1)(i) of this section or net gain described in paragraph (a)(1)(iii) of this section.

(d) *Net gain.* This paragraph (d) describes special rules for purposes of paragraph (a)(1)(iii) of this section.

(1) *Definition of disposition.* For purposes of section 1411 and the regulations thereunder, the term *disposition* means a sale, exchange, transfer, conversion, cash settlement, cancellation, termination, lapse, expiration, or other disposition (including a deemed disposition, for example, under section 877A).

(2) *Limitation.* The calculation of net gain may not be less than zero. Losses allowable under section 1211(b) are permitted to offset gain from the disposition of assets other than capital assets that are subject to section 1411.

(3) *Net gain attributable to the disposition of property*—(i) *General rule.* Net gain attributable to the disposition of property is the gain described in section 61(a)(3) recognized from the disposition of property reduced, but not below zero, by losses deductible under section 165, including losses attributable to casualty, theft, and abandonment or other worthlessness. The rules in subchapter O of chapter 1 and the regulations thereunder apply. See, for example, § 1.61–6(b). For purposes of this paragraph, net gain includes, but is not limited to, gain or loss attributable to the disposition of property from the investment of working capital (as defined in § 1.1411–6); gain or loss attributable to the disposition of a life insurance contract; and gain attributable to the disposition of an annuity contract to the extent the sales price of the annuity exceeds the annuity's surrender value.

(ii) *Examples.* The following examples illustrate the provisions of this paragraph (d)(3). For purposes of these examples, assume that the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example 1. Calculation of net gain. (i) In Year 1, A, an unmarried individual, realizes a capital loss of $40,000 on the sale of P stock and realizes a capital gain of $10,000 on the sale of Q stock, resulting in a net capital loss of $30,000. Both P and Q are C corporations. A has no other capital gain or capital loss in Year 1. In addition, A receives wages of $300,000 and earns $5,000 of gross income from interest. For income tax purposes, under section 1211(b), A may use $3,000 of the net capital loss against other income. Under section 1212(b)(1), the remaining $27,000 is a capital loss carryover. For purposes of determining A's Year 1 net gain under paragraph (a)(1)(iii) of this section, A's gain of $10,000 on the sale of the Q stock is reduced by A's loss of $40,000 on the sale of the P stock. In addition, A may reduce net investment income by the $3,000 of the excess of capital losses over capital gains allowed for income tax purposes under section 1211(b).

(ii) In Year 2, A has a capital gain of $30,000 on the sale of Y stock. Y is a C corporation. A has no other capital gain or capital loss in Year 2. For income tax purposes, A may reduce the $30,000 gain by the Year 1 section 1212(b) $27,000 capital loss carryover. For purposes of determining A's Year 2 net gain under paragraph (a)(1)(iii) of this section, A's $30,000 gain may also be reduced by the $27,000 capital loss carryover from Year 1. Therefore, in Year 2, A has $3,000 of net gain for purposes of paragraph (a)(1)(iii) of this section.

Example 2. Calculation of net gain. The facts are the same as in *Example 1,* except that in Year 1, A also realizes a gain of $20,000 on the sale of Rental Property D, all of which is treated as ordinary income under section 1250. For income tax purposes, under section 1211(b), A may use $3,000 of the net capital loss against other income. Under section 1212(b)(1) the remaining $27,000 is a capital loss carryover. For purposes of determining A's net gain under paragraph (a)(1)(iii) of this section, A's gain of $10,000 on the sale of the Q stock is reduced by A's loss of $40,000 on the sale of the P stock. A's $20,000 gain on the sale of Rental Property D is reduced to the extent of the $3,000 loss allowed under section 1211(b). Therefore, A's net gain for Year 1 is $17,000 ($20,000 gain treated as ordinary income on the sale of Rental Property D reduced by $3,000 loss allowed under section 1211).

Example 3. Section 121(a) exclusion. (i) In Year 1, A, an unmarried individual, sells a house that A has owned and used as A's principal residence for the five years preceding the sale and realizes $200,000 in gain. In addition to the gain realized from the sale of A's principal residence, A also realizes $7,000 in long-term capital gain. A has a $5,000 short-term capital loss carryover from a year preceding the effective date of section 1411.

(ii) For income tax purposes, under section 121(a), A excludes the $200,000 gain realized from the sale of A's principal residence from A's Year 1 gross income. In determining A's Year 1 adjusted gross income, A also reduces the $7,000 capital gain by the $5,000 capital loss carryover allowed under section 1211(b).

(iii) For section 1411 purposes, under section 121(a), A excludes the $200,000 gain realized from the sale of A's principal residence from A's Year 1 gross income and, consequently, from A's net investment income. In determining A's Year 1 net gain under paragraph (a)(1)(iii) of this section, A reduces the $7,000 capital gain by the $5,000 capital loss carryover allowed under section 1211(b).

Example 4. Section 1031 like-kind exchange. (i) In Year 1, A, an unmarried individual who is not a dealer in real estate, purchases Greenacre, a piece of undeveloped land, for $10,000. A intends to hold Greenacre for investment.

(ii) In Year 3, A enters into an exchange in which A transfers Greenacre, now valued at $20,000, and $5,000 cash for Blackacre, another piece of undeveloped land, which has a fair market value of $25,000. The exchange is a transaction for which no gain or loss is recognized under section 1031.

(iii) In Year 3, for income tax purposes, A does not recognize any gain from the exchange of Greenacre for Blackacre. A's basis in Blackacre is $15,000 ($10,000 substituted basis in Greenacre plus $5,000

additional cost of acquisition). For purposes of section 1411, A's net investment income for Year 3 does not include any realized gain from the exchange of Greenacre for Blackacre.

(iv) In Year 5, A sells Blackacre to an unrelated party for $35,000 in cash.

(v) In Year 5, for income tax purposes, A recognizes capital gain of $20,000 ($35,000 sale price minus $15,000 basis). For purposes of section 1411, A's net investment income includes the $20,000 gain recognized from the sale of Blackacre.

(4) *Gains and losses excluded from net investment income*—(i) *Exception for gain or loss attributable to property held in a trade or business not described in § 1.1411–5*—(A) *General rule.* Net gain does not include gain or loss attributable to property (other than property from the investment of working capital (as described in § 1.1411–6)) held in a trade or business not described in § 1.1411–5.

(B) *Special rules for determining whether property is held in a trade or business.* To determine whether net gain described in paragraph (a)(1)(iii) of this section is from property held in a trade or business—

(*1*) A partnership interest or S corporation stock generally is not property held in a trade or business. Therefore, gain from the sale of a partnership interest or S corporation stock is generally gain described in paragraph (a)(1)(iii) of this section. However, net gain does not include certain gain or loss attributable to the disposition of certain interests in partnerships and S corporations as provided in § 1.1411–7.

(*2*) In the case of an individual, estate, or trust that owns or engages in a trade or business directly (or indirectly through ownership of an interest in an entity that is disregarded as an entity separate from its owner under § 301.7701–3), the determination of whether net gain described in paragraph (a)(1)(iii) of this section is attributable to property held in a trade or business is made at the individual, estate, or trust level.

(*3*) In the case of an individual, estate, or trust that owns an interest in a passthrough entity (for example, a partnership or S corporation), and that entity is engaged in a trade or business, the determination of whether net gain described in paragraph (a)(1)(iii) of this section from such entity is attributable to—

(*i*) Property held in a trade or business described in § 1.1411–5(a)(1) is made at the owner level; and

(*ii*) Property held in a trade or business described in § 1.1411–5(a)(2) is made at the entity level.

(C) *Examples.* The following examples illustrate the provisions of this paragraph (d)(4)(i). For purposes of these examples, assume the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example 1. Gain from rental activity. A, an unmarried individual, rents a boat to B for $100,000 in Year 1. A's rental activity does not involve the conduct of a section 162 trade or business, and under section 469(c)(2), A's rental activity is a passive activity. In Year 2, A sells the boat to B, and A realizes and recognizes taxable gain attributable to the disposition of the boat of $500,000. Because the exception provided in paragraph (d)(4)(i)(A) of this section requires a trade or business, this exception is inapplicable, and therefore, A's $500,000 gain will be taken into account under § 1.1411–4(a)(1)(iii).

Example 2. Installment sale. (i) PRS, partnership for Federal income tax purposes, operates an automobile dealership. B and C, unmarried individuals, each own a 40% interest in PRS and both materially participate in the activities of PRS for all relevant years. Therefore, with respect to B and C, PRS is not a trade or business described in section 1411(c)(2) and § 1.1411–5. D owns the remaining 20% of PRS. Assume, for purposes of this example, that PRS is a passive activity with respect to D, and therefore is a trade or business described in section 1411(c)(2)(A) and § 1.1411–5(a)(1).

(ii)(A) In Year 0, a year preceding the effective date of section 1411, PRS relocates its dealership to a larger location. As a result of the relocation, PRS sells its old dealership facility to a real estate developer in exchange for $1,000,000 cash and a $4,500,000 promissory note, fully amortizing over the subsequent 15 years, and bearing adequate stated interest. PRS reports the sale transaction under section 453. PRS's adjusted tax basis in the old dealership facility is $1,075,000. Assume for purposes of this example that PRS has $300,000 of recapture income (within the meaning of section 453(i)); the buyer is not related to PRS, B, C, or D; and the buyer is not assuming any liabilities of PRS in the transaction.

(B) For chapter 1 purposes, PRS has realized gain on the transaction of $4,425,000 ($5,500,000 less $1,075,000). Pursuant to section 453(i), PRS will take into account $300,000 of the recapture income in Year 0, and the gain in excess of the recapture income ($4,125,000) will be taken into account under the installment method. For purposes of section 453, PRS's profit percentage is 75% ($4,125,000 gain divided by $5,500,000 gross selling price). In Year 0, PRS will take into account $750,000 of capital gain attributable to the $1,000,000 cash payment. In the subsequent 15 years, PRS will receive annual payments of $300,000 (plus interest). Each payment will result in PRS recognizing $225,000 of capital gain (75% of $300,000).

(iii)(A) In Year 1, PRS receives a payment of $300,000 plus the applicable amount of interest. For purposes of chapter 1, PRS recognizes $225,000 of capital gain. B and C's distributive share of the gain is $90,000 each and D's distributive share of the gain is $45,000.

(B) The old dealership facility constituted property held in PRS's trade or business. In the case of section 453 installment sales, section 453 governs the timing of the gain recognition, but does not alter the character of the gain. See § 1.1411–1(a). The determination of whether the gain is attributable to the disposition of property used in a trade or business described in paragraph (d)(4)(i) of this section constitutes an element of the gain's character for Federal tax purposes. As a result, the applicability of paragraph (d)(4)(i) of this section is determined in Year 0 and applies to all gain received on the promissory note during the 15 year payment period. This result is consistent with the section 469 determination of the passive or nonpassive classification of the gain under § 1.469–2T(c)(2)(i)(A).

(C) In the case of D, PRS's trade or business is described in section 1411(c)(2)(A) and § 1.1411–5(a)(1). Therefore, the exclusion in paragraph (d)(4)(i) of this section does not apply, and D must include the $45,000 of gain in D's net investment income.

(D) In the case of B and C, PRS's trade or business is not described in section 1411(c)(2) or § 1.1411–5. Therefore, B and C exclude the $90,000 gain from net investment income pursuant to paragraph (d)(4)(i) of this section.

(iv) In Year 2, C dies and C's 40% interest in PRS passes to Estate.

(v)(A) In Year 3, PRS receives a payment of $300,000 plus the applicable amount of interest. For purposes of chapter 1, PRS recognizes $225,000 of capital gain. B and Estate each have a distributive share of the gain equal to $90,000 and D's distributive share of the gain is $45,000.

(B) The calculation of net investment income for B and D in Year 3 is the same as in (iii) for Year 1.

(C) In the case of Estate, the distributive share of the $90,000 gain constitutes income in respect of a decedent (IRD) under section 691(a)(4) and subchapter K. See § 1.1411–1(a). Assume that Estate paid estate taxes of $5,000 that were attributable to the $90,000 of IRD. Pursuant to section 691(c)(4), the amount of gain taken into account in computing Estate's taxable income in Year 3 is $85,000 ($90,000 reduced by the $5,000 of allocable estate taxes). Pursuant to section 691(a)(3) and § 1.691(a)–3(a), the character of the gain to the Estate is the same character as the gain would have been if C had survived to receive it. Although the amount of taxable gain for chapter 1 has been reduced, the remaining $85,000 retains its character attributable to the disposition of property used in a trade or business described in paragraph (d)(4)(i) of this section. Therefore, Estate may exclude the $85,000 gain from net investment income pursuant to paragraph (d)(4)(i) of this section.

(ii) (ii) *Other gains and losses excluded from net investment income.* Net gain, as determined under paragraph (d) of this section, does not include gains and losses excluded from

net investment income by any other provision in §§ 1.1411–1 through 1.1411–10. For example, see § 1.1411–7 (certain gain or loss attributable to the disposition of certain interests in partnerships and S corporations) and § 1.1411–8(b)(4)(ii) (net unrealized appreciation attributable to employer securities realized on a disposition of those employer securities).

(iii) *Adjustment for capital loss carryforwards for previously excluded income.* [Reserved]

(e) *Net investment income attributable to certain entities*—(1) *Distributions from estates and trusts*—(i) *In general.* Net investment income includes a beneficiary's share of distributable net income, as described in sections 652(a) and 662(a), to the extent that, under sections 652(b) and 662(b), the character of such income constitutes gross income from items described in paragraphs (a)(1)(i) and (ii) of this section or net gain attributable to items described in paragraph (a)(1)(iii) of this section, with further computations consistent with the principles of this section, as provided in § 1.1411–3(e).

(ii) *Distributions of accumulated net investment income from foreign nongrantor trusts to United States beneficiaries.* [Reserved]

(2) *CFCs and PFICs.* For purposes of calculating net investment income, additional rules in § 1.1411–10(c) apply to an individual, an estate, or a trust that is a United States shareholder that owns an interest in a controlled foreign corporation (CFC) or that is a United States person that directly or indirectly owns an interest in a passive foreign investment company (PFIC).

(3) *Treatment of income from common trust funds.* [Reserved]

(f) *Properly allocable deductions*—(1) *General rule*—(i) *In general.* Unless provided elsewhere in §§ 1.1411–1 through 1.1411–10, only properly allocable deductions described in this paragraph (f) may be taken into account in determining net investment income.

(ii) *Limitations.* Any deductions described in this paragraph (f) in excess of gross income and net gain described in section 1411(c)(1)(A) are not taken into account in determining net investment income in any other taxable year, except as allowed under chapter 1.

(2) *Properly allocable deductions described in section 62*—(i) *Deductions allocable to gross income from rents and royalties.* Deductions described in section 62(a)(4) allocable to rents and royalties described in paragraph (a)(1)(i) of this section are taken into account in determining net investment income.

(ii) *Deductions allocable to gross income from trades or businesses described in § 1.1411–5.* Deductions described in section 62(a)(1) allocable to income from a trade or business described in § 1.1411–5 are taken into account in determining net investment income to the extent the deductions have not been taken into account in determining self-employment income within the meaning of § 1.1411–9.

(iii) *Penalty on early withdrawal of savings.* Deductions described in section 62(a)(9) are taken into account in determining net investment income.

(iv) *Net operating loss.* The total section 1411 NOL amount of a net operating loss deduction allowed under section 172 is allowed as a properly allocable deduction in determining net investment income for any taxable year. See paragraph (h) of this section for the calculation of the total section 1411 NOL amount of a net operating loss deduction.

(v) *Examples.* The following examples illustrate the provisions of this paragraph (f)(2). For purposes of these examples, assume the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example 1. (i) A, an individual, is a 40% shareholder in SCo, an S corporation. SCo is engaged in a trade or business described in section 1411(c)(2)(A). SCo is the only passive activity owned by A. In Year 1, SCo reported a loss of $11,000 to A which was comprised of gross operating income of $29,000 and operating deductions of $40,000. A's at risk amount at the beginning of Year 1 is $7,000. There were no other events that affected A's at risk amount in Year 1.

(ii) For purposes of calculating A's net investment income, A's $29,000 distributive share of SCo's gross operating income is income within the meaning of section 1411(c)(1)(A)(ii).

(iii) As a result of A's at risk limitation, for chapter 1 purposes, A may only deduct $7,000 of the operating deductions in excess of the gross operating income. The remaining $4,000 deductions are suspended because A's amount at risk at the end of Year 1 is zero.

(iv) For purposes of section 469, A has passive activity gross income of $29,000 and passive activity deductions of $36,000 ($40,000 of operating deductions allocable to A less $4,000 suspended under section 465). Because A has no other passive activity income from any other source, section 469 limits A's passive activity deductions to A's passive activity gross income. As a result, section 469 allows A to deduct $29,000 of SCo's operating deduction and suspends the remaining $7,000.

(v) For purposes of calculating A's net investment income, A has $29,000 of properly allocable deductions allowed by section 1411(c)(1)(B) and paragraph (f)(2)(ii) of this section.

Example 2. (i) Same facts as *Example 1.* In Year 2, SCo reported net income of $13,000 to A, which was comprised of gross operating income of $43,000 and operating deductions of $30,000. There were no other events that affected A's at risk amount in Year 2.

(ii) For purposes of calculating A's net investment income, A's $43,000 distributive share of gross operating income is income within the meaning of section 1411(c)(1)(A)(ii).

(iii) Pursuant to section 465(a)(2), A's deductions attributable to the gross income of SCo include the $30,000 deduction allocable to A in Year 2 plus the $4,000 loss that was suspended and carried over to Year 2 from Year 1 pursuant to section 465(a)(2). Under section 465(a)(2), the $4,000 of losses from Year 1 are treated as deductions from the activity in Year 2. As a result, A net operating income from SCo in Year 2 is $9,000 ($43,000 − $30,000 − $4,000) in Year 2. A's amount at risk at the end of Year 2 is $9,000.

(iv) For purposes of section 469, A has passive activity gross income of $43,000. A's passive activity deductions attributable to SCo are the sum of the Year 2 operating deductions allocable to A from S ($30,000), deductions formerly suspended by section 465 ($4,000), and passive activity losses suspended by section 469 ($7,000). Therefore, in Year 2, A has passive activity deductions of $41,000. Because A's passive activity gross income exceeds A's passive activity deductions, section 469 does not limit any of the deductions in Year 2. At the end of Year 2, A has no suspended passive activity losses.

(v) Although A's distributive share of Year 2 deductions allocable to SCo's operating income was $30,000; the operative provisions of sections 465 and 469 do not change the character of the deductions when such amounts are suspended under either section. Furthermore, section 465(a)(2) and §§ 1.469–1(f)(4) and 1.469–2T(d)(1) treat amounts suspended from prior years as deductions in the current year. See § 1.1411–1(a). Therefore, for purposes of calculating A's net investment income, A has $41,000 of properly allocable deductions allowed by section 1411(c)(1)(B) and paragraph (f)(2)(ii) of this section.

(3) *Properly allocable deductions described in section 63(d).* In determining net investment income, the following itemized deductions are taken into account:

(i) *Investment interest expense.* Investment interest (as defined in section 163(d)(3)) to the extent allowed under section 163(d)(1). Any investment interest not allowed under section 163(d)(1) is treated as investment interest paid or accrued by the taxpayer in the succeeding taxable year. The following example illustrates the provisions of this paragraph. For purposes of this example, assume that the taxpayer uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

(A) In Year 1, A, an unmarried individual, pays interest of $4,000 on debt incurred to purchase stock. Under § 1.163–8T, this

interest is allocable to the stock and is investment interest within the meaning of section 163(d)(3). A has no investment income as defined by section 163(d)(4). A has $10,000 of income from a trade or business that is a passive activity (as defined in § 1.1411–5(a)(1)) with respect to A. For income tax purposes, under section 163(d)(1), A may not deduct the $4,000 investment interest in Year 1 because A does not have any section 163(d)(4) net investment income. Under section 163(d)(2), the $4,000 investment interest is a carryforward of disallowed interest that is treated as investment interest paid by A in the succeeding taxable year. Similarly, for purposes of determining A's Year 1 net investment income, A may not deduct the $4,000 investment interest.

(B) In Year 2, A has $5,000 of section 163(d)(4) net investment income. For both income tax purposes and for determining section 1411 net investment income, A's $4,000 carryforward of interest expense disallowed in Year 1 may be deducted in Year 2.

(ii) *Investment expenses.* Investment expenses (as defined in section 163(d)(4)(C)).

(iii) *Taxes described in section 164(a)(3).* Taxes imposed on income described in section 164(a)(3) that are allocable to net investment income pursuant to paragraph (g)(1) of this section. Foreign income, war profits, and excess profits taxes are allowable as deductions under section 164(a)(3) in determining net investment income only if the taxpayer does not choose to take any foreign tax credits under section 901 with respect to the same taxable year. See section 275(a)(4). For rules applicable to refunds of taxes described in this paragraph, see paragraph (g)(2) of this section.

(iv) *Items described in section 72(b)(3).* In the case of an amount allowed as a deduction to the annuitant for the annuitant's last taxable year under section 72(b)(3), such amount is allowed as a properly allocable deduction in the same taxable year if the income from the annuity (had the annuitant lived to receive such income) would have been included in net investment income under paragraph (a)(1)(i) of this section (and not excluded from net investment income by reason of § 1.1411–8).

(v) *Items described in section 691(c).* Deductions for estate and generation-skipping taxes allowed by section 691(c) that are allocable to net investment income; provided, however, that any portion of the section 691(c) deduction described in section 691(c)(4) is taken into account instead in computing net gain under paragraph (d) and not under this paragraph (f)(3)(v).

(vi) *Items described in section 212(3).* Amounts described in section 212(3) and § 1.212–1(l) to the extent they are allocable to net investment income pursuant to paragraph (g)(1) of this section.

(vii) *Amortizable bond premium.* A deduction allowed under section 171(a)(1) for the amortizable bond premium on a taxable bond (for example, see § 1.171–2T(a)(4)(i)(C) for the treatment of a bond premium carryforward as a deduction under section 171(a)(1)).

(viii) *Fiduciary expenses.* In the case of an estate or trust, amounts described in § 1.212–1(i) to the extent they are allocable to net investment income pursuant to paragraph (g)(1) of this section.

(4) *Loss deductions*—(i) *General rule.* Losses described in section 165, whether described in section 62 or section 63(d), are allowed as properly allocable deductions to the extent such losses exceed the amount of gain described in section 61(a)(3) and are not taken into account in computing net gain by reason of paragraph (d) of this section.

(ii) *Examples.* The following examples illustrate the provisions of this paragraph (f)(4). For purposes of these examples, assume the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example 1. (i) A, an unmarried individual, owns an interest in PRS, a partnership for Federal income tax purposes. PRS is engaged in a trading business described in section 1411(c)(2)(B) and § 1.1411–5(a)(2) and has made a valid and timely election under section 475(f)(2). A's distributive share from PRS in Year 1 consists of $125,000 of interest and dividends and $60,000 of ordinary losses from the trading business. In addition to A's investment in PRS, A sold undeveloped land in Year 1 for a long-term capital gain of $50,000. A has no capital losses carried over from a preceding year.

(ii) For purposes of chapter 1, A includes the $125,000 of interest and dividends, $60,000 of ordinary loss, and $50,000 of long-term capital gain in the computation of A's adjusted gross income.

(iii) For purposes of calculating net investment income, A includes the $125,000 of interest and dividends. Pursuant to paragraph (d) of this section, A takes into account the $60,000 ordinary loss from PRS and the $50,000 of long-term capital gain in the computation of A's net gain. A's losses ($60,000) exceed A's gains ($50,000). Therefore, A's net gain under paragraph (d) of this section is zero. Additionally, A is allowed a deduction under paragraph (f)(4)(i) of this section for $10,000 (the amount of ordinary losses that were allowable under chapter 1 in excess of the amounts taken into account in computing net gain). A's net investment income in Year 1 is $115,000.

Example 2. (i) In Year 1, T, a nongrantor trust, incurs a capital loss of $5,000 on the sale of publicly traded stocks. In addition, T receives $17,000 of interest and dividend income. T has no capital losses carried over from a preceding year.

(ii) For purposes of chapter 1, T includes the $17,000 of interest and dividends and only $3,000 of the capital loss in the computation of adjusted gross income. The remaining $2,000 capital loss is carried over to Year 2.

(iii) For purposes of calculating net investment income, T includes the $17,000 of interest and dividends in net investment income. Pursuant to paragraph (d) of this section, T takes into account the $3,000 capital loss allowed by chapter 1. T's losses ($3,000) exceed T's gains ($0). Therefore, T's net gain under paragraph (d) of this section is zero. However, T is allowed a deduction under paragraph (f)(4)(i) of this section for $3,000 (the amount of losses that were allowable under chapter 1 in excess of the amounts taken into account in computing net gain). T's net investment income in Year 1 is $14,000.

Example 3. (i) In Year 1, B, an unmarried individual, incurs a short-term capital loss of $15,000 on the sale of publicly traded stocks. B also receives annuity income of $50,000. In addition, B disposes of property used in his sole proprietorship (which is not a trade or business described in section 1411(c)(2) or § 1.1411–5(a) for a gain of $21,000. Pursuant to section 1231, the gain of $21,000 is treated as a long-term capital gain for purposes of chapter 1. B has no capital losses carried over from a preceding year.

(ii) For purposes of chapter 1, B includes the $50,000 of annuity income in the computation of adjusted gross income. The $21,000 long-term capital gain is offset by the $15,000 short-term capital loss, so B includes $6,000 of net long-term capital gain in the computation of adjusted gross income.

(iii) For purposes of calculating net investment income, B includes the $50,000 of annuity income in net investment income. Pursuant to paragraph (d)(4)(i) of this section, B's net gain does not include the $21,000 long-term capital gain because it is attributable to property held in B's sole proprietorship (a nonpassive activity). Pursuant to paragraph (d) of this section, T takes into account the $15,000 capital loss allowed by chapter 1. B's losses ($15,000) exceed B's gains ($0). Therefore, A's net gain under paragraph (d) of this section is zero. However, B is allowed a deduction under paragraph (f)(4)(i) of this section for $15,000 (the amount of losses that were allowable under chapter 1 in excess of the amounts taken into account in computing net gain). B's net investment income in Year 1 is $35,000.

(5) *Ordinary loss deductions for certain debt instruments.* An amount treated as an ordinary loss by a holder of a contingent payment debt instrument under § 1.1275–4(b) or an inflation-indexed debt instrument under § 1.1275–7(f)(1).

(6) *Other deductions.* Any other deduction allowed by subtitle A that is

identified in published guidance in the **Federal Register** or in the Internal Revenue Bulletin (see § 601.601(d)(2)(ii)(*b*) of this chapter) as properly allocable to gross income or net gain under this section.

(7) *Application of limitations under sections 67 and 68.* Any deductions described in this paragraph (f) that are subject to section 67 (the 2-percent floor on miscellaneous itemized deductions) or section 68 (the overall limitation on itemized deductions) are allowed in determining net investment income only to the extent the items are deductible for chapter 1 purposes after the application of sections 67 and 68. For this purpose, section 67 applies before section 68. The amount of deductions subject to sections 67 and 68 that may be deducted in determining net investment income after the application of sections 67 and 68 is determined as described in paragraph (f)(7)(i) and (f)(7)(ii) of this section.

(i) *Deductions subject to section 67.* The amount of miscellaneous itemized deductions (as defined in section 67(b)) tentatively deductible in determining net investment income after applying section 67 (but before applying section 68) is the lesser of:

(A) The portion of the taxpayer's miscellaneous itemized deductions (before the application of section 67) that is properly allocable to items of income or net gain included in determining net investment income, or

(B) The taxpayer's total miscellaneous itemized deductions allowed after the application of section 67, but before the application of section 68.

(ii) *Deductions subject to section 68.* The amount of itemized deductions allowed in determining net investment income after applying sections 67 and 68 is the lesser of:

(A) The sum of the amount determined under paragraph (f)(7)(i) of this section and the amount of itemized deductions not subject to section 67 that are properly allocable to items of income or net gain included in determining net investment income, or

(B) The total amount of itemized deductions allowed after the application of sections 67 and 68.

(iii) *Itemized deductions.* For purposes of paragraph (f)(7)(ii), itemized deductions do not include any deduction described in section 68(c).

(iv) *Example.* The following example illustrates the provisions of this paragraph (f)(7). For purposes of these examples, assume the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

(A) A, an unmarried individual, has adjusted gross income in Year 1 as follows:

Wages	$1,600,000
Interest income	400,000
Adjusted gross income	2,000,000

In addition, A has the following items of expense qualifying as itemized deductions:

Investment expenses	$70,000
Job-related expenses	30,000
Investment interest expense	75,000
State income taxes	120,000

A's investment expenses and job-related expenses are miscellaneous itemized deductions. In addition, A's investment interest expense and investment expenses are properly allocable to net investment income (within the meaning of this section). A's job-related expenses are not properly allocable to net investment income. Of the state income tax expense, A applied a reasonable method pursuant to paragraph (g)(1) of this section to properly allocate $20,000 to net investment income.

(B) A's 2-percent floor under section 67 is $40,000 (2% of $2,000,000). For Year 1, assume the section 68 limitation starts at adjusted gross income of $200,000. The section 68 overall limitation disallows $54,000 of A's itemized deductions that are subject to section 68 (3% of the excess of the $2,000,000 adjusted gross income over the $200,000 limitation threshold).

(C)(1) A's total miscellaneous itemized deductions allowable before the application of section 67 is $100,000 ($70,000 in investment expenses plus $30,000 in job-related expenses), and the total miscellaneous deductions allowed after the application of section 67 is $60,000 ($100,000 minus $40,000).

(2) The amount of the miscellaneous itemized deductions properly allocable to net investment income after the application of section 67 is $60,000 (the lesser of $70,000 in investment expenses that are deductible as a miscellaneous itemized deduction and properly allocable to net investment income or $60,000 of miscellaneous itemized deductions allocable to net investment income allowed after the application of section 67).

(D)(1) The amount of itemized deductions allocable to net investment income after applying section 67 to deductions that are also miscellaneous itemized deductions but before applying section 68 is $155,000. This amount is the sum of $60,000 of miscellaneous itemized deductions determined in (C)(2), plus $20,000 in state income tax properly allocable to net investment income, plus $75,000 of investment interest expense. However, under section 68(c)(2), the $75,000 deduction for investment interest expenses is not subject to the section 68 limitation on itemized deductions and is excluded from the computation under § 1.1411–4(f)(7). Thus, the amount of itemized deductions allocable to net investment income and subject to section 68, after applying section 67 but before applying section 68, is $80,000.

(2) A's total itemized deductions allowed subject to the limitation under section 68 and after application of section 67, but before the application of section 68, are the following:

Miscellaneous itemized deductions	$60,000
State income tax	120,000
Deductions subject to section 68	180,000

(3) Of A's itemized deductions that are subject to the limitation under section 68, the amount allowed after the application of section 68 is $126,000 ($180,000 minus the $54,000 disallowed in (B)).

(E) Under paragraph (f)(7)(ii) of this section, the amount of itemized deductions allowed in determining net investment income after applying sections 67 and 68 is the lesser of $80,000 (the sum of $60,000 determined under paragraph (C)(2) and $20,000 state income tax allocable to net investment income) or $126,000 (determined under (D)(3)). Therefore, A's itemized deductions that are properly allocable to net investment income are $155,000 ($80,000 of properly allocable itemized deductions subject to section 67 or 68 plus $75,000 of investment interest expense (which is not subject to either section 67 or section 68 limitations)).

(g) *Special rules*—(1) *Deductions allocable to both net investment income and excluded income.* In the case of a properly allocable deduction described in section 1411(c)(1)(B) and paragraph (f) of this section that is allocable to both net investment income and excluded income, the portion of the deduction that is properly allocable to net investment income may be determined by taxpayers using any reasonable method. Examples of reasonable methods of allocation include, but are not limited to, an allocation of the deduction based on the ratio of the amount of a taxpayer's gross income (including net gain) described in § 1.1411–4(a)(1) to the amount of the taxpayer's adjusted gross income (as defined under section 62 (or section 67(e) in the case of an estate or trust)). In the case of an estate or trust, an allocation of a deduction pursuant to rules described in § 1.652(b)–3(b) (and § 1.641(c)–1(h) in the case of an ESBT) is also a reasonable method.

(2) *Recoveries of properly allocable deductions*—(i) *General rule.* If a taxpayer is refunded, reimbursed, or otherwise recovers any portion of an amount deducted as a section 1411(c)(1)(B) properly allocable deduction in a prior year, and such amount is not otherwise included in net investment income in the year of recovery under section 1411(c)(1)(A),

the amount of the recovery will reduce the taxpayer's total section 1411(c)(1)(B) properly allocable deductions in the year of recovery (but not below zero). The preceding sentence applies regardless of whether the amount of the recovery is excluded from gross income by reason of section 111.

(ii) *Recoveries of items allocated between net investment income and excluded income.* In the case of a refund of any item that was deducted under section 1411(c)(1)(B) in a prior year and the gross amount of the deduction was allocated between items of net investment income and excluded income pursuant to paragraph (g)(1) of this section, the amount of the reduction in section 1411(c)(1)(B) properly allocable deductions in the year of receipt under this paragraph (g)(2) is the total amount of the refund multiplied by a fraction. The numerator of the fraction is the amount of the total deduction allocable to net investment income in the prior year to which the refund relates. The denominator of the fraction is the total amount of the deduction in the prior year to which the refund relates.

(iii) *Recoveries with no prior year benefit.* For purposes of this paragraph (g)(2), section 111 applies to reduce the amount of any reduction required by paragraph (g)(2)(i) of this section to the extent that such previously deducted amount did not reduce the tax imposed by section 1411. To the extent a deduction is taken into account in computing a taxpayer's net operating loss deduction under paragraph (h) of this section, section 111(c) applies. Except as provided in the preceding sentence, for purposes of this paragraph (g)(2), no reduction of section 1411(c)(1)(B) properly allocable deductions is required in a year when such recovered item is attributable to an amount deducted in a taxable year—

(A) Preceding the effective date of section 1411, or

(B) In which the taxpayer was not subject to section 1411 solely because that individual's (as defined in § 1.1411–2(a)) modified adjusted gross income (as defined in § 1.1411–2(c)) does not exceed the applicable threshold in § 1.1411–2(d) or such estate's or trust's (as defined in § 1.1411–3(a)(1)(i)) adjusted gross income does not exceed the amount described in section 1411(a)(2)(B)(ii) and § 1.1411–3(a)(1)(ii)(B)(*2*).

(iv) *Examples.* The following examples illustrate the provisions of this paragraph (g)(2). For purposes of these examples, assume the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example 1. Recovery of amount included in income. A, an individual, is a 40% limited partner in LP. LP is a passive activity to A. In Year 1, A's distributable share of section 1411(c)(1)(A)(ii) income and properly allocable deductions described in § 1.1411–4(f)(2)(ii) were $50,000 and $37,000, respectively. In Year 2, LP received a refund of a properly allocable deduction described in § 1.1411–4(f)(2)(ii). A's distributable share of the recovered deduction is $2,000. Since the $2,000 recovery constitutes gross income described in section 1411(c)(1)(A)(ii) in Year 2, A does not reduce any properly allocable deductions attributable to Year 2.

Example 2. State income tax refund. In Year 1, D, an individual, allocated $15,000 of taxes out of a total of $75,000 to net investment income under paragraph (f)(3)(iii) of this section. D received no tax benefit from the deduction in Year 1 for chapter 1 purposes due to the alternative minimum tax, but it did reduce D's section 1411 tax. In Year 3, D received a refund of $5,000. For chapter 1 purposes, D excludes the $5,000 refund from gross income in Year 3 by reason of section 111. In Year 3, D allocated $30,000 of state income taxes out of a total of $90,000 to net investment income under paragraph (f)(3)(iii) of this section. Although the refund is excluded from D's gross income, D must nonetheless reduce Year 3's section 1411(c)(1)(B) properly allocable deductions by $1,000 ($5,000 × ($15,000/$75,000)). D's allocation of 33⅓% of section 164(a)(3) taxes in Year 3 to net investment income is irrelevant to the calculation of the amount of the reduction required by this paragraph (g)(2).

Example 3. State income tax refund with no prior year benefit. Same facts as *Example 2,* except in Year 1, D's section 1411(c)(1)(B) properly allocable deductions exceeded D's section 1411(c)(1)(A) income by $300. As a result, D was not subject to section 1411 in Year 1. Pursuant to paragraph (g)(2)(iii) of this section, D does not reduce Year 3's section 1411(c)(1)(B) properly allocable deductions for recoveries of amounts to the extent that such deductions did not reduce the tax imposed by section 1411. Therefore, D must reduce Year 3's section 1411(c)(1)(B) properly allocable deductions by $700 ($1,000 less $300).

(3) *Deductions described in section 691(b).* For purposes of paragraph (f) of this section, properly allocable deductions include items of deduction described in section 691(b), provided that the item otherwise would have been deductible to the decedent under § 1.1411–4(f). For example, an estate may deduct the decedent's unpaid investment interest expense in computing its net investment income because section 691(b) specifically allows the deduction under section 163, and § 1.1411–4(f)(3)(i) allows those deductions as well. However, an estate or trust may not deduct a payment of real estate taxes on the decedent's principal residence that were unpaid at death in computing its net investment income because, although real estate taxes are deductible under section 164 and specifically are allowed by section 691(b), the real estate taxes would not have been a properly allocable deduction of the decedent under § 1.1411–4(f).

(4) *Amounts described in section 642(h).* For purposes of the calculation of net investment income under this section, one or more beneficiaries succeeding to the property of the estate or trust, within the meaning of section 642(h), shall—

(i) Treat excess capital losses of the estate or trust described in section 642(h)(1) as capital losses of the beneficiary in the calculation of net gain in paragraph (d) and paragraph (f)(4) of this section, as applicable, in a manner consistent with section 642(h)(1);

(ii) Treat excess net operating losses of the estate or trust described in section 642(h)(1) as net operating losses of the beneficiary in the calculation of net investment income in paragraphs (f)(2)(iv) and (h) of this section in a manner consistent with section 642(h)(1); and

(iii) Treat the deductions described in paragraph (f) of this section (other than those taken into account under paragraph (g)(4)(i) or (ii) of this section) that exceed the gross investment income described in paragraph (a)(1) of this section (after taking into account any modifications, adjustments, and special rules for calculating net investment income in section 1411 and the regulations thereunder) of a terminating estate or trust as a section 1411(c)(1)(B) deduction of the beneficiary in a manner consistent with section 642(h)(2).

(5) *Treatment of self-charged interest income.* Gross income from interest (within the meaning of section 1411(c)(1)(A)(i) and paragraph (a)(1)(i) of this section) that is received by the taxpayer from a nonpassive activity of such taxpayer, solely for purposes of section 1411, is treated as derived in the ordinary course of a trade or business not described in § 1.1411–5. The amount of interest income that is treated as derived in the ordinary course of a trade or business not described in § 1.1411–5, and thus excluded from the calculation of net investment income, under this paragraph (g)(5) is limited to the amount that would have been considered passive activity gross income under the rules of § 1.469–7 if the payor was a passive activity of the taxpayer. For purposes of this rule, the term nonpassive activity does not include a trade or business described in

§ 1.1411–5(a)(2). However, this rule does not apply to the extent the corresponding deduction is taken into account in determining self-employment income that is subject to tax under section 1401(b).

(6) *Treatment of certain nonpassive rental activities*—(i) *Gross income from rents.* To the extent that gross rental income described in paragraph (a)(1)(i) of this section is treated as not derived from a passive activity by reason of § 1.469–2(f)(6) or as a consequence of a taxpayer grouping a rental activity with a trade or business activity under § 1.469–4(d)(1), such gross rental income is deemed to be derived in the ordinary course of a trade or business within the meaning of paragraph (b) of this section.

(ii) *Gain or loss from the disposition of property.* To the extent that gain or loss resulting from the disposition of property is treated as nonpassive gain or loss by reason of § 1.469–2(f)(6) or as a consequence of a taxpayer grouping a rental activity with a trade or business activity under § 1.469–4(d)(1), then such gain or loss is deemed to be derived from property used in the ordinary course of a trade or business within the meaning of paragraph (d)(4)(i) of this section.

(7) *Treatment of certain real estate professionals*—(i) *Safe Harbor.* In the case of a real estate professional (as defined in section 469(c)(7)(B)) that participates in one or more rental real estate activities for more than 500 hours during such year, or has participated in such real estate activities for more than 500 hours in any five taxable years (whether or not consecutive) during the ten taxable years that immediately precede the taxable year, then—

(A) Such gross rental income from that rental activity is deemed to be derived in the ordinary course of a trade or business within the meaning of paragraph (b) of this section; and

(B) Gain or loss resulting from the disposition of property used in such rental real estate activity is deemed to be derived from property used in the ordinary course of a trade or business within the meaning of paragraph (d)(4)(i) of this section.

(ii) *Definitions*—(A) *Participation.* For purposes of establishing participation under this paragraph (g)(7), any participation in the activity that would count towards establishing material participation under section 469 shall be considered.

(B) *Rental real estate activity.* The term *rental real estate activity* used in this paragraph (g)(7) is a rental activity within the meaning of § 1.469–1T(e)(3). An election to treat all rental real estate as a single rental activity under § 1.469–9(g) also applies for purposes of this paragraph (g)(7). However, any rental real estate that the taxpayer grouped with a trade or business activity under § 1.469–4(d)(1)(i)(A) or (d)(1)(i)(C) is not a rental real estate activity.

(iii) *Effect of safe harbor.* The inability of a real estate professional to satisfy the safe harbor in this paragraph (g)(7) does not preclude such taxpayer from establishing that such gross rental income and gain or loss from the disposition of property, as applicable, is not included in net investment income under any other provision of section 1411.

(8) *Treatment of former passive activities*—(i) *Section 469(f)(1)(A) losses.* Losses allowed in computing taxable income by reason of the rules governing former passive activities in section 469(f)(1)(A) are taken into account in computing net gain under paragraph (d) of this section or as properly allocable deductions under paragraph (f) of this section, as applicable, in the same manner as such losses are taken into account in computing taxable income (as defined in section 63). The preceding sentence applies only to the extent the net income or net gain from the former passive activity (as defined in section 469(f)(3)) is included in net investment income.

(ii) *Section 469(f)(1)(C) losses.* Losses allowed in computing taxable income by reason of section 469(f)(1)(C) are taken into account in computing net gain under paragraph (d) of this section or as properly allocable deductions under paragraph (f) of this section, as applicable, in the same manner as such losses are taken into account in computing taxable income (as defined in section 63).

(iii) *Examples.* The following examples illustrate the provisions of this paragraph (g)(8). For purposes of these examples, assume the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example 1. (i) B, an individual taxpayer, owns a 50% interest in SCorp, an S corporation engaged in the trade or business of retail clothing sales. B also owns a single family rental property, a passive activity. B materially participates in the retail sales activity of SCorp, but B has $10,000 of suspended losses from prior years when the retail sales activity of SCorp was a passive activity of B. Therefore, the retail sales activity of SCorp is a former passive activity within the meaning of section 469(f)(3).

(ii) In Year 1, B reports $205,000 of wages, $7,000 of nonpassive net income, $500 of interest income (attributable to working capital) from SCorp's retail sales activity, and $1,000 of net rental income from the single family rental property. B's Year 1 modified adjusted gross income (as defined in § 1.1411–2(c)) is $205,500; which includes $205,000 of wages, $500 of interest income, $7,000 of nonpassive income from SCorp, $7,000 of section 469(f)(1)(A) losses, $1,000 of passive income from the single family rental property and $1,000 of section 469(f)(1)(C) losses.

(iii) For purposes of the calculation of B's Year 1 net investment income, B includes the $500 of interest income and $1,000 of net passive income from the single family rental property. The $7,000 of nonpassive income from SCorp's retail sales activity is excluded from net investment income because the income is not attributable to a trade or business described in § 1.1411–5. Therefore, pursuant to the rules of paragraph (g)(8)(i) of this section, the $7,000 of section 469(f)(1)(A) losses are not taken into account in computing B's net investment income. However, pursuant to the rules of paragraph (g)(8)(ii) of this section, the $1,000 of passive losses allowed by reason of section 469(f)(1)(C), which are allowed as a deduction in Year 1 by reason of B's $1,000 of passive income from the single family rental property are allowed in computing B's net investment income. As a result, B's net investment income is $500 ($500 of interest income plus $1,000 of passive rental income less $1,000 of section 469(f)(1)(C) losses). Although the $500 of interest income is attributable to SCorp and includable in B's net investment income, such income is not taken into account when calculating the amount of section 469(f)(1)(A) losses allowed in the current year. Therefore, such income is not taken into account in computing the amount of section 469(f)(1)(A) losses allowed by reason of paragraph (g)(8)(i) of this section. Pursuant to section 469(b), B carries forward $2,000 of suspended passive losses attributable to SCorp's retail sales activity to Year 2.

Example 2. Same facts as *Example 1.* In Year 2, B materially participates in the retail sales activity of SCorp, and disposes of his entire interest in SCorp for a $9,000 long-term capital gain. Pursuant to § 1.469–2T(e)(3), the $9,000 gain is characterized as nonpassive income. Pursuant to section 469(f)(1)(A), the remaining $2,000 of suspended passive loss is allowed because the $9,000 gain is treated as nonpassive income. Assume that under section 1411(c)(4) and § 1.1411–7, B takes into account only $700 of the $9,000 gain in computing net investment income for Year 2. Pursuant to paragraph (g)(8)(i) of this section, B may take into account $700 of the $2,000 loss allowed by section 469(f)(1)(A) in computing net investment income for Year 2. Pursuant to paragraph (g)(8)(i) of this section, B may not deduct the remaining $1,300 passive loss allowed for chapter 1 in calculating net investment income for Year 2.

(9) *Treatment of section 469(g)(1) losses.* Losses allowed in computing taxable income by reason of section 469(g) are taken into account in computing net gain under paragraph (d) of this section or as properly allocable

deductions under paragraph (f) of this section, as applicable, in the same manner as such losses are taken into account in computing taxable income (as defined in section 63).

(10) *Treatment of section 707(c) guaranteed payments.* [Reserved]

(11) *Treatment of section 736 payments.* [Reserved]

(12) *Income and deductions from certain notional principal contracts.* [Reserved]

(13) *Treatment of income or loss from REMIC residual interests.* [Reserved]

(h) *Net operating loss*—(1) *General rule.* For purposes of paragraph (f)(2)(iv) of this section, the total section 1411 NOL amount of a net operating loss deduction for a taxable year is calculated by first determining the applicable portion of the taxpayer's net operating loss for each loss year under paragraph (h)(2) of this section. Next, the applicable portion for each loss year is used to determine the section 1411 NOL amount for each net operating loss carried from a loss year and deducted in the taxable year as provided in paragraph (h)(3) of this section. The section 1411 NOL amounts of each net operating loss carried from a loss year and deducted in the taxable year are then added together as provided in paragraph (h)(4) of this section. This sum is the total section 1411 NOL amount of the net operating loss deduction for the taxable year that is allowed as a properly allocable deduction in determining net investment income for the taxable year. For purposes of this paragraph (h), both the amount of a net operating loss for a loss year and the amount of a net operating loss deduction refer to such amounts as determined for purposes of chapter 1.

(2) *Applicable portion of a net operating loss.* In any taxable year in which a taxpayer incurs a net operating loss, the applicable portion of such loss is the lesser of:

(i) The amount of the net operating loss for the loss year that the taxpayer would incur if only items of gross income that are used to determine net investment income and only properly allocable deductions are taken into account in determining the net operating loss in accordance with section 172(c) and (d); or

(ii) The amount of the taxpayer's net operating loss for the loss year.

(3) *Section 1411 NOL amount of a net operating loss carried to and deducted in a taxable year.* The section 1411 NOL amount of each net operating loss that is carried from a loss year that is allowed as a deduction is the total amount of such net operating loss carried from the loss year allowed as a deduction under section 172(a) in the taxable year multiplied by a fraction. The numerator of the fraction is the applicable portion of the net operating loss for that loss year, as determined under paragraph (h)(2) of this section. The denominator of the fraction is the total amount of the net operating loss for the same loss year.

(4) *Total section 1411 NOL amount of a net operating loss deduction.* The section 1411 NOL amounts of each net operating loss carried to and deducted in the taxable year as determined under paragraph (h)(3) of this section are added together to determine the *total* section 1411 NOL amount of the net operating loss deduction for the taxable year that is properly allocable to net investment income.

(5) *Examples.* The following examples illustrate the provisions of this paragraph (h). For purposes of these examples, assume the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example 1. (i)(A) In Year 1, A, an unmarried individual, has the following items of income and deduction: $200,000 in wages, $50,000 in gross income from a trade or business of trading in financial instruments or commodities (as defined in § 1.1411–5(a)(2)) (trading activity), $10,000 of dividends, $1,000,000 in loss from his sole proprietorship (which is not a trade or business described in § 1.1411–5), $12,000 of non-business investment expenses, and $250,000 in trading loss deductions. As a result, for income tax purposes A sustains a section 172(c) net operating loss of $1,000,000. A makes an election under section 172(b)(3) to waive the carryback period for this net operating loss.

(B) For purposes of section 1411, A's net investment income for Year 1 is the excess (if any) of $60,000 ($50,000 trading activity gross income plus $10,000 dividend income) over $262,000 ($250,000 trading loss deductions plus $12,000 nonbusiness expenses).

(C) The amount of the net operating loss for Year 1 determined under section 172 that A would incur if only items of gross income that are used to determine net investment income and only properly allocable deductions are taken into account is $200,000. This amount is the excess of $250,000 trading loss deductions, over $50,000 trading activity gross income. Under section 172(d)(4), in determining the net operating loss, the $12,000 nonbusiness expenses are allowed only to the extent of the $10,000 dividend income. The $200,000 net operating loss determined using only properly allocable deductions and gross income items used in determining net investment income is less than A's actual net operating loss for Year 1 of $1,000,000, and accordingly the applicable portion for Year 1 is $200,000. The ratio used to calculate section 1411 NOL amounts of A's Year 1 net operating loss is $200,000 (net operating loss determined using only properly allocable deductions and gross income items used in determining net investment income)/ $1,000,000 (net operating loss), or 0.2.

(ii) For Year 2, A has $250,000 of wages, no gross income from the trading activity, $300,000 of income from his sole proprietorship, and $10,000 in trading loss deductions. For income tax purposes, A deducts $540,000 of the net operating loss carried over from Year 1. In addition, under § 1.1411–2(c), the $540,000 net operating loss will be allowed as a deduction in computing A's Year 2 modified adjusted gross income. Because A's modified adjusted gross income is $0, A is not subject to net investment income tax. For purposes of A's net investment income calculation, the section 1411 NOL amount of the $540,000 net operating loss from Year 1 that A deducts in Year 2 is $108,000 ($540,000 multiplied by .2 (the fraction determined based on the applicable portion of the net operating loss in the loss year)). The amount of the Year 1 net operating loss carried over to Year 3 is $460,000. For purposes of A's net investment income calculation, this net operating loss carryover amount includes a section 1411 NOL amount of $92,000 ($460,000 multiplied by 0.2). The section 1411 NOL amount may be applied in determining A's net investment income in Year 3.

(iii)(A) For Year 3, A has $400,000 of wages, $200,000 in trading gains which are gross income from the trading activity, $250,000 of income from his sole proprietorship, and $10,000 in trading loss deductions. For income tax purposes, A deducts the remaining $460,000 of the net operating loss from Year 1. In addition, under § 1.1411–2(c), the $460,000 net operating loss deduction reduces A's Year 3 modified adjusted gross income to $380,000.

(B) A's section 1411 NOL amount of the net operating loss deduction for Year 3 is $92,000, which is the $460,000 net operating loss deduction for Year 3 multiplied by 0.2.

(C) A's net investment income for Year 3 before the application of paragraph (f)(2)(iv) of this section is $190,000 ($200,000 in gross income from the trading activity, minus $10,000 in trading loss deductions). After the application of paragraph (f)(2)(iv) of this section, A's net investment income for Year 3 is $98,000 ($190,000 minus $92,000, the total section 1411 NOL amount of the net operating loss deduction).

Example 2. (i) The facts for Year 1 are the same as in *Example 1.*

(ii)(A) For Year 2, A has $100,000 in wages, $200,000 in gross income from the trading activity, $15,000 of dividends, $250,000 in losses from the sole proprietorship, $10,000 of non-business investment expenses, and $355,000 in trading loss deductions. As a result, for income tax purposes A sustains a section 172(c) net operating loss of $300,000. A makes an election under section 172(b)(3) to waive the carryback period for the Year 2 net operating loss.

(B) For purposes of section 1411, A's net investment income for Year 2 is the excess (if any) of $215,000 ($200,000 trading activity gross income plus $15,000 dividend income)

over $365,000 ($355,000 trading loss deductions plus $10,000 nonbusiness expenses).

(C) The amount of the net operating loss for Year 2 determined under section 172 that A would incur if only items of gross income that are used to determine net investment income and only properly allocable deductions are taken into account is $150,000. This amount is the excess of $365,000 ($355,000 trading loss deductions plus $10,000 nonbusiness expenses) over $215,000 ($200,000 trading activity gross income plus $15,000 dividend income). Under section 172(d)(4), in determining the net operating loss, the $10,000 nonbusiness expenses are allowed in full against the $15,000 dividend income. The $150,000 net operating loss determined using only properly allocable deductions and gross income items used in determining net investment income is less than A's actual net operating loss for Year 2 of $300,000, and accordingly the applicable portion is $150,000. The ratio used to calculate the section 1411 NOL amount of A's Year 2 net operating loss is $150,000 (the applicable portion)/$300,000 (net operating loss), or 0.5.

(iii) For Year 3, A has $250,000 of wages, no gross income from the trading activity, $300,000 of income from his sole proprietorship, and $10,000 in trading loss deductions. For income tax purposes, A deducts $540,000 of the net operating loss from Year 1. In addition, under § 1.1411–2(c), the $540,000 net operating loss will be allowed as a deduction in computing A's Year 3 modified adjusted gross income. Because A's modified adjusted gross income is $0, A is not subject to net investment income tax. The section 1411 NOL amount of the $540,000 net operating loss from Year 1 that A deducts in Year 3 is $108,000 ($540,000 multiplied by 0.2 (the fraction used to calculate the section 1411 NOL amount of the net operating loss)), and this is also the total section 1411 NOL amount for Year 3. The amount of the Year 1 net operating loss carried over to Year 4 is $460,000. This net operating loss carryover amount includes a section 1411 NOL amount of $92,000 ($460,000 multiplied by 0.2) that may be applied in determining net investment income in Year 4. None of the Year 2 net operating loss is deducted in Year 3 so that the $300,000 Year 2 net operating loss (including the section 1411 NOL amount of $150,000) is carried to Year 4.

(iv)(A) For Year 4, A has $150,000 of wages, $450,000 in trading gains which are gross income from the trading activity, $250,000 of income from his sole proprietorship, and $10,000 in trading loss deductions. For income tax purposes, A deducts the remaining $460,000 of the net operating loss carryover from Year 1 and the $300,000 net operating loss carryover from Year 2, for a total net operating loss deduction in Year 4 of $760,000. In addition, under § 1.1411–2(c), the $760,000 net operating loss deduction reduces A's Year 4 modified adjusted gross income to $80,000.

(B) A's total section 1411 NOL amount of the net operating loss deduction for Year 4 is $242,000, which is the sum of the $92,000 ($460,000 net operating loss carryover from Year 1 and deducted in Year 4 multiplied by 0.2 (the ratio used to calculate the section 1411 NOL amount of the Year 1 net operating loss)) plus $150,000 ($300,000 net operating loss carryover from Year 2 and deducted in Year 4 multiplied by 0.5 (the ratio used to calculate the section 1411 NOL amount of the Year 2 net operating loss)).

(C) A's net investment income for Year 4 before the application of paragraph (f)(2)(iv) of this section is $440,000 ($450,000 in gross income from the trading activity, minus $10,000 in trading loss deductions). After the application of paragraph (f)(2)(iv) of this section, A's net investment income for Year 4 is $198,000 ($440,000 minus $242,000, the total section 1411 NOL amount of the Year 4 net operating loss deduction).

(i) *Effective/applicability date.* This section applies to taxable years beginning after December 31, 2013. However, taxpayers may apply this section to taxable years beginning after December 31, 2012, in accordance with § 1.1411–1(f).

§ 1.1411–5 Trades or businesses to which tax applies.

(a) *In general.* A trade or business is described in this section if such trade or business involves the conduct of a trade or business, and such trade or business is either—

(1) A passive activity (within the meaning of paragraph (b) of this section) with respect to the taxpayer; or

(2) The trade or business of a trader trading in financial instruments (as defined in paragraph (c)(1) of this section) or commodities (as defined in paragraph (c)(2) of this section).

(b) *Passive activity*—(1) *In general.* A passive activity is described in this section if—

(i) Such activity is a trade or business; and

(ii) Such trade or business is a passive activity with respect to the taxpayer within the meaning of section 469 and the regulations thereunder.

(2) *Application of income recharacterization rules*—(i) *Income and gain recharacterization.* To the extent that any income or gain from a trade or business is recharacterized as ''not from a passive activity'' by reason of §§ 1.469–2T(f)(2), § 1.469–2(f)(5), or § 1.469–2(f)(6), such trade or business does not constitute a passive activity within the meaning of paragraph (b)(1)(ii) of this section solely with respect to such recharacterized income or gain.

(ii) *Gain recharacterization.* To the extent that any gain from a trade or business is recharacterized as ''not from a passive activity'' by reason of § 1.469–2(c)(2)(iii) and does not constitute portfolio income under § 1.469–2(c)(2)(iii)(F), such trade or business does not constitute a passive activity within the meaning of paragraph (b)(1)(ii) of this section solely with respect to such recharacterized gain.

(iii) *Exception for certain portfolio recharacterizations.* To the extent that any income or gain from a trade or business is recharacterized as ''not from a passive activity'' and is further characterized as portfolio income under § 1.469–2T(f)(10) or § 1.469–2(c)(2)(iii)(F), then such trade or business constitutes a passive activity within the meaning of paragraph (b)(1)(ii) of this section solely with respect to such recharacterized income or gain.

(3) *Examples.* The following examples illustrate the principles of paragraph (b)(1) of this section and the ordinary course of a trade or business exception in § 1.1411–4(b). In each example, unless otherwise indicated, the taxpayer uses a calendar taxable year, the taxpayer is a United States citizen, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example 1. Rental activity. A, an unmarried individual, rents a commercial building to B for $50,000 in Year 1. A is not involved in the activity of the commercial building on a regular and continuous basis, therefore, A's rental activity does not involve the conduct of a trade or business, and under section 469(c)(2), A's rental activity is a passive activity. Because paragraph (b)(1)(i) of this section is not satisfied, A's rental income of $50,000 is not derived from a trade or business described in paragraph (b)(1) of this section. However, A's rental income of $50,000 still constitutes gross income from rents within the meaning of § 1.1411–4(a)(1)(i) because rents are included in the determination of net investment income under § 1.1411–4(a)(1)(i) whether or not derived from a trade or business described in paragraph (b)(1) of this section.

Example 2. Application of grouping rules under section 469. In Year 1, A, an unmarried individual, owns an interest in PRS, a partnership for Federal income tax purposes. PRS is engaged in two activities, X and Y, which constitute trades or businesses, and neither of which constitute trading in financial instruments or commodities (within the meaning of paragraph (a)(2) of this section). Pursuant to § 1.469–4, A has properly grouped X and Y together as one activity (the grouped activity). A participates in X for more than 500 hours during Year 1 and would be treated as materially participating in activity X within the meaning of § 1.469–5T(a)(1) if A's material participation were determined only with respect to activity X. A only participates in Y for 50 hours during Year 1. If not for the grouping of the X and Y activities together, A would not be treated as materially participating in Y within the meaning of § 1.469–5T(a). However, pursuant to §§ 1.469–4 and 1.469–5T(a)(1), A materially participates in the grouped activity.

Therefore, for purposes of paragraph (b)(1)(ii) of this section, neither X nor Y is a passive activity with respect to A. Accordingly, with respect to A, neither X nor Y is a trade or business described in paragraph (b)(1) of this section.

Example 3. Application of the rental activity exceptions. B, an unmarried individual, is a partner in PRS, which is engaged in an equipment leasing activity. The average period of customer use of the equipment is seven days or less (and therefore meets the exception in § 1.469–1T(e)(3)(ii)(A)). B materially participates in the equipment leasing activity (within the meaning of § 1.469–5T(a)). The equipment leasing activity constitutes a trade or business. In Year 1, B has modified adjusted gross income (as defined in § 1.1411–2(c)) of $300,000, all of which is derived from PRS. All of the income from PRS is derived in the ordinary course of the equipment leasing activity, and all of PRS's property is held in the equipment leasing activity. Of B's allocable share of income from PRS, $275,000 constitutes gross income from rents (within the meaning of § 1.1411–4(a)(1)(i)). While $275,000 of the gross income from the equipment leasing activity meets the definition of rents in § 1.1411–4(a)(1)(i), the activity meets one of the exceptions to rental activity in § 1.469–1T(e)(3)(ii) and B materially participates in the activity. Therefore, the trade or business is not a passive activity with respect to B for purposes of paragraph (b)(1)(ii) of this section. Because the rents are derived in the ordinary course of a trade or business not described in paragraph (a) of this section, the ordinary course of a trade or business exception in § 1.1411–4(b) applies, and the rents are not described in § 1.1411–4(a)(1)(i). Furthermore, because the equipment leasing trade or business is not a trade or business described in paragraph (a)(1) or (a)(2) of this section, the $25,000 of other gross income is not net investment income under § 1.1411–4(a)(1)(ii). However, the $25,000 of other gross income may be net investment income by reason of section 1411(c)(3) and § 1.1411–6 if it is attributable to PRS's working capital. Finally, gain or loss from the sale of the property held in the equipment leasing activity will not be subject to § 1.1411–4(a)(1)(iii) because, although it is attributable to a trade or business, it is not a trade or business to which the section 1411 tax applies.

Example 4. Application of section 469 and other gross income under § 1.1411–4(a)(1)(ii). Same facts as *Example 3,* except B does not materially participate in the equipment leasing trade or business and therefore the trade or business is a passive activity with respect to B for purposes of paragraph (b)(1)(ii) of this section. Accordingly, the $275,000 of gross income from rents is described in § 1.1411–4(a)(1)(i) because the rents are derived from a trade or business that is a passive activity with respect to B. Furthermore, the $25,000 of other gross income from the equipment leasing trade or business is described in § 1.1411–4(a)(1)(ii) because the gross income is derived from a trade or business described in paragraph (a)(1) of this section. Finally, gain or loss from the sale of the property used in the equipment leasing trade or business is subject to § 1.1411–4(a)(1)(iii) because the trade or business is a passive activity with respect to B, as described in paragraph (b)(1)(ii) of this section.

Example 5. Application of the portfolio income rule and section 469. C, an unmarried individual, is a partner in PRS, a partnership engaged in a trade or business that does not involve a rental activity. C does not materially participate in PRS within the meaning of § 1.469–5T(a). Therefore, the trade or business of PRS is a passive activity with respect to C for purposes of paragraph (a)(1) of this section. C's $500,000 allocable share of PRS's income consists of $450,000 of gross income from a trade or business and $50,000 of gross income from dividends and interest (within the meaning of § 1.1411–4(a)(1)(i)) that is not derived in the ordinary course of the trade or business of PRS. Therefore, C's $500,000 allocable share of PRS's income is subject to section 1411. C's $50,000 allocable share of PRS's income from dividends and interest is subject to § 1.1411–4(a)(1)(i) because the share is gross income from dividends and interest that is not derived in the ordinary course of a trade or business (that is, the ordinary course of a trade or business exception in § 1.1411–4(b) is inapplicable). C's $450,000 allocable share of PRS's income is subject to § 1.1411–4(a)(1)(ii) because it is gross income from a trade or business that is a passive activity.

(c) *Trading in financial instruments or commodities*—(1) *Definition of financial instruments.* For purposes of section 1411 and the regulations thereunder, the term *financial instruments* includes stocks and other equity interests, evidences of indebtedness, options, forward or futures contracts, notional principal contracts, any other derivatives, or any evidence of an interest in any of the items described in this paragraph (c)(1). An evidence of an interest in any of the items described in this paragraph (c)(1) includes, but is not limited to, short positions or partial units in any of the items described in this paragraph (c)(1).

(2) *Definition of commodities.* For purposes of section 1411 and the regulations thereunder, the term *commodities* refers to items described in section 475(e)(2).

(d) *Effective/applicability date.* This section applies to taxable years beginning after December 31, 2013. However, taxpayers may apply this section to taxable years beginning after December 31, 2012, in accordance with § 1.1411–1(f).

§ 1.1411–6 Income on investment of working capital subject to tax.

(a) *General rule.* For purposes of section 1411, any item of gross income from the investment of working capital will be treated as not derived in the ordinary course of a trade or business, and any net gain that is attributable to the investment of working capital will be treated as not derived in the ordinary course of a trade or business. In determining whether any item is gross income from or net gain attributable to an investment of working capital, principles similar to those described in § 1.469–2T(c)(3)(ii) apply. See § 1.1411–4(f) for rules regarding properly allocable deductions with respect to an investment of working capital and § 1.1411–7 for rules relating to the adjustment to net gain on the disposition of interests in a partnership or S corporation.

(b) *Example.* The following example illustrates the principles of this section. Assume for purposes of the example that the taxpayer uses a calendar taxable year, the taxpayer is a United States citizen, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example. (i) A, an unmarried individual, operates a restaurant, which is a section 162 trade or business but is not a trade or business described in § 1.1411–5(a)(1) with respect to A. A owns and conducts the restaurant business through S, an S corporation wholly-owned by A. S is able to pay all of the restaurant's current obligations with cash flow generated by the restaurant. S utilizes an interest-bearing checking account at a local bank to make daily deposits of cash receipts generated by the restaurant, and also to pay the recurring ordinary and necessary business expenses of the restaurant. The average daily balance of the checking account is approximately $2,500, but at any given time the balance may be significantly more or less than this amount depending on the short-term cash flow needs of the business. In addition, S has set aside $20,000 for the potential future needs of the business in case the daily cash flow into and from the checking account becomes insufficient to pay the restaurant's recurring business expenses. S does not currently need to spend or use the $20,000 capital to conduct the restaurant business, and S deposits and maintains the $20,000 in an interest-bearing savings account at a local bank.

(ii) Both the $2,500 average daily balance of the checking account and the $20,000 savings account balance constitute working capital under § 1.469–2T(c)(3)(ii) and, pursuant to paragraph (a) of this section, the interest generated by this working capital will not be treated as derived in the ordinary course of S's restaurant business. Accordingly, the interest income derived by S from its checking and savings accounts and allocated to A under section 1366 constitutes gross income from interest under § 1.1411–4(a)(1)(i).

(c) *Effective/applicability date.* This section applies to taxable years beginning after December 31, 2013. However, taxpayers may apply this section to taxable years beginning after

December 31, 2012, in accordance with § 1.1411–1(f).

§ 1.1411–7 Exception for dispositions of interests in partnerships and S corporations. [Reserved]

§ 1.1411–8 Exception for distributions from qualified plans.

(a) *General rule.* Net investment income does not include any distribution from a qualified plan or arrangement. For this purpose, the term qualified plan or arrangement means any plan or arrangement described in section 401(a), 403(a), 403(b), 408, 408A, or 457(b).

(b) *Rules relating to distributions.* This paragraph (b) provides rules for purposes of paragraph (a) of this section. For purposes of section 1411(c)(5) and this section, a distribution means the following:

(1) *Actual distributions.* Any amount actually distributed from a qualified plan or arrangement, as defined in paragraph (a) of this section, is a distribution within the meaning of section 1411(c)(5), and thus is not included in net investment income. Examples include a rollover to an eligible retirement plan within the meaning of section 402(c)(8)(B), a distribution of a plan loan offset amount within the meaning of Q&A–13(b) of § 1.72(p)–1, and certain corrective distributions under the Internal Revenue Code (Code).

(2) *Amounts treated as distributed.* Any amount that is treated as distributed from a qualified plan or arrangement under the Code for purposes of income tax is a distribution within the meaning of section 1411(c)(5), and thus is not included in net investment income. Examples include a conversion to a Roth IRA described in section 408A and a deemed distribution under section 72(p).

(3) *Amounts includible in gross income.* Any amount that is not treated as a distribution but is otherwise includible in gross income pursuant to a rule relating to amounts held in a qualified plan or arrangement described in paragraph (a) of this section is a distribution within the meaning of section 1411(c)(5), and thus is not included in net investment income. For example, any income of the trust of a qualified plan or arrangement that is applied to purchase a participant's life insurance coverage (the P.S. 58 costs) is a distribution within the meaning of section 1411(c)(5), and thus is not included in net investment income.

(4) *Amounts related to employer securities*—(i) *Dividends related to employer securities.* Any dividend that is deductible under section 404(k) and is paid in cash directly to plan participants or beneficiaries is a distribution within the meaning of section 1411(c)(5), and thus is not included in net investment income. However, any amount paid as a dividend after the employer securities have been distributed from a qualified plan is not a distribution within the meaning of section 1411(c)(5), and thus is included in net investment income.

(ii) *Amounts related to the net unrealized appreciation in employer securities.* The amount of any net unrealized appreciation attributable to employer securities (within the meaning of section 402(e)(4)) realized on a disposition of those employer securities is a distribution within the meaning of section 1411(c)(5), and thus is not included in net investment income. However, any appreciation in value of the employer securities after the distribution from the qualified plan is not a distribution within the meaning of section 1411(c)(5), and is included in net investment income.

(c) *Effective/applicability date.* This section applies to taxable years beginning after December 31, 2013. However, taxpayers may apply this section to taxable years beginning after December 31, 2012, in accordance with § 1.1411–1(f).

§ 1.1411–9 Exception for self-employment income.

(a) *General rule.* Except as provided in paragraph (b) of this section, net investment income does not include any item taken into account in determining self-employment income that is subject to tax under section 1401(b) for such taxable year. For purposes of section 1411(c)(6) and this section, *taken into account* means income included and deductions allowed in determining net earnings from self-employment. However, amounts excepted in determining net earnings from self-employment under section 1402(a)(1)–(17), and thus excluded from self-employment income under section 1402(b), are not taken into account in determining self-employment income and thus may be included in net investment income if such amounts are described in § 1.1411–4. Except as provided in paragraph (b) of this section, if net earnings from self-employment consist of income or loss from more than one trade or business, all items taken into account in determining the net earnings from self-employment with respect to these trades or businesses (see § 1.1402(a)–2(c)) are considered taken into account in determining the amount of self-employment income that is subject to tax under section 1401(b) and therefore not included in net investment income.

(b) *Special rule for traders.* In the case of gross income described in §§ 1.1411–4(a)(1)(ii) and (a)(1)(iii) derived from a trade or business of trading in financial instruments or commodities (as described in § 1.1411–5(a)(2)), the deductions described in § 1.1411–4(f)(2)(ii) properly allocable to the taxpayer's trade or business of trading in financial instruments or commodities are taken into account in determining the taxpayer's self-employment income only to the extent that such deductions reduce the taxpayer's net earnings from self-employment (after aggregating under § 1.1402(a)–2(c) the net earnings from self-employment from any trade or business carried on by the taxpayer as an individual or as a member of a partnership). Any deductions described in § 1.1411–4(f)(2)(ii) that exceed the amount of net earnings from self-employment, in the aggregate (if applicable), are allowed in determining the taxpayer's net investment income under section 1411 and the regulations thereunder.

(c) *Examples.* The following examples illustrate the provisions of this section. For purposes of these examples, assume the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example 1. Exclusion from self-employment income. A is a general partner in PRS, a partnership carrying on a trade or business that is not a trade or business of trading in financial instruments or commodities (within the meaning of § 1.1411–5(a)(2)). During Year 1, A's distributive share from PRS is $1 million, $300,000 of which is attributable to the gain on the sale of PRS's capital assets. Section 1402(a)(3)(A) provides an exclusion from net earnings from self-employment for any gain or loss from the sale or exchange of a capital asset. For Year 1, A has $700,000 self-employment income subject to self-employment tax. This $700,000 subject to self-employment tax is not included as part of net investment income under paragraph (a) of this section. However, the $300,000 attributable to the gain on PRS's sale of a capital asset is excluded from net earnings from self-employment, and from self-employment income, and thus is not covered by the exception in section 1411(c)(6). Therefore, the $300,000 attributable to the gain on PRS's sale of a capital asset is included as net investment income if the other requirements of section 1411 are satisfied.

Example 2. Two trades or businesses. B is an individual engaged in two trades or businesses, Business X and Business Y, neither of which is the trade or business of trading in financial instruments or commodities (as described in § 1.1411–5(a)(2)). B carries on Business X as a sole

proprietor and B is also a general partner in a partnership that carries on Business Y. Business Y is a nonpassive activity of B. During Year 1, B had net earnings from self-employment consisting of the aggregate of a $50,000 loss (that is, after application of the exclusions under section 1402(a)(1)–(17)) from Business X, and $70,000 in income (after application of the exclusions under section 1402(a)(1)–(17)) from B's distributive share from the partnership from carrying on Business Y. Thus, B's net earnings from self-employment in Year 1 are $20,000. For Year 1, all of B's income, deductions, gains, and losses from Business X and distributive share from the partnership carrying on Business Y, other than those amounts excluded due to application of section 1402(a)(1)–(17), are taken into account in determining B's net earnings from self-employment and self-employment income for such taxable year. Accordingly, in calculating B's net investment income (as defined in § 1.1411–4) for Year 1, B will not take into account the items of income, loss, gain, and deduction that comprise B's $50,000 loss attributable to Business X (after application of the exclusions under section 1402(a)(1)–(17)), and the items of income, loss, gain, and deduction that comprise B's $70,000 distributable share attributable to B's general partnership interest (after application of the exclusions under section 1402(a)(1)–(17)). Rather, only items of income, loss, gain, and deduction from the two separate businesses that were excluded from the calculation of B's net earnings from self-employment income due to the application of the exclusions under section 1402(a)(1)–(17), such as any capital gains and losses excluded under section 1402(a)(3), are considered for purposes of calculating B's net investment income for Year 1 in connection with these two trades or businesses.

Example 3. Special rule for trader with single trade or business. D is an individual engaged in the trade or business of trading in commodities (as described in § 1.1411–5(a)(2)). D made a valid and timely election under section 475(f)(2). D derives $400,000 of trading gains, which are gross income described in § 1.1411–4(a)(1) and $15,000 of expenses described in § 1.1411–4(f)(2)(ii) from carrying on the trade or business. Pursuant to sections 475(f)(1)(D) and 1402(a)(3)(A), none of the gross income is taken into account in determining D's net earnings from self-employment and self-employment income. Therefore, under paragraph (a) of this section, the $400,000 of gross income is not covered by the exception in section 1411(c)(6). Because D had $0 net earnings from self-employment, the $15,000 of deductions did not reduce D's net earnings from self-employment under paragraph (b) of this section and § 1.1411–(4)(f)(2)(ii). Therefore, the $15,000 of deductions may reduce D's gross income of $400,000 for purposes of section 1411.

Example 4. Special rule for trader with multiple trades or businesses. E is an individual engaged in two trades or businesses, Business X (which is not a trade or business of trading in financial instruments or commodities) and Business Y (which is a trade or business of trading in financial instruments or commodities (as described in § 1.1411–5(a)(2)). E made a valid and timely election under section 475(f) with respect to Business Y. During Year 1, E had net earnings from self-employment from Business X of $35,000. During Year 1, E also had $300,000 of trading gains, which are gross income described in § 1.1411–4(a)(1) and $40,000 of expenses described in § 1.1411–4(f)(2)(ii) from Business Y. E's $300,000 of gross income from Business Y is excluded from net earnings from self-employment and self-employment income pursuant to sections 475(f)(1)(D) and 1402(a)(3)(A). E's $40,000 of deductions from Business Y reduce E's $35,000 of net earnings from self-employment from Business X to $0. Pursuant to paragraph (b) of this section and § 1.1411–4(f)(2)(ii), the remaining $5,000 of deductions from Business Y are taken into account in determining E's net investment income (by reducing E's gross income of $300,000 from Business Y to $295,000) for purposes of section 1411.

(d) *Effective/applicability date.* This section applies to taxable years beginning after December 31, 2013. However, taxpayers may apply this section to taxable years beginning after December 31, 2012, in accordance with § 1.1411–1(f).

§ 1.1411–10 Controlled foreign corporations and passive foreign investment companies.

(a) *In general.* This section provides rules that apply to an individual, estate, or trust that is a United States shareholder of a controlled foreign corporation (CFC), or that is a United States person that directly or indirectly owns an interest in a passive foreign investment company (PFIC). In addition, this section provides rules that apply to an individual, estate, or trust that owns an interest in a domestic partnership or an S corporation that is either a United States shareholder of a CFC or that has made an election under section 1295 to treat a PFIC as a qualified electing fund (QEF). References in this section to an election under paragraph (g) of this section being in effect relate to an election that is applicable to the person that is determining the section 1411 consequences with respect to holding a particular CFC or QEF.

(b) *Amounts derived from a trade or business described in § 1.1411–5*—(1) *In general.* Except as provided in paragraph (b)(2) of this section, an amount included in gross income under section 951(a) or section 1293(a) that is also income derived from a trade or business described in section 1411(c)(2) and § 1.1411–5 (applying the relevant rules in § 1.1411–4(b)) is taken into account as net investment income under section 1411(c)(1)(A)(ii) and § 1.1411–4(a)(1)(ii) for purposes of section 1411 and the regulations thereunder when it is taken into account for purposes of chapter 1, and the rules in paragraphs (c) through (g) of this section do not apply to that amount. For purposes of section 1411 and the regulations thereunder, an amount included in gross income under section 1296(a) that is also income derived from a trade or business described in section 1411(c)(2) and § 1.1411–5 (applying the relevant rules in § 1.1411–4(b)), is net investment income within the meaning of section 1411(c)(1)(A)(ii) and § 1.1411–4(a)(1)(ii), and the rules in paragraph (c)(2)(ii) of this section do not apply to that amount.

(2) *Coordination rule for changes in trade or business status.* With respect to stock of a CFC or QEF for which an election under paragraph (g) of this section is not in effect, the rules in paragraphs (c) through (f) of this section apply to a distribution of earnings and profits described in paragraph (c)(1)(i)(A) of this section that was not taken into account as net investment income under paragraph (b) of this section.

(c) *Calculation of net investment income*—(1) *Dividends.* For purposes of section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i), net investment income is calculated by taking into account the amount of dividends described in this paragraph (c)(1).

(i) *Distributions of previously taxed earnings and profits*—(A) *Rules when an election under paragraph (g) of this section is not in effect with respect to the shareholder*—(*1*) *General rule.* Except as otherwise provided in this paragraph (c)(1)(i), with respect to stock of a CFC or QEF for which an election under paragraph (g) of this section is not in effect, a distribution of earnings and profits that is not treated as a dividend for chapter 1 purposes under section 959(d) or section 1293(c) is a dividend for purposes of section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i) if the distribution is attributable to amounts that are or have been included in gross income for chapter 1 purposes under section 951(a) or section 1293(a) in a taxable year beginning after December 31, 2012. Solely, for this purpose, distributions of earnings and profits attributable to amounts that are or have been included in gross income for chapter 1 purposes under section 951(a) or section 1293(a) are considered first attributable to those earnings and profits, if any, derived from the current taxable year, and then from prior taxable years beginning with the most recent prior taxable year, and with respect to amounts included under section 951(a), without regard to whether the earnings and profits are

described in section 959(c)(1) or section 959(c)(2).

(*2*) *Exception for distributions attributable to earnings and profits previously taken into account for purposes of section 1411.* A distribution of earnings and profits that is not treated as a dividend for chapter 1 purposes under section 959(d) or section 1293(c) is not treated as a dividend for purposes of section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i), to the extent that an individual, estate, or trust establishes, by providing information that is similar to, and in the same manner as, the information described in § 1.959–1(d) (relating to previously taxed earnings and profits), that the distribution is attributable to—

(*i*) Amounts included in gross income by any person for chapter 1 purposes under section 951(a) or section 1293(a) that have been taken into account by any person as net investment income by reason of paragraph (b) of this section or an election under paragraph (g) of this section; or

(*ii*) Amounts included in gross income by any person as a dividend pursuant to section 1248(a) that, by reason of paragraph (c)(3)(ii) of this section, have been taken into account by any person as net investment income under section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i).

(B) *Rule when an election under paragraph (g) of this section is in effect with respect to the shareholder.* Except as otherwise provided in this paragraph (c)(1)(i), if an election under paragraph (g) of this section is in effect, a distribution of earnings and profits that is not treated as a dividend for chapter 1 purposes under section 959(d) or section 1293(c) is not treated as a dividend for purposes of section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i).

(C) *Special rule for certain distributions related to 2013 taxable years*—(*1*) *Scope.* The rule in this paragraph (c)(1)(i)(C) applies to individuals, estates, and trusts that were subject to section 1411 during a taxable year that began after December 31, 2012, and before January 1, 2014, and that satisfy all of the conditions set forth in paragraph (c)(1)(i)(C)(*2*) of this section. This rule also applies to all domestic partnerships and S corporations that satisfy all of the conditions set forth in paragraph (c)(1)(i)(C)(*2*) of this section.

(*2*) *Rule.* A distribution of earnings and profits from a CFC or QEF, with respect to which an election under paragraph (g) is in effect, that is not treated as a dividend for chapter 1 purposes under section 959(d) or section 1293(c) is a dividend for purposes of section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i) to the extent that—

(*i*) The distribution of earnings and profits is attributable to an amount included by an individual, estate, trust, domestic partnership, S corporation or common trust fund in gross income for chapter 1 purposes under section 951(a) or section 1293(a) with respect to the CFC or QEF for a taxable year that began after December 31, 2012, and before January 1, 2014;

(*ii*) The individual, estate, trust, domestic partnership, S corporation, or common trust fund made the election under paragraph (g) of this section with respect to the CFC or QEF in a taxable year that began after December 31, 2013; and

(*iii*) The individual, estate, trust, domestic partnership, S corporation, or common trust fund did not make the election described in paragraph (g)(4)(iii) of this section (concerning making an election under paragraph (g) of this section for a taxable year that begins before January 1, 2014).

(*3*) *Ordering rule.* Solely, for purposes of this paragraph (c)(1)(i)(C)(*3*), distributions of earnings and profits attributable to amounts that have been included in gross income for chapter 1 purposes under section 951(a) or section 1293(a) are considered first attributable to the earnings and profits derived from a taxable year that began after December 31, 2012, and before January 1, 2014.

(ii) *Excess distributions that constitute dividends.* To the extent an excess distribution within the meaning of section 1291(b) constitutes a dividend within the meaning of section 316(a), the amount is included in net investment income for purposes of section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i).

(2) *Net gain.* For purposes of section 1411(c)(1)(A)(iii) and § 1.1411–4(a)(1)(iii), the rules in this paragraph (c)(2) apply in determining net gain attributable to the disposition of property.

(i) *Gains treated as excess distributions.* Gains treated as excess distributions under section 1291(a)(2) are included in determining net gain attributable to the disposition of property for purposes of section 1411(c)(1)(A)(iii) and § 1.1411–4(a)(1)(iii).

(ii) *Inclusions and deductions with respect to section 1296 mark to market elections.* Amounts included in gross income under section 1296(a)(1) and amounts allowed as a deduction under section 1296(a)(2) are taken into account in determining net gain attributable to the disposition of property for purposes of section 1411(c)(1)(A)(iii) and § 1.1411–4(a)(1)(iii).

(iii) *Gain or loss attributable to the disposition of stock of CFCs and QEFs.* With respect to stock of a CFC or QEF for which an election under paragraph (g) of this section is not in effect, for purposes of calculating the net gain under §§ 1.1411–4(a)(1)(iii) and 1.1411–4(d) that is attributable to the direct or indirect disposition of that stock (including for purposes of determining gain or loss on the direct or indirect disposition of that stock by a domestic partnership, S corporation, or common trust fund), basis is determined in accordance with the provisions of paragraph (d) of this section.

(iv) *Gain or loss attributable to the disposition of interests in domestic partnerships or S corporations that own directly or indirectly stock of CFCs or QEFs.* With respect to stock of a CFC or QEF for which an election under paragraph (g) of this section is not in effect, for purposes of calculating the net gain under §§ 1.1411–4(a)(1)(iii) and 1.1411–4(d) that is attributable to the disposition of an interest in a domestic partnership or S corporation that directly or indirectly owns that stock, basis is determined in accordance with the provisions of paragraph (d) of this section.

(3) *Application of section 1248.* With respect to stock of a CFC or QEF for which an election under paragraph (g) of this section is not in effect, for purposes of section 1411 and § 1.1411–4—

(i) In determining the gain recognized on the sale or exchange of stock of a foreign corporation for section 1248(a) purposes, basis is determined in accordance with the provisions of paragraph (d) of this section; and

(ii) Section 1248(a) applies without regard to the exclusion for certain earnings and profits under sections 1248(d)(1) and (d)(6), except that those exclusions will apply with respect to the earnings and profits of a foreign corporation that are attributable to:

(A) Amounts taken into account as net investment income under paragraph (b) of this section; and

(B) Amounts previously included in gross income for chapter 1 purposes under section 951(a) or section 1293(a) in a taxable year beginning before December 31, 2012, and that have not yet been distributed. For this purpose, the determination of whether earnings and profits that are attributable to amounts previously taxed in a taxable year beginning before December 31, 2012, have been distributed is determined based on the rules described in paragraph (c)(1)(i) of this section.

(4) *Amounts distributed by an estate or trust.* Net investment income of a

beneficiary of an estate or trust includes the beneficiary's share of distributable net income, as described in sections 652 and 662 and as modified by paragraph (f) of this section, to the extent that the beneficiary's share of distributable net income includes items that, if they had been received directly by the beneficiary, would have been described in this paragraph (c).

(5) *Properly allocable deductions*—(i) *General rule.* For purposes of section 1411(c)(1)(B) and § 1.1411–4(f), the section 163(d)(1) investment expense deduction may be calculated by—

(A) Increasing the amount of investment income determined for chapter 1 purposes under section 163(d)(4)(B) by the amount of dividends described in § 1.1411–10(c) that are derived from a CFC or QEF with respect to which an election under paragraph (g) of this section is not in effect;

(B) Decreasing the amount of investment income for determined chapter 1 purposes under section 163(d)(4)(B) by the amount included in gross income for chapter 1 purposes under section 951(a) or section 1293(a) that is attributable to a CFC or QEF with respect to which an election under paragraph (g) of this section is not in effect; and

(C) Increasing or decreasing, as applicable, the amount of investment income for chapter 1 purposes under section 163(d)(4)(B) by the difference between the amount calculated with respect to a disposition under paragraphs (c)(2)(iii) and (c)(2)(iv) of this section and the amount of the gain or loss attributable to the relevant disposition as calculated for chapter 1 purposes.

(ii) *Additional rules.* For purposes of section 1411(c)(1)(B) and § 1.1411–4(f), if the method of calculation described in paragraph (c)(5)(i) of this section is applied:

(A) The amount of investment interest not allowed as a deduction under section 163(d)(2) must be calculated consistent with the method of calculation described in paragraph (c)(5)(i).

(B) The method of calculation must be adopted by an individual, estate, or trust no later than the first year in which the individual, estate, or trust is subject to section 1411.

(C) The method of calculation must be applied with respect to all CFCs and QEFs for all taxable years with respect to which an election under paragraph (g) of this section is not in effect.

(D) A method of calculation under this paragraph is a method of accounting, which must be applied consistently, and may only be changed by the taxpayer by securing the consent of the Commissioner in accordance with § 1.446–1(e) and following the administrative procedures issued under § 1.446–1(e)(3)(ii).

(d) *Conforming basis adjustments*—(1) *Basis adjustments under sections 961 and 1293*—(i) *Stock held by individuals, estates, or trusts.* With respect to stock of a CFC or QEF which is held by an individual, estate, or trust, either directly or indirectly through one or more entities each of which is foreign, for which an election under paragraph (g) of this section is not in effect—

(A) The basis increases made pursuant to sections 961(a) and 1293(d) for amounts included in gross income for chapter 1 purposes under sections 951(a) and 1293(a) in taxable years beginning after December 31, 2012, are not taken into account for purposes of section 1411 and the regulations thereunder; and

(B) The basis decreases made pursuant to sections 961(b) and 1293(d) attributable to amounts treated as dividends for purposes of section 1411 under paragraph (c)(1)(i) of this section are not taken into account for purposes of section 1411 and the regulations thereunder.

(ii) *Stock held by domestic partnerships or S corporations*—(A) *Rule when an election under paragraph (g) of this section is not in effect.* The rules of this paragraph (d)(1)(ii)(A) apply with respect to stock of a CFC or QEF held directly by a domestic partnership or S corporation, or indirectly through one or more entities each of which is foreign, for which an election under paragraph (g) of this section is not in effect. If an individual, estate, or trust is a shareholder of an S corporation, or if an individual, estate, or trust directly, or through one or more tiers of passthrough entities (including an S corporation), owns an interest in a domestic partnership, the S corporation or domestic partnership, as the case may be, will not take into account for purposes of section 1411 and the regulations thereunder the basis increases made by the domestic partnership or S corporation pursuant to sections 961(a) and 1293(d) for amounts included in gross income for chapter 1 purposes under sections 951(a) and 1293(a) for taxable years beginning after December 31, 2012, and the basis decreases made by the domestic partnership or S corporation pursuant to sections 961(b) and 1293(d) attributable to amounts treated as dividends for purposes of section 1411 under paragraph (c)(1)(i) of this section (the section 1411 recalculated basis). If the domestic partnership or S corporation disposes of the stock of a CFC or QEF, the section 1411 recalculated basis will be used to determine the distributive share or pro rata share of the gain or loss for purposes of section 1411 for partners or shareholders.

(B) *Rules when an election under paragraph (g) of this section is in effect.* If an election under paragraph (g) of this section is in effect with respect to stock of a CFC or QEF held directly or indirectly by a domestic partnership or S corporation, the partner's distributive share or the shareholder's pro rata share of the gain or loss for purposes of section 1411 is the same as the distributive share or pro rata share of the gain or loss for purposes of chapter 1. See *Example 6* of paragraph (h) of this section.

(2) *Special rules for partners that own interests in domestic partnerships that own directly or indirectly stock of CFCs or QEFs.* The rules of this paragraph (d)(2) apply with respect to stock of a CFC or QEF for which an election under paragraph (g) of this section is not in effect, and that is held by a domestic partnership, either directly or indirectly through one or more entities each of which is foreign. In such a case, the basis increases provided under section 705(a)(1)(A) to the partners for purposes of chapter 1 that are attributable to amounts that the domestic partnership includes or included in gross income under section 951(a) or section 1293(a) for a taxable year beginning after December 31, 2012, are not taken into account for purposes of section 1411. Instead, each partner's adjusted basis in the partnership interest is increased by its share of any distributions to the partnership from the CFC or QEF that are treated as dividends for purposes of section 1411 under paragraph (c)(1)(i) of this section. Similar rules apply when the stock of the CFC or QEF is held in a tiered partnership structure. For purposes of determining net investment income under section 1411 and the regulations thereunder, the partner's adjusted basis in the partnership interest as calculated under this paragraph (d)(2) is used to determine all tax consequences related to tax basis (for example, loss limitation rules and the characterization of partnership distributions).

(3) *Special rules for S corporation shareholders that own interests in S corporations that own directly or indirectly stock of CFCs or QEFs.* The rules of this paragraph (d)(3) apply with respect to stock of a CFC or QEF for which an election under paragraph (g) of this section is not in effect, and that is held by an S corporation, directly or indirectly through one or more entities

each of which is foreign. In such case, the basis increases provided in section 1367(a)(1)(A) to its shareholders for chapter 1 purposes that are attributable to amounts that the S corporation includes or included in gross income for chapter 1 purposes under section 951(a) or section 1293(a) for taxable years beginning after December 31, 2012, are not taken into account for purposes of section 1411. Instead, each shareholder's adjusted basis of stock in the S corporation is increased by its share of the distributions to the S corporation from the CFC or QEF that are treated as dividends for purposes of section 1411 under paragraph (c)(1)(i) of this section. Similar rules apply when the S corporation holds an interest in a CFC or QEF through a partnership. For purposes of determining net investment income under section 1411 and the regulations thereunder, the shareholder's adjusted basis in the stock of the S corporation as calculated under this paragraph (d)(3) is used to determine all tax consequences related to tax basis (for example, loss limitation rules and the characterization of S corporation distributions).

(4) *Special rules for participants in common trust funds.* Rules similar to the rules in paragraphs (d)(2) and (3) of this section apply to ownership interests in common trust funds (as defined in section 584).

(e) *Conforming adjustments to modified adjusted gross income and adjusted gross income*—(1) *Individuals.* Solely for purposes of section 1411(a)(1)(B)(i) and the regulations thereunder, the term *modified adjusted gross income* means modified adjusted gross income as defined in § 1.1411–2(c)(1)—

(i) Increased by amounts included in net investment income under paragraphs (c)(1)(i), (c)(1)(ii), (c)(2)(i), and (c)(4) of this section that are not otherwise included in gross income for chapter 1 purposes;

(ii) Increased or decreased, as applicable, by the difference between the amount calculated with respect to a disposition under paragraphs (c)(2)(iii) and (iv) of this section and the amount of the gain or loss attributable to the relevant disposition as calculated for chapter 1 purposes;

(iii) Decreased by any amount included in gross income for chapter 1 purposes under section 951(a) or section 1293(a) attributable to a CFC or QEF with respect to which no election under paragraph (g) of this section is in effect; and

(iv) To the extent the section 163(d)(1) investment interest expense deduction is calculated using the method of calculation set forth in paragraph (c)(5) of this section and the deduction is taken into account under § 1.1411–4(f)(2), increased or decreased, as appropriate, by the difference between the amount of the section 163(d)(1) investment interest expense deduction calculated under paragraph (c)(5) of this section and the amount calculated for chapter 1 purposes.

(2) *Estates and trusts.* Solely for purposes of section 1411(a)(2)(B)(i) and the regulations thereunder, the term *adjusted gross income* means adjusted gross income as defined in § 1.1411–3(a)(1)(ii)(B)(*1*) adjusted by the following amounts to the extent those amounts are not distributed by the estate or trust—

(i) Increased by amounts included in net investment income under paragraphs (c)(1)(i), (c)(1)(ii), (c)(2)(i), and (c)(4) of this section that are not otherwise included in gross income for chapter 1 purposes;

(ii) Increased or decreased, as applicable, by the difference between the amount calculated with respect to a disposition under paragraphs (c)(2)(iii) and (iv) of this section and the amount of the gain or loss attributable to the relevant disposition as calculated for chapter 1 purposes;

(iii) Decreased by any amount included in gross income for chapter 1 purposes under section 951(a) or section 1293(a) attributable to a CFC or QEF with respect to which no election under paragraph (g) of this section is in effect; and

(iv) To the extent the section 163(d)(1) investment interest expense deduction is calculated using the method of calculation set forth in paragraph (c)(5) of this section and taken into account under § 1.1411–4(f)(2), increased or decreased, as appropriate, by the difference between the amount of the section 163(d)(1) investment interest expense deduction calculated under paragraph (c)(5) of this section and the amount calculated for chapter 1 purposes.

(f) *Application to estates and trusts.* All of the items described in paragraph (c) of this section are included in the net investment income of an estate or trust or its beneficiaries. The amounts described in paragraphs (e)(2)(i) through (iv) of this section, regardless of whether the estate or trust receives those amounts directly or indirectly through another estate or trust, increase or decrease, as applicable, the estate's or trust's distributable net income for purposes of section 1411. The estate or trust, or the beneficiaries thereof, must take those amounts into account in a manner reasonably consistent with the general operating rules for estates and trusts in § 1.1411–3 and subchapter J in computing the undistributed net investment income of the estate or trust and the net investment income of the beneficiaries.

(g) *Election with respect to CFCs and QEFs*—(1) *Effect of election.* If an election under paragraph (g) of this section is made with respect to a CFC or QEF, amounts included in gross income for chapter 1 purposes under section 951(a) or section 1293(a)(1)(A) with respect to the CFC or QEF in taxable years beginning with the taxable year for which the election is made are treated as net investment income for purposes of § 1.1411–4(a)(1)(i), and amounts included in gross income under section 1293(a)(1)(B) with respect to the QEF in taxable years beginning with the taxable year for which the election is made are taken into account in calculating net gain attributable to the disposition of property under § 1.1411–4(a)(1)(iii). See paragraphs (c)(1)(i)(B) and (c)(1)(i)(C) of this section for the effect of this election on certain distributions of previously taxed earnings and profits.

(2) *Years to which election applies*—(i) *In general.* An election under paragraph (g) of this section applies to the taxable year for which it is made and all subsequent taxable years, and applies to all subsequently acquired interests in the CFC or QEF. An election under paragraph (g) of this section is irrevocable.

(ii) *Termination of interest in CFC or QEF.* Complete termination of a person's interest in the CFC or QEF does not terminate the person's election under paragraph (g) of this section with respect to the CFC or QEF. Thus, if the person reacquires stock of the CFC or QEF, that stock is considered to be stock for which an election under paragraph (g) of this section has been made and is in effect.

(iii) *Termination of partnership.* If a domestic partnership that makes the election under paragraph (g) of this section is terminated pursuant to section 708(b)(1)(B), the election is binding on the new partnership.

(3) *Who may make the election.* An individual, estate, trust, domestic partnership, S corporation, or common trust fund may make an election under paragraph (g) of this section with respect to each CFC or QEF that it holds directly or indirectly through one or more entities, each of which is foreign. In addition, an individual, estate, trust, domestic partnership, S corporation, or common trust fund may make an election under paragraph (g) of this section with respect to a CFC or QEF

that it holds indirectly through a domestic partnership, S corporation, estate, trust, or common trust fund if the domestic partnership, S corporation, estate, trust, or common trust fund does not make the election. The election, if made, for an estate or trust must be made by the fiduciary of that estate or trust.

(4) *Time and manner for making the election*—(i) *Individuals, estates, and trusts*—(A) *General rule.* Except as otherwise provided in this paragraph, in order for an election under paragraph (g) of this section by an individual, estate, or trust (other than a CRT) with respect to a CFC or QEF to be effective, the election must be made no later than the first taxable year beginning after December 31, 2013, during which the individual, estate, or trust—

(*1*) Includes an amount in gross income for chapter 1 purposes under section 951(a) or section 1293(a) with respect to the CFC or QEF; and

(*2*) Is subject to tax under section 1411 or would be subject to tax under section 1411 if the election were made with respect to the stock of the CFC or QEF.

(B) *Special rule for charitable remainder trusts (CRTs).* Except as otherwise provided in this paragraph, in order for an election under paragraph (g) of this section by a CRT with respect to a CFC or QEF to be effective, the election must be made no later than the first taxable year beginning after December 31, 2013, during which the CRT includes an amount in gross income for chapter 1 purposes under section 951(a) or section 1293(a) with respect to the CFC or QEF.

(ii) *Certain domestic passthrough entities.* Except as otherwise provided in this paragraph, in order for an election under paragraph (g) of this section by a domestic partnership, S corporation, or common trust fund with respect to a CFC or a QEF to be effective, the election must be made no later than the first taxable year beginning after December 31, 2013, during which the domestic partnership S corporation, or common trust fund—

(A) Includes an amount in gross income for chapter 1 purposes under section 951(a) or section 1293(a) with respect to the CFC or QEF; and

(B) Has a direct or indirect owner that is subject to tax under section 1411 or would be subject to tax under section 1411 if the election were made.

(iii) *Taxable years that begin before January 1, 2014*—(A) *Individuals, estates, or trusts.* An individual, estate, or trust may make an election under paragraph (g) of this section for a taxable year that begins before January 1, 2014.

(B) *Certain domestic passthrough entities.* A domestic partnership, S corporation, or common trust fund may make an election under paragraph (g) of this section for a taxable year that begins before January 1, 2014, provided that all of its partners, shareholders, or participants, as the case may be, consent to the election. In the case of a partner, shareholder, or participant that is a partnership, S corporation, or common trust fund, all of the partners, shareholders, and participants also must consent to the election.

(iv) *Time for making election.* In all cases, the election under paragraph (g) of this section must be made in the manner prescribed by forms, instructions, or in other guidance on the individual's, estate's, trust's, domestic partnership's, S corporation's, or common trust fund's original or amended return for the taxable year for which the election is made. An election can be made on an amended return only if the taxable year for which the election is made, and all taxable years that are affected by the election, are not closed by the period of limitations on assessments under section 6501. An individual, estate, trust, domestic partnership, S corporation, or common trust fund may not seek an extension of time to make the election under any other provision of the law, including § 301.9100 of this chapter.

(h) *Examples.* The following examples illustrate the rules of this section. In each example, unless otherwise indicated, the individuals, the foreign corporation (FC), the QEF (QEF), and the partnership (PRS) use a calendar taxable year. Further, the gross income or gain with respect to an interest in FC is not derived in a trade or business described in § 1.1411–5.

Example 1. (i) *Facts.* A, a United States citizen, is the sole shareholder of FC, a controlled foreign corporation (within the meaning of section 957). A is a United States shareholder (within the meaning of section 951(b)) with respect to FC. In 2012, A includes $40,000 in gross income for chapter 1 purposes under section 951(a)(1)(A) with respect to FC. On December 31, 2012, A's basis in the stock of FC for chapter 1 purposes is $500,000, which includes an increase to basis under section 961(a) of $40,000. The amount of FC's earnings and profits that are described in section 959(c)(2) is $40,000, the amount of FC's earnings and profits that are described in section 959(c)(3) is $20,000, and FC does not have any earnings and profits that are described in section 959(c)(1). No election is made under paragraph (g) of this section. During 2013, A does not include any amounts in income under section 951(a) with respect to FC, A does not receive any distributions from FC, and there is no change in the amount of FC's earnings and profits. In 2014, A includes $10,000 in gross income for chapter 1 purposes under section 951(a)(1)(A) with respect to FC. As a result, A's basis in the stock of FC for chapter 1 purposes increases by $10,000 to $510,000 pursuant to section 961(a). During 2015, FC distributes $30,000 to A, which is not treated as a dividend for purposes of chapter 1 under section 959(d). As a result, A's basis in the stock of FC for chapter 1 purposes is decreased by $30,000 to $480,000 pursuant to section 961(b).

(ii) *Results for section 1411 purposes.* In 2014, A does not include the $10,000 section 951(a) income inclusion in A's net investment income under section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i). Pursuant to paragraph (e)(1)(iii) of this section, A decreases A's modified adjusted gross income for section 1411 purposes by $10,000 in 2014, and pursuant to paragraph (d)(1)(i) of this section, A's adjusted basis is not increased by $10,000 and remains at $500,000. In 2015, pursuant to paragraph (c)(2)(i) of this section, A includes $10,000 of the distribution of previously taxed earnings and profits as a dividend for purposes of determining A's net investment income because $10,000 of the $30,000 distribution is attributable to amounts that A included in gross income for chapter 1 purposes under section 951(a) in a tax year that began after December 31, 2012. Pursuant to paragraph (e)(1)(i) of this section, A increases A's modified adjusted gross income for section 1411 purposes by $10,000 in 2015. Under paragraph (d)(1)(i) of this section, A's adjusted basis is not decreased by the $10,000 that is treated as a dividend for section 1411 purposes, and thus, A's adjusted basis in FC for section 1411 purposes is decreased under section 961 only by $20,000 to $480,000.

Example 2. (i) *Facts.* Same facts as *Example 1.* In addition, during 2016, A includes $15,000 in gross income for chapter 1 purposes under section 951(a)(1)(A) with respect to FC. As a result, A's basis in the stock of FC for chapter 1 purposes increases by $15,000 to $495,000 pursuant to section 961(a). During 2017, A sells all of A's shares of FC for $550,000 and, prior to the application of section 1248, recognizes $55,000 ($550,000 minus $495,000) of long-term capital gain for chapter 1 purposes. For purposes of calculating the amount included in income as a dividend pursuant to section 1248(a) for chapter 1 purposes, the earnings and profits of FC attributable to A's shares in FC which were accumulated after December 31,1962 and during the period which A held the stock while FC was a controlled foreign corporation is $55,000, $35,000 of which is excluded pursuant to section 1248(d)(1). Therefore, after the application of section 1248, for chapter 1 purposes, upon the sale of the FC stock, A recognizes $35,000 of long-term capital gain and a $20,000 dividend.

(ii) *Results for section 1411 purposes.* (A) In 2016, A does not include the $15,000 section 951(a)(1)(A) income inclusion in A's net investment income under section 1411(c)(1)(A)(i) and § 1411(c)(1)(A)(i). Pursuant to paragraph (e)(1)(ii) of this section, A decreases A's modified adjusted gross income for section 1411 purposes by $15,000, and, pursuant to paragraph (d)(1)(i)

of this section, A's adjusted basis remains at $480,000.

(B) During 2017, prior to the application of section 1248, A recognizes $70,000 ($550,000 minus $480,000) of gain for section 1411 purposes. Pursuant to paragraph (c)(3) of this section, for section 1411 purposes, section 1248(a) applies to the gain on the sale of FC calculated for section 1411 purposes ($70,000) and section 1248(d)(1) does not apply, except with respect to the $20,000 of earnings and profits of FC that are attributable to amounts previously included in income for chapter 1 purposes under section 951 for a taxable year beginning before December 31, 2012. Accordingly, for purposes of calculating the amount of income includible as a dividend under section 1248(a), A has $55,000 of earnings and profits, $20,000 of which is excluded pursuant to section 1248(d)(1). Therefore, after the application of section 1248, for section 1411 purposes A has $35,000 of long-term capital gain and a $35,000 dividend. For purposes of calculating net investment income in 2017, A includes $35,000 as a dividend under section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i) and $35,000 as a gain under section 1411(c)(1)(A)(iii) and § 1.1411–4(a)(1)(iii).

Example 3. (i) *Facts.* Same facts as *Example 2,* except that A timely makes an election under paragraph (g)(4)(i) of this section for 2014 (and thus for all subsequent years).

(ii) *Results for section 1411 purposes.* A does not have any adjustments to A's modified adjusted gross income for section 1411 purposes for 2014, 2015, 2016 or 2017 because the election under paragraph (g)(4)(i) of this section was timely made. Pursuant to paragraph (g)(2) of this section, for purposes of calculating A's net investment income in 2014, the $10,000 that A included in income for chapter 1 purposes under section 951(a) is net investment income for purposes of section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i). A has no amount of net investment income with respect to FC in 2015. Pursuant to paragraph (g)(2) of this section, for purposes of calculating A's net investment income in 2016, the $15,000 that A included in income for chapter 1 purposes under section 951(a) is net investment income for purposes of section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i). For purposes of calculating A's net investment income in 2017, the amount of gain on the disposition of the FC shares is the same as the amount calculated for chapter 1 purposes. Applying section 1248, A includes $35,000 as a gain under section 1411(c)(1)(A)(iii) and § 1.1411–4(a)(1)(iii), and $20,000 as a dividend under section 1411(c)(1)(A)(i) and § 1.1411–4(a)(1)(i).

Example 4. Domestic partnership holding QEF stock. (i) *Facts.* (A) C, a United States citizen, owns a 50% interest in PRS, a domestic partnership. D, a United States citizen, and E, a United States citizen, each own a 25% interest in PRS. All allocations of partnership income and losses are pro rata based on ownership interests. PRS owns an interest in QEF, a foreign corporation that is a passive foreign investment company (within the meaning of section 1297(a)). PRS, a United States person, made an election under section 1295 with respect to QEF applicable to the first year of its holding period in QEF. As of December 31, 2012, for chapter 1 purposes, C's basis in his partnership interest is $100,000, D's basis in his partnership interest is $50,000, E's basis in his partnership interest is $50,000, and PRS's adjusted basis in its QEF stock is $80,000, which includes an increase in basis under section 1293(d) of $40,000. As of December 31, 2012, the amount of QEF's earnings that have been included in income by PRS under section 1293(a), but have not been distributed by QEF, is $40,000. PRS also has cash of $60,000 and domestic C corporation stock with an adjusted basis of $60,000. During 2013, PRS does not include any amounts in income under section 1293(a) with respect to QEF, PRS does not receive any distributions from QEF, and there are no adjustments to the basis of C, D, or E in their interests in PRS.

(B) During 2014, PRS has income of $40,000 under section 1293(a) with respect to QEF and has no other partnership income. PRS does not make an election under paragraph (g) of this section.

(C) During 2015, QEF distributes $60,000 to PRS. PRS has no income for the year.

(ii) *Results for 2014.* (A) For chapter 1 purposes, as a result of the $40,000 income inclusion under section 1293(a), PRS's basis in its QEF stock is increased by $40,000 under section 1293(d)(1) to $120,000. Under § 1.1293–1(c)(1) and section 702, C's, D's, and E's distributive shares of the section 1293(a) income inclusion are $20,000, $10,000, and $10,000, respectively. Under section 705(a)(1)(A), C increases his adjusted basis in his partnership interest by $20,000 to $120,000, and D and E each increase his adjusted basis in his partnership interest by $10,000 to $60,000.

(B) For section 1411 purposes, pursuant to paragraph (d)(1)(ii) of this section, PRS's basis in QEF is not increased by the $40,000 income inclusion (it remains at $80,000). Because PRS did not make an election under paragraph (g) of this section, C, D and E do not have net investment income with respect to the income inclusion, and pursuant to paragraph (d)(2) of this section, they do not increase their adjusted bases in their interests in PRS (each remains at $50,000). Pursuant to paragraph (e)(1)(ii) of this section, C reduces his modified adjusted gross income by $20,000, and D and E each reduce their modified adjusted gross income by $10,000.

(iii) *Results for 2015.* (A) For chapter 1 purposes, the distribution of $60,000 from QEF to PRS is not a dividend under section 1293(c), and PRS decreases its basis in QEF by $60,000 under section 1293(d)(2) to $60,000.

(B) Pursuant to paragraph (c)(1)(i) of this section, $40,000 of the distribution is a dividend for section 1411 purposes because PRS included $40,000 in gross income for chapter 1 purposes under section 1293(a) in a tax year that began after December 31, 2012. For section 1411 purposes, pursuant to paragraph (d)(1)(ii) of this section, section 1293(d) will not apply to reduce PRS's basis in QEF to the extent of the $40,000 of the distribution that is treated as a dividend under paragraph (c)(2)(i) of this section. Thus, PRS's basis in QEF is decreased only by $20,000 for purposes of section 1411 and is $60,000. The $40,000 distribution of previously taxed earnings and profits that is treated as a dividend for section 1411 purposes is allocated $20,000 to C, $10,000 to D, and $10,000 to E. Because PRS did not make an election under paragraph (g) of this section, pursuant to paragraph (c)(2)(i) of this section, C has $20,000 of net investment income, and D and E each has $10,000 of net investment income as a result of the distribution by QEF, and pursuant to paragraph (d)(2) of this section, C increases his adjusted basis in PRS by $20,000 to $120,000, and D and E each increases his adjusted basis in PRS by $10,000 to $60,000. Pursuant to paragraph (e)(1)(i) of this section, C increases his modified adjusted gross income by $20,000, and D and E each increases his modified adjusted gross income by $10,000.

Example 5. Sale of partnership interest. (i) *Facts.* Same facts as *Example 4.* In addition, in 2016, D sells his entire interest in PRS to F for $100,000.

(ii) *Results for 2016.* For chapter 1 purposes, D has a gain of $40,000 ($100,000 minus $60,000). For section 1411 purposes, D has a gain of $40,000 ($100,000 minus $60,000), and thus, has net investment income of $40,000. No adjustments to modified adjusted gross income are necessary under paragraph (e) of this section.

Example 6. Domestic partnership's sale of QEF stock. (i) *Facts.* Same facts as *Example 4.* In addition, in 2016 PRS has income of $60,000 under section 1293(a) with respect to QEF, and in 2017, PRS sells its entire interest in QEF for $170,000.

(ii) *Results for 2016.* (A) For chapter 1 purposes, as a result of the $60,000 income inclusion under section 1293(a), PRS's basis in its QEF stock is increased by $60,000 under section 1293(d)(1) to $120,000. Under § 1.1293–1(c)(1) and section 702, C's, D's, and E's distributive shares of the section 1293(a) income inclusion are $30,000, $15,000, and $15,000 respectively. Under section 705(a)(1)(A), C increases his adjusted basis in his partnership interest by $30,000 to $150,000, and D and E each increases his adjusted basis in his partnership interest by $15,000 to $75,000.

(B) For section 1411 purposes, pursuant to paragraph (d)(1)(ii) of this section, PRS's basis in QEF is not increased by the $60,000 income inclusion (it remains at $60,000). Because PRS did not make an election under paragraph (g) of this section, C, D and E do not have net investment income with respect to the income inclusion, and pursuant to paragraph (d)(2) of this section, they do not increase their adjusted bases in their interests in PRS (C remains at $120,000, and D and E each remain at $60,000). Pursuant to paragraph (e)(1)(ii) of this section, C reduces his modified adjusted gross income by $30,000, and D and E each reduce their modified adjusted gross income by $15,000.

(iii) *Results for 2017.* (A) For chapter 1 purposes, PRS has a gain of $50,000 ($170,000 minus $120,000), which is allocated 50% ($25,000) to C, 25% ($12,500) to D, and 25% ($12,500) to E.

(B) Based on PRS's basis in the stock of QEF for section 1411 purposes, PRS has a gain for section 1411 purposes of $110,000 ($170,000 minus $60,000), which in the absence of an election by PRS under paragraph (g) of this section, results in gain of $55,000 to C, $27,500 to D, and $27,500 to E. Therefore, C has net investment income of $55,000, and D and E each have net investment income of $27,500. Pursuant to paragraph (e)(1)(ii) of this section, C increases his modified adjusted gross income by $30,000, and D and E each increase their modified adjusted gross income by $15,000.

(i) *Effective/applicability date.* This section applies to taxable years beginning after December 31, 2013. However, taxpayers may apply this section to taxable years beginning after December 31, 2012, in accordance with § 1.1411–1(f).

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

■ **Par. 6.** The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805***

■ **Par. 7.** In § 602.101, paragraph (b) is amended by adding the following entry to the table in numerical order to read as follows:

§ 602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR Part or section where identified and described	Current OMB control No.
* * * * *	
1.1411–10(g)	1545–2227
* * * * *	

John Dalrymple,

Deputy Commissioner for Services and Enforcement.

Approved: November 14, 2013.

Mark J. Mazur,

Assistant Secretary of the Treasury (Tax Policy).

[FR Doc. 2013–28410 Filed 11–26–13; 4:15 pm]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG–130843–13]

RIN 1545–BL74

Net Investment Income Tax

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Withdrawal of notice of proposed rulemaking and notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations under section 1411 of the Internal Revenue Code (Code). These regulations provide guidance on the computation of net investment income. The regulations affect individuals, estates, and trusts whose incomes meet certain income thresholds.

DATES: The proposed rule published December 5, 2012 (77 FR 72612), is withdrawn as of December 2, 2013. Comments on this proposed rule must be received by March 3, 2014. Comments on the collection of information for this proposed rule should be received by January 31, 2014.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG–130843–13), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG–130843–13), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue NW., Washington, DC, or sent electronically, via the Federal eRulemaking portal at *www.regulations.gov* (IRS REG–130843–13).

FOR FURTHER INFORMATION CONTACT: Concerning the proposed regulations, David H. Kirk or Adrienne M. Mikolashek at (202) 317–6852; concerning submissions of comments or to request a hearing, Oluwafunmilayo Taylor, (202) 317–6901 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in this notice of proposed rulemaking has been submitted to the Office of Management and Budget for review in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) under control number 1545–2227. Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, SE:W:CAR:MP:T:T:SP, Washington, DC 20224. Comments on the collection of information should be received by January 31, 2014. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the IRS, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information; and

Estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

The collection of information in these proposed regulations is in § 1.1411–7(g).

The information collected in proposed § 1.1411–7(g) is required by the IRS to verify the taxpayer's reported adjustment under section 1411(c)(4). This information will be used to determine whether the amount of tax has been reported and calculated correctly. The likely respondents are owners of interests in partnerships and S corporations.

The burden for the collection of information contained in these proposed regulations will be reflected in the burden on Form 8960 or another form that the IRS designates, which will request the information in the proposed regulations.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by section 6103.

Background

I. *Statutory Background*

Section 1402(a)(1) of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, 124 Stat. 1029) added section 1411 to a new chapter 2A of subtitle A (Income Taxes) of the Code effective for taxable years beginning after December 31, 2012. Section 1411 imposes a 3.8 percent tax on certain individuals, estates, and trusts.

In the case of an individual, section 1411(a)(1) imposes a tax (in addition to any other tax imposed by subtitle A) for each taxable year equal to 3.8 percent of the lesser of: (A) The individual's net investment income for such taxable year, or (B) the excess (if any) of: (i) The individual's modified adjusted gross income for such taxable year, over (ii) the threshold amount. Section 1411(b) provides that the threshold amount is: (1) In the case of a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), $250,000; (2) in the case of a married taxpayer (as defined in section 7703) filing a separate return, $125,000; and (3) in the case of any other individual, $200,000. Section 1411(d) defines modified adjusted gross income as adjusted gross income increased by the excess of: (1) The amount excluded from gross income under section 911(a)(1), over (2) the amount of any deductions (taken into account in computing adjusted gross income) or exclusions disallowed under section 911(d)(6) with respect to the amount excluded from gross income under section 911(a)(1).

In the case of an estate or trust, section 1411(a)(2) imposes a tax (in addition to any other tax imposed by subtitle A) for each taxable year equal to 3.8 percent of the lesser of: (A) The estate's or trust's undistributed net investment income, or (B) the excess (if any) of (i) the estate's or trust's adjusted gross income (as defined in section 67(e)) for such taxable year, over (ii) the dollar amount at which the highest tax bracket in section 1(e) begins for such taxable year.

Section 1411(c)(1) provides that net investment income means the excess (if any) of: (A) The sum of (i) gross income from interest, dividends, annuities, royalties, and rents, other than such income derived in the ordinary course of a trade or business to which the tax does not apply, (ii) other gross income derived from a trade or business to which the tax applies, and (iii) net gain (to the extent taken into account in computing taxable income) attributable to the disposition of property other than property held in a trade or business to which the tax does not apply; over (B) the deductions allowed by subtitle A that are properly allocable to such gross income or net gain.

II. Regulatory Background

This document contains proposed amendments to 26 CFR part 1 under section 1411 of the Code. On December 5, 2012, the Treasury Department and the IRS published a notice of proposed rulemaking in the **Federal Register**

(REG–130507–11; 77 FR 72612) relating to the Net Investment Income Tax. On January 31, 2013, corrections to the proposed regulations were published in the **Federal Register** (78 FR 6781) (collectively, the ''2012 Proposed Regulations''). Final regulations, issued contemporaneously with these proposed regulations in the Rules and Regulations section of this issue of the **Federal Register**, contain amendments to the Income Tax Regulations (26 CFR Part 1), which finalize the 2012 Proposed Regulations (the ''2013 Final Regulations''). However, the Treasury Department and the IRS also are proposing amendments to the 2013 Final Regulations to provide additional clarification and guidance with respect to the application of section 1411 to certain specific types of property. Furthermore, the Treasury Department and the IRS are also interested in receiving comments about other aspects of section 1411 that are not addressed in the 2013 Final Regulations or these proposed regulations. If such comments are received, the Treasury Department and the IRS will consider them for inclusion on future Guidance Priority Lists.

The Treasury Department and the IRS received comments on the 2012 Proposed Regulations requesting that they address the treatment of section 707(c) guaranteed payments for capital, section 736 payments to retiring or deceased partners for section 1411 purposes, and certain capital loss carryovers. After consideration of all comments received, the Treasury Department and the IRS believe that it is appropriate to address the treatment of these items in regulations. Because such guidance had not been proposed in the 2012 Proposed Regulations, it is being issued for notice and comment in these new proposed regulations.

The Treasury Department and the IRS also received comments on the simplified method for applying section 1411 to income recipients of charitable remainder trusts (CRTs) that was proposed in the 2012 Proposed Regulations. The comments recommended that the section 1411 classification incorporate the existing category and class system under section 664. These proposed regulations provide special rules for the application of the section 664 system to CRTs that derive income from controlled foreign corporations (CFCs) or passive foreign investment companies (PFICs) with respect to which an election under § 1.1411–10(g) is not in place. Specifically, these proposed regulations coordinate the application of the rules applicable to shareholders of CFCs and PFICs in § 1.1411–10 with the section 664 category and class system adopted in § 1.1411–3(d)(2) of the 2013 Final Regulations.

Furthermore, these proposed regulations allow CRTs to elect to apply the section 664 system adopted in the 2013 Final Regulations or the simplified method set forth in the 2012 Proposed Regulations. Some comments responding to the 2012 Proposed Regulations requested that we provide an election. The Treasury Department and the IRS request comments with regard to whether or not taxpayers believe this election is preferable to the section 664 system adopted in the 2013 Final Regulations. If it appears that there is no significant interest in having the election, the Treasury Department and the IRS may omit it from the regulations when finalized, and the simplified method contained in the 2012 Proposed Regulations would no longer be an option.

These proposed regulations also address the net investment income tax characterization of income and deductions attributable to common trust funds (CTFs), residual interests in real estate mortgage investment conduits (REMICs), and certain notional principal contracts.

The Treasury Department and the IRS also received comments on the 2012 Proposed Regulations questioning the proposed regulation's methodology for adjusting a transferor's gain or loss on the disposition of its partnership interest or S corporation stock. In view of these comments, the 2013 Final Regulations removed § 1.1411–7 of the 2012 Proposed Regulations and reserved § 1.1411–7 in the 2013 Final Regulations. This notice of proposed rulemaking proposes revised rules regarding the calculation of net gain from the disposition of a partnership interest or S corporation stock (each a ''Passthrough Entity'') to which section 1411(c)(4) may apply.

Explanation of Provisions

1. Overview of Proposed Regulations

These proposed regulations propose additions and modifications to the 2013 Final Regulations, including guidance with respect to certain paragraphs that were reserved in the 2013 Final Regulations.

To coordinate these proposed regulations with the 2013 Final Regulations, the proposed regulations are proposed to have the same effective date as the 2013 Final Regulations. However, any provisions adopted when these proposed regulations are finalized that are more restrictive than these proposed regulations would apply prospectively only. Taxpayers may rely on these proposed regulations for purposes of compliance with section 1411 until the issuance of these regulations as final regulations. See § 1.1411–1(f).

2. Special Rules for Certain Partnership Payments

Section 731(a) treats gain from distributions as gain from the sale or exchange of a partnership interest. In general, the section 1411 treatment of gain to a partner under section 731 is governed by the rules of section 1411(c)(1)(A)(iii). Such gain is thus generally treated as net investment income for purposes of section 1411 (other than as determined under section 1411(c)(4)). However, certain partnership payments to partners are treated as not from the sale or exchange of a partnership interest. These payments include section 707(c) guaranteed payments for services or the use of capital and certain section 736 distributions to a partner in liquidation of that partner's partnership interest. Because these payments are not treated as from the sale or exchange of a partnership interest, their treatment under section 1411 may differ from the general rule of section 1411(c)(1)(A)(iii). The proposed regulations therefore provide rules for the section 1411 treatment of these payments.

A. Section 707(c) Payments

Section 707(c) provides that a partnership payment to a partner is a ''guaranteed payment'' if the payment is made for services or the use of the capital, and the payment amount does not depend on partnership income. Section 1.707–1(c) provides that guaranteed payments to a partner for services are considered as made to a person who is not a partner, but only for the purposes of section 61(a) (relating to gross income) and, subject to section 263, section 162(a) (relating to trade or business expenses). Section 1.704–1(b)(2)(iv)(*o*) provides that guaranteed payments are not part of a partner's distributive share for purposes of section 704(b).

The proposed regulations' treatment of section 707(c) guaranteed payments under section 1411 depends on whether the partner receives the payment for services or the use of capital. The proposed regulations exclude all section 707(c) payments received for services from net investment income, regardless of whether these payments are subject to self-employment tax, because payments for services are not included in net investment income.

The Treasury Department and the IRS believe that guaranteed payments for the use of capital share many of the characteristics of substitute interest, and therefore should be included as net investment income. This treatment is consistent with existing guidance under section 707(c) and other sections of the Code in which guaranteed payments for the use of capital are treated as interest. See, for example, §§ 1.263A–9(c)(2)(iii) and 1.469–2(e)(2)(ii).

B. Treatment of Section 736 Payments

i. In General

Section 736 applies to payments made by a partnership to a retiring partner or to a deceased partner's successor in interest in liquidation of the partner's entire interest in the partnership. Section 736 does not apply to distributions made to a continuing partner, distributions made in the course of liquidating a partnership entirely, or to payments received from persons other than the partnership in exchange for the partner's interest. Section 736 categorizes liquidating distributions based on the nature of the payment as in consideration for either the partner's share of partnership property or the partner's share of partnership income. Section 736(b) generally treats a payment in exchange for the retiring partner's share of partnership property as a distribution governed by section 731. Section 736(a) treats payments in exchange for past services or use of capital as either distributive share or a guaranteed payment. Section 736(a) payments also include payments to retiring general partners of service partnerships in exchange for unrealized receivables (other than receivables described in the flush language of section 751(c)) or for goodwill (other than payments for goodwill provided for in the partnership agreement) (collectively, ''Section 736(a) Property'').

Because the application of section 1411 depends on the underlying nature of the payment received, the section 736 categorization controls whether a liquidating distribution is treated as net investment income for purposes of section 1411. Thus, the treatment of the payment for purposes of section 1411 differs depending on whether the distribution is a section 736(b) distribution in exchange for partnership property or a section 736(a) distribution in exchange for past services, use of capital, or Section 736(a) Property. Among section 736(a) payments, the proposed regulations further differentiate the treatment of payments depending on: (i) Whether or not the payment amounts are determined with regard to the income of the partnership and (ii) whether the payment relates to Section 736(a) Property or relates to services or use of capital.

Section 1.469–2(e)(2)(iii) contains rules pertaining to whether section 736 liquidating distributions paid to a partner will be treated as income or loss from a passive activity. Where payments to a retiring partner are made over a period of years, the composition of the assets and the status of the partner as passive or nonpassive may change. Section 1.469–2(e)(2)(iii) contains rules on the extent to which those payments are classified as passive or nonpassive for purposes of section 469. The proposed regulations generally align the section 1411 characterization of section 736 payments with the treatment of the payments as passive or nonpassive under § 1.469–2(e)(2)(iii).

ii. Treatment of Section 736(b) Payments

Section 736(b) payments to retiring partners in exchange for partnership property (other than payments to retiring general partners of service partnerships in exchange for Section 736(a) Property) are governed by the rules generally applicable to partnership distributions. Thus, gain or loss recognized on these distributions is treated as gain or loss from the sale or exchange of the distributee partner's partnership interest under section 731(a).

The proposed regulations provide that section 736(b) payments will be taken into account as net investment income for section 1411 purposes under section 1411(c)(1)(A)(iii) as net gain or loss from the disposition of property. If the retiring partner materially participates in a partnership trade or business, then the retiring partner must also apply § 1.1411–7 of these proposed regulations to reduce appropriately the net investment income under section 1411(c)(4). Gain or loss relating to section 736(b) payments is included in net investment income under section 1411(c)(1)(A)(iii) regardless of whether the payments are classified as capital gain or ordinary income (for example, by reason of section 751).

In the case of section 736(b) payments that are paid over multiple years, the proposed regulations provide that the characterization of gain or loss as passive or nonpassive is determined for all payments as though all payments were made at the time that the liquidation of the exiting partner's interest commenced and is not retested annually. The proposed regulations thus adopt for section 1411 purposes the section 469 treatment of section 736(b) payments paid over multiple years as set forth in § 1.469–2(e)(2)(iii)(A).

iii. Treatment of Section 736(a) Payments

As described in part 2.B.i., section 736 provides for several different categories of liquidating distributions under section 736(a). Payments received under section 736(a) may be an amount determined with regard to the income of the partnership taxable as distributive share under section 736(a)(1) or a fixed amount taxable as a guaranteed payment under section 736(a)(2). The categorization of the payment as distributive share or guaranteed payment will govern the treatment of the payment for purposes of section 1411.

The determination of whether section 736(a) payments received over multiple years are characterized as passive or nonpassive depends on whether the payments are received in exchange for Section 736(a) Property. With respect to section 736(a)(1) payments in exchange for Section 736(a) Property, § 1.469–2(e)(2)(iii)(B) provides a special rule that computes a percentage of passive income that would result if the partnership sold the retiring partner's entire share of Section 736(a) Property at the time that the liquidation of the partner's interest commenced. The percentage of passive income is then applied to each payment received. See § 1.469–2(e)(2)(iii)(B)(*1*). These rules apply to section 736(a)(1) and section 736(a)(2) payments for Section 736(a) Property. The proposed regulations adopt this treatment as set forth in section 469 for purposes of section 1411.

a. Section 736(a)(1) payments taxable as distributive share

Section 736(a)(1) provides that if the amount of a liquidating distribution (other than a payment for partnership property described in section 736(b)) is determined with regard to the partnership's income, then the payment is treated as a distributive share of income to the retiring partner. For purposes of section 1411, the items of income, gain, loss, and deduction attributable to the distributive share are taken into account in computing net investment income under section 1411(c)(1) in a manner consistent with the item's chapter 1 character and treatment. For example, if the partner's distributive share includes income from a trade or business not described in section 1411(c)(2), that income will be excluded from net investment income. However, if the distributive share

includes, for example, interest income from working capital, then that income is net investment income.

The proposed regulations treat section 736(a)(1) payments unrelated to Section 736(a) Property as characterized annually as passive or nonpassive by applying the general rules of section 469 to each payment in the year received. To the extent that any payment under section 736(a)(1) is characterized as passive income under the principles of section 469, that payment also will be characterized as passive income for purposes of section 1411.

b. Section 736(a)(2) payments taxable as guaranteed payments

Section 736(a)(2) provides that if the amount of a liquidating distribution (other than a payment for partnership property described in section 736(b)) is determined without regard to the partnership's income, then the payment is treated as a guaranteed payment as described in section 707(c). Payments under section 736(a)(2) might be in exchange for services, use of capital, or Section 736(a) Property. The section 1411 treatment of guaranteed payments for services or the use of capital follows the general rules for guaranteed payments set forth in part 2.A of this preamble. Thus, section 736(a)(2) payments for services are not included as net investment income, and section 736(a)(2) payments for the use of capital are included as net investment income.

Section 736(a)(2) payments in exchange for Section 736 Property are treated as gain or loss from the disposition of a partnership interest, which is generally included in net investment income under section 1411(c)(1)(A)(iii). If the retiring partner materially participates in a partnership trade or business, then the retiring partner must also apply § 1.1411–7 of these proposed regulations to reduce appropriately the net investment income under section 1411(c)(4). To the extent that section 736(a)(2) payments exceed the fair market value of Section 736(a) Property, the proposed regulations provide that the excess will be treated as either interest income or as income in exchange for services, in a manner consistent with the treatment under § 1.469–2(e)(2)(iii).

iv. Application of Section 1411(c)(4) to Section 736 Payments

The proposed regulations provide that section 1411(c)(4) applies to section 736(a)(2) and section 736(b) payments. Thus, the inclusion of these payments as net investment income may be limited if the retiring partner materially participated in all or a portion of the partnership's trade or business. The extent of any limitation is determined under the rules of § 1.1411–7.

The proposed regulations provide that, when section 736 payments are made over multiple years, the characterization of gain or loss as passive or nonpassive and the values of the partnership assets are computed for all payments as though all payments were made at the time that the liquidation of the exiting partner's interest commenced, similar to the treatment in § 1.469–2(e)(2)(iii)(A).

If a partner's net investment income is reduced pursuant to section 1411(c)(4), then the difference between the amount of gain recognized for chapter 1 and the amount includable in net investment income after the application of section 1411(c)(4) is treated as an addition to basis, in a manner similar to an installment sale for purposes of calculating the partner's net investment income attributable to these payments.

v. Additional Public Comments

Commentators to the 2012 Proposed Regulations requested that the Treasury Department and the IRS issue guidance under section 1411 regarding the treatment of section 736 payments to retiring and deceased partners. Some commentators sought clarification regarding the interaction between section 736 payments and the net investment income exclusions in sections 1411(c)(5) and 1411(c)(6).

Section 1411(c)(5) provides that net investment income shall not include certain items of income attributable to distributions from specifically enumerated qualified plans. One commentator suggested that section 736 payments should be excluded from net investment income under section 1411(c)(5) as analogous to qualified plan distributions. The Treasury Department and the IRS believe that section 1411(c)(5) does not apply to section 736 payments because these payments do not originate from a qualified plan described in section 1411(c)(5). Therefore, section 736 payments are not excluded by reason of section 1411(c)(5).

Section 1411(c)(6) provides that net investment income does not include any item taken into account in determining self-employment income for a taxable year on which a tax is imposed by section 1401(b). In the context of section 1411(c)(6), § 1.1411–9(a) of the 2013 Final Regulations provides that the term ''taken into account'' for self-employment tax purposes does not include amounts excluded from net earnings from self-employment under sections 1402(a)(1)–(17). Commentators suggested that certain section 736 payments are excluded from net earnings from self-employment by reason of section 1402(a)(10) and § 1.1402(a)–17, and therefore should be excluded from net investment income under section 1411(c)(6) for similar policy reasons. The Treasury Department and the IRS believe that section 1411(c)(6) does not apply to section 736 payments, except to the extent that such payments are taken into account, within the meaning of § 1.1411–9(a), in determining net earnings from self-employment. In such a case, the section 736 payment would be subject to self-employment tax and therefore is not included in net investment income by reason of section 1411(c)(6) and § 1.1411–9(a).

Commentators also recommended special rules for the interaction between section 736 payments and the section 469 material participation rules solely for purposes of section 1411. As discussed in this part of the preamble, the proposed section 1411 rules rely heavily on the chacterization of the section 736 payments under section 469. Therefore, the Treasury Department and the IRS do not believe that special section 469 rules are necessary solely for purposes of section 1411.

3. Treatment of Certain Capital Loss Carryforwards

In general, under chapter 1, capital losses that exceed capital gains are allowed as a deduction against ordinary income only to the extent allowed by section 1211(b). In the case of capital losses in excess of the amounts allowed by section 1211(b), section 1212(b)(1) treats these losses as incurred in the following year. Section 1.1411–4(d) adopts these principles when computing net gain under section 1411(c)(1)(A)(iii). Therefore, capital losses incurred in a year prior to the effective date of section 1411 may be taken into account in the computation of section 1411(c)(1)(A)(iii) net gain by reason of the mechanics of section 1212(b)(1). However, certain capital losses may not be taken into account in determining net investment income within the meaning of section 1411(c)(1)(A)(iii) or by reason of the exception in section 1411(c)(4)(B) (generally, an ''excluded capital loss''). In the case of section 1411(c)(1)(A)(iii), § 1.1411–4(d)(4)(i) provides that capital losses attributable to the disposition of property used in a trade or business not described in section 1411(c)(2) and § 1.1411–5 are excluded from the computation of net gain. In the case of section 1411(c)(4)(B), some or all of a capital loss resulting from the

disposition of certain partnerships or S corporations is excluded from the determination of net gain. Although these capital losses are excluded from the calculation of net gain in the year of recognition by reason of § 1.1411–4(d)(4), such losses may not be fully offset by capital gains for chapter 1 purposes in the same year. In that case, some (or all) of the capital loss carryforward will constitute excluded capital losses in the subsequent year(s) by reason of the mechanics of section 1212(b)(1). Several commentators identified this issue and requested that the Treasury Department and the IRS provide guidance on the identification, tracking, and use of embedded, excluded capital losses within a capital loss carryforward.

In response to these comments, proposed § 1.1411–4(d)(4)(iii) creates an annual adjustment to capital loss carryforwards to prevent capital losses excluded from the net investment income calculation in the year of recognition from becoming deductible losses in future years. The annual adjustment in § 1.1411–4(d)(4)(iii) provides a method of identification and an ordering rule that eliminate the need for taxpayers to maintain a separate set of books and records for this item to comply with section 1411. However, the rule requires that taxpayers perform the calculation annually, regardless of whether they have a section 1411 tax liability in a particular year, to maintain the integrity of the rule's carryforward adjustment amounts for a subsequent year in which they are subject to liability under section 1411.

The rule provides that, for purposes of computing net gain in § 1.1411–4(d) and any properly allocable deduction for excess losses in § 1.1411–4(f)(4) (if any), the taxpayer's capital loss carryforward from the previous year is reduced by the lesser of: (A) the amount of capital loss taken into account in the current year by reason of section 1212(b)(1), or (B) the amount of net capital loss excluded from net investment income in the immediately preceding year. For purposes of (B), the amount of net capital loss excluded from net investment income in the previous year includes amounts excluded by reason of § 1.1411–4(d)(4) (amount of capital losses recognized in the preceding year) plus the amount of the previous year's adjustment required by this rule. Section 1.1411–4(d)(4)(iii) provides a multi-year example to illustrate the application of the rule.

The mechanics of the capital loss adjustment accomplishes several objectives. First, the rule causes all capital losses incurred prior to 2013 to be allowable losses for the computation of net gain under § 1.1411–4(d) and any properly allocable deduction for excess losses in § 1.1411–4(f)(4) (if any). This result is accomplished by the application of part (B) of the rule described in the preceding paragraph. Since the adjustment is based on the lesser of (A) or (B), the amount of excluded capital losses in the year immediately before the effective date of section 1411 is zero, so the loss adjustment in the year following the effective date of section 1411 will also be zero. Second, the rule only requires an adjustment when a taxpayer has excluded losses embedded within a capital loss carryforward. Therefore, taxpayers with no excluded capital losses do not have to make any adjustment. Third, the rule also provides a mechanism for ordering the use of capital losses to offset gains. The rule causes excluded capital gains recognized in the current year to be offset by excluded capital losses that are embedded in the capital loss carryforward from the previous year. This matching is accomplished by the use of the term ''net capital loss'' in § 1.1411–4(d)(4)(iii)(B). If the excluded gain exceeds the amount of excluded capital loss included in the carryforward amount and any excluded capital loss amounts recognized in the current year, the amount of adjustment will be zero in the subsequent year because there was no ''net capital loss'' in the preceding year. In this situation, no adjustment is required because the previous year's excluded gains were fully absorbed by the excluded losses. Finally, the rule allows taxpayers to use capital non-excluded losses for purposes of the excess loss deduction in § 1.1411–4(f)(4) before subjecting excluded losses to the limitation.

4. Treatment of Income and Deductions From Common Trust Funds (CTFs)

Section 584(c) provides that each participant in a CTF shall include in its taxable income, whether or not distributed and whether or not distributable, its proportionate share of: (1) short-term capital gain or loss, (2) long-term capital gain or loss, and (3) ordinary taxable income or the ordinary net loss of the CTF. The flush language of section 584(c) further provides that ''the proportionate share of each participant in the amount of dividends received by the CTF and to which section 1(h)(11) applies shall be considered for purposes of such paragraph as having been received by such participant.''

Section 584(d) provides, in relevant part, that ''[t]he taxable income of a common trust fund shall be computed in the same manner and on the same basis as in the case of an individual, except …after excluding all items of gain and loss from sales or exchanges of capital assets, there shall be computed (A) an ordinary taxable income which shall consist of the excess of the gross income over deductions; or (B) an ordinary net loss which shall consist of the excess of the deductions over the gross income.''

The Treasury Department and the IRS have become aware that taxpayers may be considering the use of CTFs to recharacterize income items that otherwise would be includable in net investment income under section 1411. Because section 584(c)(3) simply requires the participant to include in its income its share of ''net ordinary income or loss,'' taxpayers may attempt to claim that section 584(c)(3) ordinary income or loss inclusions are not explicitly section 1411(c)(1)(A)(i) net investment income, and therefore escape taxation under section 1411.

Using a CTF to recharacterize the underlying character of CTF income for section 1411 purposes is closely analogous to the past use of CTFs to cleanse unrelated business taxable income (UBTI) for tax-exempt participants. In 1984, the Treasury Department and the IRS promulgated § 1.584–2(c)(3), which created a special look-through rule to prevent taxpayers from using CTFs to recharacterize UBTI. Section 1.584–2(c)(3) provides, in relevant part, that ''any amount of income or loss of the common trust fund which is included in the computation of a participant's taxable income for the taxable year shall be treated as income or loss from an unrelated trade or business to the extent that such amount would have been income or loss from an unrelated trade or business if such participant had made directly the investments of the common trust fund.''

Similarly, proposed § 1.1411–4(e)(3) includes a rule that provides income or loss from a CTF is net investment income or deduction to the extent that such amount would have been net investment income or deduction if the participant had made directly the investments of the CTF.

5. Treatment of Income and Deductions Related to Residual Interests in REMICs

The 2012 Proposed Regulations did not explicitly address income and deductions related to residual interests in REMICs. A REMIC residual interest represents an equity-like interest in a REMIC. A REMIC is not treated as carrying on a trade or business for purposes of section 162, and a REMIC's

taxable income or net loss generally is derived from dispositions of qualified mortgages or permitted investments, interest income from the mortgages, and interest expense from the regular interests (treated as debt) issued by the REMIC. Section 860C(a)(1) generally requires the holder of a REMIC residual interest to take into account the daily portion of the REMIC's taxable income or net loss. One commentator suggested that the regulations expressly include income from a REMIC residual interest in determining net investment income. The Treasury Department and the IRS agree with this comment because, if a taxpayer directly held the underlying assets of the REMIC, the items of income, gain, loss, and deductions attributable to those assets would be taken income account in computing net investment income. Therefore, the proposed regulations provide that a holder of a residual interest in a REMIC takes into account the daily portion of taxable income (or net loss) under section 860C in determining net investment income.

6. Treatment of Income and Deductions From Certain Notional Principal Contracts (NPCs)

Under the 2012 Proposed Regulations (and the 2013 Final Regulations), gain on the disposition of an NPC is included in net investment income, and any other gross income from an NPC (including net income attributable to periodic payments on an NPC) is included in net investment income if it is derived from a trade or business described in § 1.1411–5. Several commentators on the 2012 Proposed Regulations suggested that the proper treatment of periodic payments on an NPC should not turn solely upon whether the NPC was entered into as part of a trading business and recommended that NPC periodic payments should be included in net investment income. One commentator indicated that the omission of NPC periodic income seems unusual and inconsistent with the portions of the 2012 Proposed Regulations (and 2013 Final Regulations) that provide for the inclusion in net investment income of substitute interest and substitute dividends.

After consideration of the comments, the Treasury Department and the IRS agree that periodic payments on an NPC should be included in net investment income even if the net income from such payments is not derived in a trade or business described in § 1.1411–5. As a result, the proposed regulations provide that net income (or net deduction) attributable to periodic and nonperiodic payments on an NPC under § 1.446–3(d) is taken into account in determining net investment income. However, the proposed regulations only apply to the net income (or net deduction) on an NPC described in § 1.446–3(c)(1) that is referenced to property (including an index) that produces (or would produce if the property were to produce income) interest, dividends, royalties, or rents if the property were held directly by the taxpayer. The proposed regulations would not affect the treatment of net income attributable to periodic and nonperiodic payments on any NPC derived in a trade or business described in § 1.1411–5, that is net investment income under section 1411(c)(1)(A)(ii).

7. Charitable Remainder Trusts (CRTs) With Income From Controlled Foreign Corporations (CFCs) or Passive Foreign Investment Companies (PFICs)

Section 1.1411–3(d)(2) of the 2013 Final Regulations provides rules on the categorization and distribution of net investment income from a CRT based on the existing section 664 category and class system. In general, § 1.1411–3(d)(2) provides that, if a CRT has both excluded income and accumulated net investment income (ANII) in an income category, such excluded income and ANII constitute separate classes of income for purposes of § 1.664–1(d)(1)(i)(b). Section 1.1411–10 of the 2013 Final Regulations provides rules for calculating net investment income when a taxpayer owns a direct or indirect interest in a CFC or PFIC.

The 2013 Final Regulations reserve paragraph § 1.1411–3(d)(2)(ii) for special rules that the Treasury Department and the IRS believe are necessary to apply the section 664 category and class system contained in § 1.664–1(d), and adopted by § 1.1411–3(d)(2), to CRTs that own interests in certain CFCs or PFICs. The special rules generally apply to taxpayers that: (i) Own CFCs or qualified electing funds (QEFs) with respect to which an election under § 1.1411–10(g) is not in place; or (ii) are subject to the rules of section 1291 with respect to a PFIC. These proposed regulations provide those special rules and are proposed to apply to taxable years beginning after December 31, 2013. There are no special rules necessary for a United States person that has elected to mark to market its PFIC stock under section 1296. See § 1.1411–10(c)(2)(ii).

A. CFCs and QEFs

For purposes of chapter 1, a United States shareholder (as defined in section 951(b)) of a CFC is required to include certain amounts in income currently under section 951(a) (section 951 inclusions). Similarly, a U.S. person that owns shares of a PFIC also is required to include amounts in income currently under section 1293(a) (section 1293 inclusions) if the person makes a QEF election under section 1295 with respect to the PFIC.

For purposes of chapter 1, a CRT's section 951 inclusions and section 1293 inclusions are included in the appropriate section 664 category and class for the year in which those amounts are includable in the CRT's income for purposes of chapter 1. The application of the ordering rules in § 1.664–1(d)(1) determines the tax character of the annuity or unitrust distributions to the CRT's income beneficiary. These ordering rules are equally applicable for purposes of section 1411 under the 2013 Final Regulations. In the case of a CRT that directly or indirectly owns an interest in a CFC or QEF, some portion of the annual distribution(s) may consist of current or previous years' section 951 inclusions or section 1293 inclusions.

As discussed in the preamble to the 2013 Final Regulations, § 1.1411–10 generally provides that distributions of previously taxed earnings and profits attributable to section 951 inclusions and section 1293 inclusions that are not treated as dividends for purposes of chapter 1 under section 959(d) or section 1293(c) are dividends for purposes of section 1411, absent an election under § 1.1411–10(g). Without that election, taxpayers generally do not include section 951 inclusions or section 1293 inclusions in net investment income for purposes of section 1411. As a result, the timing of income derived from an investment in a CFC or QEF may be different for purposes of chapter 1 and section 1411. Thus, § 1.1411–10(e) provides adjustments to a taxpayer's modified adjusted gross income (MAGI), or to the adjusted gross income (AGI) of an estate or trust, when the taxpayer owns a CFC or QEF with respect to which an election is not in place to coordinate the rules in § 1.1411–10 with calculation of the section 1411 tax, the applicability of which is based, in part, on MAGI or AGI.

B. Section 1291 Funds

The Final 2013 Regulations also provide special rules that apply to a United States shareholder of a PFIC who is subject to the tax and interest charge applicable to excess distributions under section 1291. Accordingly, § 1.1411–10(e) also provides adjustments to a taxpayer's MAGI, or to the AGI of an

estate or trust, when the taxpayer owns a PFIC and is subject to these special rules. In particular, MAGI (or AGI for an estate or trust) is increased by: (i) The amount of any excess distribution to the extent the distribution is a dividend under section 316(a) and is not otherwise included in income for purposes of chapter 1 under section 1291(a)(1)(B), and (ii) any gain treated as an excess distribution under section 1291(a)(2) to the extent not otherwise included in income for purposes of chapter 1 under section 1291(a)(1)(B).

C. Rules in Proposed Regulation § 1.1411–3(d)(2)(ii)

The rules in proposed § 1.1411–3(d)(2)(ii) coordinate the rules of § 1.1411–10 with the section 664 category and class system. These proposed regulations contain three rules that generally apply when a CRT directly or indirectly owns an interest in a CFC or QEF and a § 1.1411–10(g) election is not in effect with respect to the CFC or QEF. First, § 1.1411–3(d)(2)(ii)(A) provides that section 951 inclusions and section 1293 inclusions that are included in gross income for purposes of chapter 1 for a calendar year and in one or more categories described in § 1.664–1(d)(1) are considered excluded income (within the meaning of § 1.1411–1(d)) in the year the amount is included in income for purposes of chapter 1.

Second, proposed § 1.1411–3(d)(2)(ii)(B) provides that, when a CRT receives a distribution of previously taxed earnings and profits that is not treated as a dividend for purposes of chapter 1 under section 953(d) and 1293(c) but that is taken into account as net investment income for purposes of section 1411 (referred to as an *NII Inclusion Amount*), the CRT must allocate such amounts among the categories described in section 664(b)(1)–(3). For this purpose, the NII Inclusion Amount includes net investment income described in § 1.1411–10(c)(1)(i) (certain distributions from a CFC or QEF), § 1.1411–10(c)(1)(ii) (certain distributions from a section 1291 fund), § 1.1411–10(c)(2)(i) (gain derived from the disposition of a section 1291 fund), and § 1.1411–10(c)(4) (distributions from an estate or trust attributable to income or gain derived from a CFC or QEF with respect to which an election under § 1.1411–10(g) is not in effect). Specifically, proposed § 1.1411–3(d)(2)(ii)(B) provides that, to the extent the CRT has amounts of excluded income in the Ordinary Income Category and the Capital Gain Category under § 1.664–1(d)(1), the NII Inclusion Amount is allocated to the CRT's classes of excluded income in the Ordinary Income Category, and then to the classes of excluded income in the Capital Gain Category, in turn, until exhaustion of each such class, beginning with the class of excluded income within a category with the highest Federal income tax rate. Any remaining NII Inclusion Amount not so allocated to classes within the Ordinary Income and Capital Gain Categories shall be placed in the category described in section 664(b)(3) (the Other Income Category). To the extent the CRT distributes amounts from this Other Income Category, that distribution shall constitute a distribution described in § 1.1411–10(c)(4) and thus § 1.1411–10(e)(1) causes the beneficiary to increase its MAGI (or AGI for an estate or trust) by the same amount.

The third rule in proposed § 1.1411–3(d)(2)(ii) addresses the differential in gain or loss associated with tax basis disparities between chapter 1 and section 1411 that are caused by the recognition of income under chapter 1 and of the corresponding net investment income in different taxable years. See § 1.1411–10(d) for special basis calculation rules for CFC, QEFs, and partnerships and S corporations that own interests in CFCs or QEFs. The proposed rules for the allocation of such gain or loss within the section 664 categories and classes generally are consistent with the allocation rules for NII Inclusions Amounts, except that the Capital Gain Category is the first category to which the gain or loss is to be allocated, and then the Ordinary Income Category. The order of the categories is changed for gains and losses to more closely match the adjustments to the income that produced the net investment income, and to minimize the need for adjustments to MAGI or AGI.

Proposed § 1.1411–3(d)(2)(ii)(C)(*1*) provides rules similar to proposed § 1.1411–3(d)(2)(ii)(B) for gains that are higher for section 1411 purposes than they are for chapter 1 purposes. The difference between the rule for gains in proposed §§ 1.1411–3(d)(2)(ii)(C)(*1*) and 1.1411–3(d)(2)(ii)(B) is that proposed § 1.1411–3(d)(2)(ii)(C)(*1*) requires this additional gain to be allocated within the Capital Gain Category before any allocation within the Ordinary Income Category. The Treasury Department and the IRS believe this difference more accurately reflects the nature of the net investment income within the section 664 category and class system because this NII Inclusion Amount is attributable to a transaction that generated capital gain or loss (rather than ordinary income inclusions and dividends attributable to proposed § 1.1411–3(d)(2)(ii)(B) items).

Proposed § 1.1411–3(d)(2)(ii)(C)(*2*) provides rules similar to proposed § 1.1411–3(d)(2)(ii)(C)(*1*) for losses (and gains that are lower for section 1411 purposes than they are for chapter 1), but with a different ordering rule. In these cases, the tax basis is higher for section 1411 (generating a smaller gain or larger loss for 1411 purposes). However, unlike dividends and gains addressed in proposed §§ 1.1411–3(d)(2)(ii)(B) and 1.1411–3(d)(2)(ii)(C)(*1*), respectively, which can require an increase in MAGI (or AGI for an estate or trust), losses are accompanied by a reduction in MAGI (or AGI for an estate or trust) under § 1.1411–10(e). Therefore, proposed § 1.1411–3(d)(2)(ii)(C)(*2*) generally follows the ordering rule for gains with one exception. The loss ordering rule in proposed § 1.1411–3(d)(2)(ii)(C)(*2*) begins with allocating the decrease to the Other Income Category that was created or increased in the current or previous year, presumably due to an allocation under § 1.1411–3(d)(2)(ii)(B). The purpose of the different ordering rule is to eliminate the ANII within Other Income Category first in an effort to reduce the incidence of required MAGI (or AGI for an estate or trust) adjustments by the beneficiary. Once this income is eliminated, the CRT or beneficiary will not have to separately account for a MAGI (or AGI for an estate or trust) increase because the timing differences caused by § 1.1411–10 may have been corrected within the 664 class and category system before such income is distributed to the beneficiary.

8. Simplified Method for Charitable Remainder Trusts

The 2012 Proposed Regulations provided a method for the CRT to track net investment income received after December 31, 2012, and later distributed to the beneficiary. Section 1.1411–3(c)(2)(i) of the 2012 Proposed Regulations provided that distributions from a CRT to a beneficiary for a taxable year consist of net investment income in an amount equal to the lesser of the total amount of the distributions for that year, or the current and accumulated net investment income of the CRT.

As discussed in part 4.C of the preamble to the 2013 Final Regulations, multiple commentators asked that the final regulations follow the existing rules under section 664 that create subclasses in each category of income as the tax rates on certain types of income are changed from time to time. However, some of the commentators

suggested that the final regulations allow the trustee to elect between the method described in the 2012 Proposed Regulations and the existing rules under section 664.

These proposed regulations provide CRTs with a choice of methods. Section 1.1411–3(d)(2) of the 2013 Final Regulations, along with the proposed additions in these proposed regulations, provide guidance on the application of the section 664 method of tracking net investment income. Proposed § 1.1411–3(d)(3) allows the CRT to elect to use the simplified method included in the 2012 Proposed Regulations, with one modification. Proposed § 1.1411–3(d)(3)(ii) provides that a CRT that elects to use the simplified method is not limited by the general excess deduction rule in § 1.1411–4(f)(1)(ii). Section 1.1411–4(f)(1)(ii) provides that section 1411(c)(1)(B) deductions in excess of gross income and net gain described in section 1411(c)(1)(A) are not taken into account in determining net investment income in any other taxable year, except as allowed under chapter 1. In the case of CRTs, for chapter 1 purposes, the section 664(d) regulations allow for losses within each income class to be carried forward to offset income earned by the CRT within the same class in a future year. Therefore, this provision of the simplified method retains the chapter 1 principle that a CRT's losses are carried forward and offset income in future years. For example, if a CRT has a long-term capital loss of $10,000 in year 1 and a $11,000 long-term capital gain in year 2, the section 664(d) regulations provide that the CRT will have $1,000 of long-term gain available for distribution in year 2. Proposed § 1.1411–3(d)(3)(ii) is intended to provide the same result such that the CRT would have $1,000 of accumulated net investment income available for distribution in year 2.

In the case of a CRT established after December 31, 2012, the CRT's election must be made on its income tax return for the taxable year in which the CRT is established. In the case of a CRT established before January 1, 2013, the CRT's election must be made on its income tax return for its first taxable year beginning on or after January 1, 2013. Additionally, the CRT may make the election on an amended return for that year only if neither the taxable year for which the election is made, nor any taxable year that is affected by the election, for both the CRT and its beneficiaries, is closed by the period of limitations on assessments under section 6501. Once made, the election is irrevocable.

If, after consideration of all comments received in response to these proposed regulations, it appears that there is no significant interest among taxpayers in having the option of using the simplified method, the Treasury Department and the IRS may omit this election from the regulations when finalized.

9. Calculation of Gain or Loss Attributable to the Disposition of Certain Interests in Partnerships and S Corporations

Section 1411(c)(4)(A) provides that, in the case of a disposition of an interest in a partnership or of stock in an S corporation (either, a ''*Passthrough Entity*''), gain from the disposition shall be taken into account under section 1411(c)(1)(A)(iii) only to the extent of the net gain which would be taken into account by the transferor if the Passthrough Entity sold all of its property for fair market value immediately before the disposition of the interest. Section 1411(c)(4)(B) provides a similar rule for losses from dispositions.

The 2012 Proposed Regulations required that a transferor of a partnership interest or S corporation stock first compute its gain (or loss) from the disposition of the interest in the Passthrough Entity to which section 1411(c)(4) may apply, and then reduce that gain (or loss) by the amount of non-passive gain (or loss) that would have been allocated to the transferor upon a hypothetical sale of all of the Passthrough Entity's assets for fair market value immediately before the transfer. The Treasury Department and the IRS received several comments questioning this approach based on the commentators' reading of section 1411(c)(4) to include gain/loss from the disposition of a partnership interest or S corporation stock *only to the extent of* the transferor's share of gain/loss from the Passthrough Entity's passive assets.

The 2013 Final Regulations do not provide rules regarding the calculation of net gain from the disposition of an interest in a Passthrough Entity to which section 1411(c)(4) may apply. After considering the comments received, the Treasury Department and the IRS have withdrawn the 2012 Proposed Regulations implementing section 1411(c)(4) and are issuing this notice of proposed rulemaking to propose revised rules for the implementation of section 1411(c)(4) adopting the commentators' suggestion. Accordingly, the 2013 Final Regulations reserve on this issue.

Proposed § 1.1411–7(b) provides a calculation to determine how much of the gain or loss that is recognized for chapter 1 purposes is attributable to property owned, directly or indirectly, by the Passthrough Entity that, if sold, would give rise to net gain within the meaning of section 1411(c)(1)(A)(iii) (''*Section 1411 Property*''). Section 1411 Property is any property owned by, or held through, the Passthrough Entity that, if sold, would result in net gain or loss allocable to the partner or shareholder that is includable in determining the partner or shareholder's net investment income under § 1.1411–4(a)(1)(iii). This definition recognizes that the items of property inside the Passthrough Entity that constitute Section 1411 Property might vary among transferors because a transferor may or may not be ''passive'' with respect to the property.

Proposed § 1.1411–7(c) provides an optional simplified reporting method that qualified transferors may use in lieu of the calculation described in proposed § 1.1411–7(b). Proposed § 1.1411–7(d) contains additional rules that apply when a transferor disposes of its interest in the Passthrough Entity in a deferred recognition transaction to which section 1411 applies. Proposed § 1.1411–7(f) provides rules for adjusting the amount of gain or loss computed under this paragraph for transferors subject to basis adjustments required by § 1.1411–10(d). Proposed § 1.1411–7(g) provides rules for information disclosures by a Passthrough Entity to transferors and for information reporting by individuals, trusts, and estates.

A. Applicability of Section 1411(c)(4)

In the case of an individual, trust, or estate, the proposed regulations provide that section 1411(c)(4) applies to ''*Section 1411(c)(4) Dispositions.*'' A Section 1411(c)(4) Disposition is the disposition of an interest in a Passthrough Entity by an individual, estate, or trust if: (i) The Passthrough Entity is engaged in one or more trades or businesses, or owns an interest (directly or indirectly) in another Passthrough Entity that is engaged in one or more trades or businesses, other than the business of trading in financial instruments or commodities (within the meaning of § 1.1411–5(a)(2)); and (ii) one or more of the trades or businesses of the Passthrough Entity is not a passive activity (within the meaning of § 1.1411–5(a)(1)) of the transferor. Thus, if the transferor materially participates in one or more of the Passthrough Entity's trades or businesses (other than a trade or business of trading in financial instruments or commodities), then the transferor must use section 1411(c)(4) to calculate how much of the

chapter 1 gain or loss from the disposition to include under section 1411(c)(1)(A)(iii). Section 1411(c)(4) only applies to dispositions of equity interests in partnerships and stock in S corporations, and does not apply to gain or loss recognized on, for example, indebtedness owed to the taxpayer by a partnership or S corporation.

Proposed § 1.1411–7(a)(3) also addresses dispositions by Passthrough Entities of interests in lower-tier Passthrough Entities (a ''*Subsidiary Passthrough Entity*''). Proposed § 1.1411–7(a)(3)(ii) provides a ''look through rule'' that treats a partner or shareholder as owning a proportionate share of any Subsidiary Passthrough Entity, as if the partner or shareholder owned the interest directly. Thus, each partner of the upper-tier Passthrough Entity must determine whether the disposition of the Subsidiary Passthrough Entity is a Section 1411(c)(4) Disposition based on whether the disposition would qualify as a Section 1411(c)(4) Disposition if that owner owned its interest in the Subsidiary Passthrough Entity directly.

The Treasury Department and the IRS anticipate that taxpayers who dispose of an interest in a partial recognition transaction or partial disposition transaction will apply the principles of this section by including a pro rata amount of gain or loss from the Passthrough Entity's Section 1411 Property. In addition, the Treasury Department and the IRS believe that the application of section 1411(c)(4) to gain or loss on distributions from a Passthrough Entity is adequately addressed in section 469, which is incorporated into section 1411(c)(4) through the general definition of passive activity contained in section 1411(c)(2)(A). Thus, the proposed regulations do not include special rules on partial recognition, partial disposition, and distribution transactions. However, the Treasury Department and the IRS request comments on whether additional rules on these topics are required.

B. Definitions and Special Rules

Proposed § 1.1411–7(a)(2) contains certain definitions and special rules that are unique to determining gain or loss under section 1411(c)(4) and apply only for purposes of proposed § 1.1411–7.

i. Definitions

Proposed § 1.1411–7 refers to partnerships or S corporations collectively as ''Passthrough Entities'' and the disposition of an interest in one of these entities is referred to as a ''Section 1411(c)(4) Disposition.'' The purpose of section 1411(c)(4) is to allow gain attributable to non-passive activities to be excluded from the calculation of section 1411 tax upon the disposition of an interest in a Passthrough Entity. To accomplish this, section 1411(c)(4)(A) provides that gain from the disposition of an interest in a Passthrough Entity shall be taken into account in computing net investment income only to the extent of the amount of gain the transferor would have included under section 1411(c)(1)(A)(iii) if the Passthrough Entity sold all of its assets immediately before the Section 1411(c)(4) Disposition. The proposed regulations refer to the property that would generate gain for inclusion in section 1411(c)(1)(A)(iii) as ''Section 1411 Property.''

ii. Rules for Certain Liquidations

Proposed § 1.1411–7(a)(4)(i) provides that if a fully taxable disposition of the Passthrough Entity's assets is followed by the liquidation of the Passthrough Entity as part of a single plan, then the disposition will be treated as an asset sale for purposes of section 1411. Thus, no additional gain or loss is included in net investment income under § 1.1411–4(a)(1)(iii) on the subsequent liquidation of the Passthrough Entity by any transferor provided that the transferor would have satisfied proposed § 1.1411–7(a)(3) prior to the sale. The proposed regulations also state that, when an S corporation makes a section 336(e) or section 338(h)(10) election on the sale of its stock, the transaction will be treated under section 1411 as a fully taxable asset sale by the Passthrough Entity followed by a liquidation of the entity. Thus, no additional gain or loss is included in net investment income on the subsequent liquidation of the S corporation stock, provided a section 336(e) or section 338(h)(10) election is in effect.

iii. Rules for S Corporation Shareholders

Proposed § 1.1411–7(a)(4) provides two special rules for S corporation shareholders. First, proposed § 1.1411–7(a)(4)(ii) provides that the Passthrough Entity will be considered an S corporation for purposes of section 1411 and proposed § 1.1411–7 even though § 1.1362–3(a) treats the day of the transfer as the first date of the Passthrough Entity's C corporation short year (as defined therein). Second, proposed § 1.1411–7(a)(4)(iii) provides that the calculation under proposed § 1.1411–7(b) does not take into account any adjustment resulting from the hypothetical imposition of tax under section 1374 as a result of the proposed § 1.1411–7(b) deemed sale. This provision was also included in the 2012 Proposed Regulations. See also part 9.H of this preamble for a discussion of the application of section 1411(c)(4) to Qualified Subchapter S Trusts.

C. Calculation of Gain or Loss Includable in Net Investment Income

i. Primary Method—Proposed § 1.1411–7(b)

Proposed § 1.1411–7(b) provides the calculation for determining the amount of the transferor's gain or loss under section 1411(c)(1)(A)(iii) from the disposition of an interest in a Passthrough Entity. For dispositions resulting in chapter 1 gain, the transferor's gain equals the lesser of: (i) The amount of gain the transferor recognizes for chapter 1 purposes, or (ii) the transferor's allocable share of net gain from a deemed sale of the Passthrough Entity's Section 1411 Property (in other words, property which, if sold, would give rise to gain or loss that is includable in determining the transferor's net investment income under § 1.1411–4(a)(1)(iii)). The proposed regulations contain a similar rule when a transferor recognizes a loss for chapter 1 purposes.

The 2012 Proposed Regulations required that a transferor of an interest in a Passthrough Entity in which the transferor materially participated value each asset held by the Passthrough Entity to determine the total amount of gain or loss to include under section 1411(c)(4). Commentators indicated that this valuation requirement imposed undue administrative burdens on the transferor. The Treasury Department and the IRS acknowledge that for transferors of certain active interests in Passthrough Entities this property-by-property valuation requirement could be burdensome. Accordingly, these proposed regulations instead direct the transferor to rely on the valuation requirements under § 1.469–2T(e)(3), which the materially participating transferor should already be applying for purposes of chapter 1. These valuation requirements allow the transferor to compute gain or loss activity by activity.

Section 1.469–2T(e)(3) addresses dispositions of partnership interests and S corporation stock in the context of the passive activity loss rules for purposes of chapter 1. Section 1.469–2T(e)(3) provides guidance on allocating disposition gains or losses among the activities of the entity. These rules require the taxpayer to determine the overall gain or loss from each activity (regardless of whether or not the taxpayer materially participates in the

activity). For this purpose, § 1.469–2T(e)(3)(ii)(B)(1)(i) requires the taxpayer to compute for each activity ''the amount of net gain . . . that would have been allocated to the holder of such interest with respect thereto if the passthrough entity had sold its entire interest in such activity for its fair market value on the applicable valuation date.'' Section 1.469–2T(e)(3)(ii)(B)(*2*)(*i*) contains a corollary rule for dispositions at a loss.

Thus, the proposed regulations require a materially participating transferor to calculate its section 1411(c)(4) gain or loss by reference to the activity gain and loss amounts computed for chapter 1 purposes under §§ 1.469–2T(e)(3)(ii)(B)(*1*)(*i*) and (e)(3)(ii)(B)(*2*)(*i*). Specifically for purposes of section 1411, the transferor's allocable share of gain or loss from a deemed sale of the Passthrough Entity's Section 1411 Property equals the sum of the transferor's allocable shares of net gains and net losses (as determined under the section 469 principles described above) from a hypothetical deemed sale of the activities in which the transferor does not materially participate.

Because section 1411(c)(4) applies to all activities in which a transferor in a Section 1411(c)(4) Disposition does not materially participate (whether held at a gain or a loss), certain provisions under 469 do not apply for purposes of these rules. Proposed § 1.1411–7(b)(1)(i)(B) and (b)(1)(ii)(B) both apply § 1.469–2T(e)(3) without the recharacterization rule of § 1.469–2T(e)(3)(iii) because the recharacterization rule in § 1.469–2T(e)(3)(iii) is intended to recharacterize gains in certain circumstances as not being from a passive activity, and is thus not relevant in the context of section 1411.

The Treasury Department and the IRS request comments on other possible methods that would implement section 1411(c)(4) for dispositions described in proposed § 1.1411–7(a)(3)(i) (individuals, estates, and trusts) and proposed § 1.1411–7(a)(3)(ii) (tiered Passthrough Entity structures) in a manner consistent with the statute while reducing the administrative burden to the transferor and the Passthrough Entity.

ii. Optional Simplified Reporting Method—Proposed § 1.1411–7(c)

The proposed regulations also allow certain transferors to apply an optional simplified method in proposed § 1.1411–7(c) for calculating gain or loss for purposes of § 1.1411–4(a)(1)(iii). The Treasury Department and the IRS believe a simplified method is warranted when the amount of gain associated with passive assets owned by the Passthrough Entity is likely to be relatively small. To use the optional simplified reporting method, the transferor must meet certain qualifications under proposed § 1.1411–7(c)(2) and not be otherwise excluded under proposed § 1.1411–7(c)(3). Use of this simplified method is not mandatory for qualifying transferors. However, as discussed in part 10.G of this preamble, the Passthrough Entity may not be required under proposed § 1.1411–7(g) to provide (but is not precluded from providing) a transferor who qualifies to use the simplified method with information that the transferor would need to report under the primary method described in proposed § 1.1411–7(g).

The simplified reporting method is intended to limit the information sharing burden on Passthrough Entities by allowing transferors to rely on readily available information to calculate the amount of gain or loss included in net investment income under section 1411(c)(4). For this purpose, the optional simplified method relies on historic distributive share amounts received by the transferor from the Passthrough Entity to extrapolate a percentage of the assets within the Passthrough Entity that are passive with respect to the transferor for purposes of section 1411(c)(4). For example, if ten percent of the income reported on the applicable Schedules K–1 is of a type that would be included in net investment income, then the simplified reporting method presumes that ten percent of the chapter 1 gain on the disposition of the transferor's interest relates to Section 1411 Property of the Passthrough Entity for purposes of section 1411(c)(4).

a. Qualifications

To qualify for the optional simplified reporting method, a transferor in a Section 1411(c)(4) Disposition must meet at least one of two requirements. A transferor satisfies the first requirement if: (i) The sum of the transferor's allocable share during the ''*Section 1411 Holding Period*'' (as defined in the following paragraph, but generally the year of the disposition and the preceding two years) of separately stated items of income, gain, loss, and deduction (with any separately stated loss and deduction items included as positive numbers) of a type that the transferor would take into account in calculating net investment income is five percent or less of the sum of all separately stated items of income, gain, loss, and deduction (with any separately stated loss and deduction items included as positive numbers) allocated to the transferor during the Section 1411 Holding Period, and (ii) the gain recognized under chapter 1 by the transferor from the disposition of the Passthrough Entity is $5 million or less (including gains from multiple dispositions as part of a plan). A transferor satisfies the second alternative requirement if the gain recognized under chapter 1 by the transferor from the disposition of the Passthrough Entity is $250,000 or less (including gains from multiple dispositions as part of a plan). All dispositions of interests in the Passthrough Entity that occur during the transferor's taxable year will be presumed to be part of a plan.

Section 1411 Holding Period is defined to mean the year of disposition and the transferor's two taxable years preceding the disposition or the time period the transferor held the interest, whichever is less. Where the transferor acquires its interest from another Passthrough Entity in a nonrecognition transaction during the year of disposition or the prior two taxable years, the transferor must include in its Section 1411 Holding Period the period that the previous owner or owners held the interest. Also, where the transferor transferred an interest in a Subsidiary Passthrough Entity to a Passthrough Entity in a nonrecognition transaction during the year of the disposition or the prior two taxable years, the transferor must include in its Section 1411 Holding Period that period that it held the interest in the Subsidiary Passthrough Entity.

b. Nonavailability of Optional Simplified Reporting Method

Proposed § 1.1411–7(c)(4) provides certain exceptions for situations in which a transferor is ineligible to use the optional simplified reporting method. These exceptions include situations in which the transferor's historical distributive share amounts are less likely to reflect the gain in the Passthrough Entity's Section 1411 Property on the date of the transferor's disposition. The proposed regulations provide five exceptions for this purpose: (i) Transferors that have held the interest for less than 12 months, (ii) certain contributions and distributions during the Section 1411 Holding Period, (iii) Passthrough Entities that have significantly modified the composition of their assets, (iv) S corporations that have recently converted from C corporations, and (v) partial dispositions.

The first exception requires that the transferor has held directly the interest in the Passthrough Entity (or held the interest indirectly in the case of a Subsidiary Passthrough Entity) for the twelve-month period preceding the Section 1411(c)(4) Disposition.

The second exception provides that a transferor is ineligible to use the optional simplified reporting method if the transferor transferred Section 1411 Property (other than cash or cash equivalents) to the Passthrough Entity, or received a distribution of property (other than Section 1411 property) from the Passthrough Entity, as part of a plan that includes the transfer of the interest in the Passthrough Entity. A transferor who contributes, directly or indirectly, Section 1411 Property (other than cash or cash equivalents) within 120 days of the disposition of the interest in the Passthrough Entity is presumed to have made the contribution as part of a plan that includes the transfer of the interest in the Passthrough Entity.

The third exception focuses on changes to the composition of the Passthrough Entity's assets during the Section 1411 Holding Period. Under this exception, the transferor is ineligible to use the optional simplified reporting method if the transferor knows or has reason to know that the percentage of the Passthrough Entity's gross assets that consists of Section 1411 Property (other than cash or cash equivalents) has increased or decreased by 25 percentage points or more during the transferor's Section 1411 Holding Period due to contributions, distributions, or asset acquisitions or dispositions in taxable or nonrecognition transactions.

The fourth exception provides that the optional simplified reporting method is not available if the Passthrough Entity was a C corporation during the Section 1411 Holding Period, and elected under section 1361 during that period to be taxed as an S corporation.

The final exception provides that a transferor partner cannot use the optional simplified reporting method if the transferor transfers only a partial interest that does not represent a proportionate share of all of the partner's economic rights in the partnership. For example, a partner who transfers a preferred interest in a partnership while retaining a common interest in that partnership cannot use the optional simplified reporting method.

iii. Request for Comments

The Treasury Department and the IRS request comments on the proposed section 1411(c)(4) calculation and on the optional simplified reporting method, including recommendations for other simplified means of calculating the gain or loss under section 1411(c)(4). The Treasury Department and the IRS also request comments regarding all aspects of the provisions relating to eligibility for the simplified method, including whether the 25 percentage point threshold for changes in the asset composition of a Passthrough Entity through is appropriate.

D. Tiered Passthrough Dispositions

The Treasury Department and the IRS have reserved proposed § 1.1411–7(e) to further consider a simplified method for determining the section 1411(c)(4) gain resulting from the disposition by a Passthrough Entity of an interest in a Subsidiary Passthrough Entity as illustrated by the following example: A holds an interest in UTP, a Passthrough Entity that owns a 50-percent interest in LTP, a Subsidiary Passthrough Entity that is a real estate development company. A is a real estate developer and elected to group his real estate activities under § 1.469–9. When UTP sells its interest in LTP, any gain from the sale of that interest allocable to A through UTP may qualify under proposed § 1.1411–7(a)(2). However, A lacks access to the books of LTP that would allow A to compute its section 1411(c)(4) inclusion under the general rule of proposed § 1.1411–7(b). Additionally, A receives insufficient information from UTP to allow A to determine whether A qualifies to apply the Optional Simplified Reporting Method of proposed § 1.1411–7(c) or to undertake that computation. The Treasury Department and the IRS request comments regarding a simplified method for determining the section 1411(c)(4) gain resulting in such cases, including a detailed technical analysis with examples.

E. Deferred Recognition Transactions

To address the application of proposed § 1.1411–7 to deferred recognition transactions, such as installment sales and certain private annuities, the proposed regulations provide that the calculations under proposed §§ 1.1411–7(b)(1), 1.1411–7(c)(2) and 1.1411–7(c)(4) (as applicable) are performed in the year of disposition as though the entire gain was recognized and taken into account in that year. For this purpose, it is assumed that any contingencies potentially affecting consideration to the transferor that are reasonably expected to occur will occur, and in the case of annuities based on the life expectancy of one or more individuals, the present value of the annuity (using existing Federal tax valuation methods) is used to determine the estimated gain. This approach allows the transferor to determine its section 1411 inclusion for each future installment. If under this approach no gain or loss from the disposition would be included in net investment income, then the transferor excludes each payment received from the deferred recognition transaction from net investment income. If under this approach only a portion of the chapter 1 gain on the disposition would be included in net investment income, then the difference between the gain recognized for chapter 1 purposes and the gain recognized for section 1411 purposes is considered an addition to basis, and after taking those basis adjustments into account, gain amounts are included in net investment income under § 1.1411–4(a)(1)(iii) as payments are received in accordance with the existing rules for installment sales or private annuities.

F. Adjustment to Gain or Loss Due to Section 1411 Basis Differences

In addition to the calculation of gain or loss included in net investment income by reason of section 1411(c)(4) and proposed § 1.1411–7, proposed § 1.1411–7(f)(2) adjusts the gain or loss to take into account any disparities in the transferor's interest in the Passthrough Entity as a result of § 1.1411–10(d) (relating to certain income from controlled foreign corporations and passive foreign investment companies where no § 1.1411–10(g) election is made). These adjustments apply after applying the calculations set forth in paragraphs (b) through (e) of proposed § 1.1411–7. Because the proposed § 1.1411–7(f)(2) adjustments operate independently of the rules in paragraphs (b) through (e) of proposed § 1.1411–7, they may result in gain for section 1411 purposes that exceeds chapter 1 gain (or a loss that exceeds the chapter 1 loss), or may result in a section 1411 loss when the transferor recognizes a chapter 1 gain (or vice versa).

G. Information Reporting

Several commentators to the 2012 Proposed Regulations requested revisions to the proposed information reporting requirements. Other commentators expressed concern that 2012 Proposed Regulations lacked provisions to compel a Passthrough Entity to provide the transferor with information required to comply with the 2012 Proposed Regulations § 1.1411–7. In response, these proposed regulations simplify the information reporting

requirements for transferors of interests in Passthrough Entities and impose information reporting requirements on certain Passthrough Entities to ensure that the transferor has sufficient information to comply with the computational requirements of proposed § 1.1411–7.

i. Information Reporting by the Passthrough Entity

To compute the amount of gain or loss under proposed § 1.1411–7(b), the transferors that compute section 1411(c)(4) gain or loss under the primary computation method of proposed § 1.1411–7(b) must generally obtain from the Passthrough Entity the transferor's allocable share of the net gain or loss from the deemed sale of the Passthrough Entity's Section 1411 Property. However, the proposed regulations only require the Passthrough Entity to provide this information to transferors that are ineligible for the optional simplified reporting method in proposed § 1.1411–7(c).

If a transferor qualifies to use the optional simplified reporting method in proposed § 1.1411–7(c), but prefers to determine net gain or loss under proposed § 1.1411–7(b), then the transferor must negotiate with the Passthrough Entity the terms under which the information will be supplied.

ii. Information Reporting by the Seller

Any transferor applying proposed § 1.1411–7, including in reliance on the proposed regulations, must attach a statement to the transferor's income tax return for the year of disposition. That statement must include: (1) The taxpayer's name and taxpayer identification number; (2) the name and taxpayer identification number of the Passthrough Entity in which the interest was transferred; (3) the amount of the transferor's gain or loss on the disposition of the interest under chapter 1; and (4) the amount of adjustment to gain or loss by reason of basis differences for chapter 1 and section 1411 purposes. The transferor must also attach a copy of any information provided by the Passthrough Entity to the transferor relating to the transferor's allocable share of gain or loss from the deemed sale of the Passthrough Entity's Section 1411 Property.

H. Qualified Subchapter S Trusts (QSSTs)

The preamble to the 2012 Proposed Regulations requested comments on whether special coordination rules are necessary to address dispositions of stock in an S corporation held by a QSST. Specifically, the request for comments deals with the application of section 1411(c)(4) to the existing QSST stock disposition mechanics in § 1.1361–1(j)(8).

In general, if an income beneficiary of a trust that meets the QSST requirements under section 1361(d)(3) makes a QSST election, the income beneficiary is treated as the section 678 owner with respect to the S corporation stock held by the trust. Section 1.1361–1(j)(8), however, provides that the trust, rather than the income beneficiary, is treated as the owner of the S corporation stock in determining the income tax consequences of the disposition of the stock by the QSST. Section 1361(d)(1)(C) and the last sentence of § 1.1361–1(j)(8) provide that, solely for purposes of applying sections 465 and 469 to the income beneficiary, a disposition of S corporation stock by a QSST is treated as a disposition by the income beneficiary. However, in this special case, the QSST beneficiary, for chapter 1 purposes, does not have any passive activity gain from the disposition. Therefore, the entire suspended loss (to the extent not allowed by reason of the beneficiary's other passive net income in the disposition year) is a section 469(g)(1) loss, and is considered a loss from a nonpassive activity.

For purposes of section 1411, the inclusion of the operating income or loss of an S corporation in the beneficiary's net investment income is determined in a manner consistent with the treatment of a QSST beneficiary in chapter 1 (as explained in the preceding paragraph), which includes the determination of whether the S corporation is a passive activity of the beneficiary under section 469. However, because gain or loss resulting from the sale of S corporation stock by the QSST will be reported by the QSST and taxed to the trust by reason of § 1.1361–1(j)(8), it is not clear whether the beneficiary's section 469 status with respect to the S corporation is attributed to the trust.

One commentator recommended that the disposition of S corporation stock by a QSST should be treated as a disposition of the stock by the income beneficiary for purposes of determining material participation for purposes of section 1411. In addition, the commentator recommended that the final regulations confirm that the special rule stated in the last sentence of § 1.1361–1(j)(8) applies for purposes of section 1411 as it does for section 469 and 465.

After consideration of the comments, these proposed regulations provide that, in the case of a QSST, the application of section 1411(c)(4) is made at the trust level. This treatment is consistent with the chapter 1 treatment of the QSST by reason of § 1.1361–1(j)(8). However, these proposed regulations do not provide any special computational rules for QSSTs within the context of section 1411(c)(4) for two reasons. First, the treatment of the stock sale as passive or nonpassive income is determined under section 469, which involves the issue of whether there is material participation by the trust. As discussed in part 4.F of the preamble to the 2013 Final Regulations, the Treasury Department and the IRS believe that the issue of material participation by estates and trusts, including QSSTs, is more appropriately addressed under section 469.

Additionally, one commentator noted that the IRS has addressed the treatment of certain asset sales as the functional equivalent of stock sales for purposes of § 1.1361–1(j)(8) in a limited number of private letter rulings. In these cases, the private letter rulings held that gain from the sale of assets, which was followed by a liquidation, would be taxed at the trust level under § 1.1361–1(j)(8) rather than being taxed at the beneficiary level. The commentator recommended that an asset sale followed by a liquidation, within the context of § 1.1361–1(j)(8), should have a similar result under section 1411(c)(4). Similar to the issue of material participation by QSSTs discussed in the preceding paragraph, the Treasury Department and the IRS believe that the issue of whether an asset sale (deemed or actual) is the equivalent of a stock sale for purpose of the QSST rules should be addressed under the § 1.1361–1(j) QSST regulations, rather than in § 1.1411–7. However, the Treasury Department and the IRS believe that proposed § 1.1411–7(a)(4)(i), which provides that asset sales followed by a liquidation is a disposition of S corporation stock for purposes of section 1411(c)(4), address the commentator's QSST issue.

Second, with respect to the section 1411 treatment of the disposition by the beneficiary by reason of section 1361(d)(1)(C) and the last sentence of § 1.1361–1(j)(8), the Treasury Department and the IRS believe that the general administrative principles enumerated in § 1.1411–1(a), when combined with the general treatment of section 469(g) losses within § 1.1411–4, provide an adequate framework for the treatment of QSSTs beneficiaries without the need for a special computational rule within § 1.1411–7.

Proposed Applicability Date

These regulations are proposed to apply for taxable years beginning after

December 31, 2013, except that § 1.1411–3(d)(3) is proposed to apply to taxable years beginning after December 31, 2012.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to the proposed regulations. Pursuant to the Regulatory Flexibility Act (RFA) (5 U.S.C. chapter 6), it is hereby certified that the proposed regulations will not have a significant economic impact on a substantial number of small entities. The applicability of the proposed regulations are limited to individuals, estates, and trusts, that are not small entities as defined by the RFA (5 U.S.C. 601). Accordingly, the RFA does not apply. Therefore, a regulatory flexibility analysis is not required. Pursuant to section 7805(f) of the Code, the proposed regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for a Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any comments that are submitted timely to the IRS as prescribed in this preamble under the ''**ADDRESSES**'' heading. The Treasury Department and the IRS specifically request comments on all aspects of the proposed rules. All comments will be available at *www.regulations.gov* or upon request. A public hearing will be scheduled if requested in writing by any person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the public hearing will be published in the **Federal Register**.

Drafting Information

The principal authors of the proposed regulations are David H. Kirk and Adrienne M. Mikolashek, IRS Office of the Associate Chief Counsel (Passthroughs and Special Industries). However, other personnel from the Treasury Department and the IRS participated in their development.

List of Subjects in 26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

Partial Withdrawal of Notice of Proposed Rulemaking

Accordingly, under the authority of 26 U.S.C. 7805, § 1.1411–7 of the notice of proposed rulemaking (REG–130507–11) that was published in the **Federal Register** on December 5, 2012 (77 FR 72612) is withdrawn.

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 1 is proposed to be amended as follows:

PART 1—INCOME TAXES

■ **Paragraph 1.** The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

■ **Par. 2.** Section 1.1411–0 is amended by:

■ 1. Revising the entries under § 1.1411–3 for paragraphs (d)(2)(ii), (d)(3) and adding entries (d)(3)(i) through (iii).

■ 2. Revising the entries under § 1.1411–4 for paragraphs (d)(4)(iii), (e)(3), and (g)(10) through (13).

■ 3. Adding entries to § 1.1411–7.

The revisions and additions to read as follows:

§ 1.1411–0 Table of contents.

* * * * *

§ 1.1411–3 Application to estates and trusts.

* * * * *

(d) * * *

(2) * * *

(ii) Special rules for CRTs with income from certain CFCs or PFICs.

(3) Elective simplified method.

(i) Treatment of annuity or unitrust distributions.

(ii) Properly allocable deductions in excess of gross income.

(iii) Procedural requirements for making election.

* * * * *

§ 1.1411–4 Definition of net investment income.

* * * * *

(d) * * *

(4) * * *

(iii) Adjustment for capital loss carryforwards for previously excluded income

* * * * *

(e) * * *

(3) Treatment of income from common trust funds.

* * * * *

(g) * * *

(10) Treatment of section 707(c) guaranteed payments.

(11) Treatment of section 736 payments.

(i) In general.

(ii) Treatment of section 736(a)(1) payments.

(A) General rule.

(B) Examples.

(iii) Treatment of section 736(a)(2) payments.

(A) Payments for unrealized receivables and goodwill.

(B) Payments not for unrealized receivables or goodwill.

(iv) Treatment of section 736(b) payments.

(v) Application of section 1411(c)(4) to section 736 payments.

(12) Income and deductions from certain notional principal contracts.

(i) In general.

(ii) Notional principal contracts.

(13) Treatment of income or loss from REMIC residual interests.

* * * * *

§ 1.1411–7 Exception for dispositions of certain active interests in partnerships and S corporations

(a) In general.

(1) General application.

(2) Definitions.

(3) Section 1411(c)(4) dispositions.

(i) Transfers by individuals, estates, and trusts.

(ii) Transfers by passthrough entities.

(4) Special rules.

(i) Certain liquidations.

(ii) Excluded gain or loss.

(iii) Rules applicable to S corporation shareholders.

(A) Certain S corporation dispositions.

(B) S corporations subject to section 1374.

(C) Treatment of Qualified Subchapter S Trusts (QSSTs).

(b) Calculation.

(1) In general.

(i) Gain on disposition of interest.

(ii) Loss on disposition of interest.

(2) Examples.

(c) Optional simplified reporting.

(1) In general.

(2) Qualifications.

(i) Minimal section 1411 property.

(ii) Minimal gain or loss.

(3) Nonapplicability.

(4) Optional simplified reporting calculation.

(5) Examples.

(d) Deferred recognition transactions.

(e) Tiered passthrough disposition. [Reserved]

(f) Adjustment to net gain or loss.

(g) Information reporting.

(1) Information to be provided by passthrough entity to transferor.

(2) Information reporting by transferors.

(h) Effective/applicability date.

■ **Par 3.** Section 1.1411–3 is amended by:

■ 1. Revising paragraph (d)(2)(ii).

■ 2. Revising paragraph (d)(2)(iii) by adding *Example 2* through *Example 5.*

■ 3. Revising paragraph (d)(3).

■ 4. Revising paragraph (f).

The revisions and additions read as follows:

§ 1.1411–3 Application to estates and trusts.

* * * * *

(d) * * *

(2) * * *

(ii) *Special rules for CRTs with income from certain CFCs or PFICs.* If a CRT is a trust described in § 1.1411–10(a), and the CRT includes an amount in gross income under section 951(a) or section 1293(a) from a CFC or QEF that is not also income derived from a trade or business described in section 1411(c)(2) and § 1.1411–5 (except as provided in § 1.1411–10(b)(2)) and an election under § 1.1411–10(g) is not in effect with respect to the CFC or QEF, or the CRT is treated as receiving an excess distribution within the meaning of section 1291(b) or recognizing gain treated as an excess distribution under section 1291(a)(2), then the following rules apply for purposes of section 1411 with regard to income derived from the CFC, QEF, or PFIC—

(A) Amounts included in gross income for chapter 1 purposes under section 951(a) or section 1293(a) in a calendar year with respect to the CFC or QEF, and in one or more categories described in § 1.664–1(d)(1) are considered excluded income in that calendar year;

(B) For the year in which the CRT is treated as receiving any of the items of net investment income described in paragraphs (c)(1)(i), (c)(1)(ii), (c)(2)(i), and (c)(4) of § 1.1411–10 that otherwise are not included in gross income for purposes of chapter 1 for that year (''*NII Inclusion Amount''*) with respect to the CFC, QEF, or PFIC, the rules of this paragraph (d)(2)(ii)(B) apply; and

(*1*) For purposes of determining the character under section 664 of a distribution to the unitrust or annuity recipient of a CRT, the NII Inclusion Amount treated as received by the CRT shall be allocated among the categories described in section 664(b)(1) through (b)(3), and among the classes within each category as described in § 1.664–1(d)(1), in the manner described in this paragraph (d)(2)(ii)(B). Specifically, to the extent the CRT has amounts of excluded income in the categories described in section 664(b)(1) (the Ordinary Income Category) or section 664(b)(2) (the Capital Gain Category), the NII Inclusion Amount shall be allocated to the CRT's classes of excluded income in the Ordinary Income Category, and then to the classes of excluded income in the Capital Gain Category, in turn, until exhaustion of each such class, beginning with the class of excluded income within a category with the highest Federal income tax rate.

(*2*) Any remaining NII Inclusion Amount not so allocated to classes within the Ordinary Income and Capital Gain Categories shall be placed in the category described in section 664(b)(3) (the Other Income Category). To the extent the CRT distributes amounts from this Other Income Category, that distribution shall constitute a distribution described in § 1.1411–10(c)(4).

(*3*) A distribution by the CRT of excluded income first is deemed to carry out net investment income to the extent of the NII Inclusion Amount that has been allocated to excluded income in that class.

(*4*) As a result, a distribution of excluded income will carry out to the unitrust or annuity recipient net investment income attributable to the items described in this paragraph (d)(2)(ii)(B).

(C) In the case of a difference between the amount calculated with respect to a disposition under paragraph (c)(2)(iii) or (c)(2)(iv) of § 1.1411–10 and the amount attributable to the relevant disposition for purposes of chapter 1, the following rules apply—

(*1*) If the amount of the gain from the disposition for purposes of section 1411 is higher (or the loss smaller) than the amount of the gain (or loss) calculated for purposes of chapter 1, such difference shall be considered an NII Inclusion Amount and shall be allocated as described in paragraph (d)(2)(ii)(B) of this section. However, in applying paragraph (d)(2)(ii)(B) of this section to this increase, the order of the classes and categories to which the allocation is made shall be changed as follows: the increase shall be allocated first to the class in the Capital Gain Category that reflects the nature of the increase (short-term or long-term), then to other classes in that category, in turn until exhausted, then to the classes in the Ordinary Income Category, and finally to the Other Income Category.

(*2*) If the amount of the gain from the disposition for purposes of section 1411 is smaller (or the loss higher) than the amount of the gain (or loss) calculated for purposes of chapter 1, such difference shall reduce accumulated net investment income in the CRT's categories and their respective classes as follows—

(*i*) To the extent that the CRT has amounts in the Other Income Category by reason of the application of paragraph (d)(2)(ii)(B) or (d)(2)(ii)(C)(*1*) of this section for the current or prior years, to the Other Income Category; and

(*ii*) Any excess difference in the same order as specified in paragraph (d)(2)(ii)(C)(*1*) of this section.

(iii) * * *

Example 2. (i) In 2010, A creates a net income with makeup CRT (NIMCRUT). A is the sole income beneficiary of the NIMCRUT for 15 years. As of December 31, 2012, the NIMCRUT had $2,000 of dividend income and $180,000 of long-term capital gain within the Ordinary Income and Capital Gain Categories, respectively. Because both of these amounts were received by the NIMCRUT during a taxable year beginning before 2013, both constitute excluded income within the meaning of § 1.1411–1(d). In Year 1, the NIMCRUT acquires an interest in a CFC. The NIMCRUT does not make the § 1.1411–10(g) election with respect to the CFC. In Year 1, the NIMCRUT receives a section 951(a) inclusion of $5,000 and makes no distributions to A. For all years, income derived with respect to the CFC is not income derived in a trade or business described in section 1411(c)(2) and § 1.1411–5.

(ii) In Year 1, § 1.1411–3(d)(2)(ii)(A) treats the section 951 inclusion as excluded income and allocates it to the class of non-NII with a 39.6% tax rate in the Ordinary Income Category under § 1.664–1(d)(1).

YEAR 1 ENDING CATEGORY AND CLASS BALANCES

Category	Class	Excluded/NII	Tax rate (percent)	Amount
Ordinary Income	Interest and Other Income (including section 951 Inclusions).	Excluded	39.6	$5,000
	Qualified Dividends	Excluded	20.0	2,000
Capital Gain	Long-Term	NII	23.8	0

YEAR 1 ENDING CATEGORY AND CLASS BALANCES—Continued

Category	Class	Excluded/NII	Tax rate (percent)	Amount
	Long-Term	Excluded	20.0	180,000
Other Income				None

(iii) The NIMCRUT makes no distributions to its sole income beneficiary in Year 2. In Year 3, the CFC distributes $4,000 to the NIMCRUT (which constitutes net investment income under § 1.1411–10(c)(1)(i)), the NIMCRUT has a total of $800 of post-2012 interest, and the NIMCRUT distributes $4,000 to the beneficiary.

CATEGORY AND CLASS BALANCES IMMEDIATELY BEFORE BOTH THE CFC DISTRIBUTION AND THE NIMCRUT'S YEAR 3 DISTRIBUTION TO A

Category	Class	Excluded/NII	Tax rate (percent)	Amount
Ordinary Income	Interest (post-2012)	NII	43.4	$800
	Interest and Other Income (including section 951 Inclusions).	Excluded	39.6	5,000
	Qualified Dividends	Excluded	20.0	2,000
Capital Gain	Long-Term	NII	23.8	0
	Long-Term	Excluded	20.0	180,000
Other Income				None

Section 1.1411–3(d)(2)(ii)(B) will cause the $4,000 distribution from the CFC to be allocated first to the class of excluded income within the Ordinary Income Category with the highest Federal tax rate (the Interest and Other Income class). The distribution to A consists of $800 of post-2012 interest (subject to section 1411) and $3,200 from the Interest and Other Income class, of which all $3,200 constitutes NII by reason of the allocation under § 1.1411–3(d)(2)(ii)(B). Of the $1,800 remaining in that category after the distribution to A, $800 will carry out NII to A, and will be includable in A's net investment income, when it is distributed to A in the future. Because the $3,200 distributed to A from this class is subject to both income tax and tax under section 1411 for Year 3, the timing differential attributable to the rules in § 1.1411–10 has been corrected within the NIMCRUT before the income is distributed to A.

YEAR 3 ENDING CATEGORY AND CLASS BALANCES

[Immediately following the distribution to A]

Category	Class	Excluded/NII	Tax rate (percent)	Amount
Ordinary Income	Interest (post-2012)	NII	43.4	$0
	Interest & Other Income (including section 951 Inclusions).	Excluded	39.6	*1,800
	Qualified Dividends	Excluded	20.0	2,000
Capital Gain	Long-Term	NII	23.8	0
	Long-Term	Excluded	20.0	180,000
Other Income				None

* Of which $800 will carry out NII to A when distributed.

Example 3. (i) Assume the same facts as in *Example 2,* except that, in Year 2, the NIMCRUT has a section 951 inclusion in the amount of $4,000, taxable interest income of $800, tax exempt interest of $4,000. Assume the CRT has $1,100 undistributed capital gain from a taxable year ending before December 31, 2012.

CATEGORY AND CLASS BALANCES IMMEDIATELY BEFORE THE YEAR 2 DISTRIBUTION TO A

Category	Class	Excluded/NII	Tax rate (percent)	Amount
Ordinary Income	Interest (post-2012)	NII	43.4	$800
	Interest and Other Income (including section 951 Inclusions).	Excluded	39.6	9,000
	Qualified Dividends	Excluded	20.0	2,000
Capital Gain	Long-Term	NII	23.8	0
	Long-Term	Excluded	20.0	1,100
Other Income		Excluded		4,000

(ii) In Year 2, the NIMCRUT made a $4,800 distribution to A in that same year (leaving a net balance in the Interest and Other Income class of $5,000 at the end of Year 2).

CATEGORY AND CLASS BALANCES AS OF DECEMBER 31, YEAR 2

[Immediately following the distribution to A]

Category	Class	Excluded/NII	Tax rate (percent)	Amount
Ordinary Income	Interest (post-2012)	NII	43.4	$0
	Interest and Other Income (including section 951 Inclusions).	Excluded	39.6	5,000
	Qualified Dividends	Excluded	20.0	2,000
Capital Gain	Long-Term	NII	23.8	0
	Long-Term	Excluded	20.0	1,100
Other Income		Excluded		4,000

A's net investment income in Year 2 will include $800 of taxable interest income, but will not include the $4,000 of other ordinary income.

(iii) In Year 3, the NIMCRUT received a distribution from the CFC of $9,000, and assume, for purposes of this example, that the NIMCRUT distributes $6,000 to A. Section 1.1411–3(d)(2)(ii)(B) will cause the $9,000 distribution from the CFC to be allocated first to the class of excluded income within the Ordinary Income Category with the highest Federal tax rate (thus, $5,000 to the Other Income class and $2,000 to Qualified Dividends). The $2,000 balance of the Year 3 distribution from the CFC is allocated under § 1.1411–3(d)(2)(ii)(B) as follows: $1,100 to the Long-Term Capital Gain class of non-NII (so the distribution to A from this class in the future will carry out $1,100 of NII to A), and the remaining $900 to the Other Income Category (so the distribution to A from this class in the future will carry out $900 of NII to A).

The distribution to A consists of $5,000 of Interest and Other Income class and $1,000 of Qualified Dividends, all of which constitutes NII by reason of the allocation under § 1.1411–3(d)(2)(ii)(B).

CATEGORY AND CLASS BALANCES AS OF DECEMBER 31, YEAR 3

[Immediately following the distribution to A]

Category	Class	Excluded/NII	Tax rate (percent)	Amount
Ordinary Income	Interest (post-2012)	NII	43.4	$0
	Interest & Other Income (section 951 inclusion)	Excluded	39.6	0
	Qualified Dividends	Excluded	20.0	* 1,000
Capital Gain	Long-Term	NII	23.8	0
	Long-Term	Excluded	20.0	* 1,100
Other Income		NII	3.8	900
Other Income		Excluded	0.0	3,100

* All of which will carry out NII to A when distributed in the future.

A's net investment income in Year 3 will include $5,000 of other ordinary income and $1,000 of qualified dividend income.

Example 4. (i) Same facts as in *Example 2,* except that the NIMCRUT distributes $7,000 to A in Year 2. This distribution consists of the section 951 inclusion and the accumulated qualified dividends.

(ii) In Year 2, the NIMCRUT will report $5,000 of ordinary income and $2,000 of qualified dividends to A. Both amounts will constitute excluded income to A. In this case, A does not have to adjust MAGI because the section 951 inclusion is treated in the same way as any other type of excluded income within the Ordinary Income Category.

YEAR 2 ENDING CATEGORY AND CLASS BALANCES

[Immediately following the distribution to A]

Category	Class	Excluded/NII	Tax rate (percent)	Amount
Ordinary Income	Interest and Other Income (including section 951 Inclusions).	Excluded	39.6	$0
	Qualified Dividends	Excluded	20.0	0
Capital Gain	Long-Term	NII	23.8	0
	Long-Term	Excluded	20.0	180,000
Other Income				None

(iii) When the CFC distributes $4,000 to the NIMCRUT in Year 3, § 1.1411–3(d)(2)(ii)(B)(*1*) requires the NIMCRUT to allocate that $4,000 to the NIMCRUT's accumulated balance of long-term capital gains recognized by the NIMCRUT prior to December 31, 2012, so that the first $4,000 of the NIMCRUT's long-term capital gains distributed to A in the future will carry out NII to A.

CATEGORY AND CLASS BALANCES IMMEDIATELY BEFORE THE YEAR 3 DISTRIBUTION TO A

Category	Class	Excluded/NII	Tax rate (percent)	Amount
Ordinary Income	Interest and Other Income (including section 951 Inclusions).	Excluded	39.6	$0
	Qualified Dividends	Excluded	20.0	0
Capital Gain	Long-Term	Excluded	20.0	* 180,000
Other Income				None

* Of which $4,000 will carry out NII to A when distributed in the future.

When the NIMCRUT distributes the $4,000 to A in the future, the NIMCRUT will report $4,000 of long-term capital gain to A that also constitutes net investment income. No MAGI adjustments associated with that distribution will be required by A.

YEAR 3 ENDING CATEGORY AND CLASS BALANCES

[Immediately following the distribution to A]

Category	Class	Excluded/NII	Tax rate (percent)	Amount
Ordinary Income	Interest and Other Income (including section 951 Inclusions).	Excluded	39.6	$0
	Qualified Dividends	Excluded	20.0	0
Capital Gain	Long-Term	Excluded	20.0	176,000
Other Income				None

Example 5. (i) Same facts as in *Example 4,* except that the NIMCRUT's entire balance of accumulated long-term capital gain was received after 2012 and thus is ANII.

(ii) When the CFC distributes $4,000 to the NIMCRUT in Year 3, § 1.1411–3(d)(2)(ii)(B)(*1*) requires the NIMCRUT to allocate that $4,000 to excluded income within the Ordinary Income or Capital Gain Categories. In this case, the NIMCRUT does not have any excluded income remaining within those categories. As a result, § 1.1411–3(d)(2)(ii)(B)(*2*) requires the excess portion of the CFC distribution not allocable to excluded income in the Ordinary Income or Capital Gain Categories ($4,000 in this case) to be allocated to the Other Income Category.

CATEGORY AND CLASS BALANCES IMMEDIATELY BEFORE THE YEAR 3 DISTRIBUTION TO A

Category	Class	Excluded/NII	Tax rate (percent)	Amount
Ordinary Income	Interest and Other Income (including section 951 Inclusions).	Excluded	39.6	$0
	Qualified Dividends	Excluded	20.0	0
Capital Gain	Long-Term	NII	23.8	180,000
	Long-Term	Excluded	20.0	0
Other Income		NII	3.8	4,000

When the NIMCRUT distributes the $4,000 to A, the NIMCRUT will report $4,000 of long-term capital gains to A that also constitute net investment income. No MAGI adjustments associated with the distribution are required by A.

YEAR 3 ENDING CATEGORY AND CLASS BALANCES

[Immediately following the distribution to A]

Category	Class	Excluded/NII	Tax rate (percent)	Amount
Ordinary Income	Interest and Other Income (including section 951 Inclusions).	Excluded	39.6	$0
	Qualified Dividends	Excluded	20.0	0
Capital Gain	Long-Term	NII	23.8	176,000
	Long-Term	Excluded	20.0	0
Other Income		NII	3.8	4,000

After the NIMCRUT distributes all income within the Ordinary and Capital Gain categories, the NIMCRUT will distribute the $4,000 of Other Income to A. Such income will have a zero percent tax rate for chapter 1 purposes but will constitute net investment income. In this case, § 1.1411–3(d)(2)(ii)(B)(*2*) provides that the future distribution will be considered a distribution of net investment income from a trust within the meaning of § 1.1411–10(c)(4). As a result, § 1.1411–10(e) requires A to increase MAGI for the year of that distribution.

(3) *Elective simplified method*—(i) *Treatment of annuity or unitrust distributions.* If a CRT makes a valid election under this paragraph (d)(3), the rules of paragraph (d)(2) of this section shall not apply, and the net investment

income of the beneficiary attributable to the beneficiary's annuity or unitrust distribution from the CRT shall include an amount equal to the lesser of—

(A) The beneficiary's share of the total amount of the distributions for that year; or

(B) The beneficiary's same share of the accumulated net investment income (as defined in paragraph (d)(1)(iii) of this section) of the CRT.

(ii) *Properly allocable deductions in excess of gross income.* In computing the amount described in paragraph (d)(3)(i)(B) of this section, notwithstanding § 1.1411–4(f)(1)(ii) (limitations on deductions in excess of income), if in a taxable year a CRT's properly allocable deductions described in section 1411(c)(1)(B) and the regulations thereunder exceed the gross investment income and net gain described in section 1411(c)(1)(A) and the regulations thereunder, then such excess deductions shall reduce the amount described in paragraph (d)(3)(i)(B) of this section for that taxable year and, to the extent of any remaining excess deductions, for subsequent taxable years of the CRT.

(iii) *Procedural requirements for making election.* In the case of a CRT established after December 31, 2012, a CRT wanting to make the election under paragraph (d)(3) of this section must do so on its income tax return for the taxable year in which the CRT is established. In the case of a CRT established before January 1, 2013, the CRT wanting to make the election under paragraph (d)(3) of this section must do so on the return for its first taxable year beginning on or after January 1, 2013. Once made, the election is irrevocable. In lieu of the relief provisions under § 301.9100–3, the CRT may make the election on an amended return for that year only if the taxable year for which the election is made, and all taxable years that are affected by the election, for both the CRT and its beneficiaries, are not closed by the period of limitations on assessments under section 6501.

* * * * *

(f) *Effective/applicability date.* This section applies to taxable years beginning after December 31, 2013, except that paragraphs (d)(1), (d)(2)(i), *Example 1* of (d)(2)(iii), and (d)(3) of this section applies to taxable years of CRTs that begin after December 31, 2012. However, taxpayers may apply this section to taxable years beginning after December 31, 2012, in accordance with § 1.1411–1(f).

* * * * *

■ **Par 4.** Section 1.1411–4 is amended by revising paragraphs (d)(4)(iii), (e)(3), and (g)(10) through (13) to read as follows:

§ 1.1411–4 Definition of net investment income.

* * * * *

(d) * * *

(4) * * *

(iii) *Adjustment for capital loss carryforwards for previously excluded income*—(A) *General rule.* For purposes of calculating net gain in paragraph (d) of this section (and any allowable loss described in paragraph (f)(4) of this section, if applicable), capital losses are reduced by the lesser of—

(*1*) The amount of capital loss taken into account in the current year by reason of section 1212(b)(1); or

(*2*) The amount of net capital loss excluded from net investment income in the preceding year by reason of paragraph (d)(4) of this section.

(B) *Example.* The following example illustrates the provisions of this paragraph (d)(4)(iii). For purposes of this example, assume the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example. (i)(A) In Year 1, A, an unmarried individual, disposes of 100 shares of publicly traded stock for a short-term capital gain of $4,000. In addition, A disposes of a partnership interest and recognizes a long-term capital loss of $19,000. Assume that the entire amount of $19,000 loss is not allowed against net investment income pursuant to section 1411(c)(4)(B), § 1.1411–7, and paragraph (d)(4)(ii) of this section. A has no capital loss carryovers from the year preceding Year 1.

(B) For purposes of chapter 1, A reports net capital loss of $15,000, of which $3,000 is allowed as a deduction in computing taxable income under section 1211(b)(1), and the remaining $12,000 is carried forward into Year 2 as a long-term capital loss pursuant to section 1212(b)(1).

(C) For purposes of calculating net investment income, A reports $4,000 of net gain. The $19,000 loss taken into account in computing A's taxable income in Year 1 is not taken into account in computing net gain. Therefore, there are no losses in excess of gains in Year 1 for which a deduction is allowed under paragraph (f)(4) of this section.

(ii)(A) In Year 2, A has no capital gain or loss transactions.

(B) For purposes of chapter 1, A reports net capital loss of $12,000, of which $3,000 is allowed as a deduction in computing taxable income under section 1211(b)(1), and the remaining $9,000 is carried forward into Year 3 as a long-term capital loss pursuant to section 1212(b)(1).

(C) For purposes of calculating net investment income, A must adjust the $12,000 capital loss carryover from Year 1 pursuant to paragraph (d)(4)(iii) of this section. The amount of the adjustment is the lesser of—

(*1*) The amount of capital loss taken into account in the current year by reason of section 1212(b)(1) ($12,000), or

(*2*) The amount of net capital loss excluded from net investment income in Year 1 by reason of paragraph (d)(4) of this section ($19,000). The $19,000 loss was the amount disallowed by reason of paragraph (d)(4)(ii) of this section, and there were no other adjustments under paragraphs (d)(4)(i) or (d)(4)(iii) of this section in Year 1.

(D) The amount of capital loss carryover that is taken into account by A in computing net investment income in Year 2 is $0 ($12,000 carryover amount less the adjustment of $12,000). Accordingly, when calculating net investment income, A has no losses in excess of gains, and no deduction is available to A under paragraph (f)(4) of this section.

(iii)(A) In Year 3, A recognizes a $5,000 short-term capital gain from the disposition of property described in paragraph (d)(4)(i) of this section, and a $1,000 short-term capital loss from the disposition of publicly traded stock.

(B) For purposes of chapter 1, A reports net capital loss carryover from Year 2 of $9,000. In addition, the short-term capital gain of $5,000 and $1,000 short-term capital loss net to produce $4,000 of short-term capital gain. A reports a net capital loss of $5,000 ($5,000—$1,000—$9,000), of which $3,000 is allowed as a deduction in computing taxable income under section 1211(b)(1), and the remaining $2,000 is carried forward into Year 4 as a long-term capital loss pursuant to section 1212(b)(1).

(C) For purposes of calculating net investment income, A may exclude the $5,000 capital gain from the calculation of net gain pursuant to paragraph (d)(4)(i) of this section. In addition, A must adjust the $9,000 capital loss carryover from Year 2 pursuant to paragraph (d)(4)(iii) of this section. The amount of the adjustment is the lesser of—

(*1*) The amount of capital loss taken into account in the current year by reason of section 1212(b)(1) ($9,000); or

(*2*) The amount of net capital loss excluded from net investment income in Year 2 by reason of paragraph (d)(4) of this section ($12,000). The $12,000 loss was the amount disallowed by reason of paragraph (d)(4)(iii) of this section, and there were no other adjustments under paragraphs (d)(4)(i) or (d)(4)(ii) of this section in Year 2.

(D) The amount of capital loss carryover that is taken into account by A in computing net investment income in Year 3 is $0 ($9,000 carryover amount less the adjustment of $9,000). Accordingly, when calculating net investment income, A excludes $5,000 of gain under paragraph (d)(4)(i) of this section and the $9,000 capital loss carryover under paragraph (d)(4)(iii) of this section. The amount of losses taken into account for purposes of computing net gain is $1,000 (attributable to the $1,000 short-term capital loss from the disposition of publicly traded stock). Pursuant to paragraph (f)(4) of this

section, A is entitled to a deduction of $1,000 because the $1,000 capital loss exceeds the gains, and the loss is less than the amount of allowable loss for chapter 1 purposes ($3,000).

(iv)(A) In Year 4, A recognizes a $8,000 long-term capital loss on the disposition of raw land to which paragraph (d)(4)(i) of this section does not apply.

(B) For purposes of chapter 1, A reports net capital loss carryover from Year 3 of $2,000. The $8,000 long-term capital loss is added to the $2,000 capital loss carryforward to produce a $10,000 long-term capital loss, of which $3,000 is allowed as a deduction in computing taxable income under section 1211(b)(1), and the remaining $7,000 is carried forward into Year 5 as a long-term capital loss pursuant to section 1212(b)(1).

(C) For purposes of calculating net investment income, A takes into account the $8,000 capital loss from the sale of the land. In addition, A must adjust the $2,000 capital loss carryover from Year 3 pursuant to paragraph (d)(4)(iii) of this section. The amount of the adjustment is the lesser of—

(*1*) The amount of capital loss taken into account in the current year by reason of section 1212(b)(1) ($2,000); or

(*2*) The amount of net capital loss excluded from net investment income in Year 3 by reason of paragraph (d)(4) of this section ($4,000). The $4,000 loss is the sum of the $5,000 gain disallowed by reason of paragraph (d)(4)(i) of this section and the $9,000 loss disallowed by reason of paragraph (d)(4)(iii) of this section, and there were no other adjustments under paragraph (d)(4)(ii) of this section in Year 3.

(D) The amount of capital loss carryover that is taken into account by A in computing net investment income in Year 3 is $0 ($2,000 carryover amount less the adjustment of $2,000). The amount of losses taken into account for purposes of computing net gain is $8,000 (attributable to the $8,000 capital loss from the disposition of raw land). Pursuant to paragraph (f)(4) of this section, A is entitled to a deduction of $3,000 because the $8,000 capital loss exceeds the gains, and only $3,000 of the loss is allowable for chapter 1 purposes under section 1211(b)(1).

(v)(A) In Year 5, A has no capital gain or loss transactions.

(B) For purposes of chapter 1, A reports net capital loss carryover from Year 4 of $7,000: $3,000 is allowed as a deduction in computing taxable income under section 1211(b)(1), and the remaining $4,000 is carried forward into Year 6 as a long-term capital loss pursuant to section 1212(b)(1).

(C) For purposes of calculating net investment income, A must adjust the $7,000 capital loss carryover from Year 4 pursuant to paragraph (d)(4)(iii) of this section. The amount of the adjustment is the lesser of—

(*1*) The amount of capital loss taken into account in the current year by reason of section 1212(b)(1) ($7,000); or

(*2*) The amount of net capital loss excluded from net investment income in Year 4 by reason of paragraph (d)(4) of this section ($2,000). The $2,000 loss was the amount disallowed by reason of paragraph (d)(4)(iii) of this section, and there were no other adjustments under paragraphs (d)(4)(i) or (d)(4)(ii) of this section in Year 4.

(D) The amount of capital loss carryover that is taken into account by A in computing net investment income in Year 5 is $5,000 ($7,000 carryover amount less the adjustment of $2,000). The amount of losses taken into account for purposes of computing net gain is $5,000 carried over from Year 4. Pursuant to paragraph (f)(4) of this section, A is entitled to a deduction of $3,000 because the $5,000 capital loss exceeds the gains, and only $3,000 of the loss is allowable for chapter 1 purposes under section 1211(b)(1).

(vi)(A) In Year 6, A has no capital gain or loss transactions.

(B) For purposes of chapter 1, A reports net capital loss carryover from Year 5 of $4,000: $3,000 is allowed as a deduction in computing taxable income under section 1211(b)(1), and the remaining $1,000 is carried forward into Year 7 as a long-term capital loss pursuant to section 1212(b)(1).

(C) For purposes of calculating net investment income, A must adjust the $4,000 capital loss carryover from Year 5 pursuant to paragraph (d)(4)(iii) of this section. The amount of the adjustment is the lesser of—

(*1*) The amount of capital loss taken into account in the current year by reason of section 1212(b)(1) ($4,000); or

(*2*) The amount of net capital loss excluded from net investment income in Year 5 by reason of paragraph (d)(4) of this section ($2,000). The $2,000 loss was the amount disallowed by reason of paragraph (d)(4)(iii) of this section, and there were no other adjustments under paragraphs (d)(4)(i) or (d)(4)(ii) of this section in Year 5.

(D) The amount of capital loss carryover that is taken into account by A in computing net investment income in Year 6 is $2,000 ($4,000 carryover amount less the adjustment of $2,000). The amount of losses taken into account for purposes of computing net gain is $2,000 carried over from Year 5. Pursuant to paragraph (f)(4) of this section, A is entitled to a deduction of $2,000 because the $2,000 capital loss exceeds the gains, and the loss is less than the amount of allowable loss for chapter 1 purposes ($3,000). As a result, the entire $8,000 loss from the raw land has been taken into account in computing A's net investment income ($3,000 in Years 4 and 5, and $2,000 in Year 6).

(vii)(A) In Year 7, A has no capital gain or loss transactions.

(B) For purposes of chapter 1, A reports net capital loss carryover from Year 6 of $1,000. The entire $1,000 is allowed as a deduction in computing taxable income under section 1211(b)(1). A has no capital losses to carry over to Year 8.

(C) For purposes of calculating net investment income, A must adjust the $1,000 capital loss carryover from Year 6 pursuant to paragraph (d)(4)(iii) of this section. The amount of the adjustment is the lesser of—

(*1*) The amount of capital loss taken into account in the current year by reason of section 1212(b)(1) ($1,000); or

(*2*) The amount of net capital loss excluded from net investment income in Year 6 by reason of paragraph (d)(4) of this section ($2,000). The $2,000 loss was the amount disallowed by reason of paragraph (d)(4)(iii) of this section, and there were no other adjustments under paragraphs (d)(4)(i) or (d)(4)(ii) of this section in Year 6.

(D) The amount of capital loss carryover that is taken into account by A in computing net investment income in Year 6 is $0 ($1,000 carryover amount less the adjustment of $1,000). Therefore, when calculating net investment income, A has no losses in excess of gains, and no deduction is available to A under paragraph (f)(4) of this section.

(e) * * *

(3) *Treatment of income from common trust funds.* If a taxpayer is a participant in a common trust fund and the taxpayer includes under section 584 any item of income, deduction, gain, or loss, then section 1411 and the regulations thereunder apply to that item to the same extent as if the participant had made directly the investments of the common trust fund to which the items are attributable.

* * * * *

(g) * * *

(10) *Treatment of section 707(c) guaranteed payments.* Net investment income does not include section 707(c) payments received for services. Except to the extent provided in paragraph (g)(11)(iii)(A) of this section, section 707(c) payments received for the use of capital are net investment income within the meaning of section 1411(c)(1)(A)(i) and paragraph (a)(1)(i) of this section.

(11) *Treatment of section 736 payments*—(i) *In general.* The treatment of payments received by a retiring partner or a deceased partner's successor in interest described in section 736 is determined under the rules of this paragraph (g)(11). Section 736 payments are not distributions from a plan or arrangement described in section 1411(c)(5) and § 1.1411–8. To the extent that any portion of a section 736 payment is taken into account in computing a taxpayer's net earnings from self-employment (within the meaning of § 1.1411–9), then such amount is not taken into account in computing net investment income by reason of section 1411(c)(6) and § 1.1411–9.

(ii) *Treatment of section 736(a)(1) payments*—(A) *General rule.* In the case of a payment described in section 736(a)(1) as a distributive share of partnership income, the items of income, gain, loss, and deduction attributable to such distributive share are taken into account in computing net investment income in section 1411(c) in a manner consistent with the item's character and treatment for chapter 1 purposes. See § 1.469–2(e)(2)(iii) for rules concerning the item's character and treatment for chapter 1.

(B) *Examples.* The following examples illustrate the provisions of this paragraph (g)(11)(ii). For purposes

of these examples, assume the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example 1. Distributive share for goodwill. (i) A retires from PRS, a business entity classified as a partnership for Federal income tax purposes, and is entitled, pursuant to the partnership agreement, to receive 10% of PRS's net income for 60 months commencing immediately following A's retirement in exchange for A's fair market value share of PRS's unrealized receivables. PRS is not engaged in a trade or business described in section 1411(c)(2)(B) (a trading business). A will provide no services to PRS for the 60-month period following A's retirement. Prior to A's retirement, A materially participated in PRS's trade or business within the meaning of § 1.469–5T. As a result, PRS is characterized by A as a nonpassive activity for section 469 purposes. For purposes of section 1411, PRS was not a trade or business described in section 1411(c)(2)(A) prior to A's retirement.

(ii) In Year 3, pursuant to the partnership agreement, A received a cash payment of $20,000. A's distributive share of PRS income in Year 3 included $70,000 of gross income from operations and $50,000 of deductions from operations. PRS's status as a passive or nonpassive activity is determined under § 1.469–2(e)(2)(iii) at the time the liquidation of A's partnership interest commenced, and remains fixed for the duration of A's liquidation payments. Therefore, PRS is a nonpassive activity with respect to A in Year 3 pursuant to § 1.469–2(e)(2)(iii). As a result, the gross income is not attributable to a trade or business described in section 1411(c)(2)(A) or § 1.1411–5(a)(1). Accordingly, A's distributive share of $70,000 of gross income and $50,000 of associated deductions are not includable in A's net investment income in Year 3.

(iii) If PRS's distributive share of operational income and deductions was attributable to a trade or business described in section 1411(c)(2)(B) or § 1.1411–5(a)(2), the $70,000 of gross income amounts would be included in A's net investment income under section 1411(c)(1)(A)(ii) and paragraph (c) of this section and the $50,000 of associated deductions would be properly allocable to such income under section 1411(c)(1)(B) and § 1.1411–4(f)(2)(ii).

Example 2. Excess distributive share payments. Assume the same facts as in *Example 1* except that PRS provides A an additional 2% of PRS's net income for 48 months commencing immediately following A's retirement as an incentive for A to retire earlier than planned. In the case of the additional 2% distributive share, the section 736(a) income characterization rule in § 1.469–2(e)(2)(iii) does not apply because the payment exceeds the value of PRS's unrealized receivables (which was established to equal 10% of PRS's income for 60 months in *Example 1*). As a result, A must determine whether PRS is a trade of business described in section 1411(c)(2)(A) and § 1.1411–5(a)(1) in Year 3 in order to determine whether the distributive share of operating income and deductions is includable in net investment income. If PRS is engaged in a trade or business described in section 1411(c)(2)(A) and § 1.1411–5(a)(1) with respect to A in Year 3, then the distributive share will be taken into account in computing A's net investment income.

(iii) *Treatment of section 736(a)(2) payments*—(A) *Payments for unrealized receivables and goodwill.* In the case of a payment described in section 736(a)(2), the portion (if any) of the payment that is allocable to the unrealized receivables (within the meaning of section 751(c)) and goodwill of the partnership (as described and calculated in § 1.469–2(e)(2)(iii)(B)) is included in net investment income under section 1411(c)(1)(A)(iii) and paragraphs (a)(1)(iii) and (d) of this section as gain from the disposition of a partnership interest.

(B) *Payments not for unrealized receivables or goodwill.* In the case of a section 736(a)(2) payment not described in paragraph (g)(11)(iii)(A) of this section, the payment is characterized as a payment for services or as the payment of interest in a manner consistent with the payment's characterization under § 1.469–2(e)(2)(ii). See paragraph (g)(9) of this section.

(iv) *Treatment of section 736(b) payments.* Gain or loss attributable to section 736(b) payments is included in net investment income under section 1411(c)(1)(A)(iii) and paragraphs (a)(1)(iii) and (d) of this section as gain or loss from the disposition of a partnership interest. A taxpayer who elects under § 1.736–1(b)(6) must apply the principles that are applied to installment sales in § 1.1411–7(d).

(v) *Application of section 1411(c)(4) to section 736 payments.* Section 1411(c)(4) and § 1.1411–7 apply to gain or loss attributable to section 736 payments described in paragraphs (g)(11)(iii)(A) and (g)(11)(iv) of this section. In the case of section 736 payments that are received in more than one taxable year, the rules for calculating gain or loss under section 1411(c)(4) and § 1.1411–7 are applied at the time the liquidation of the partner's interest commenced. The principles that are applied to installment sales in § 1.1411–7(d) also apply for purposes of this section.

(12) *Income and deductions from certain notional principal contracts*—(i) *In general.* Net income for a taxable year taken into account by a taxpayer under § 1.446–3(d) that is attributable to a notional principal contract described in paragraph (g)(12)(ii) of this section is net investment income described in section 1411(c)(1)(A) and paragraph (a)(1) of this section. A net deduction for a taxable year taken into account by a taxpayer under § 1.446–3(d) that is attributable to a notional principal contract described in paragraph (g)(12)(ii) of this section is a properly allocable deduction described in section 1411(c)(1)(B) and paragraph (f) of this section.

(ii) *Notional principal contracts.* For purposes of paragraph (g)(12)(i) of this section, a notional principal contract is any notional principal contract described in § 1.446–3(c)(1) that is referenced to property (including an index) that produces (or would produce if the property were to produce income) interest, dividends, royalties, or rents if the property were held directly by the taxpayer. For purposes of the preceding sentence, an interest rate swap, cap, or floor is treated as a notional principal contract that is referenced to a debt instrument.

(13) *Treatment of income or loss from REMIC residual interests.* The daily portion of taxable income determined under section 860C(a)(2) taken into account in determining tax under chapter 1 by the holder of a residual interest in a REMIC and any inducement fee included in income under § 1.446–6(a) are treated as net investment income under section 1411(c)(1)(A) and paragraph (a)(1) of this section. The daily portion of net loss determined under section 860C(a)(2) taken into account in determining tax under Chapter 1 by the holder of a residual interest in a REMIC is a properly allocable deduction described in section 1411(c)(1)(B) and paragraph (f) of this section.

* * * * *

■ **Par. 5.** Section 1.1411–7 is added to read as follows:

§ 1.1411–7 Exception for dispositions of certain active interests in partnerships and S corporations.

(a) *In general*—(1) *General application.* In the case of a transferor that disposes of an interest in a partnership or S corporation described in paragraph (a)(3) of this section (transferor), the gain or loss from the disposition recognized under chapter 1 that is taken into account under § 1.1411–4(a)(1)(iii) shall be calculated in accordance with this section. The calculation in paragraph (b) of this section reflects the net gain or net loss that the transferor would take into account if the partnership or S corporation sold all of its Section 1411 Property (as defined in paragraph (a)(2)(iv) of this section) for fair market value immediately before the disposition of such interest. In certain

instances, transferors may qualify to use an alternative calculation described in paragraph (c) of this section in lieu of the calculation described in paragraph (b) of this section. Paragraph (d) of this section contains additional rules for Section 1411(c)(4) Dispositions (as defined in paragraph (a)(2)(ii) of this section) in deferred recognition transactions. Paragraph (f) of this section provides rules for adjusting the amount of gain or loss computed under this paragraph (a)(1) for transferors subject to basis adjustments required by § 1.1411–10(d). Paragraph (g) of this section provides rules for information disclosures by a partnership or S corporation to transferors and for information reporting by individuals, trusts, and estates. If a transferor disposes of an interest in a partnership or S corporation not described in paragraph (a)(3) of this section, then this section does not apply and the full amount of the gain or loss, as computed under chapter 1 and adjusted by § 1.1411–10(d) (if applicable), is taken into account in computing the transferor's net investment income.

(2) *Definitions.* For purposes of this section—

(i) The term *Passthrough Entity* means an entity taxed as a partnership or an S corporation. For purposes of this section, a reference to an interest in any S corporation shall mean a reference to stock in such S corporation.

(ii) The term *Section 1411(c)(4) Disposition* means a disposition of an interest in a Passthrough Entity described in paragraph (a)(3) of this section.

(iii) The term *Section 1411 Holding Period* means the year of disposition and the transferor's two taxable years preceding the disposition or the time period the transferor held the interest, whichever is less; provided, however, that for purposes of applying this paragraph (a)(2)(iii), the transferor will—

(A) Include the period that a previous owner or owners held the interest transferred if the transferor acquired its interest from another Passthrough Entity in a nonrecognition transaction during the year of disposition or the prior two taxable years;

(B) Include the period that the transferor held an interest in a Subsidiary Passthrough Entity if the transferor transferred that interest to a Passthrough Entity in a nonrecognition transaction during the year of disposition or the prior two taxable years; and

(C) Include the period that a previous owner or owners held the interest transferred if the transferor acquired its interest by gift.

(iv) The term *Section 1411 Property* means property owned by or held through the Passthrough Entity that, if disposed of by the entity, would result in net gain or loss allocable to the transferor of a type that is includable in determining net investment income of the transferor under § 1.1411–4(a)(1)(iii).

(v) The term *Subsidiary Passthrough Entity* means an interest in a Passthrough Entity owned, directly or indirectly, by another Passthrough Entity.

(3) *Section 1411(c)(4) Dispositions*—(i) *Transfers by individuals, estates, and trusts.* The disposition by a transferor of an interest in a Passthrough Entity is a Section 1411(c)(4) Disposition only if—

(A) The Passthrough Entity is engaged in one or more trades or businesses (within the meaning of section 162), or owns an interest (directly or indirectly) in a Subsidiary Passthrough Entity that is engaged in one or more trades or businesses (within the meaning of section 162), that is not described in § 1.1411–5(a)(2) (trading in financial instruments or commodities); and

(B) One or more of the trades or businesses of the Passthrough Entity described in paragraph (a)(3)(i)(A) of this section is not a § 1.1411–5(a)(1) (passive activity) trade or business of the transferor.

(ii) *Transfers by Passthrough Entities.* Where a Passthrough Entity (the ''holder'') disposes of an interest in a Subsidiary Passthrough Entity, that disposition qualifies as a Section 1411(c)(4) Disposition with respect to a partner or shareholder of the Passthrough Entity if the partner or shareholder would satisfy the requirements of paragraph (a)(3)(i) of this section if it held the interest in the Subsidiary Passthrough Entity directly. For this purpose, the partner or shareholder shall be treated as owning a proportionate share of any Subsidiary Passthrough Entity in which the partner or shareholder owns an indirect interest through one or more tiers of Passthrough Entities.

(4) *Special rules*—(i) *Certain liquidations.* If a fully taxable disposition of all of the Passthrough Entity's assets is followed by the complete liquidation of the Passthrough Entity as part of a single plan, then the disposition will be treated as an asset sale for purposes of section 1411, and no additional gain or loss will be included in net investment income under § 1.1411–4(a)(1)(iii) on the subsequent liquidation of the Passthrough Entity by any transferor who would have satisfied paragraph (a)(3) of this section prior to the sale. A sale of stock in an S corporation with respect to which an election under section 336(e) or section 338(h)(10) is made shall be treated as a fully taxable disposition of the Passthrough Entity's assets followed by the liquidation of the Passthrough Entity for purposes of this paragraph (a)(4)(i).

(ii) *Excluded gain or loss.* The difference between the amount of gain or loss taken into account in computing taxable income for purposes of chapter 1 and the amount of gain or loss taken into account after the application of this section shall constitute excluded income or excluded loss, as applicable, for purposes of § 1.1411–4(d)(4)(ii).

(iii) *Rules applicable to S corporation shareholders*—(A) *Certain S corporation dispositions.* If the transfer of an interest in an S corporation causes the S election to terminate on the day of the transfer, then the corporation shall continue to be treated as an S corporation for purposes of applying the rules of this section to the transferor notwithstanding that § 1.1362–3(a) treats the day of the transfer as the first day of the corporation's C corporation short year (as defined therein).

(B) *S corporations subject to section 1374.* For purposes of the calculation under paragraph (b) of this section, the amount of gain or loss allocated to the transferor is determined under section 1366(a), and the allocation does not take into account any reduction in the transferor's pro rata share of gains under section 1366(f)(2) resulting from the hypothetical imposition of tax under section 1374 as a result of the deemed sale.

(C) *Treatment of Qualified Subchapter S Trusts (QSSTs).* In the case of a disposition of S corporation stock by a QSST, the rules of this section are applied by treating the QSST as the owner of the S corporation stock.

(b) *Calculation*—(1) *In general.* A transferor of an interest in a Passthrough Entity who disposes of that interest in a Section 1411(c)(4) Disposition may use the simplified calculation in paragraph (c) of this section if it meets the eligibility requirements set forth in paragraph (c)(2) of this section. Any other transferor who disposes of an interest in a Passthrough Entity in a Section 1411(c)(4) Disposition must include gain or loss under § 1.1411–4(a)(1)(iii) determined in accordance with this paragraph (b).

(i) *Gain on disposition of interest.* If the transferor recognized a gain from the disposition, the amount of the net gain included in § 1.1411–4(a)(1)(iii) is the lesser of—

(A) the transferor's gain on the disposition of the interest in the Passthrough Entity as determined in accordance with chapter 1; or

(B) the transferor's allocable share of the chapter 1 net gain from a deemed sale of the Passthrough Entity's Section 1411 Property as determined using the principles of § 1.469–2T(e)(3) (allocation of gain or loss to activities of the Passthrough Entity) where the net gain is the sum of the amounts of net gain and net loss allocable to the transferor as determined under §§ 1.469–2T(e)(3)(ii)(B)(*1*)(*i*) and 1.469–2T(e)(3)(ii)(B)(*2*)(*i*) that would constitute income to the transferor for purposes of section 1411 if sold by the Passthrough Entity. The general rules of § 1.469–2T(e)(3) apply in calculating the transferor's allocable share of the net gain under this section; however, the gain recharacterization rule of § 1.469–2T(e)(3)(iii) shall not apply in any case. The calculation of net gain in this paragraph (b)(1)(i) shall not be less than zero.

(ii) *Loss on disposition of interest.* If the transferor recognizes a loss from the disposition, the amount of the net loss included in § 1.1411–4(a)(1)(iii) is the lesser of—

(A) The transferor's loss (expressed as a positive number) on the disposition of the interest in the Passthrough Entity as determined in accordance with chapter 1; or

(B) The transferor's allocable share of the chapter 1 net loss (expressed as a positive number) from the deemed sale of the entity's Section 1411 Property as determined in accordance with § 1.469–2T(e)(3) (allocation of gain or loss to activities of the Passthrough Entity) where the net loss is the sum of the amounts of net gain and net loss allocable to the transferor as determined under §§ 1.469–2T(e)(3)(ii)(B)(*1*)(*i*) and 1.469–2T(e)(3)(ii)(B)(*2*)(*i*) that would constitute income or loss to the transferor for purposes of section 1411 if sold by the Passthrough Entity. The general rules of § 1.469–2T(e)(3) apply in calculating the transferor's allocable share of the net gain under this section; however, the gain recharacterization rule of § 1.469–2T(e)(3)(iii) shall not apply in any case. The calculation of net gain in this paragraph (b)(1)(ii) shall not be less than zero. For purposes of this paragraph (b)(1)(ii), the loss limitation provisions imposed by sections 704(d) and 1366(d) shall not apply.

(2) *Examples.* The following examples illustrate the principles of paragraph (b)(1) of this section. For purposes of these examples, assume that the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example 1. (i) *Facts.* A owns a one-half interest in P, a calendar year partnership. In Year 1, A sells its interest for $200,000. A's adjusted basis for the interest sold is $120,000. Thus, A recognizes $80,000 of gain from the sale (chapter 1 gain). P is engaged in three trade or business activities, X, Y, and Z, none of which are § 1.1411–5(a)(2) (trading in financial instruments or commodities) trades or businesses. P also owns marketable securities. For Year 1, A materially participates in activity Z, thus it is not a § 1.1411–5(a)(1) (passive activity) trade or business of A. A, however, does not materially participate in activities X and Y, so these activities are § 1.1411–5(a)(1) trades or businesses of A. Because P is engaged in at least one trade or business and at least one of those trades or businesses is not passive to the transferor A, A determines its amount of § 1.1411–4(a)(1)(iii) gain or loss from net investment income under § 1.1411–7. Assume for purposes of this example, A is not eligible to compute its § 1.1411–4(a)(1)(iii) gain or loss under the optional simplified reporting method discussed in paragraph (c) of this section. The fair market value and adjusted basis of the gross assets used in P's activities are as follows:

	Adjusted basis	Fair market value	Gain/loss	A's Share gain/loss
X (Passive as to A)	$136,000	$96,000	($40,000)	($20,000)
Y (Passive as to A)	60,000	124,000	64,000	32,000
Z (Non-passive as to A)	40,000	160,000	120,000	60,000
Marketable securities	4,000	20,000	16,000	8,000
Total	240,000	400,000	160,000	80,000

(ii) *Analysis.* Under paragraph (b)(1) of this section, A must determine the portion of gain or loss from the sale of P's Section 1411 Property allocable to A. Under paragraph (b)(1)(ii) of this section, A's allocable share of gain from P's Section 1411 Property is $20,000 (($20,000) from X + $32,000 from Y + $8,000 from the marketable securities). Because the $20,000 allocable to A from a deemed sale of P's Section 1411 Property is less than A's $80,000 chapter 1 gain, A will include $20,000 under § 1.1411–4(a)(1)(iii).

Example 2. Assume the same facts as *Example 1,* but A materially participates in activities Y and Z and does not materially participate in activity X. Under paragraph (b)(1)(i) of this section, A's allocable share of P's Section 1411 Property is ($12,000) (($20,000) from X + $8,000 from the marketable securities). Because A sold its interest for a chapter 1 gain, the amount allocable to A from a deemed sale of P's Section 1411 Property cannot be less than zero. Accordingly, A includes no gain or loss under § 1.1411–4(a)(1)(iii).

(c) *Optional simplified reporting*—(1) *In general.* A transferor of an interest in a Passthrough Entity in a Section 1411(c)(4) Disposition may use the simplified reporting rules of paragraph (c)(4) of this section if it satisfies the eligibility requirements set forth in paragraph (c)(2) of this section and is not described in paragraph (c)(3) of this section. All other transferors of interests in Passthrough Entities in Section 1411(c)(4) Dispositions must use the calculation set forth in paragraph (b) of this section. Paragraph (d) of this section contains additional rules for Section 1411(c)(4) Dispositions in deferred recognition transactions.

(2) *Qualifications.* Unless described in paragraph (c)(3) of this section, a transferor of an interest in a Passthrough Entity in a Section 1411(c)(4) Disposition may determine the amount of net gain or net loss that is taken into account under § 1.1411–4(a)(1)(iii) in accordance with paragraph (c)(4) of this section if either or both of the requirements in paragraph (c)(2)(i) or (c)(2)(ii) of this section are satisfied:

(i) *Five percent threshold.* The sum of separately stated income, gain, loss, and deduction items (with any separately stated loss and deduction items included as positive numbers) of a type the transferor would take into account in calculating net investment income (as defined in § 1.1411–1(d)) that are allocated to the transferor in respect of the transferred interest is five percent or less of the sum of all separately stated items of income, gain, loss, and deduction (with any separately stated loss and deduction items included as positive numbers) allocated to the transferor in respect of the transferred interest during the Section 1411 Holding Period, and the total amount of chapter 1 gain or loss recognized by the transferor from the disposition of interests in the Passthrough Entity does not exceed $5 million (including gains

or losses from multiple dispositions as part of a plan). All dispositions of interests in the Passthrough Entity that occur during the taxable year will be presumed to be part of a plan. In calculating the percentage described in the first sentence of this paragraph (c)(2)(i), if the transferor acquired the transferred interest in a transaction described in paragraph (a)(2)(iii)(A) or (a)(2)(iii)(C) of this section, then items of income, gain, loss, or deduction allocated to the transferor include any such items allocated to the transferor's predecessor (or predecessors) in interest during the Section 1411 Holding Period. If the transferor transferred an interest in a Subsidiary Passthrough Entity to the Passthrough Entity in a transaction described in paragraph (a)(2)(iii)(B) of this section, then items of income, gain, loss or deduction allocated to the transferor include any items allocated to the transferor during the Section 1411 Holding Period in respect of the interest in the Subsidiary Passthrough Entity.

(ii) *$250,000 gain or loss threshold.* The total amount of chapter 1 gain or loss recognized by the transferor from the disposition of interests in the Passthrough Entity does not exceed $250,000 (including gains or losses from multiple dispositions as part of a plan). All dispositions of interests in the Passthrough Entity that occur during the taxable year will be presumed to be part of a plan.

(3) *Nonapplicability.* A transferor is not eligible to use the simplified reporting method of paragraph (c)(4) of this section if any of the following conditions are met:

(i) The transferor has held directly the interest in the Passthrough Entity (or held the interest indirectly in the case of a Subsidiary Passthrough Entity) for less than twelve months preceding the Section 1411(c)(4) Disposition.

(ii) The transferor transferred, directly or indirectly, Section 1411 Property (other than cash or cash equivalents) to the Passthrough Entity (or a Subsidiary Passthrough Entity described in paragraph (a)(2)(v) of this section), or received a distribution of property (other than Section 1411 property) from the Passthrough Entity (or a Subsidiary Passthrough Entity described in paragraph (a)(2)(v) of this section), during the Section 1411 Holding Period as part of a plan that includes the transfer of the transferor's interest in the Passthrough Entity. A transferor who contributed, directly or indirectly, Section 1411 Property (other than cash or cash equivalents) within 120 days of the disposition of the interest in the Passthrough Entity is presumed to have made the contribution as part of a plan that includes the transfer of the interest in the Passthrough Entity.

(iii) The Passthrough Entity is a partnership, and the transferor transfers a partial interest that represents other than a proportionate share of all of the transferring partner's economic rights in the partnership.

(iv) The transferor knows or has reason to know that the percentage of the Passthrough Entity's gross assets that consist of Section 1411 Property has increased or decreased by 25 percentage points or more during the transferor's Section 1411 Holding Period due to contributions, distributions, or asset acquisitions or dispositions in taxable or nonrecognition transactions.

(v) The Passthrough Entity, which is the subject of the Section 1411(c)(4) Disposition, was taxable as a C corporation during the Section 1411 Holding Period, but during that period elects under section 1362 to be taxable as an S corporation under section 1361.

(4) *Optional simplified reporting calculation.* The amount of net gain or loss from the transferor's Section 1411(c)(4) Disposition that is includable in § 1.1411–4(a)(1)(iii) is determined by multiplying the transferor's chapter 1 gain on the disposition by a fraction, the numerator of which is the sum of income, gain, loss, and deduction items (with any separately stated loss and deduction items netted as negative numbers) of a type that are taken into account in the calculation of net investment income (as defined in § 1.1411–1(d)) that are allocated to the transferor during the Section 1411 Holding Period and the denominator of which is the sum of all items of income, gain, loss, and deduction allocated to the transferor during the Section 1411 Holding Period (with any separately stated loss and deduction items netted as negative numbers). If the quotient of the fraction is either greater than one or less than zero, then the fraction shall be one; provided, however, that if the numerator is a negative amount in connection with a computation of overall chapter 1 gain on the sale or a positive amount in connection with a computation of overall chapter 1 loss on the sale, then the fraction shall be zero. In calculating the fraction described in the first sentence of this paragraph (c)(4), if the transferor acquired the transferred interest in a transaction described in paragraph (a)(2)(iii)(A) or (C) of this section, then items of income, gain, loss, or deduction allocated to the transferor include any such items allocated to the transferor's predecessor (or predecessors) in interest during the Section 1411 Holding Period. If the transferor transferred an interest in a Subsidiary Passthrough Entity to the Passthrough Entity in a transaction described in paragraph (a)(2)(iii)(B) of this section, then items of income, gain, loss or deduction allocated to the transferor include any items allocated to the transferor during the Section 1411 Holding Period in respect of the interest in the Subsidiary Passthrough Entity.

(5) *Examples.* The following examples illustrate the principles of paragraph (c)(4) of this section. For purposes of these examples, assume that the taxpayer is a United States citizen, uses a calendar taxable year, and Year 1 and all subsequent years are taxable years in which section 1411 is in effect:

Example 1. Facts. A owns a one-half interest in P, a partnership. In Year 1, A sells the interest for $2,000,000. A's adjusted basis for the interest sold is $1,100,000. Because P is engaged in at least one trade or business and at least one of those trades or businesses is not passive to the transferor A, A determines its amount of § 1.1411–4(a)(1)(iii) gain or loss from net investment income under § 1.1411–7. None of the nonapplicability conditions set forth in section 1.1411–7(c)(3) apply. The aggregate net income from P's activities allocable to A for the year of disposition and the two preceding tax years are as follows:

	Aggregate income/ (loss)
X (Non-Passive as to A)	$1,800,000
Y (Passive as to A)	(10,000)
Marketable securities	20,000

(ii) *Analysis.* During A's Section 1411 Holding Period, A was allocated $30,000 of gross items of a type taken into account in the calculation of net investment income ($10,000 of loss from activity Y and $20,000 of income from marketable securities). The total amount of A's allocated net items during the Section 1411 Holding Period equals $1,810,000 ($1,800,000 income from activity X, $10,000 loss from activity Y, and $20,000 income from marketable securities). Thus, less than 5% ($30,000/1,810,000) of A's allocations during the Section 1411 Holding Period are of a type that are taken into account in the computation of net investment income, and because A's chapter 1 gain recognized of $2,000,000 is less than $5,000,000, A qualifies under § 1.1411–7(c)(2)(ii) to use the optional simplified method.

(iii) Under paragraph (c)(4) of this section, A's percentage of Section 1411 Property is determined by dividing A's allocable shares of income and loss of a type that are taken into account in the calculation of net investment income (as defined in § 1.1411–1(d)) that are allocated to the transferor by the Passthrough Entity during the Section 1411 Holding Period is $10,000 ($10,000 loss from Y + $20,000 income from marketable securities) by $1,810,000, which is the sum of A's share of income and loss from all of P's activities ($1,800,000 + ($10,000) +

20,000). Thus, A's gain for purposes of § 1.1411–4(a)(1)(iii) is $4,972.32 ($900,000 chapter 1 gain multiplied by the fraction 10,000/1,810,000).

Example 2. Assume the same facts as *Example 1,* but A sells the interest in P for $900,000. Under paragraph (c)(3) of this section, A's percentage of Section 1411 Property is determined by dividing A's allocable share of income and loss of a type that are taken into account in the calculation of net investment income (as defined in § 1.1411–1(d)) that are allocated to the transferor by the Passthrough Entity during the Section 1411 Holding Period is $10,000 ($10,000 loss from Y + $20,000 income from marketable securities) by $1,810,000, which is the sum of A's share of income and loss from all of P's activities ($1,800,000 + ($10,000) + 20,000). Because A's allocable share during the Section 1411 Holding Period of income and loss of a type that is taken into account in calculating net investment income was a positive amount, and A sells its interest for an overall chapter 1 loss, A uses a fraction of 0 to compute its net investment income under paragraph (c)(4) of this section. Thus, A has no gain or loss for purposes of § 1.1411–4(a)(1)(iii) ($200,000 chapter 1 loss multiplied by a fraction of 0).

(d) *Deferred recognition transactions.* In the case of a disposition of a Passthrough Entity in an installment sale under section 453 (or in exchange for an annuity contract), the calculations described in paragraphs (b) and (c) of this section shall be applied in the year of the disposition as if the entire amount of gain recognized for chapter 1 is taken into account by the transferor in the year of the disposition. For this purpose, it is assumed that any contingencies potentially affecting consideration to the transferor that are reasonably expected to occur will occur, and in the case of annuities based on the life expectancy of one or more individuals, the present value of the annuity (using existing Federal tax valuation methods) is used to determine the estimated gain. If the calculations in this section result in a transferor excluding only a portion of the chapter 1 gain from net investment income, the amount of excluded gain will constitute an addition to basis for purposes of applying section 453 to determine the amount of gain is includable in net investment income under § 1.1411–4(a)(1)(iii) as payments are received.

(e) *Disposition of tiered Passthrough Entities.* [Reserved]

(f) *Adjustment to net gain or loss.* In the case of a disposition of an interest in a Passthrough Entity where the transferor's basis in the interest for section 1411 purposes does not equal the transferor's basis for chapter 1 purposes due to basis adjustments required by § 1.1411–10(d), then the following rules apply:

(i) If the transferor's basis for section 1411 purposes is higher than the transferor's basis for chapter 1 purposes, then the difference reduces the amount of gain or increases the amount of loss, as applicable, that is includable in net investment income under this section.

(ii) If the transferor's basis for section 1411 purposes is lower than the transferor's basis for chapter 1 purposes, then the difference increases the amount of gain or reduces the amount of loss, as applicable, that is includable in net investment income under this section.

(iii) The adjustments to gain or loss includable in net investment income under this paragraph (f) are taken into account by the transferor immediately following the calculation of gain or loss under paragraphs (a)(4)(i), (b)(1) or (c)(4) of this section, as applicable.

(g) *Information reporting*—(1) *Information to be provided by passthrough entity to transferor.* Where the Passthrough Entity knows, or has reason to know, that the transferor satisfies paragraph (a)(3)(i) of this section but does not satisfy paragraph (c) of this section, then the Passthrough Entity shall provide the transferor with information as to the transferor's allocable share of the net gain or loss from the deemed sale of the Passthrough Entity's Section 1411 Property as described in paragraph (b)(1) of this section and such other information as may be required by forms, instructions, or in other guidance to allow the transferor to compute gain or loss under this section.

(2) *Information reporting by transferors.* Any transferor making a calculation under this section must attach a statement to the transferor's return for the year of disposition containing certain information as required by this paragraph (g)(2) and any other information required by guidance and applicable forms and instructions issued by the Commissioner to allow the transferor to compute gain or loss under this section. In the case of a disposition in a transaction described in paragraph (d) of this section, the information required by this paragraph (g)(2) shall apply in the year of the disposition, or in the first year the taxpayer is subject to section 1411 (determined without regard to the effect of this section), whichever is later. The statement must include—

(i) The name and taxpayer identification number of the Passthrough Entity of which the interest was transferred;

(ii) The amount of the transferor's gain or loss on the disposition of the interest for purposes of chapter 1;

(iii) The information provided by the Passthrough Entity to the transferor by reason of paragraph (g)(1) of this section; and

(iv) The amount of adjustment to gain or loss by reason of paragraph (f) of this section, if any.

(h) *Effective/applicability date.* This section applies to taxable years beginning after December 31, 2013. However, taxpayers may apply this section to taxable years beginning after December 31, 2012 in accordance with § 1.1411–1(f).

John Dalrymple,

Deputy Commissioner for Services and Enforcement.

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Part VI

Commodity Futures Trading Commission

17 CFR Parts 39, 140, and 190

Derivatives Clearing Organizations and International Standards; Final Rule

COMMODITY FUTURES TRADING COMMISSION

17 CFR Parts 39, 140, and 190

RIN 3038–AE06

Derivatives Clearing Organizations and International Standards

AGENCY: Commodity Futures Trading Commission.

ACTION: Final rule.

SUMMARY: The Commodity Futures Trading Commission (''Commission'') is adopting final regulations to establish additional standards for compliance with the derivatives clearing organization (''DCO'') core principles set forth in the Commodity Exchange Act (''CEA'') for systemically important DCOs (''SIDCOs'') and DCOs that elect to opt-in to the SIDCO regulatory requirements (''Subpart C DCOs''). Pursuant to the new regulations, SIDCOs and Subpart C DCOs are required to comply with the requirements applicable to all DCOs, which are set forth in the Commission's DCO regulations on compliance with core principles, to the extent those requirements are not inconsistent with the new requirements set forth herein. The new regulations include provisions concerning: procedural requirements for opting in to the regulatory regime as well as substantive requirements relating to governance, financial resources, system safeguards, special default rules and procedures for uncovered losses or shortfalls, risk management, additional disclosure requirements, efficiency, and recovery and wind-down procedures. These additional requirements are consistent with the Principles for Financial Market Infrastructures (''PFMIs'') published by the Committee on Payment and Settlement Systems and the Board of the International Organization of Securities Commissions (''CPSS–IOSCO''). In addition, the Commission is adopting certain delegation provisions and certain technical clarifications.

DATES: This rule is effective December 31, 2013, except for the amendments to 17 CFR 39.31 and 140.94, which are effective December 13, 2013, and the amendments to 190.09, which are effective December 2, 2013.

FOR FURTHER INFORMATION CONTACT: Ananda Radhakrishnan, Director, Division of Clearing and Risk (''DCR''), at 202–418–5188 or *aradhakrishnan@cftc.gov;* Robert B. Wasserman, Chief Counsel, DCR, at 202–418–5092 or *rwasserman@cftc.gov;* M. Laura Astrada, Associate Chief Counsel, DCR, at 202–418–7622 or *lastrada@cftc.gov;* Peter A. Kals, Special Counsel, DCR, at 202–418–5466 or *pkals@cftc.gov;* Jocelyn Partridge, Special Counsel, DCR, at 202–418–5926 or *jpartridge@cftc.gov;* or Tracey Wingate, Special Counsel, DCR, at 202–418–5319 or *twingate@cftc.gov,* in each case, at the Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street NW., Washington, DC 20581.

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I. Background

A. Regulatory Framework for Registered DCOs

On July 21, 2010, President Obama signed the Dodd-Frank Wall Street Reform and Consumer Protection Act (''Dodd-Frank Act'').[1] Title VII of the Dodd-Frank Act, entitled the ''Wall Street Transparency and Accountability Act of 2010,''[2] amended the Commodity Exchange Act (''CEA'' or the ''Act'')[3] to establish a comprehensive regulatory framework for over-the-counter (''OTC'') derivatives, including swaps.

Section 725(c) of the Dodd-Frank Act amended Section 5b(c)(2) of the CEA, which sets forth core principles that a DCO must comply with in order to register and maintain registration with the Commission. In furtherance of the goals of the Dodd-Frank Act to reduce risk, increase transparency, and promote market integrity, the Commission, pursuant to the Commission's enhanced rulemaking authority,[4] adopted regulations establishing standards for compliance with the DCO core principles.[5]

B. Designation of DCOs as Systemically Important under Title VIII of the Dodd-Frank Act

Title VIII of the Dodd-Frank Act, entitled ''Payment, Clearing, and Settlement Supervision Act of 2010,''[6]

[1] Dodd-Frank Wall Street Reform and Consumer Protection Act, Public Law 111–203, 124 Stat. 1376 (2010). The text of the Dodd-Frank Act may be accessed at *http://www.cftc.gov/ucm/groups/public/@swaps/documents/file/hr4173_enrolledbill.pdf.*

[2] Section 701 of the Dodd-Frank Act.

[3] 7 U.S.C. 1 *et seq.*

[4] *See* Section 725(c)(2)(i) of the Dodd-Frank Act (giving the Commission explicit authority to promulgate rules regarding the core principles pursuant to its rulemaking authority under Section 8a(5) of the CEA, 7 U.S.C. 12a(5)).

[5] *See* Derivatives Clearing Organization General Provisions and Core Principles, 76 FR 69334 (Nov. 8, 2011). These regulations are set forth in Subpart A and Subpart B of part 39 of the Commission's regulations (''Subpart A'' and ''Subpart B,'' respectively).

[6] Section 801 of the Dodd-Frank Act.

was enacted to mitigate systemic risk in the financial system and promote financial stability.[7] Section 804 of the Dodd-Frank Act requires the Financial Stability Oversight Council (''Council'') to designate those financial market utilities (''FMUs'')[8] that the Council determines are, or are likely to become, systemically important.[9]

In determining whether an FMU is systemically important, the Council uses a detailed two-stage designations process, using certain statutory considerations[10] and other metrics to assess, among other things, ''whether possible disruptions [to the functioning of an FMU] are potentially severe, not necessarily in the sense that they themselves might trigger damage to the U.S. economy, but because such disruptions might reduce the ability of financial institutions or markets to perform their normal intermediation functions.''[11] On July 18, 2012, the Council designated eight FMUs as systemically important under Title VIII.[12] Two of these are CFTC-registered DCOs[13] for which the Commission is the Supervisory Agency.[14]

C. Existing Standards for SIDCOs

Section 805 of the Dodd-Frank Act directs the Commission to consider relevant international standards and existing prudential requirements when prescribing risk management standards governing the operations related to payment, clearing, and settlement activities for FMUs that are (1) designated as systemically important by the Council and (2) engaged in activities for which the Commission is the Supervisory Agency.[15] More generally, Section 752 of the Dodd-Frank Act directs the Commission to consult and coordinate with foreign regulatory authorities on the establishment of consistent international standards with respect to the regulation of, among other things, swaps, futures, and options on futures.[16]

In 2013, after careful consideration of the comments on the rules that it had proposed for SIDCOs in 2010 and 2011,[17] and in light of domestic and international market and regulatory developments, the Commission finalized regulations for SIDCOs in a manner consistent with the PFMIs.[18] Most recently, the Commission proposed the regulations for SIDCOs and Subpart C DCOs that are being adopted herein (the ''Proposal'').[19]

D. DCO Core Principles and Regulations for Registered DCOs

As noted in the Proposal, in order to register and maintain registration status with the Commission, DCOs must comply with all of the DCO core principles set forth in Section 5b(c)(2) of the CEA, as amended by Section 725 of the Dodd-Frank Act, as well as all applicable Commission regulations. The Proposal did, however, identify and discuss those core principles and related Commission regulations that were most relevant to the proposed regulations. Specifically, the Proposal discussed the following DCO core principles and related Commission regulations Core Principle B (Financial Resources) and regulations 39.11 and 39.29; Core Principle D (Risk Management) and regulation 39.13; Core Principle G (Default Rules and Procedures) and regulation 39.16; Core Principle I (System Safeguards) and regulations 39.18 and 39.30; Core Principle L (Public Information) and regulation 39.21; Core Principle O (Governance Fitness Standards); Core Principle P (Conflicts of Interest); and Core Principle Q (Composition of Governing Boards).[20]

E. PFMIs

1. Overview

In the SIDCO Final Rule, the Commission determined that, for purposes of meeting its obligation pursuant to Section 805(a)(2)(A) of the Dodd-Frank Act, the PFMIs, which were developed by CPSS–IOSCO over a period of several years,[21] were the

[7] Section 802(b) of the Dodd-Frank Act.

[8] An FMU includes any person that manages or operates a multilateral system for the purpose of transferring, clearing, or settling payments, securities, or other financial transactions among financial institutions or between financial institutions and the person. Section 803(6)(A) of the Dodd-Frank Act.

[9] Section 804(a)(1) of the Dodd-Frank Act. The term ''systemically important'' means a situation where the failure of or a disruption to the functioning of a financial market utility could create, or increase, the risk of significant liquidity or credit problems spreading among financial institutions or markets and thereby threaten the stability of the financial system of the United States. Section 803(9) of the Dodd-Frank Act. *See also* Authority to Designate Financial Market Utilities as Systemically Important, 76 FR 44763, 44774 (July 27, 2011) (final rule).

[10] Under Section 804(a)(2) of the Dodd-Frank Act, in determining whether an FMU is or is likely to become systemically important, the Council must take into consideration the following: (A) The aggregate monetary value of transactions processed by the FMU; (B) the aggregate exposure of an FMU to its counterparties; (C) the relationship, interdependencies, or other interactions of the FMU with other FMUs or payment, clearing or settlement activities; (D) the effect that the failure of or a disruption to the FMU would have on critical markets, financial institutions or the broader financial system; and (E) any other factors the Council deems appropriate.

[11] 76 FR 44766.

[12] *See* Press Release, Financial Stability Oversight Council, Financial Stability Oversight Council Makes First Designations in Effort to Protect Against Future Financial Crises (July 18, 2012), available at *http://www.treasury.gov/press-center/press-releases/Pages/tg1645.aspx.*

[13] While Chicago Mercantile Exchange, Inc. (''CME Clearing''), ICE Clear Credit LLC (''ICE Clear Credit''), and The Options Clearing Corporation (''OCC'') are the CFTC-registered DCOs that were designated as systemically important by the Council, the CFTC is the Supervisory Agency only for CME Clearing and ICE Clear Credit; the Securities and Exchange Commission (''SEC'') serves as OCC's Supervisory Agency.

[14] *See* Section 803(8)(A) of the Dodd-Frank Act (defining ''Supervisory Agency'' as the federal agency that has primary jurisdiction over a designated financial market utility under federal banking, securities or commodity futures laws).

[15] *See* Section 805(a)(2) of the Dodd-Frank Act. The Commission notes that, under section 805 of the Dodd-Frank Act, the Commission also has the authority to prescribe risk management standards governing the operations related to payment, clearing, and settlement activities for FMUs that are designated as systemically important by the Council and are engaged in activities for which the Commission is the appropriate financial regulator.

[16] Section 752(a) of the Dodd-Frank Act, codified at 15 U.S.C. 8325, provides, in relevant part, that in order to promote effective and consistent global regulation of swaps and security based swaps, the CFTC, the SEC, and the prudential regulators (as that term is defined in section 1a(30) of the CEA), as appropriate, shall consult and coordinate with foreign regulatory authorities on the establishment of international standards with respect to the regulation of swaps and swap entities. In addition, section 752(b) of the Dodd-Frank Act states that in order to promote effective and consistent global regulation of contracts of sale of a commodity for future delivery and options on such contracts, the CFTC shall consult and coordinate with foreign regulatory authorities on the establishment of international standards with respect to the regulation of contracts of a sale of a commodity for future delivery and on options on such contracts.

[17] See Financial Resources Requirements for Derivatives Clearing Organizations, 75 FR 63113, 63119 (Oct. 14, 2010) (notice of proposed rulemaking) and Risk Management Requirements for Derivatives Clearing Organizations, 76 FR 3697 (Jan. 20, 2011) (notice of proposed rulemaking).

[18] Specifically, in that final rulemaking, the Commission amended part 39 by creating a Subpart C and adding regulations that (1) increased the minimum financial resource requirements for SIDCOs, (2) restricted the use of assessments by SIDCOs in meeting such financial resource obligations, (3) enhanced the system safeguards requirements for SIDCOs, and (4) granted the Commission special enforcement authority over SIDCOs pursuant to Section 807 of the Dodd-Frank Act. *See* Enhanced Risk Management Standards for Systemically Important Derivatives Clearing Organizations, 78 FR 49663 (Aug. 15, 2013) (''SIDCO Final Rule'').

[19] Derivatives Clearing Organizations and International Standards, 78 FR 50260 (Aug. 16, 2013) (notice of proposed rulemaking).

[20] For a summary and description of these core principles and Commission regulations, *see* 78 FR 50262–50263.

[21] *See* Committee on Payment and Settlement Systems and the Technical Committee of the

Continued

international standards most relevant to the risk management of SIDCOs.[22] The PFMIs set out 24 principles which address the risk management and efficiency of a financial market infrastructure's (''FMI'') operations.[23] Assessments of observance with the PFMIs focus also on the ''key considerations'' set forth for each of the principles.[24] While Subpart A and Subpart B of part 39 of the Commission's regulations incorporate the vast majority of the standards set forth in the PFMIs,[25] the Commission, which is a member of the Board of IOSCO, has an obligation under Section 805(a) of the Dodd-Frank Act to implement regulations relating to risk management that conform with applicable international standards. The PFMIs are such standards and, with this rulemaking, the Commission intends to adopt rules and regulations that are fully consistent with the standards set forth in the PFMIs by the end of 2013. To that end, the Commission has recognized that in certain instances, the standards set forth in the PFMIs may not be fully covered by the requirements set forth in Subpart A and Subpart B of part 39 of the Commission's regulations. Thus, this rulemaking revises Subpart C to address those gaps, specifically with respect to the following PFMI principles: Principle 2 (Governance); Principle 3 (Framework for the comprehensive management of risks); Principle 4 (Credit risk); Principle 6 (Margin); Principle 7 (Liquidity risk); Principle 9 (Money settlements); Principle 14 (Segregation and portability); Principle 15 (General business risk); Principle 16 (Custody and investment risks); Principle 17 (Operational risk); Principle 21 (Efficiency and effectiveness); Principle 22 (Communication procedures and standards); and Principle 23 (Disclosure of rules, key procedures, and market data).[26]

F. The Role of the PFMIs in International Banking Standards

The Commission notes that where a central counterparty (''CCP'') is not prudentially supervised in a jurisdiction that has domestic rules and regulations that are consistent with the standards set forth in the PFMIs, the implementation of certain international banking regulations will have significant cost implications for that CCP and its market participants. In July of 2012, the Basel Committee on Banking Supervision (''BCBS''),[27] the international body that sets standards for the regulation of banks, published the ''Capital Requirements for Bank Exposures to Central Counterparties'' (''Basel CCP Capital Requirements''), which sets forth interim rules governing the capital charges arising from bank exposures to CCPs related to OTC derivatives, exchange traded derivatives, and securities financing transactions.[28] The Basel CCP Capital Requirements create financial incentives for banks, including their subsidiaries and affiliates,[29] to clear financial derivatives with CCPs that are prudentially supervised in a jurisdiction where the relevant regulator has adopted rules or regulations that are consistent with the standards set forth in the PFMIs. Specifically, the Basel CCP Capital Requirements introduce new capital charges based on counterparty risk for banks conducting financial derivatives transactions through a CCP.[30] These incentives include (1) lower capital charges for exposures arising from derivatives cleared through a qualified CCP (''QCCP'') and (2) significantly higher capital charges for exposures arising from derivatives cleared through non-qualifying CCPs. A QCCP is defined as an entity that (i) is licensed to operate as a CCP, and is permitted by the appropriate regulator to operate as such, and (ii) is prudentially supervised in a jurisdiction where the relevant regulator has established and publicly indicated that it applies to the CCP, on an ongoing basis, domestic rules and regulations that are consistent with the PFMIs.[31]

The failure of a CCP to achieve QCCP status could result in significant costs to its bank customers. As one market participant noted, the ''ramifications for failure to achieve QCCP status are onerous for banks' CCP exposures and can result in capital charges on trade exposures that are 10–20 times larger than capital charges for QCCP trade exposures.'' [32] The increased capital charges for transactions through non-qualifying CCPs may have significant business and operational implications for U.S. DCOs that operate internationally and are not QCCPs. For instance, banks faced with such higher capital charges may transfer their clearing business away from such DCOs to a QCCP in order to benefit from the preferential capital charges provided by the Basel CCP Capital Requirements. Alternatively, banks may reduce or discontinue their clearing business altogether. Banks may also pass through the higher costs of transacting on a non-qualifying DCO that result from the higher capital charges to their customers. Accordingly, customers using such banks as intermediaries may transfer their business to an intermediary at a QCCP. In short, a DCO's failure to be a QCCP may cause it to face a competitive disadvantage in retaining members and customers.

International Organization of Securities Commissions, ''Principles for Financial Market Infrastructures,'' (April 2012) available at *http://www.iosco.org/library/pubdocs/pdf/IOSCOPD377.pdf. See also* the Financial Stability Board June 2012 Third Progress Report on Implementation, available at *http://www.financialstabilityboard.org/publications/r_120615.pdf* (Noting publication of the PFMIs as achieving ''an important milestone in the global development of a sound basis for central clearing of all standardised OTC derivatives'').

[22] In making this determination, the Commission noted that ''the adoption and implementation of the PFMIs by numerous foreign jurisdictions highlights the role these principles play in creating a global, unified set of international risk management standards for CCPs.'' *See* 78 FR 49666.

[23] *See id.,* ¶ 1.19.

[24] *See* Committee on Payment and Settlement Systems and the Board of the International Organization of Securities Commissions Principles for Financial Market Infrastructures: Disclosure Framework and Assessment Methodology (Dec. 2012) (hereinafter ''Disclosure Framework and Assessment Methodology''), available at *http://www.iosco.org/library/pubdocs/pdf/IOSCOPD396.pdf.*

[25] Indeed, Subpart A and Subpart B were informed by the consultative report for the PFMIs. *See generally* 76 FR 69334.

[26] For a summary and description of these principles, *see* 78 FR 50263–50266.

[27] The BCBS is comprised of senior representatives of bank supervisory authorities and central banks from around the world including, Argentina, Australia, Belgium, Brazil, Canada, China, France, Germany, Hong Kong SAR, India, Indonesia, Italy, Japan, Korea, Luxembourg, Mexico, the Netherlands, Russia, Saudi Arabia, Singapore, South Africa, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States. *See* Bank for International Settlements, Basel III: A Global Regulatory Framework for More Resilient Banks and Banking Systems, December 2010 (revised June 2011), available at *http://www.bis.org/publ/bcbs189.htm.*

[28] *See* ''Capital Requirements for Bank Exposures to Central Counterparties'' (July 2012), available at *www.bis.org/publ/bcbs227.pdf.* The Basel CCP Capital Requirements are one component of Basel III, a framework that ''is part of a comprehensive set of reform measures developed by the BCBS to strengthen the regulation, supervision and risk management of the international banking sector.'' *See* Bank for International Settlement's Web site for compilation of documents that form the regulatory framework of Basel III, available at *http://www.bis.org/bcbs/basel3.htm.*

[29] ''Bank'' is defined in accordance with the Basel framework to mean a bank, banking group or other entity (*i.e.* bank holding company) whose capital is being measured. *See* ''Basel III: A Global Regulatory Framework,'' Definition of Capital, paragraph 51. The term ''bank,'' as used herein, also includes subsidiaries and affiliates of the banking group or other entity. The Commission notes that a bank may be a client and/or a clearing member of a DCO.

[30] *See* Basel CCP Capital Requirements, Annex 4, Section II, 6(i). *See generally* 78 FR 50266–50267.

[31] *See* Basel CCP Capital Requirements, Section I, A: General Terms.

[32] CME at 5, n. 18.

G. New Regulations Applicable to SIDCOs and Subpart C DCOs

As described in detail in section II below, this final rulemaking includes a new defined term, a Subpart C DCO, to allow registered DCOs that are not SIDCOs to elect to become subject to the provisions in Subpart C of part 39 of the Commission's regulations (''Subpart C''). Further, this rulemaking revises Subpart C so that Subpart C applies to SIDCOs and Subpart C DCOs, and includes new or revised standards for governance, financial resources, system safeguards, default rules and procedures for uncovered losses or shortfalls, risk management, disclosure, efficiency, and recovery and wind-down procedures. These requirements address the remaining gaps between the Commission's regulations and the PFMI standards. Thus, Subpart C, together with the provisions in Subpart A and Subpart B, establish domestic rules and regulations that are consistent with the PFMIs. Because Subparts A, B, and C apply to SIDCOs and Subpart C DCOs on a continuing basis, SIDCOs and Subpart C DCOs should be QCCPs for purposes of the Basel CCP Capital Requirements.[33]

The Commission received twelve comment letters, nine of which commented on the Proposal.[34] All nine of these letters were generally supportive of the Proposal's goals. Given the importance of obtaining QCCP status for a U.S.-based DCO, the Commission requested comment on additional measures that the Commission should take to help ensure that Subpart C DCOs obtain QCCP status. MGEX responded by asserting that steps should be taken to ''ensure that the [Commission's] proposed regulations will be recognized by applicable regulators as being consistent with the PFMIs and that all DCOs subject to those regulations would be considered QCCPs in all relevant jurisdictions.'' [35] MGEX also requested that the Commission ''coordinate with other regulators'' to provide a ''uniform framework that recognizes the oversight provided by multiple regulatory jurisdictions so as not to unnecessarily burden DCOs with requirements established by multiple regulatory jurisdictions.[36] As noted in the Proposal, the Commission believes that the Subpart C regulations in combination with the provisions contained in Subpart A and Subpart B would establish domestic rules and regulations that are consistent with the PFMIs. Because SIDCOs and Subpart C DCOs would have the requirements of Subpart A, Subpart B and Subpart C applied to them on a continuing basis, such entities should qualify as QCCPs for purposes of the Basel CCP Capital Requirements.[37] In addition, the Commission notes that it actively coordinates with other domestic and international regulators informally, as required by applicable law (such as through the rulemaking consultation process under Title VIII), and through participation in several working groups and international organizations (such as IOSCO).[38] ISDA, which expressed support for the Commission's goal of implementing regulations for DCOs that are consistent with the PFMIs by the end of 2013, suggested that the Commission issue this rulemaking as an interim final rule ''so that market participants will have an opportunity to provide additional substantive comments.'' [39] The Commission declines to do so. As is the case with other regulations, part 39 of the Commissions regulations may be reviewed or revised by the Commission as necessary.

The following section will address discuss the comments received on specific aspects of the Proposal in connection with explaining each of the amended and new regulations adopted herein.

II. Discussion of Revised and New Regulations

A. Regulation 39.2 (Definitions)

The Commission proposed amending regulation 39.2 by revising one definition and adding six new defined terms. First, the Commission proposed a technical amendment to the definition of ''systemically important derivatives clearing organization.'' The definition had described a SIDCO as a registered DCO ''which has been designated by the [Council] to be systemically important . . .'' The proposed definition described a SIDCO as a registered DCO ''which is currently designated . . .''

Second, the Commission proposed to add a definition for the phrase ''activity with a more complex risk profile,'' to provide greater clarity as to the types of activities that would trigger a Cover Two financial resources requirement. The Commission proposed to define ''activity with a more complex risk profile'' to include clearing credit default swaps, credit default futures, and derivatives that reference either credit default swaps or credit default futures, as well as any other activity designated as such by the Commission. The phrase ''activity with a more complex risk profile'' currently appears in regulation 39.29 (Financial resources requirements), which the Commission proposed to revise and renumber as regulation 39.33.[40]

The Commission also proposed to add a definition for the term ''subpart C derivatives clearing organization.'' The proposed definition would include any registered DCO that is not a SIDCO and that has elected to become subject to Subpart C.

Finally, the Commission proposed to add definitions for ''depository institution,'' ''U.S. branch or agency of a foreign banking organization,'' and ''trust company.'' These terms are used in the provisions concerning liquidity set forth in paragraphs (c) and (d) of revised regulation 39.29, which the Proposal renumbered as regulation 39.33.[41] As proposed, a ''depository institution'' would have the meaning set forth in Section 19(b)(1)(A) of the Federal Reserve Act (12 U.S.C. 461(b)(1)(A)). A ''U.S. branch or agency of a foreign banking organization'' would mean the U.S. branch or agency of a foreign banking organization as defined in Section 1(b) of the International Banking Act of 1978 (12 U.S.C. 3101). A ''trust company'' would mean a trust company that is a member of the Federal Reserve System, under

[33] *See* QCCP definition *supra* Section I.F.

[34] All comment letters are available through the Commission's Web site at: *http://comments.cftc.gov/PublicComments/CommentList.aspx?id=1391.* Comments addressing the Proposal were received from the European Commission and the following parties: CME Group Inc. (''CME''); The Futures Industry Association (''FIA''); IntercontinentalExchange, Inc. (''ICE''); International Swaps and Derivatives Association Inc. (''ISDA''); LCH.Clearnet Group Limited (''LCH''); The Minneapolis Grain Exchange (''MGEX''); New York Portfolio Clearing LLC (''NYPC''); and Chris Barnard.

[35] MGEX at 6.

[36] *Id.* In addition, ISDA's comment letter addressed the Commission's examination of SIDCOs and Subpart C DCOs. Specifically, ISDA stated that revised Subpart C should specify whether the Commission will evaluate a SIDCO's or Subpart C DCO's compliance with Subpart C as part of its general rule enforcement review program, or whether SIDCOs and Subpart C DCOs will be subject to a more rigorous and more frequent (*e.g.,* annual) review process. ISDA at 4. This comment does not pertain to any of the proposed regulations and is, therefore, outside the scope of the Proposal. However, the Commission notes that Section 807(a) of the Dodd-Frank Act requires the Commission to examine a SIDCO at least once annually.

[37] 78 FR 50297.

[38] The Commission intends to cooperate with other regulators, both domestically and internationally, to foster efficient and effective communication and consultation so that we may support each other in fulfilling our respective mandates with respect to SIDCOs and Subpart C DCOs. *See* PFMIs, Responsibility E.

[39] ISDA at 1.

[40] *See* Section II.E., *infra.*

[41] *See id.*

Section 1 of the Federal Reserve Act (12 U.S.C. 221), but that does not meet the definition of ''depository institution.''

The Commission received only one comment on the substance of the proposed definitions. Chris Barnard stated that he approved of the fact that the definition of ''activity with a more complex risk profile'' includes credit default swaps and other activities designated as such by the Commission under regulation 39.33(a).

In addition, the Commission received a comment regarding the wording of a defined term. MGEX expressed concern regarding the title ''Subpart C DCO.'' Specifically, MGEX stated that the title ''itself implies to the public that the [Subpart C] DCO is of significantly lesser status'' as compared to a SIDCO.[42] MGEX requested that the Commission instead use the term ''Qualified Central Counterparty'' in its regulations and to define that term to include any DCO that is held to the standards set forth in Subpart C. The Commission declines to adopt this suggestion.

SIDCOs and registered DCOs that elect to opt-in to these heightened standards are not identically situated in that a SIDCO is required to comply with the standards set forth in Subpart C because of its importance to the US financial markets. In other words, a Subpart C DCO may rescind its election whereas a SIDCO may not. In addition, there may be circumstances in which the Commission may want to apply a particular regulation only to SIDCOs. For example, regulation 39.41, enacted pursuant to section 807c of the Dodd-Frank Act, grants the Commission special enforcement authority over SIDCOs, but not Subpart C DCOs. Moreover, SIDCOs are required to comply with regulation 40.10, enacted consistent with section 806 of the Dodd-Frank Act, which, among other things, requires them to provide notice to the Commission not less than 60 days in advance of proposed changes to their rules, procedures, or operations that could materially affect the nature or level of risks presented by the systemically important derivatives clearing organization. This requirement is not imposed on Subpart C DCOs. Thus, it is necessary and appropriate for the Commission to retain the ability to differentiate between SIDCOs and other registered DCOs in its regulations.

Moreover, as discussed below, MGEX and other commenters have noted that the proposed opt-in structure is important in that it allows registered DCOs that are not SIDCOs to be eligible for QCCP status. Once a Subpart C DCO successfully attains QCCP status, the Commission notes that, in general, its regulations do not prohibit a Subpart C DCO (or a SIDCO) from stating that it is a QCCP in its marketing materials. Indeed, the Commission expects that Subpart C DCOs would market themselves as QCCPs, which is why a Subpart C DCO is prohibited from marketing itself as a QCCP while in the process of rescinding its election.

For the reasons stated above, the Commission believes that the proposed revised and new definitions are appropriate and, therefore, is adopting them as proposed.

B. Regulation 39.30 (Scope)

The Commission proposed expanding regulation 39.28 (and renumbering it regulation 39.30) so that Subpart C would apply to SIDCOs and Subpart C DCOs. As described above, the rules proposed in Subpart C address the gaps between Commission regulations and the standards set forth in the PFMIs.[43] As such, a DCO that is subject to the requirements of Subpart A, Subpart B, and Subpart C should meet the requirements for QCCP status and benefit from the lower capital charges on clearing member banks and bank customers of clearing members for exposures resulting from derivatives cleared through QCCPs.[44] Such a DCO may also be viewed more favorably by potential members or customers of members in that it would be seen to be held to international standards.

The Commission requested comment on the proposed rules.

LCH and MGEX argued that the amended and new provisions of Subpart C should pertain to all registered DCOs. LCH asserted that the BCBS capital rules provide significant incentives for a DCO to meet the high standards embodied in the PFMIs or face the real risk that bank clearing members will cease to clear through them and therefore all DCOs should be required to comply with these standards.[45] MGEX argued that the Commission's proposed opt-in regime grants SIDCOs an unfair competitive advantage over other DCOs.[46] MGEX suggested that the Commission consider holding all registered DCOs to these higher standards and to provide an ''opt-out'' mechanism for those registered DCOs that are not SIDCOs that do not wish to attain QCCP status.[47] In addition, LCH and MGEX requested that, if the Commission elects to finalize the proposed regulations with the opt-in regime, DCOs be permitted to petition the Commission for additional time to comply with all of the Subpart C regulations.[48]

The Commission has decided to adopt regulation 39.30 as proposed. First, because of the potential benefits resulting from QCCP status, as described above, the Commission believes that a DCO that has not been designated to be systemically important should have the option to elect to become subject to Subpart C.[49] However, the Commission does not believe that a DCO that is not a SIDCO should be required to be held to Subpart C if it does not elect to because of the potential costs associated with compliance with these standards. In addition, and as discussed in more detail below, those DCOs that elect to be held to Subpart C may choose the effective date of their election. Because a Subpart C DCO is not required to comply with the regulations set forth in Subpart C until the specified effective date, a Subpart C DCO has a certain amount of control over the date on which it must comply with the Subpart C regulations.

Further, the Commission concludes that a SIDCO should be required to comply with revised Subpart C in order to maintain risk management standards that enhance the safety and efficiency of a SIDCO, reduce systemic risks, foster transparency, and support the stability of the broader financial system.[50] In order to support financial stability, a SIDCO must operate in a safe and sound manner. If it fails to measure, monitor, and manage its risks effectively, a SIDCO could pose significant risk to its participants and the financial system more broadly.[51] The Commission shares the stated objectives of the PFMIs, namely to enhance the safety and efficiency of FMIs and, more broadly, reduce systemic risk and foster transparency and financial stability.[52] As discussed in the Proposal, the PFMIs

[42] MGEX at 4.

[43] *See also supra* Section I.G.

[44] *See supra* Section I.F.

[45] LCH at 3.

[46] MGEX at 2–3.

[47] MGEX at 3.

[48] LCH at 3–4; MGEX at 4.

[49] As a technical matter, the Commission proposed to move existing paragraph (c) of renumbered regulation 39.30 (requiring a SIDCO to provide notice to the Commission in advance of any proposed change to its rules, procedures, or operations that could materially affect the nature or level of risks presented by the SIDCO, in accordance with the requirements of regulation 40.10) to proposed new regulation 39.42. Because the other provisions of proposed regulation 39.30 would pertain exclusively to the scope of Subpart C, it would be appropriate for existing paragraph (c) to be codified in a separate regulation. *See infra* Section II.N. for further detail.

[50] *See* SIDCO Final Rule (Discussion of risk management standards). *See also* Section 805(b) of the Dodd-Frank Act.

[51] *See supra* Section I.E.

[52] PFMIs ¶ 1.15.

have been adopted and implemented by numerous foreign jurisdictions.[53] The Commission notes that none of the commenters opposed holding all SIDCOs to the Subpart C regulations. The Commission believes that a global, unified set of international risk management standards for systemically important CCPs can help support the stability of the broader financial system. As such, for the reasons described above and in the Proposal, the Commission believes that SIDCOs should be required to comply with all of the requirements set forth in part 39 of the Commission's regulations, including the standards set forth in Subpart C, as revised herein.

C. Regulation 39.31 (Election to become subject to the provisions of Subpart C)

As discussed above and in the Proposal,[54] the Basel CCP Capital Requirements impose significantly higher capital charges on banks (including their subsidiaries and affiliates) that clear financial derivatives through CCPs that do not qualify as QCCPs (*i.e.,* CCPs that are licensed and supervised in a jurisdiction where the relevant regulator applies to the CCP, on an ongoing basis, domestic rules and regulations that are not consistent with the PFMIs).[55] Because such charges could create incentives for banks to migrate their business to CCPs that are QCCPs or to avoid clearing,[56] U.S. DCOs that operate internationally, but are not QCCPs, may face a substantial competitive disadvantage. The Subpart C requirements, as amended herein, address any remaining gaps between the Commission's existing regulations and the PFMI standards.[57] Accordingly, a DCO that is subject to the collective obligations contained in Subpart A, Subpart B and Subpart C should be a QCCP for purposes of the Basel CCP Capital Requirements.[58]

Regulation 39.31, as proposed, would provide a mechanism whereby a DCO that has not been designated by the Council as systemically important may elect to become subject to the provisions of Subpart C (*i.e.,* may ''opt'' to become subject to the regulations otherwise applicable only to SIDCOs) and, thereby, attain QCCP status, should the DCO individually determine that the benefits of achieving such status outweigh the costs associated with implementing the Subpart C regulations. The Commission also proposed procedures for withdrawing or rescinding that election.

The Commission received five comment letters regarding proposed regulation 39.31.[59] These comments generally supported the adoption of procedures that would provide non-SIDCO DCOs the opportunity to become QCCPs through adherence to an enhanced regulatory regime.[60] LCH, for example, ''strongly supported'' the adoption of ''heightened regulatory standards that would allow both SIDCOs and non-SIDCOs to be QCCPs.'' [61] The European Commission similarly stated that central counterparties ''that wish to operate under safer standards and compete on the basis of the quality of their risk-management . . . should not be prevented from doing so.'' [62]

MGX and LCH disagreed, however, with the proposed ''opt-in'' approach and suggested alternative means for achieving the Commission's objectives.[63] As mentioned above, both LCH and MGEX suggested that the Commission require all currently registered DCOs to be held to the enhanced regulatory requirements proposed to be applicable only to SIDCOs and Subpart C DCOs.[64] LCH asserted that ''it is important for all CCPs which clear swaps and other derivatives . . . to adhere to the higher standards.'' [65] MGEX claimed that requiring DCOs that have not been designated by the Council as systemically important to ''opt-in'' to Subpart C compliance is ''unnecessarily burdensome and discriminatory'' in comparison to the regulatory treatment of SIDCOs.[66] In support of its position, MGEX noted that SIDCOs will be held to the same standards as Subpart C DCOs, but will not be required to submit a Subpart C Election Form, or to otherwise engage in the Subpart C election process in order to become a QCCP.[67] MGEX contended that requiring all currently registered DCOs to be held to the enhanced regulatory regime would negate the need for a Subpart C Election Form and, therefore, would treat all DCOs identically in terms of their registration status and requirements, which would enable DCOs to spend the time that they would otherwise spend on preparing a Subpart C Election Form on ensuring their compliance with the Subpart C regulations.[68]

MGEX recognized, however, ''a number of potential issues'' with universal application of the Subpart C requirements.[69] For example, this proposed alternative, by itself, would not provide flexibility for DCOs that do not wish to be held to the higher standards and could require the Commission to expend ''considerable resources to verify compliance for each currently registered DCO shortly after implementation'' and to engage in the processes necessary to revoke the Subpart C DCO status of those DCOs that fail to satisfy the proposed regulations.[70] Both MGEX and LCH suggested alternatives. Specifically, these commenters recommended that the Commission replace the proposed ''opt-in'' regime with a regime under which the Subpart C standards would be applicable to all DCOs, but a DCO would be permitted to ''opt-out'' of the heightened standards, if it believed that attaining QCCP status was not important for its business.[71] Both entities recommended that the opt-out regime be accompanied by an extension of the compliance deadline [72] for all or some of the substantive proposed Subpart C regulations.[73] Specifically, LCH and MGEX voiced concern that it would be difficult or unlikely for non-SIDCO DCOs to satisfy the Subpart C election and implementation requirements necessary to achieve QCCP status prior

[53] *See* 78 FR 50260, 50268.

[54] *See* discussion of the role of the PFMIs in international banking standards *supra* Section I.F., 78 FR 50266–9.

[55] *See* Basel CCP Capital Requirements at Section I.A.: General Terms.

[56] As noted above, banks alternatively may reduce or discontinue their clearing business or pass through to their customers any higher costs of transacting through a DCO that is not a QCCP. *See* discussion of the role of the PFMIs in International Banking Standards *supra* Section I.F; 78 FR 50267, 50269.

[57] *See* discussion of the new regulations applicable to SIDCOs and Subpart C DCOs *supra* Section I.G.

[58] *Id.*

[59] Comments on proposed regulation 39.31 were received from the European Commission, FIA, ISDA, LCH and MGEX.

[60] *See, e.g.,* European Commission at 1, LCH at 2, MGEX at 1–2.

[61] LCH at 1. *See also* MGEX at 1 (''MGEX applauds the Commission for attempting to establish an avenue by which DCOs not designated as systemically important could qualify for [QCCP] status.'').

[62] European Commission at 1.

[63] *See* LCH at 2–4, MGEX at 2–6.

[64] *See* LCH at 3, MGEX at 3.

[65] LCH at 2.

[66] MGEX at 2.

[67] *Id.*

[68] MGEX at 3–4.

[69] MGEX at 3.

[70] *Id.*

[71] *See* LCH at 2–4, MGEX at 3–4.

[72] The Commission notes that, there is no general ''compliance deadline'' for non-SIDCO DCOs. While a non-SIDCO that wishes to become a Subpart C DCO must satisfy all of the Subpart C requirements (except the specific obligations for which the DCO is permitted to apply for additional time to comply) at the time it elects to become subject to Subpart C, a DCO is not required to make that election at any particular time or at all, unless it determines that the cost of such compliance is usurped by the benefits it would receive through Subpart C status.

[73] LCH at 2–4, MGEX at 3–4.

to December 31, 2013.[74] LCH specifically stated that additional time is necessary to come into compliance with the regulations ''governing financial resources, system safeguards, risk management, and recovery and wind-down plans.'' [75] Both MGEX and LCH commented on the particular difficulty of developing a recovery and wind down plan citing, respectively, the ''complexity and potential effects the contents of such a plan would have on the operation of a DCO'' [76] and the fact that the Commission has not previously proposed any requirements with respect to such plans.[77]

In support of their requests for additional time to comply with the Subpart C requirements, LCH and MGEX cited the time needed to identify gaps between their current rules and procedures and the Subpart C regulations, to implement any necessary changes to comply with the Subpart C regulations, and to prepare and submit their Subpart C Election Forms.[78] Both entities objected to the amount of time between the publication of the Proposal and the time when compliance will be required in order to qualify for QCCP status by the end of the 2013.[79]

MGEX also objected to the alleged disparate treatment afforded SIDCOs which ''have been able to prepare for compliance with the enhanced standards at least since the release of the PFMIs in April 2012.'' [80] In addition, LCH asserted that, as proposed, the Commission would be requiring Subpart C DCOs to come into compliance with all aspects of the PFMIS ''prior to many non-US CCPs.'' [81] LCH suggested that adopting the final regulations, but permitting compliance at a later date, would allow the Commission to adopt the PFMIs prior to the end of 2013 while, at the same time, providing DCOs with an ''ability to achieve QCCP status by the end of 2013.'' [82]

The Commission continues to believe that non-SIDCO DCOs that are willing and able to satisfy the enhanced regulatory requirements contained in Subpart C, should, when they are able to do so, be afforded the opportunity to attain QCCP status and to reap the benefits that may result from that designation [83] and that the application of Subpart C non-SIDCO DCOs that wish to become subject to regulations that are consistent with the standards set forth in the PFMIs helps promote the international consistency called for in Section 752 of the Dodd-Frank Act.[84] Commenters addressing proposed regulation 39.31 were unanimously supportive of this objective. Accordingly, the Commission has determined to adopt a regulatory framework that permits a DCO that has not been designated as systemically important by the Council to elect to become subject to the heightened standards set forth in Subpart C.

In response to the comments recommending that the'' Commission apply the regulatory requirements to all DCOs or employ an ''opt-out'' regime in lieu of the proposed ''opt-out'' procedures, the Commission notes that neither commenter advocating such alternatives provided any quantitative data or qualitative analyses of the costs and benefits of its suggested alternatives, particularly as compared to the Commission's Proposal. The Commission believes it would be inappropriate to adopt the proffered alternatives absent such analyses and without sufficient opportunity for the public to review and comment upon them.

The Commission also is concerned that an ''opt-out'' regime would unfairly shift certain costs associated with the Subpart C regulations to those non-SIDCO DCOs that do not intend to avail themselves of the opportunity to become QCCPs. Specifically, regulation 39.31, as proposed and finalized herein, would require only those non-SIDCO DCOs that wish to become subject to the Subpart C regulations (and to attain the benefits of QCCP status) to complete and file a Subpart C Election Form. Non-SIDCO DCOs that do not wish to become subject to the Subpart C regulations (nor to obtain the benefits of QCCP status) are not obligated to take any further action. In contrast, an ''opt-out'' regime would impose an obligation to file an opt-out application on those DCOs that do not intend to seek the benefit of QCCP status, while removing the Subpart C Election Form obligation from those DCOs that do.

In response to commenters' requests for additional time for Subpart C DCOs to comply with the new Subpart C regulations, and as discussed in more detail below, the Commission has determined that it would be appropriate to permit SIDCOs and Subpart C DCOs to request extensions of time to comply with the requirements for system safeguards, default rules and procedures for uncovered credit losses or liquidity, and recovery and wind-down plans contained in regulations 39.34, 39.35 and 39.39, respectively.[85] The Commission is declining, however, to permit requests from a DCO for, or to generally provide, a wholesale extension of time to comply with the new Subpart C regulations. Thus, a DCO seeking to become a Subpart C DCO will otherwise be required to be in compliance with the Subpart C regulations at the time it makes its

[74] LCH at 2, MGEX at 2. The Basel III Counterparty Credit Risk and Exposures to Central Counterparties-Frequently Asked Questions (''Basel III FAQs'') state that, if a CCP's primary regulator has publicly stated that it is working towards implementing regulations consistent with the PFMIs, then such CCP may be treated as a QCCP until December 31, 2013. After December 31, 2013, the Basel III FAQs state that the CCP's primary regulator must have implemented regulations consistent with the PFMIs and these regulations must be applied to the CCP on an ongoing basis in order for such CCP to be eligible for QCCP status. *See* Basel III FAQs, Question 5.6, available at: *http://www.bis.org/publ/bcbs237.pdf.*

[75] *See* LCH at 3, 4.

[76] MGEX at 4.

[77] *See* LCH at 3, 4.

[78] *See* LCH at 3, MGEX at 3.

[79] *See* LCH at 4, MGEX at 2.

[80] MGEX at 2.

[81] LCH at 4. In support of this assertion, however, LCH cites to just one aspect of the Subpart C requirements—the recovery and wind-down plans—which may not be required of certain EU CCPs in order to become and maintain QCCP status. Specifically, LCH asserts that ''CCPs in the European Union will not be required to provide recovery and wind-down plans to become and remain QCCPs as EMIR, which implements the PFMIs in Europe, does not include such a requirement. EU legislation implementing the recovery and wind resolution aspects of the PMIs is not expected to be proposed by the European Commission until early next year'' and ''implementation is unlikely before 2016 at the earliest.'' *Id.* LCH also notes that laws in some EU jurisdictions will require CCPs to have recovery plans prior to implementation of EU legislation. LCH at 4, n. 4. As noted below, the Commission will permit SIDCOs and Subpart C DCOs the opportunity to request that the Commission grant the SIDCO or Subpart C DCO an extension of the deadline with respect to recovery and wind-down plans for up to one year. *See infra* Section II.K. (Regulation 39.39 (Recovery and wind down for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)).

[82] *See* LCH at 2, 4. LCH claims that requiring a Subpart C DCO to comply with the Subpart C regulations by the end of 2013 would ''likely result in Subpart C DCO's not being able to achieve QCCP status prior to that time'' and that the failure of a Subpart C DCO to achieve QCCP status would put the Subpart C DCO at a completive disadvantage to non-QCCPs that are ''grandfathered'' as QCCPs. LCH at 2. As noted below, the Commission believes that permitting Subpart C DCOs a broad-based opportunity to delay compliance with the Subpart C regulations, as suggested by LCH, could put a DCO at greater risk of failing to obtain QCCP status.

[83] *See* 78 FR 50268–50269.

[84] *See* discussion of existing standards for SIDCOs *supra* Section I.C.

[85] *See infra* Section II.F. (Regulation 39.34 (System safeguards for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)), Section G (Regulation 39.35 (Default rules or procedures for uncovered credit losses or liquidity shortfalls (recovery) for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)), and Section II.K (Regulation 39.35 (Recovery and wind-down for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)).

Subpart C election. The new Subpart C regulations finalized herein seek to provide DCOs that have not been designated by the Council as systemically important the opportunity to qualify as QCCPs. Despite LCH's assertion to the contrary,[86] the Commission is concerned that a broad-based extension of the compliance deadline (in contrast to individually justified extensions with respect to particular requirements) would be more likely to jeopardize the ability of a Subpart C DCO to achieve QCCP status. As noted above, rules and regulations that are consistent with the PFMIs must be *implemented* by the end of 2013.[87] Moreover, as noted above, a QCCP is defined, in part, as a CCP that is prudentially supervised in a jurisdiction where the relevant regulator applies to the CCP, on an ongoing basis, domestic rules and regulations that are consistent with the PFMIs.[88]

The Commission further notes that a non-SIDCO DCO is obligated to comply with the Subpart C regulations only if—and when—the DCO affirmatively elects to become subject to such regulations, based upon its own examination of the benefits (including, but not limited to, the opportunity to attain QCCP status) and burdens thereof. No non-SIDCO DCO is obligated to elect to become a Subpart C DCO and thereby comply with the Subpart C regulations by December 31, 2013 or any other date unless it believes that it is prudent to do so in light of its particular business. The Commission stands ready to review the application of any DCO that is prepared to be held to the Subpart C standards, whether the DCO is prepared to do so on December 31, 2013 or any later date.

The Commission also disagrees with commenters' assertions that potential Subpart C DCOs have only recently been advised of the nature of the additional regulations to which they, if they choose, will be subject. The final PFMIs were published in April of 2012. In the same month, the Commission and other domestic financial regulators issued a joint press release explicitly notifying the public of the publication of the final PFMIs.[89] At a minimum, therefore, DCOs have been on notice of the specific requirements of the PFMIs since April 2012. Moreover, the Basel CCP Capital Requirements were published in July of 2012, and as mentioned above, the Basel FAQs, which were published in December of 2012, state that during 2013, if a CCP regulator has not yet implemented the PFMIs but has publicly stated that it is working towards implementing these principles, the CCPs that are regulated by the CCP regulator may be treated as QCCPs.[90] Thus, by December of 2012, DCOs were on notice of the preferential capital treatment that would result from becoming subject to regulations that are consistent with the PFMIs by the end of 2013.

1. Regulation 39.31(a)—Eligibility Requirements

Regulation 39.31(a), as proposed, set forth the two categories of entities that would be eligible to elect to become subject to the provisions in Subpart C. As proposed: (1) A DCO that is not a SIDCO could request such election using the procedures set forth in proposed regulation 39.31(b) and (2) an entity applying for registration as a DCO pursuant to regulation 39.3 (''DCO Applicant'') could request the election in conjunction with its application for registration (''Registration Application'') using the procedures set forth in proposed regulation 39.31(c). The Commission did not receive any comments specifically addressing proposed regulation 39.31(a). Accordingly, for the reasons cited in the Proposal,[91] the Commission is adopting regulation 39.31(a) as proposed.

2. Regulation 39.31(b)—Subpart C Election and Withdrawal Procedures for Registered DCOs

Regulation 39.31(b), as proposed, would establish the procedures by which a DCO that is already registered could elect to become subject to the provisions of Subpart C and the procedure by which the DCO could withdraw that election.[92] Comments generally addressing the Proposal to adopt regulations that would permit a DCO to elect to become subject to Subpart C (*i.e.,* comments on the ''opt-in'' regime) are discussed above.[93] In addition, the Commission received one comment referencing the Subpart C Election Form. MGEX asserted that the Commission should ''waive'' the Subpart C Election Form as ''it seems overly burdensome and costly for a currently registered DCO to be required to complete an entirely new application which calls for submission of the same or similar information and analysis that the DCO previously provided [in its DCO Application]''.[94] In support of this request, MGEX cites to a statement in the Proposal that the Commission ''anticipates considerable overlap between the information and documentation contained in the Registration Application files [sic] by a DCO Applicant and the information and documentation that would be required to be submitted to the Commission as part of the Subpart C Election Form.''[95] This reference is misplaced. The cited statement was made in the portion of the Proposal describing the proposed election and withdrawal procedures for new DCO applicants.[96] The ''overlap in information and documentation'' to which the Commission was referring is the overlap between the materials that would be submitted by *new* applicants for DCO registration in their DCO applications and the materials that a newly registered DCO would supply as part of a Subpart C Election Form submitted shortly thereafter.[97] In contrast, the information supplied by a currently registered DCO as part of the Form DCO that was filed when such DCO applied for registration is likely to be stale and would need to be updated.[98] Moreover, the Subpart C Election Form simply calls for the electing DCO to demonstrate its compliance with the requirements of Subpart C, with fairly minimal formatting requirements. The form is intended to provide the Commission, clearing members, and customers (and, significantly, the regulators of such

[86] Notwithstanding its timing concerns, LCH has indicated that it intends to ''take advantage of the Subpart C election process. LCH at 3.

[87] *See supra* n 91.

[88] *See supra* Section I.F. (The Role of the PFMIs in International Banking Standards).

[89] Joint Press Release, Board of Governors of the Federal Reserve System, the Commodity Futures Trading Commission and the Securities and Exchange Commission, CPSS–IOSCO Issue Final Report on Principles for Financial Market Infrastructures'' (April 16, 2012).

[90] Basel III FAQs at 23. In the Final SIDCO Rule the Commission explicitly advised the public of its intention toward implementing regulations that are fully consistent with the PFMIs by the end of 2013. *See* SIDCO Final Rule at 4966 (''Moreover, the Commission, which is a member of the Board of IOSCO, is working towards implementing rules and regulations that are fully consistent with the PFMIs by the end of 2013'').

[91] 78 FR 50298.

[92] 78 FR 50271, 50298–99.

[93] *See supra* Section II.C. (Regulation 39.31 (Election to become subject to the provisions of Subpart C)).

[94] MGEX at 5.

[95] MGEX at 5 (citing 78 FR 50271).

[96] 78 FR 50271.

[97] This distinction is even more important in the case of a clearing organization, such as MGEX, that was ''grandfathered in'' to DCO status under the Commodity Futures Modernization Act of 2000 (Pub. L. No. 106–554, 114 Stat. 2763, sec. 112(f) (adding sec. 5a(b) to the CEA) and thus never filed an application for registration as a DCO.

[98] *See* Subpart C Election Form, Exhibit Instructions at no 2, (''If the [DCO] is an *Applicant,* in its Form DCO, the [DCO] may summarize such information and provide a cross reference to the Exhibit in this Subpart C Election Form that contains the required information'' (emphasis added)).

clearing members and customers) with assurance that the electing DCO will be held to and will be required to meet the standards set forth in Subpart C.[99] Thus, the Commission continues to believe that it is necessary and appropriate to require DCOs electing to become subject to Subpart C to submit such information to the Commission.

MGEX further asserts that the Subpart C Election Form requirement puts Subpart C DCOs at a risk of ''delayed regulatory approval'' not borne by SIDCOs, which it claims are ''grandfathered in to Subpart C . . . due to their SIDCO status.'' [100] MGEX states that to ''ensure equal treatment'' among all DCOs, any requirements to provide information as part of the Subpart C election process should be imposed upon SIDCOs as well.[101] The Commission notes that SIDCOs, having been designated as systemically important by the Council, are subject to annual examinations under Title VIII and are, therefore, in a different position than DCOs that have not been so designated, but wish to elect to be held to the same international standards in an effort to attain QCCP status. The Commission also notes that SIDCOs, as well as Subpart C DCOs, are required by regulation 39.37, as finalized herein, to complete and publically disclose their responses to the Disclosure Framework.[102] As such, and since SIDCOs are required to be subject to the Subpart C regulations, the Commission does not feel it necessary to require SIDCOs to complete a Subpart C Election Form. In addition, because the Commission declines to require all DCOs to comply with the regulations in Subpart C, the Subpart C Election Form is necessary to provide a mechanism by which a registered DCO may elect to become subject to Subpart C.

In its comments on proposed regulation 39.37, MGEX also asserted that, while requiring the submission of a Quantitative Disclosure Document is ''consistent with the PFMIs,'' the Commission should delay implementation of this requirement until the Quantitative Disclosure Document is finalized in order to allow DCOs time to review and comment upon it or to otherwise prepare for compliance.[103] The Commission confirms that, as noted in the Subpart C Election Form, as proposed and finalized herein, completion and publication of the Quantitative Information Disclosure will not be required until the criteria for such disclosure has been finalized and published, which has not yet occurred.

Finally, MGEX responded to the Commission's request for comment[104] on whether or not the Commission should add a requirement that the certifications contained in the Subpart C Election Form be made under penalty of perjury. MGEX opposed the addition of this requirement.[105] The Commission notes that such a requirement would be inconsistent with the current Form DCO, which does not include a similar requirement. Therefore, the Commission has decided not to add a perjury certification to the Subpart C Election Form.

Accordingly, after careful review and consideration of the comments, and for the reasons cited above and set forth in the Proposal,[106] the Commission is adopting regulation 39.31(b) as proposed. The Commission has, however, altered the Subpart C Election Form in two respects.

As discussed further below,[107] DCOs that seek to become Subpart C DCOs (as well as SIDCOs) will be permitted to request an extension of up to one year to comply with any of the provisions of regulations 39.34, 39.35, or 39.39 pursuant to those regulations.[108] The Commission has determined that, to the extent that a DCO elects to request any such extensions, it must do so prior to filing the Subpart C Election Form and the General Instructions to the Subpart C Election Form have been modified accordingly.[109] The Commission also has made technical modifications to the certifications contained in the Subpart C Election Form to account for any extensions of time granted pursuant to regulation 39.34(d) and/or 39.39(f).

As noted in the Proposal,[110] the Commission emphasizes that, consistent with the certification required to be provided by a DCO as part of its Subpart C Election Form, a DCO, as of the date that its election to become subject to Subpart C becomes effective, would be held to the requirements of Subpart C. As of that date, the DCO would be subject to examination for compliance with Subpart C and to potential enforcement action for non-compliance. This status would continue until such time, if any, that the election is properly vacated as set forth in regulation 39.31(e), as finalized.[111] To the extent that compliance with Subpart C would require the DCO to implement new rules or rule amendments, all such rules or rule amendments must be approved or permitted to take effect prior to the effective date of the DCO's election.

3. Regulation 39.31(c)—Election and Withdrawal Procedures for DCO Applicants

Regulation 39.31(c), as proposed, sets forth procedures through which a DCO Applicant could request to become subject to the provisions of Subpart C at the time the DCO Applicant files its Registration Application. The Commission did not receive any comments specifically addressing proposed regulation 39.31(c).[112] Accordingly, for the reasons cited in the Proposal,[113] the Commission is adopting regulation 39.31(c) as proposed. In the interest of administrative economy, the Commission continues to encourage DCO Applicants to make their election to become subject to Subpart C at the time that their Registration Application is filed. Simultaneous filings would appear to allow Commission resources to be used more efficiently and effectively.

4. Regulation 39.31(d)—Public Information

Regulation 39.31(d), as proposed, would provide that certain portions of the Subpart C Election Form will be considered public documents that may routinely be made available for public inspection. The Commission did not receive any comments with respect to proposed regulation 39.31(d). Accordingly, for the reasons set forth in

[99] *See* 78 FR 50269.

[100] MGEX at 5.

[101] *Id.*

[102] *See supra* Section II.I. (Regulation 39.37 (Additional disclosure for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)).

[103] MGEX at 8–9.

[104] 78 FR 50272.

[105] MGEX at 5.

[106] 78 FR 50268–69.

[107] *See infra* at sections II.F. (Regulation 39.34—System Safeguards), II.G. (Regulation 39.35—Default Rules and Procedures), and II.K. (Regulation 39.39 (Recovery and Wind-Down).

[108] Regulation 39.34(d), as finalized herein, provides that the Commission may, upon request, grant a SIDCO or Subpart C DCO an extension of up to one year to comply with any of the provisions of regulation 39.34. Regulation 39.39(f), as finalized herein, similarly provides that a SIDCO or Subpart C DCO, upon request, may be granted an extension of up to one year to comply with the provisions of regulations 39.35 and 39.39. Any such requests made by a DCO seeking to become a Subpart C DCO will become part of that DCO's Subpart C Election Form.

[109] The Commission notes that it is not prescribing a particular time period elapse between the filing of applications for compliance extensions and the filing of the Subpart C Election Form.

[110] 78 FR 50269–50270.

[111] *See infra* Section II.C.5. (Regulation 39.31(e)—Rescission).

[112] *See supra* Section II.C. (Regulation 39.31 (Election to become Subject to Subpart C) for a discussion of comments regarding the proposed opt-in regime and process generally and the Subpart C Election Form.

[113] 78 FR 50271.

the Proposal,[114] the Commission is adopting regulation 39.31(d) as proposed.

5. Regulations 39.31(e)—Rescission

Regulation 39.31(e), as proposed, would permit a Subpart C DCO to rescind its election to comply with Subpart C by filing a notice of its intent to rescind the election with the Commission. Such rescission would, however, be subject to certain conditions. As proposed, the rescission of a DCO's election to become subject to Subpart C would become effective on the date specified by the Subpart C DCO in its notice of intent to rescind the Subpart C election, except that the rescission could not become effective any earlier than 90 days after the date the notice of intent to rescind is filed with the Commission. The Subpart C DCO would be required to comply with all of the provisions of Subpart C until such rescission is effective and the Commission would retain its authority concerning any activities or events occurring during the time that the DCO maintained its status as a Subpart C DCO.

Regulation 39.31(e), as proposed, also would require a Subpart C DCO that files a notice of intent to rescind to (1) provide specified notices to each of its clearing members, and to have rules in place requiring each of its clearing members to provide such notices to each of the clearing member's customers; (2) provide specified notices to the general public; and (3) remove references to its Subpart C DCO (and QCCP) status on its Web site and in other materials that it provides to its clearing members and customers, other market participants, or members of the public. In addition, the employees and representatives of the Subpart C DCO would be prohibited from making any reference to the organization as a Subpart C DCO (or QCCP) on and after the date that the notice of its intent to rescind is filed.

The Commission received two comments addressing proposed regulation 39.31(e). ISDA recommended that the Commission modify the proposed regulation to require, as a condition to a Subpart C DCO's rescission of its Subpart C election, ''to certify that it has obtained approval from clearing members (*e.g.,* by member ballot) to rescind the election.'' [115] In response to ISDA's suggestion, the Commission believes that this is a matter of corporate governance and the DCO should follow its own policies and procedures with respect to internal decisions regarding rescission. The Commission further notes that existing regulation 39.3(e) does not require a DCO to certify that it has obtained the approval of its clearing members to vacate its DCO registration prior to filing with the Commission a request to do so [116] and, thus, requiring the certification suggested by ISDA would be in tension with existing regulations. Accordingly, the Commission has declined to accept ISDA's recommendation.

FIA recommended that the Commission extend the time period between the date that a DCO files a notice of intent to rescind its election to be subject to Subpart C and the date that such rescission could become effective from 90 days to 180 days.[117] In support of its recommendation, the FIA agreed with the view voiced by the Commission in the Proposal [118] that a delay in the effective date of the rescission is necessary to provide banks and other entities that wish to limit their cleared transactions to clearing solely through a QCCP sufficient time to transfer their business to another Subpart C DCO or a SIDCO.[119] The FIA expressed concern, however, that the 90 day delay is insufficient ''to allow a clearing member to make a determination whether to withdraw as a clearing member and, if it elects to do so, notify its customers, find one or more clearing members prepared to accept each customer and allow the new clearing member and each customer to negotiate the terms of their agreement.'' [120] The Commission recognizes that the clearing members of a DCO that has filed a notice of intent to rescind its election to become subject to Subpart C may need additional time to determine and to effectuate the actions they may wish to take in light of such filing and believes that a 180 day waiting period until such rescission may become effective is reasonable. Accordingly, the Commission has decided to lengthen the minimum time period between the date a notice of intent to rescind an election to become subject to Subpart C is filed and the date that such rescission may become effective to 180 days. For the reasons cited above and set forth in the Proposal,[121] the Commission is adopting regulation 39.31(e) as proposed in all other respects.

6. Regulations 39.31(f)—Loss of SIDCO Designation

Regulation 39.31(f), as proposed, would provide that a SIDCO that is registered with the Commission, but whose designation of systemic importance is rescinded by the Council,[122] would immediately be deemed to be a Subpart C DCO. Such Subpart C DCO would be subject to the Subpart C provisions unless and until it elects to rescind its status as a Subpart C DCO. The Commission did not receive any comments on proposed regulation 39.31(f). Accordingly, for the reasons set forth in the Proposal,[123] the Commission is adopting regulation 39.31(f) as proposed.

7. Regulation 39.31(g)

Regulation 39.31(g), as proposed, provides that all forms and notices required by regulation 39.31 shall be filed electronically with the Secretary of the Commission in the format and manner specified by the Commission. The Commission did not receive any comments on proposed regulation 39.31(g) and, thus, is adopting the regulation as proposed.

D. Regulation 39.32 (Governance for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

The Commission proposed adding regulation 39.32 in order to implement DCO Core Principles O (Governance Fitness Standards), P (Conflicts of Interest), and Q (Composition of Governing Boards) for SIDCOs and Subpart C DCOs in a manner that would be consistent with PFMI Principle 2 (Governance).[124]

As discussed above, DCO Core Principle O states that each DCO must establish governance arrangements that are transparent to fulfill public interest requirements and to permit the

[114] *Id.*

[115] ISDA at 3–4.

[116] 17 CFR 39.3(e).

[117] FIA at 5.

[118] 78 FR 50272.

[119] FIA at 4.

[120] FIA at 4–5.

[121] 78 FR 50271–72.

[122] *See* 12 CFR 1320.13(b) (procedure for the Council to rescind a designation of systemic importance for a systemically important financial market utility).

[123] 78 FR 50272.

[124] In 2010 and 2011, the Commission proposed regulations concerning the governance of DCOs (the ''2010/2011 Proposals''). *See* Requirements for Derivatives Clearing Organizations, Designated Contract Markets, and Swap Execution Facilities Regarding the Mitigation of Conflicts of Interest, 75 FR 63732 (Oct. 18, 2010); *see also* Governance Requirements for Derivatives Clearing Organizations, Designated Contract Markets, and Swap Execution Facilities, 76 FR 722 (Jan. 8, 2011). The Commission notes that the regulations contained in the 2010/2011 Proposals are the subject of a separate rulemaking. The Commission is not addressing those regulations in this rulemaking.

consideration of the views of owners and participants.[125] DCO Core Principle O also requires each DCO to establish and enforce appropriate fitness standards for (i) directors, (ii) members of any disciplinary committee, (iii) members of the DCO, (iv) any other individual or entity with direct access to the settlement or clearing activities of the DCO, and (v) any party affiliated with any entity mentioned in (i)–(v) above. In addition, DCO Core Principle P requires each DCO to establish and enforce rules to minimize conflicts of interest in the decision making process of the DCO, and DCO Core Principle Q states that each DCO must ensure that the composition of the governing board or committee of the DCO includes market participants. These core principles are substantively similar to PFMI Principle 2, which states that a CCP ''should have governance arrangements that are clear and transparent, promote the safety and efficiency of [the CCP], and support the stability of the broader financial system, other relevant public interest considerations, and the objectives of relevant stakeholders.'' Additionally, under PFMI Principle 2, a CCP should have procedures for managing conflicts of interest among board members, and board members and managers should be required to have ''appropriate skills,'' ''incentives,'' and ''experience.'' [126]

As proposed, subsection (a) (General rules) would require a SIDCO or Subpart C DCO to establish governance arrangements that: (1) Are written, clear and transparent, place a high priority on the safety and efficiency of the SIDCO or Subpart C DCO, and explicitly support the stability of the broader financial system and other relevant public interest considerations; (2) ensure that the design, rules, overall strategy, and major decisions of the SIDCO or Subpart C DCO appropriately reflect the legitimate interests of clearing members, customers of clearing members, and other relevant stakeholders; and (3) disclose, to an extent consistent with other statutory and regulatory requirements on confidentiality and disclosure: (i) Major decisions of the board of directors to clearing members, other relevant stakeholders, and to the Commission, and (ii) Major decisions of the board of directors having a broad market impact to the public.[127]

As proposed, subsection (b) (Governance arrangements) would require the rules and procedures of a SIDCO or Subpart C DCO to: (1) Describe the SIDCO's or Subpart C DCO's management structure; (2) clearly specify the roles and responsibilities of the board of directors and its committees, including the establishment of a clear and documented risk management framework; (3) clearly specify the roles and responsibilities of management; (4) establish procedures for managing conflicts of interest among board members; and (5) assign responsibility and accountability for risk decisions and for implementing rules concerning default, recovery, and wind-down.

As proposed, subsection (c) (Fitness standards for the board of directors and management) would require that board members and managers have the appropriate experience, skills, incentives and integrity; risk management and internal control personnel have sufficient independence, authority, resources and access to the board of directors; and that the board of directors include members who are not executives, officers or employees of the SIDCO or Subpart C DCO or of their affiliates.

The Commission requested comment on proposed regulation 39.32 and asked that commenters include a detailed description of any alternatives to proposed regulation 39.32 and estimates of the costs and benefits of such alternatives. LCH commented that a SIDCO or Subpart C DCO should be permitted to petition the Commission for additional time to comply with new regulation 39.32 and with all other substantive regulations contained in this rulemaking. The Commission does not believe that a SIDCO or Subpart C DCO should be permitted to petition for additional time to comply with new regulation 39.32 for the reasons stated above.[128]

LCH also requested clarification as to which major decisions of the board of directors should be disclosed under new regulation 39.32(a)(3). LCH stated that a board may make a resolution that is not determinative, for example to commence exploratory negotiations for making an acquisition. LCH stated that it did not believe Principle 2 would require it to publish such a decision because Explanatory Note 3.2.18 to Principle 2 states that an FMI need not disclose a major decision where doing so would endanger commercial confidentiality. The Commission agrees with LCH that there is a distinction between exploratory negotiations and a final decision. The Commission also agrees with the suggestion made in Explanatory Note 3.2.18 that it is reasonable for a DCO to focus on disclosing the ''outcome'' of decisions made by the board rather than decisions that are not determinative. It should also be noted that paragraph (a)(3) does not require a disclosure that would compromise ''statutory and regulatory requirements on confidentiality and disclosure.''

Similarly, MGEX requested clarification as to: what qualifies as a ''major decision'' under proposed paragraph (a)(3); which ''information'' the Commission was referring to in footnote 137 of the Proposal; and whether the disclosure provision of paragraph (a) is intended to be a ''reiteration of existing law[s] or regulation[s].'' MGEX also suggested that paragraph (a) be amended to include a provision stating that a DCO may withhold disclosing a major decision of the board of directors if disclosing it would ''stifle candid board debate or endanger commercial confidentiality.'' The Commission agrees with MGEX that regulation 39.32 affords a DCO reasonable discretion in determining which decisions are ''major'' so as to warrant disclosure under paragraph (a)(3) and which decisions should not be disclosed due to concerns about confidentiality. Moreover, paragraph (a)(3) requires disclosure of ''decisions,'' rather than the debate preceding them. The Commission concludes that the language of proposed paragraph (a)(3) suffices in these regards.

ISDA commented that regulation 39.32 should address decision-making by a SIDCO or Subpart C DCO during a crisis or emergency. Specifically, ISDA suggests that there should be a provision requiring a SIDCO or Subpart C DCO to obtain the views and approval of member representatives (*e.g.* through the DCO's risk committee or otherwise) before taking any material action in response to an emergency. The Commission has decided not to include this requested provision because the Commission has decided not to impose requirements beyond those required by Principle 2 as part of this rulemaking.

Accordingly, the Commission has decided to finalize regulation 39.32 as proposed. The governance requirements set forth in the proposed regulation were designed to enhance risk management and controls by promoting fitness standards for directors and managers, promoting transparency of

[125] *See supra* Section I.D.

[126] PFMIs at Principle 2, K.C. 4–5.

[127] The provisions concerning transparency describe which information, including the identities of board members, should be disclosed to the public and/or the Commission.

[128] *See supra* Section II.C. (Regulation 39.31 (Election to become subject to the provisions of Subpart C)).

governance arrangements, and making sure that the interests of a SIDCO's or Subpart C DCO's clearing members and, where relevant, customers are taken into account. Because of the potential impact that a SIDCO's failure could have on the U.S. financial markets, the Commission believes that that these requirements should be applicable to SIDCOs. Moreover, it would be beneficial to Subpart C DCOs, their members and customers, and the financial system generally, for regulation 39.32 to apply to Subpart C DCOs.

E. Regulation 39.33 (Financial resources requirements for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

In August of 2013, the Commission finalized Regulation 39.29, which sets forth financial resource requirements for SIDCOs in a manner that parallels the financial resources standard in Principle 4 of the PFMIs.[129] The Commission proposed to amend regulation 39.29 to enhance financial resources requirements for SIDCOs and Subpart C DCOs and to achieve consistency with the relevant provisions of the PFMIs, in particular Principle 4 and Principle 7.

The Commission first proposed to renumber existing regulation 39.29 to 39.33 and to apply the requirements set forth therein to Subpart C DCOs. The Commission further proposed, for purposes of organization, deleting from paragraph (a)(1) the requirement that, where a clearing member controls another clearing member or is under common control with another clearing member, a SIDCO treat affiliated clearing members as a single clearing member (the ''Clearing Member Aggregation Requirement''). The Commission proposed to include such language in new paragraph (a)(4) to clarify that the Clearing Member Aggregation Requirement applies when a SIDCO or Subpart C DCO calculates its financial resources requirements under regulation 39.33(a) as well as its liquidity resources requirements under regulation 39.33(c).

The Commission also proposed amending paragraph (a) to state that the Commission shall, if it deems appropriate, determine whether a SIDCO or Subpart C DCO is systemically important in multiple jurisdictions. In making this determination, the Commission would, in order to limit such determinations to appropriate cases, review whether another jurisdiction had determined the SIDCO or Subpart C DCO to be systemically important according to a designations process that considers whether the foreseeable effects of a failure or disruption of the derivatives clearing organization could threaten the stability of each relevant jurisdiction's financial system. In addition, the Commission proposed amending paragraph (a) to state that the Commission shall also determine, if it deems appropriate, whether any of the activities of a SIDCO or Subpart C DCO, in addition to clearing credit default swaps, credit default futures, or any derivatives that reference either, has a more complex risk profile and that in making this determination, the Commission may take into consideration characteristics such as non-linear and discrete jump-to-default price changes.[130] The Commission also proposed amending paragraph (b) to clarify that the prohibition on including assessments as a financial resource applies to calculating financial resources needed to cover the default of the largest and, where applicable, second largest clearing member, in extreme but plausible circumstances.[131]

The PFMI Explanatory Notes explain that liquidity risk arises in an FMI (such as a DCO) when settlement obligations are not completed when due as part of its settlement process. Liquidity risk can arise in a number of ways: between an FMI and its participants, between an FMI and other entities (such as the FMI's settlement banks and liquidity providers), or between an FMI's participants.[132] The Commission proposed adding paragraphs (c), (d), and (e) to address the liquidity of SIDCOs' and Subpart C DCOs' financial resources. The liquidity resources discussed in paragraphs (c), (d), and (e) should be sufficient to address the different exposures to liquidity risk applicable to that DCO.

Under proposed paragraph (c)(1), a SIDCO or Subpart C DCO would be required to maintain eligible liquidity resources that will enable the SIDCO or Subpart C DCO to meet its intraday, same-day, and multiday settlement obligations, as defined in regulation 39.14(a), with a high degree of confidence under a wide range of stress scenarios, including the default of the member creating the largest liquidity requirements under extreme but plausible circumstances. Under proposed paragraph (c)(2), a SIDCO or Subpart C DCO would be required to maintain liquidity resources that are sufficient to satisfy the obligations required by new paragraph (c)(1) in all relevant currencies for which the SIDCO or Subpart C DCO has settlement obligations to its clearing members.

Under proposed paragraph (c)(3), a SIDCO or Subpart C DCO would be limited to using only certain types of liquidity resources to satisfy the minimum liquidity requirement set forth in proposed paragraph (c)(1).[133] Among these ''qualifying liquidity resources'' are ''committed lines of credit,'' ''committed foreign exchange swaps,'' and ''committed repurchase agreements.'' ''Committed'' is intended to connote a legally binding contract under which a liquidity provider agrees to provide the relevant liquidity resource without delay or further evaluation of the DCO's creditworthiness, *e.g.,* a line of credit that cannot be withdrawn at the election of the liquidity provider during times of financial stress, or in the event of the default of a member of the SIDCO or Subpart C DCO.[134]

Under proposed paragraph (c)(3)(ii), a SIDCO or Subpart C DCO would be required to take appropriate steps to verify that its qualifying liquidity arrangements do not include material adverse change provisions and are enforceable, and will be highly reliable, even in extreme but plausible market conditions.

Also consistent with Principle 7, under proposed paragraph (c)(4), if a SIDCO or Subpart C DCO maintains liquid financial resources in addition to those required to satisfy the Cover One requirement, then those resources should be in the form of assets that are likely to be saleable with proceeds available promptly or acceptable as collateral for lines of credit, swaps, or repurchase agreements on an *ad hoc* basis. In addition, Principle 7 provides and proposed paragraph 39.33(c)(4) requires that a SIDCO or Subpart C DCO should consider maintaining collateral with low credit, liquidity, and market

[129] *See* SIDCO Final Rule 78 FR 49666.

[130] The Commission's amendment to regulation 140.94(a) delegates the authority to make these determinations to the Director of the Division of Clearing and Risk.

[131] The preamble to the SIDCO Final Rule adopting release made clear that paragraph (b) applied to both Cover One and Cover Two, but the Commission has decided to add clarifying language to the regulation text. *See generally* SIDCO Final Rule.

[132] *See* PFMIs, E.N. 3.7.1.

[133] In determining whether the liquidity resources that are eligible under paragraph (c)(3) are sufficient in amount to meet the obligation specified under paragraph (c)(1) (resources that ''enable'' the DCO to meet its settlement obligations), it is important to avoid double counting. For example, one may not count both a committed repurchase arrangement and U.S. Treasury Bills that would be used to collateralize that arrangement.

[134] Times of financial stress and the event of the default of a member of the DCO are, of course, the times when reliable liquidity arrangements are most needed.

risks that is typically accepted by a central bank of issue for any currency in which it may have settlement obligations, but shall not assume the availability of emergency central bank credit as a part of its liquidity plan.[135]

Pursuant to proposed paragraphs (d)(1)–(2), a SIDCO or Subpart C DCO would be required to monitor its liquidity providers in a manner consistent with Principle 7. Proposed paragraph (d)(1) would define ''liquidity provider'' to mean any of the following: (i) A depository institution, a U.S. branch or agency of a foreign banking organization, a trust company, or a syndicate of depository institutions, U.S. branches or agencies of foreign banking organizations, or a trust companies providing a line of credit, foreign exchange swap facility or repurchase facility to the SIDCO or Subpart C DCO; and (ii) Any other counterparty relied upon by a SIDCO or Subpart C DCO to meet its minimum liquidity resources requirement under paragraph (c) of this section. In addition, proposed paragraph (d)(4) would require a SIDCO or Subpart C DCO to regularly test its procedures for accessing its liquidity resources. Finally, pursuant to proposed subsection (e) and consistent with Principle 4, a SIDCO or Subpart C DCO would be required to document its supporting rationale for, and have appropriate governance arrangements relating to, the amount of total financial resources it maintains pursuant to regulation 39.33(a) and the amount of total liquidity resources it maintains pursuant to regulation 39.33(c).[136]

The Commission requested comment on all aspects of proposed regulation 39.33. ISDA, MGEX and the European Commission each commented on paragraph (a)(1). ISDA requested clarification of the term ''credit exposure,'' which the Proposal used to replace the term ''financial obligation,'' which currently appears in regulation 39.29 (renumbered as regulation 39.33 as part of this rulemaking). In response to this comment, the Commission will revert to the term financial obligation.

MGEX requested clarification that a Subpart C DCO that is neither systemically important in multiple jurisdictions nor involved in activities with a more complex risk profile would be required to meet only the Cover One financial resources requirement,[137] not the Cover Two requirement.[138] The Commission notes that MGEX understood paragraph (a)(1) correctly, and the Commission believes that the language in paragraph (a)(1) is sufficiently clear.

The European Commission disagreed with the Commission's decision to require a SIDCO or Subpart C DCO to meet the Cover Two financial resources requirement only if it is systemically important in multiple jurisdictions or is involved in activities with a more complex risk profile. The European Commission suggested that all SIDCOs should be required to comply with the Cover Two requirement for the following reasons. First, any DCO that serves non-US clearing members or non-US trading venues is systemically important.[139] In addition, any DCO that is systemically important in the U.S. is systemically important internationally.[140] Second, requiring certain DCOs to meet the Cover One requirement while requiring other DCOs to meet the Cover Two requirement would be ''detrimental to the object of building equal conditions of fair competition'' between U.S.-registered DCOs and DCOs registered in other jurisdictions.[141] Third, banking regulators cannot deem various SIDCOs and Subpart C DCOs to all be QCCPs if some are required to meet the Cover One requirement while others are requirement to meet the Cover Two requirement.[142] Fourth, differing financial resources requirements would make the European Commission's equivalence assessment of U.S.-registered DCOs more difficult.[143] Fifth, it would be more prudent from a risk management perspective if the Cover Two requirement applied to all products and not only those ''with a more complex risk profile.'' [144]

The applicability of the Cover Two requirement in paragraph (a)(1) is consistent with Principle 4 of the PFMIs. Further, while the European Commission raises important points, further work would need to be done to consider the costs versus the benefits of imposing a Cover Two financial resources requirements on all DCOs regardless of whether that DCO was affirmatively found to be systemically important by the Council (or other jurisdictions) and regardless of the types of products that DCO clears. Nonetheless, the Commission notes that the two existing SIDCOs will, in fact, be subject to a Cover Two financial resources requirement.[145]

Chris Barnard commented that he supported the language of paragraph (a)(3) (determination of whether an activity has a more complex risk profile) and that it will appropriately result in higher financial resources requirements for such activities. Chris Barnard commented further that this should improve the robustness of a DCO's clearing system and help protect the financial system from contagion.[146]

With respect to proposed paragraph (c)(2)(satisfaction of settlement in all relevant currencies), LCH commented that it seeks confirmation that the provision is intended to pertain to ''material currencies only, which are indeed the ones [for which a liquidity shortfall would be] likely to disrupt the SIDCO's [or Subpart C DCO's] services and impact financial stability.'' [147]

There is no support for the implied assertions that a DCO could fail to meet its obligations in certain currencies on time without disrupting its services or impacting financial stability, and that a DCO could forgo arrangements to meet its obligations in certain currencies consistent with Principle 7. Any default by a DCO to meet its obligations on time would be likely to disrupt its services and impact financial stability. Thus, in this context, new paragraph (c)(2) covers those currencies for which the SIDCO or Subpart C DCO has obligations to perform settlements, as defined in § 39.14(a)(1), to its clearing members.

[135] It should be noted that the requirement of proposed paragraph (c)(4) that a SIDCO or Subpart C DCO *consider* maintaining certain types of collateral, like the requirement of proposed paragraph (c)(1)(ii), does not include a requirement as to the decision to be made following such consideration.

[136] This provision is consistent with PFMI Principle 4, K.C. 4.

[137] Regulation 39.11 requires DCOs to maintain financial resources sufficient to cover a wide range of potential stress scenarios, which include, but are not limited to, the default of the participant and its affiliates that would potentially cause the largest aggregate financial exposure to the CCP in extreme but plausible market conditions, otherwise known as ''Cover One.''

[138] The term ''Cover Two'' refers to the requirement that a DCO maintain financial resources sufficient to enable it to meet its financial obligations to its clearing members notwithstanding a default by the two clearing members creating the largest combined loss (which would include both proprietary and customer accounts) for the SIDCO in extreme but plausible market conditions.

[139] European Commission at 2.

[140] *Id.*

[141] *Id.*

[142] *Id.*

[143] European Commission at 2–3.

[144] European Commission at 3.

[145] As discussed in the final rule on Enhanced Risk Management Standards for Systemically Important Derivatives Clearing Organizations, ICE Clear Credit clears credit default swaps (which is a product with a more complex risk profile) and currently meets a Cover Two requirement. *See* 78 FR 49670. Further, CME Clearing currently sizes its guaranty fund for interest rate swaps and its guaranty fund for credit default swaps to a Cover Two standard, and is required to meet a Cover Two standard for its base guaranty fund pursuant to regulation 39.29(a) by the end of 2013 because its clears credit default swaps. *See* 78 FR 49671.

[146] Chris Barnard at 2.

[147] LCH at 5.

The Commission believes that this interpretation is consistent with Principle 7. To be sure, where an FMI's obligations in a particular currency are relatively small, the depth and complexity of the arrangements necessary to establish high reliability is likely proportionately less demanding.

In addition, with respect to proposed paragraph (c)(2), CME commented that it clears derivatives that settle in approximately 14 currencies and that it would be difficult to obtain committed credit facilities for currencies other than G–7 currencies.[148] For those other currencies, CME claimed that it would be forced to require a restrictive set of margin policies, including requiring a clearing member to post margin in the same currency as the settlement currency.[149] This, CME argued, would require CME's bank affiliated clearing members to face increased capital charges because it may be difficult for cash collateral in such currencies to receive bankruptcy remote treatment (and, therefore, a smaller capital requirement) unless such cash is posted with a central bank.[150]

As an initial matter, CME provided no support for the assertion that cash collateral would not be bankruptcy remote in the case of a DCO. To the contrary, section 761(10) of the Bankruptcy Code defines customer property to include both cash and securities, and 761(16) defines member property in terms of customer property. Section 766(i) provides that, in the case of the insolvency of a clearing organization, both customer and member property will be protected.[151] A SIDCO or Subpart C DCO will have discretion to determine the most efficient means of ensuring sufficient liquidity, which may include requiring (or incentivizing) members to post all or a part of their collateral in the settlement currency.

With respect to proposed paragraph (c)(3)(i)(E), CME commented that it is inconsistent with Principle 7 to require U.S. Treasury securities, which are held by a SIDCO or Subpart C DCO for purposes of meeting the minimum amount of liquidity resources required under proposed paragraph (c)(1), to be subject to ''committed'' funding arrangements.[152] CME commented that it interprets Principle 7 to require only ''investments'' to be subject to ''prearranged and highly reliable funding arrangements'' and not ''highly marketable collateral,'' of which U.S. Treasury securities are an example.[153]

CME stated further that the European Securities and Markets Authority (ESMA), the Monetary Authority of Singapore (MAS), and the Reserve Bank of Australia (RBA) have each taken a ''more flexible approach'' than proposed paragraph (c)(3)(i)(E) in interpreting the qualifying liquid resources provisions of Principle 7.[154] According to CME, these other regulators do not, in some cases, require highly marketable collateral such as U.S. Treasury securities to be subject to committed funding facilities.[155] In addition, CME stated that other regulators do not, in some cases, require highly marketable collateral to be subject to prearranged and highly reliable funding arrangements.[156]

ISDA commented that it would be neither necessary nor appropriate to require that U.S. Treasuries, used to satisfy the minimum liquid resources requirement, be subject to prearranged and highly reliable funding arrangements.[157] According to ISDA, such a requirement has the potential to exacerbate a liquidity crisis and pass on risk from the DCO to its liquidity providers.[158]

CME further argued that it would be unnecessary to require U.S. Treasury securities to be subject to committed funding arrangements because the U.S. Treasury market is the world's global standard for reliable liquidity and that same-day settlement of U.S. Treasury securities is reliably available in material sizes for a negligible yield concession of 1–2 basis points per annum.[159] CME noted that banks are permitted to classify U.S. Treasury securities as ''High Quality Liquid Assets'' (HQLA) under the Basel III capital rules. CME also stated that due to their robust liquidity and eligibility to be pledged at the Federal Reserve Bank discount window, U.S. Treasury securities are extremely safe for banks to accept under uncommitted repurchase agreements.[160]

CME also argued that there would be several negative consequences if the Commission required a DCO to arrange for U.S. Treasury securities to be subject to a committed funding arrangement.[161] First, CME stated that this provision would necessitate CME to limit the amount of U.S. Treasury securities a CME-clearing member could deposit to meet initial margin and guaranty fund obligations.[162] To compensate, the clearing members would have to deposit additional cash. CME argued that this would be detrimental to bank affiliated clearing members because the Basel III capital rules may require banks to take higher capital charges for cash collateral than for other types of collateral, including U.S. Treasury securities because cash collateral is not confirmed to be bankruptcy remote.[163] CME also stated that there would be difficulties establishing a committed liquidity facility for U.S. Treasury securities. CME asserted that the banks that are affiliated with CME clearing members are the best sources of such liquidity resources, and such banks may be prevented from participating in a large committed facility because of the risk that they would breach their single counterparty exposure limits under proposed Basel III capital rules. As a result, bank affiliated clearing members may reduce their customer clearing business, which could, in turn, increase costs to customers or prevent customers from taking advantage of the risk mitigating benefits of central clearing.[164]

Finally, CME suggested that the market for committed liquidity facilities may not be large enough to offer a facility that would enable CME to satisfy the proposed liquidity provisions of regulation 39.33(c). CME also discussed a cost estimate for establishing committed facilities. This cost estimate is addressed in the cost benefit considerations, below.[165]

FIA also commented that U.S. Treasury securities should be considered a qualifying liquid resource under paragraph (c)(3), even if they are not subject to funding arrangements in accordance with proposed subparagraph (E)(2).[166] FIA argued that, alternatively, subparagraph (E)(2) should permit a DCO to arrange for U.S. Treasury securities to be subject to uncommitted repurchase agreements. FIA supports CME's comment that U.S. Treasury securities are ''high quality liquid assets'' under BCBS standards and have remained highly liquid during times of stress.[167]

However, in appealing to the standards established by other jurisdictions, CME acknowledged that

[148] CME at 10.

[149] *Id.*

[150] *Id.*

[151] 11 USC 761(i).

[152] CME at 10.

[153] CME at 3–4.

[154] CME at 4.

[155] *Id.*

[156] *Id.*

[157] ISDA at 4.

[158] *Id.*

[159] CME at 7–8.

[160] CME at 8.

[161] CME at 9–12.

[162] CME at 10.

[163] CME at 9. As noted above, this assertion is unsupported, and is contradicted by Subchapter IV of Chapter 7 of the Bankruptcy Code.

[164] CME at 11.

[165] CME at 12–13. *See also* section IV.C., *infra.*

[166] FIA at 3–4.

[167] *Id.*

the EMIR Regulatory Technical Standards limit CCPs to ''count[ing] 'highly marketable financial instruments . . . that the CCP *can demonstrate* are readily available and convertible into cash on a same day basis using prearranged and highly reliable funding arrangements, including in stressed market conditions.' '' [168] Similarly, CME refers to United Kingdom requirements for a liquidity resource to be qualifying that include that the CCP needs to ''*demonstrate* its ability to liquidate the resource for same day cash.'' [169] The Commission agrees that the obligation of a SIDCO or Subpart C DCO with respect to highly marketable collateral will be to demonstrate that, as stated in subparagraph (E)(2), those assets are, in fact, readily available and convertible into cash pursuant to prearranged and highly reliable funding arrangements, even in extreme but plausible market conditions.

ISDA commented that proposed paragraph (c)(3)(ii), which requires a SIDCO or Subpart C DCO to take steps to verify that the prearranged and highly reliable funding arrangements for U.S. Treasury securities or other sovereign bonds do not include material adverse change provisions, is unnecessary because the PFMIs do not specifically require this.[170] ISDA also noted that credit arrangements generally include such clauses in order to protect the financial institution providing the credit, to protect that institution's shareholders, and to prevent the spread of risk from a DCO to financial institutions.[171]

In light of these comments, the Commission has decided to make minor revisions to the language in 39.33(c)(3)(E)(1) and (E)(2) to more closely align with the language used in key consideration 5 to Principle 7.

The purpose of the reference to the material adverse change clauses is to ensure that a SIDCO or Subpart C DCO not rely on a credit or liquidity arrangement that can be declined (*i.e.,* would not be reliably enforceable) at the very point in time when the DCO would, in fact, need to use the arrangement. In other words, these funding arrangements are intended to ensure that a SIDCO or Subpart C DCO will be able to meet its obligations when they come due even after a default in extreme but plausible conditions. If a funding arrangement includes a provision that there be no material adverse changes as a condition to draw, then such funding arrangement will not in fact serve its intended purpose. By contrast, a representation that there have been no material adverse changes for some period prior to execution of a liquidity arrangement, where the truth of such representation is not a condition to enforceability of the obligation to provide liquidity, would not be a condition that defeats the purpose of the liquidity arrangement. The Commission believes this interpretation is consistent with key consideration 5 of Principle 7, which states in relevant part that ''For the purpose of meeting its minimum liquid resource requirement, an FMI's qualifying liquid resources in each currency include . . . highly marketable collateral held in custody and investments that are readily available and convertible into cash with prearranged and highly reliable funding arrangements, even in extreme but plausible market conditions.''

Accordingly, the Commission has decided to modify paragraph (c)(3)(ii) to replace the phrase ''material adverse change clause'' with ''material adverse change condition'' and to add the ''even in extreme but plausible market conditions'' language from key consideration 5 to clarify this issue and to ensure consistency with Principle 7 with respect to this point.

With respect to proposed paragraph (c)(4), ISDA commented that if a SIDCO or Subpart C DCO maintains financial resources in an amount greater than the Cover One financial resources requirement, then the SIDCO or Subpart C DCO *should be required to* maintain collateral with a low credit risk to cover such greater amount.[172] ISDA also commented that the phrase ''with proceeds available promptly'' should be deleted because it does not appear in the PFMIs and is not clearly defined.[173] The Commission notes that the financial resources at issue in this paragraph are in excess of those required by Principle 7 and regulation 39.33(a). Therefore, the Commission believes it is appropriate for attendant requirements to be less stringent than those that apply to required financial resources. In addition, the requirement in paragraph (c)(4) that a SIDCO or Subpart C DCO *should consider* maintaining collateral with low credit risk for any excess financial resources is consistent with Principle 7. Moreover, the Commission disagrees with ISDA and believe that the concept of ''with proceeds available promptly'' is covered by, and consistent with, the PFMIs.

In response to the Commission's question as to whether proposed paragraph (d)(4) should specify the frequency with which a SIDCO or Subpart C DCO must test its procedures for accessing liquidity resources, MGEX commented that it believes the proposed language is sufficient.[174] MGEX commented that the proposed language appropriately affords a DCO the discretion to determine the frequency of testing its procedures for accessing liquidity resources.[175] MGEX stated that a DCO is in the best position to determine this frequency and that unnecessary, redundant testing would cause a DCO to incur unnecessary costs.[176]

The Commission has decided to finalize regulation 39.33 as modified above. New paragraphs (c), (d), and (e) are intended to address the gaps between current part 39 requirements and standards set forth in Principle 7.[177] The Commission believes these new provisions are appropriate and will reduce risk for SIDCOs and Subpart C DCOs, their clearing members, and customers of clearing members. In particular, new paragraph (c)(1) will help prevent a SIDCO or Subpart C DCO from defaulting on its obligations to non-defaulting clearing members, which is particularly important for a SIDCO because of the potential impact that the failure of a SIDCO could have on the U.S. financial markets, because

[168] CME at 6, *quoting* European Market Infrastructure Regulation Regulatory Technical Standards, Article 33 (emphasis supplied here).

[169] CME at 6 (emphasis supplied).

[170] ISDA at 4.

[171] *Id.*

[172] *Id.*

[173] ISDA at 4–5.

[174] MGEX at 7.

[175] *Id.*

[176] *Id.*

[177] Principle 7, K.C. 2 requires a CCP to measure, monitor, and manage liquidity risk effectively. This includes the CCP maintaining sufficient liquid resources in all relevant currencies in order to effect same-day and, where applicable, intraday and multiday settlement of payment obligations in a wide range of potential stress scenarios, including the default of the participant that would create the largest aggregate payment obligations in extreme but plausible market conditions. In addition, Principle 7, K. C. 5 limits a CCP to counting only certain qualifying liquid resources for the purpose of meeting its financial resources requirement. These resources include: cash in the currency of the requisite obligations, held either at the central bank of issue or at a creditworthy commercial bank; committed lines of credit; or high quality, liquid, general obligations of a sovereign nation. In addition, Principle 7, K. C. 4 states that a CCP that is systemically important in multiple jurisdictions or that is involved in activities with a more complex risk profile should consider maintaining sufficient qualifying liquid resources to meet the default of the two participants that would create the largest aggregate payment obligations in such circumstances. Principle 7, K. C. 7 also requires a CCP to monitor its liquidity providers, including clearing members, by undertaking due diligence to confirm that they have sufficient information to understand and manage their liquidity risks and have the capacity to perform as required under their commitments to the CCP.

maintaining resources that enable the DCO to meet its intraday, same-day, and multiday settlement obligations. New paragraph (c)(2) will require a SIDCO to meet its obligations in each relevant currency in a timely manner. This is important because if a SIDCO has sufficient funds to meet an obligation, but the funds are not in the correct currency, then the SIDCO cannot meet that obligation in a timely manner, which could lead to a disruption of the SIDCO's services. Such disruption could, in turn, have a significant impact on the financial stability of the U.S. economy.

New paragraph (c)(1)(ii) will require a SIDCO or Subpart C DCO that is systemically important in multiple jurisdictions, or that is involved in activities with a more complex risk profile, to *consider* maintaining certain eligible liquidity resources that, at a minimum, will enable it to meet its intraday, same-day, and multiday settlement obligations, stress scenarios that include a default of the two clearing members creating the largest aggregate liquidity obligation for the DCO in extreme but plausible market conditions. The proposed list of these resources is consistent with those set forth in Principle 7. The financial integrity of a SIDCOs and or Subpart C DCOs might be enhanced if it *considers* meeting this enhanced standard. The provisions of new paragraph (c)(4) (pertaining to, among other issues, the liquidity of financial resources held in addition to those financial resources required by the Cover One standard) are designed to enhance the financial condition of SIDCOs and Subpart C DCOs and help reinforce stability.[178]

F. Regulation 39.34 (System safeguards for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

In August of 2013, the Commission finalized regulation 39.30, which enhanced system safeguards requirements for SIDCOs with respect to business continuity and disaster recovery, and included a two-hour recovery time objective (''RTO'').[179] As discussed in the adopting release, the two-hour RTO is consistent with Principle 17 of the PFMIs and increases the soundness and operating resiliency of the SIDCO, which in turn, increases the overall stability of the U.S. financial markets.[180] The Commission proposed renumbering regulation 39.30 as regulation 39.34 and amending the regulation to cover Subpart C DCOs in addition to SIDCOs. The Commission also made a technical correction to paragraph (b) to make clear that subparagraphs (1), (2), and (3) concern each activity necessary for the daily processing, clearing, and settlement of existing and new contracts. Finally, the Commission proposed amending the regulation to allow the Commission to, upon request, grant newly designated SIDCOs and Subpart C DCOs up to one year to comply with the provisions of regulation 39.34.[181]

MGEX commented that it ''appreciates the additional time granted for complying'' with regulation 39.34.[182] The Commission notes that MGEX's statement implies an automatic compliance extension, which is inaccurate because regulation 39.34(d) permits a SIDCO or Subpart C DCO to *request* that the Commission grant it up to one year to comply with regulation 39.34. In reviewing such requests, the Commission will be attentive to whether the DCO has a well-developed plan to comply with the requirement by the end of the requested extension, with reasonable milestones that can be monitored by the Commission. MGEX also commented that it would like flexibility in developing a business continuity and disaster recovery plan.[183] MGEX stated that the regulation would require it to hire three or four new employees outside of Minneapolis, which would be very costly.[184] MGEX suggested it would be less costly to comply with the regulation if it outsourced its business continuity compliance, but it does not wish to do that because employees, rather than contractors, are more likely to act in the best interests of MGEX.[185]

First, the Commission notes that to facilitate the two-hour RTO, regulation 39.34 specifically requires a SIDCO or Subpart C DCO to maintain personnel, who live and work outside the relevant area of the physical and technological resources the SIDCO or Subpart C DCO normally relies upon to conduct its clearing activities. This requirement might be met in a number of ways. As MGEX notes, one way is to engage outsourced personnel. An alternative would be to base employees at a geographically diverse location. In general, a SIDCO or Subpart C DCO does have flexibility in designing its business continuity and disaster recovery plan, although such plan must comply with the requirements set forth in regulation 39.34 as well as any other applicable Commission regulations. The Commission expects all SIDCOs and Subpart C DCOs to fully comply with these, and all other applicable, regulations, and anticipates that a registered DCO would carefully weigh any costs associated with compliance with Subpart C prior to electing to become subject to Subpart C. Second, the proposed amendment to allow the Commission, upon request, to grant newly designated SIDCOs and Subpart C DCOs up to one year to comply with the provisions of regulation 39.34 was intended to provide flexibility to address the time practically required to obtain the necessary physical and technological resources, and to organize human resources, as appropriate to implement a two-hour RTO. As such, the Commission has decided to finalize regulation 39.34 as proposed.

G. Regulation 39.35 (Default rules and procedures for uncovered credit losses or liquidity shortfalls (recovery) for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

The Commission proposed regulation 39.35 in order to add requirements pursuant to DCO Core Principle G, to address certain potential gaps between Commission regulations and Principles 4 and 7.[186] Regulation 39.16 currently requires a DCO to adopt procedures permitting it to take timely action to contain losses and liquidity pressures and to continue meeting its obligations in the event of a default on the obligations of a clearing member to the

[178] *See generally* Financial Stability Oversight Council 2012 Annual Report, Appendix A at 163 (finding that ''the contagion effect of a CME failure could impose material financial losses on CME's clearing members and other market participants (such as customers) and could lead to increased liquidity demands and credit problems across financial institutions, especially those that are active in the futures and options markets.'').

[179] *See* SIDCO Final Rule 78 FR 49672–49674.

[180] *Id.*

[181] In response to comments received, regulation 39.39, as finalized herein, will permit the Commission, upon request, to grant newly designated SIDCOs and Subpart C DCOs up to one year to comply with the provisions of regulation 39.35 and 39.39. To harmonize regulation 39.34 with this revision, the Commission has determined to make a technical correction to proposed regulation 39.34 that replaces the phrase ''upon application'' with the phrase ''upon request.''

[182] MGEX at 7.

[183] *Id.*

[184] *Id.*

[185] *Id.*

[186] DCO Core Principle G requires a DCO to have rules and procedures ''designed to allow for the efficient, fair, and safe management of events during which [clearing] members or participants—(I) become insolvent; or (II) otherwise default on the obligations of the members or participants to the [DCO].'' Each DCO ''is required to (I) clearly state the default procedures on the [DCO]; (II) make publicly available the default rules of the [DCO]; and (III) ensure that the [DCO] may take timely action—(aa) to contain losses and liquidity pressures; and (bb) to continue meeting each obligation of the DCO.'' *See supra* Section I.D. and 78 FR 50263.

DCO.[187] Under proposed regulation 39.35, SIDCOs and Subpart C DCOs would be required to adopt additional procedures to address certain issues arising from extraordinary stress events, including the default of one or more clearing members. Specifically, consistent with Principle 4 of the PFMIs, proposed paragraph (a) would require a SIDCO or Subpart C DCO to adopt rules and procedures addressing the following:

1. How the SIDCO or Subpart C DCO would allocate losses exceeding the financial resources available to the SIDCO or Subpart C DCO;
2. How the SIDCO or Subpart C DCO would arrange for the repayment of any funds the SIDCO or Subpart C DCO may borrow; and
3. How the SIDCO or Subpart C DCO would replenish any financial resources it may employ during such a stress event, so that the SIDCO or Subpart C DCO would be able to continue to operate in a safe and sound manner.

Consistent with Principle 7 of the PFMIs, proposed paragraph (b) would require a SIDCO or Subpart C DCO to establish rules and procedures enabling it to promptly meet all of its settlement obligations, on a same day and, where appropriate, on an intraday and multiday basis, in the context of the occurrence of either or both of the following scenarios: (i) Following an individual or combined default involving one or more clearing members' obligations to the SIDCO or Subpart C DCO or (ii) if there is an unforeseen liquidity shortfall exceeding the financial resources of the SIDCO or Subpart C DCO. Such rules and procedures should be established *ex ante* and may provide for the means of: Increasing available assets (*e.g.* by using assessments) and/or reducing the size of liabilities (*e.g.* by engaging in variation margin haircuts or tear-ups); as well as obtaining liquidity from participants (*e.g.* through rules-based repurchase arrangements); employing a sequenced application of such tools; and replenishing any credit and liquidity resources that may be employed during a stress event.

The Commission requested comment on all aspects of these proposals. MGEX requested additional time to comply with regulation 39.35, along the lines of proposed regulation 39.34(d), which permits a SIDCO or Subpart C to request that the Commission grant the SIDCO or Subpart C DCO additional time of up to one year to comply with regulation 39.34. MGEX commented that it would be very difficult, if not impossible, to perform the analyses required to satisfy regulation 39.35 by December 31, 2013. The Commission agrees and has decided to permit a SIDCO or Subpart C DCO to request up to a one year extension to comply with regulation 39.35.[188]

The Commission notes that regulation 39.35 was designed to protect SIDCOs, Subpart C DCOs, their clearing members, customers of clearing members, and the financial system more broadly by requiring SIDCOs and Subpart C DCOs to have plans and procedures to address credit losses and liquidity shortfalls beyond their prefunded resources, thus promoting their ability to promptly fulfill their obligations and continue to perform their critical functions. As proposed, regulation 39.35 addresses significant consequences that could result from a clearing member's default. Specifically, a DCO might not have sufficient financial resources following a clearing member's default either to cover the default or to fulfill its settlement obligations. Similarly, a DCO may be unable to fulfill its settlement obligations due to a liquidity shortfall exceeding its financial resources. In order to avoid the negative effect on its clearing members, their customers, and on the financial system more broadly of a DCO's failure promptly to meet its settlement obligations, it would be prudent for a DCO to have a recovery plan that addresses these scenarios and, given their importance to the U.S. financial system, it is critical for SIDCOs to have such plans. In addition, because this plan would be specified in the DCO's rules and/or procedures, it would be disclosed to clearing members, their customers, and the broader public. Such transparency would likely help clearing members, their customers, and other market participants properly allocate capital and other resources as well as facilitate the development of their own recovery plans.

For the reasons set forth above and in the Proposal, the Commission has decided to finalize regulation 39.35 substantively as proposed but will permit a SIDCO or Subpart C DCO to request that the Commission grant up to a one year extension to comply with regulation 39.35 and regulation 39.39, as discussed below.[189]

H. Regulation 39.36 (Risk management for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

As proposed, regulation 39.36 would establish additional risk management requirements for SIDCOs and Subpart C DCOs. Current regulation 39.13 establishes the risk management requirements that a DCO must meet in order to comply with Core Principle D[190] including, among other things, specific criteria for stress tests that a DCO must conduct.[191]

The Commission proposed regulation 39.36 in order to address certain gaps between Commission regulations and Principles 4, 6, 7, and 9.[192] In particular, proposed regulation 39.36 would require a SIDCO or Subpart C DCO to enhance its stress testing procedures in ways that will make it more likely that the SIDCO or Subpart C DCO will be able to understand the risks posed by its members, so that it can ensure that the relationship between its resources and obligations enables it to meet its obligations promptly.

The Commission requested comment on all aspects of proposed regulation 39.36.

MGEX, the European Commission, and Chris Barnard commented on proposed regulation 39.36(a)(stress tests of financial resources). MGEX stated that the regulation should permit a SIDCO or Subpart C DCO to have the flexibility to use stress test parameters that can be justified by relevant data and to select relevant time periods to review when conducting stress tests.[193] DCOs do have such flexibility, so long as the

[187] 17 CFR 39.16(c).

[188] The Commission has delegated authority to approve such requests. *See* Section II.O. (discussion of regulation 140.94) *infra.*

[189] *See* new paragraph (f) of regulation 39.39 and Section II.K., *infra* (discussing regulation 39.39).

[190] *See* 78 FR 50262–50263. DCO Core Principle D requires each DCO to possess the ability to manage the risks associated with discharging the responsibilities of the DCO through the use of appropriate tools and procedures. It further requires each DCO to measure its exposure to loss from the default of each clearing member not less than once during each business day and to monitor each such exposure periodically during the business day. Core Principle D also requires each DCO to limit its exposure to potential losses from defaults by clearing members, through margin requirements and other risk control mechanisms, to reduce the risk that its operations would not be disrupted and that non-defaulting clearing members would not be exposed to losses that non-defaulting clearing members cannot anticipate or control. Finally, Core Principle D requires that the margin that the DCO requires from each clearing member be sufficient to cover potential exposures in normal market conditions, and that each model and parameter used in setting such margin requirements be risk-based and reviewed on a regular basis.

[191] *See supra* Section I.D. Moreover, such stress tests should enable the SIDCO or Subpart C DCO to address procyclicality initial margin requirements and collateral haircuts, consistent with Principle 6, K.C. 3 and Principle 5, K.C. 3.

[192] *See* discussion of Principles 4 and 6 *supra* Section I.E.1.

[193] MGEX at 8.

meet the performance standards set forth in the regulation.

The European Commission stated that regulation 39.36 should be more detailed in order to set a meaningful benchmark for all SIDCOs and Subpart C DCOs.[194] For example, the European Commission suggests that SIDCOs and Subpart C DCOs should be required to conduct an assessment of the theoretical and empirical properties of the margin model and that such requirement, should prescribe minimum liquidation periods for each type of product.[195] The European Commission noted that explanatory note 3.6.7 to Principle 6 states that ''close-out periods should be set on a product-specific basis'' because less liquid products may require longer close-out periods.[196] The European Commission opined that there should be a minimum liquidation period of two-days for ''listed derivatives'' (*i.e.,* futures and options) rather than the one-day minimum prescribed in current regulation 39.13(g)(2)(ii)(A).[197] The European Commission also stated more generally that its rules and this Commission's rules diverge in the area of initial margin requirements and that this divergence ''is a source of competitive distortion between the E.U.- and U.S.-listed derivative markets as well as a threat to global financial stability.'' [198] The European Commission also stressed that this Commission's risk management rules should do more to ''mitigate the pro-cyclicality inherent to initial margin.'' [199]

Regulation 39.13(g)(2) already sets out minimum liquidation times for swaps, futures, and swaps on agricultural commodities, energy commodities, and metals. In addition, pursuant to regulation 39.13(g)(2), a DCO is already required to use ''[s]uch longer liquidation time as is appropriate based on the specific characteristics of a particular product or portfolio'' and the Commission expressly reserved the right to establish, by order, shorter or longer liquidation times for particular products or portfolios. Moreover, under that regulation, all DCOs are obligated to consider the appropriateness of liquidation times in light of the specific characteristics of particular products or portfolios. Reg. 39.36(b)(2)(i) has been amended to clarify this point with respect to SIDCOs and Subpart C DCOs.

Chris Barnard suggested that DCOs should be required to stress test the liquidity of its financial resources in such a way that considers market stress, idiosyncratic stress, combinations thereof.[200] In addition, Chris Barnard stated that assets used to offset projected funding needs should be discounted to reflect their credit risk and market volatility.[201] In response, the Commission notes that regulation 39.36(a), as proposed, would require a SIDCO or Subpart C DCO to address these topics.

With regard to paragraph (c)(6) (reporting stress test results to the risk management committee or board of directors), MGEX suggested that this provision should be amended to permit the reporting of high-level summaries, redacted versions, or subsets of stress test results.[202] Otherwise, MGEX stated that this provision would create conflicts of interest because stress test results reveal confidential information about MGEX clearing members, and members of the MGEX risk management committee or board of directors may also be MGEX clearing members.[203] The Commission expects that stress-tests will be reported to the board of directors at a summary level. In complying with new paragraph (c)(6), a DCO should structure its reporting and governance arrangements in such a way that balances effective governance and risk management with confidentiality considerations.

With respect to proposed regulation 39.36(e) (annual validation of financial and liquidity risk management models), Chris Barnard commented that persons responsible for the development, implementation, or operation of the systems and models being tested not carry out the annual validation.[204] The Commission agrees that would be a prudent aspect of an appropriately designed validation process.

The Commission has decided to finalize regulation 39.36 as amended with the clarification discussed above for the reasons discussed above and in the Proposal.

I. Regulation 39.37 (Additional disclosure for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

The Commission proposed regulation 39.37 to set forth additional public disclosure requirements for SIDCOs and Subpart C DCOs.[205] These requirements were intended to address differences between current requirements and PFMI Principles 14 and 23. In particular, proposed regulation 39.37 was designed to enable members of SIDCOs and Subpart C DCOs, their customers, and the general public to understand the risk of exposures to such DCOs, and to promote their ability to evaluate the quality of such DCOs, thereby enhancing competition and market discipline.

Specifically, proposed regulation 39.37 would require SIDCOs and Subpart C DCOs to disclose certain information to the public and to the Commission. First, consistent with Principle 23, a SIDCO or Subpart C DCO would be required to disclose its responses to the CPSS–IOSCO Disclosure Framework.[206] Further, to ensure the continued accuracy and usefulness of a SIDCO or Subpart C DCO's responses, a SIDCO or Subpart C DCO would be required to review and update them (a) at least every two years and (b) following material changes to the SIDCO's or Subpart C DCO's system or its environment.[207] A material change to the SIDCO's or Subpart C DCO's system or environment is a change that would significantly change the accuracy and usefulness of the SIDCO's or Subpart C DCO's existing responses. Under proposed regulation 39.37(c), a SIDCO or Subpart C DCO would also be required to disclose, publicly and to the Commission, relevant basic data on transaction volume and values. This requirement is intended to be consistent with the Quantitative Information Disclosure that CPSS–IOSCO are in the process of developing.[208]

Also under proposed regulation 39.37, a SIDCO or Subpart C DCO would be required, consistent with Principle 14, to publish its rules, policies, and procedures describing whether customer funds are protected on an individual or omnibus basis and whether customer funds are subject to any legal or operational constraints that may impair the ability of the SIDCO or Subpart C DCO to segregate or port the

[194] European Commission at 3.

[195] *Id.*

[196] *Id.*

[197] European Commission at 3–4.

[198] European Commission at 4.

[199] *Id.*

[200] Chris Barnard at 2.

[201] *Id.*

[202] MGEX at 8.

[203] *Id.*

[204] Chris Barnard at 2.

[205] Public disclosure requirements for all registered DCOs are set forth in Regulation 39.21, which implements DCO Core Principle L (Public Information), and requires DCOs to provide to market participants sufficient information to enable them to identify and evaluate accurately the risks and costs associated with using the services of the DCO.

[206] *See also* section II.C.2, *supra.*

[207] Available at: *http://www.bis.org/publ/cpss106.pdf.*

[208] *See supra* section II.C.2. for a discussion of the Quantitative Information Disclosure (referencing section 2.5 of the CPSS–IOSCO Disclosure Framework).

positions and related collateral of a clearing member's customers.

The Commission requested comment on all aspects of these proposals. MGEX commented that it is premature for regulation 39.37(c) to require a SIDCO or Subpart C DCO to complete the CPSS–IOSCO Quantitative Disclosure Document because that document has not yet been made available for public comment.[209] It is for this reason that MGEX also stated that it cannot comment on the potential costs of complying with regulation 39.37(c).[210] The Commission notes that regulation 39.37(c) requires the disclosure of relevant basic data on transaction volume and values, which requirement is consistent with key consideration 5 in Principle 23. Further, given the Commission's goal of establishing regulations that are consistent with the PFMIs,[211] to the extent that final international standards are established for the disclosure of relevant basic data on transaction volume and values, SIDCOs and Subpart C DCOs should look to such standards in complying with the requirements set forth in regulation 39.37(c). Further, the Commission notes that on October 15, 2013, CPSS–IOSCO published a consultative document on public quantitative disclosure standards for central counterparties.[212] Moreover, CPSS–IOSCO states that these quantitative disclosures, together with the PFMI Disclosure framework also published by CPSS–IOSCO, would form the minimum disclosures expected of CCPs under Principle 23, Key Consideration 5, of the Principles.[213] Thus, if and when such public quantitative disclosure standards are finalized, the Commission would expect SIDCOs and Subpart C DCOs to look to such standards in complying with the requirements set forth in regulation 39.37(c). Moreover, the Commission notes that MGEX is not obligated to comply with regulation 39.37(c) unless and until MGEX elects to become subject to Subpart C. As discussed above, a DCO that is not a SIDCO may submit a Subpart C Election Form any time on or after the effective date of these final rules and may, should it so choose, delay such submission until such time as the public quantitative disclosure standards for central counterparties are finalized.

The new additional disclosures will help regulators and market participants assess SIDCOs and Subpart C DCOs, particularly with respect to a SIDCO's or Subpart C DCO's compliance with the PFMIs. Because of a SIDCO's importance to the U.S. financial markets, such public assessment should help provide confidence to market participants, which could prove to be a stabilizing force in times of severe market stress. For the reasons set forth herein, and in the Proposal, the Commission has decided to adopt regulation 39.37 as proposed.

J. Regulation 39.38 (Efficiency for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

Consistent with Principle 21, the Commission proposed regulation 39.38 in order to require a SIDCO or Subpart C DCO efficiently and effectively to design its clearing and settlement arrangements, operating structure and procedures, product scope, and use of technology. Further, under proposed regulation 39.38, a SIDCO or Subpart C DCO would be required to establish clearly defined goals and objectives that are measurable and achievable, including goals with regards to minimum service levels, risk management expectations, and business priorities. Moreover, a SIDCO or Subpart C DCO would be required to facilitate efficient payment, clearing, and settlement by accommodating internationally accepted communication procedures and standards. The explanatory notes to Principle 21 observe that an efficient CCP has the required resources to perform its functions[214] and the efficiency of the CCP depends on the choice of clearing and settlement arrangement, operating structure, scope of products cleared or settled, and integration of technology and procedures.[215] In addition, the explanatory notes state that an effective CCP reliably meets its obligations in a timely manner and achieves the public policy goals of safety and efficiency for participants and the markets it serves.[216] Finally, consistent with Principle 22, proposed regulation 39.38(d) would require each SIDCO and Subpart C DCO to facilitate efficient payment, clearing, and settlement by accommodating internationally accepted communication procedures and standards.

The Commission requested comment on all aspects of these proposals. MGEX commented that regulation 39.38(d) should permit a SIDCO or Subpart C DCO to make independent business decisions for establishing communication methods that best serve its clearing members and market participants.[217] MGEX stated it is unclear as to whom or what organization is responsible for establishing international communication standards and would expect that there may be multiple acceptable communication methods.[218] MGEX suggested that the Commission take a flexible approach in reviewing the efficiency of a DCO's methods of communication.[219] The Commission notes that regulation 39.38(d) refers broadly to ''internationally accepted communication procedures and standards.'' Therefore, the Commission believes that there may be more than one way for a SIDCO or Subpart C DCO to comply with regulation 39.38(d). The Commission appreciates MGEX suggestion regarding flexibility, but as examinations are fact specific, the Commission declines to discuss what approach it would or would not take in a particular review in the abstract.

It would appear to be prudent for SIDCOs and Subpart C DCOs to comply with such international standards of efficiency and effectiveness. A SIDCO or Subpart C DCO that is inefficient or ineffective could distort financial activity and market structure, increasing financial and other risks to the SIDCO's or Subpart C DCO's participants.[220] For the reasons set forth in the foregoing discussion, and in the Proposal, the Commission has decided to finalize regulation 39.38 as proposed.

K. Regulation 39.39 (Recovery and wind-down for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

The Commission proposed regulation 39.39 to require a SIDCO or Subpart C DCO to maintain viable plans for recovery and orderly wind-down. In particular, regulation 39.39 was designed to protect the members of such DCOs and their customers, as well as the financial system more broadly from the consequences of a disorderly failure of such a DCO.

[209] MGEX at 8–9.

[210] *Id.*

[211] *See* Section II.L. discussing Regulation 39.40 (Consistency with the Principles for Financial Market Infrastructures).

[212] CPSS–IOSCO, Consultative Report, Public Quantitative Disclosure Standards for Central Counterparties, October 15, 2013, available at *http://www.bis.org/publ/cpss114.pdf.*

[213] *Id.* at 1.

[214] *See* PFMIs at E.N. 3.21.1.

[215] PFMIs at E.N. 3.21.2.

[216] PFMIs at E.N. 3.21.5.

[217] MGEX at 9.

[218] *Id.*

[219] *Id.*

[220] PFMIs at E.N. 3.21.1.

As noted above, Principle 3 requires a CCP to have a sound risk management framework for comprehensively managing legal, credit, liquidity, operational, and other risks.[221] Under Principle 3, such a framework would include identifying scenarios that may prevent the CCP from providing critical operations and services as a going concern and would assess the effectiveness of a full range of options for recovery or orderly wind-down. Similarly, Principle 15 requires a CCP to identify, monitor, and manage its general business risk and hold sufficient liquid net assets funded by equity to cover potential general business losses so that the CCP can continue operations and services as a going concern if those losses materialize.[222] Further, these liquid net assets should, at all times, be sufficient to allow for recovery or orderly wind-down of critical operations and services.[223] Although there is no Core Principle that pertains directly to the establishment of a recovery and wind-down plan, proposed regulation 39.37 promotes concepts set forth in Core Principles B (Financial Resources), D (Risk Management), G (Default Rules and Procedures), and I (System Safeguards).[224]

Accordingly, under proposed regulation 39.39, a SIDCO or Subpart C DCO would be required to develop additional plans that specifically address ''recovery'' and ''wind-down.'' The Commission proposed defining ''recovery'' as the actions of a SIDCO or Subpart C DCO, consistent with its rules, procedures, and other *ex-ante* contractual arrangements, to address any uncovered credit loss, liquidity shortfall, capital inadequacy, or business, operational or other structural weakness, including the replenishment of any depleted pre-funded financial resources and liquidity arrangements, as necessary to maintain the SIDCO's or Subpart C DCO's viability as a going concern so that it can continue to provide its critical services without requiring the commencement of an insolvency proceeding or the use of resolution powers by the Federal Deposit Insurance Corporation or any other relevant resolution authority. The Commission proposed defining ''wind-down'' as the actions of a SIDCO or Subpart C DCO to effect the permanent cessation or sale or transfer of one or more services. The Commission also proposed adding a definition for ''general business risk,'' which would mean any potential impairment of a SIDCO's or Subpart C DCO's financial position, as a business concern, as a consequence of a decline in its revenues or an increase in its expenses, such that expenses exceed revenues and result in a loss that the SIDCO or Subpart C DCO must charge against capital. In addition, the Commission proposed defining ''operational risk'' to mean the risk that deficiencies in information systems or internal processes, human errors, management failures or disruptions from external events will result in the reduction, deterioration, or breakdown of services provided by a SIDCO or Subpart C DCO. Furthermore, the Commission proposed defining ''unencumbered liquid financial assets'' to include cash and highly liquid securities. These proposed definitions were designed to be consistent with the meaning of such terms in the PFMIs. The Commission requested comment as to whether these definitions were appropriate. Specifically, the Commission requested comment on whether the definition of ''recovery'' is appropriate in light of emerging international consensus.

The Commission proposed requiring each SIDCO and Subpart C DCO to maintain viable plans for: (i) Recovery or orderly wind-down, necessitated by credit losses or liquidity shortfalls; and (ii) recovery or orderly wind-down, necessitated by general business risk, operational risk, or any other risk that threatens the SIDCO's or Subpart C DCO's viability as a going concern. The Commission also proposed requiring that the recovery and wind-down plans of SIDCOs and Subpart C DCOs meet certain standards, set forth in proposed subsection (c).[225] Under proposed regulation 39.39(d), a SIDCO or Subpart C DCO would be required to establish recovery and wind-down plans that are supported by certain resources.

The Commission requested comment on all aspects of these proposals. In their comment letters, LCH, MGEX, and NYPC suggested that the Commission provide additional time to a SIDCO or Subpart C DCO for developing recovery and wind-down plans in accordance with regulation 39.39.[226] Further, NYPC suggested that a SIDCO or Subpart C not be required to comply with regulation 39.39 until (1) CPSS–IOSCO and the Financial Stability Board finalize their reports on CCP recovery and resolution and (2) CCPs have been allowed a reasonable amount of time to implement the guidance included in such reports.[227] Because reports on CCP recovery and resolution are still under consideration by the relevant international bodies, and further work in these areas may inform the Commission's views on a SIDCO's or Subpart C DCO's recovery or wind-down plans, the Commission has decided to permit a SIDCO or Subpart C DCO to request that the Commission grant the SIDCO or Subpart C DCO up to one year to comply with regulation 39.39 and 39.35 (Default rules and procedures), in a similar manner to the process by which a SIDCO or Subpart DCO may request that the Commission grant the SIDCO or Subpart C additional time for complying with regulations 39.34 (System safeguards).[228]

ISDA suggested that regulation 39.39 include more details about the required recovery and wind-down plans, such as the details provided in CPSS–IOSCO's Consultative Report, ''Recovery of Financial Market Infrastructures.''[229] The Commission notes that the Consultative Report lists suggested tools, not mandatory standards.[230] This rulemaking, by contrast, is intended to address what the PFMIs require. Therefore, it would be inappropriate for Subpart C to reflect the Consultative Report.

With respect to proposed regulation 39.39(b)(2), MGEX commented that the Commission should delete the phrase ''or any other risk that threatens the DCO's viability as a going concern.''[231] MGEX stated that Principle 15 requires a DCO to establish recovery and orderly wind-down plans necessitated only by general business risk or operational risk.[232] MGEX commented further that this phrase is ambiguous.[233] Although the phrase does not appear in Principle 15, the Commission notes that key consideration 3 of Principle 3 specifically requires an FMI to ''identify scenarios that may potentially prevent it from being able to provide its critical operations and services as a going concern and assess the effectiveness of a full range of options for recovery or orderly wind-down.'' Thus, the inclusion of the phrase ''or any other risk that threatens the DCO's viability as

[221] *See supra* Section I.E.1.

[222] *See supra id.*

[223] *See id.*

[224] *See supra* Section I.D.

[225] 78 FR 50282.

[226] LCH at 2–4, MGEX at 9, and NYPC at 2.

[227] NYPC at 1–2.

[228] *See* new paragraph (f) of regulation 39.39, new paragraph (d) of regulation 39.34, footnote 108 *supra, and* Section II.G. *supra* (discussing regulation 39.35).

[229] ISDA at 1–2.

[230] The Consultative Report notes that it ''is not intended to create additional standards for FMIs, or authorities, beyond those set out in the CPSS–IOSCO 'Principles for financial market infrastructures'.'' *Id.* at 1.

[231] MGEX at 10.

[232] MGEX at 9–10.

[233] *Id.*

a going concern'' is consistent with the PFMIs. Moreover, a SIDCO or Subpart C DCO should be aware of, and have plans to address, the risks that threaten their viability without being limited in their analysis to pre-defined risks.

With respect to proposed regulation 39.39(d)(2), MGEX commented that a SIDCO or Subpart C DCO that demonstrates adequate liquidity capabilities should be permitted to use an established line of credit for meeting potential business losses, particularly if the line of credit is offered on the basis that the DCO meet ''certain equity covenants.'' [234] The Commission notes that, so long as the DCO has sufficient assets funded by the equity of its owners, arrangements such as this one may be effective in providing a DCO with a tool that would be adequate for providing the related liquidity necessary to comply with regulation 39.39(d)(2). A DCO would need to demonstrate that such an arrangement would: (i) enable the DCO to have sufficient unencumbered liquid financial assets to fund its recovery and wind-down plans and (ii) make that liquidity available to the DCO even in a scenario in which the DCO is facing recovery or wind-down. The Commission notes that regulation 39.39(d)(2) uses the phrase ''funded by equity . . .'' to connote financial resources that are part of the SIDCO's or Subpart C DCO's owners' equity/shareholder capital.[235]

For the reasons set forth above and in the Proposal, the Commission has decided to finalize regulation 39.39 substantively as proposed but, as discussed above, will permit a SIDCO or Subpart C DCO to request that the Commission grant the SIDCO or Subpart C DCO up to one year to comply with regulation 39.39.[236] This new regulation is intended to address certain differences between existing Commission regulations and the standards set forth in the PFMIs. In addition, it would appear to be necessary for a SIDCO to maintain and (as part of such maintenance, regularly update) a recovery and wind-down plan so as to reduce, or attempt to control, the potential impact a failure or disruption of the SIDCO's operations would have on the stability of the U.S. financial markets.

L. Regulation 39.40 (Consistency with the Principles for Financial Market Infrastructures)

Proposed regulation 39.40 was intended to make clear that Subpart C is intended to establish regulations that, together with Subpart A and Subpart B, are consistent with the DCO Core Principles set forth in Section 5b(c)(2) of the CEA and the PFMIs. Specifically, to the extent of any ambiguity, the Commission intends to interpret the regulations set forth in part 39 in a manner that is consistent with the standards set forth in the PFMIs.

The Commission requested comment on all aspects of this proposal. ISDA commented that regulation 39.40 should state that subpart C is intended to be consistent with the PFMIs ''except to the extent inconsistent with other regulations of the Commission.'' According to ISDA, this would make clear that part 22, which pertains to the protection of Cleared Swaps Customer Collateral by DCOs and FCMs, would not be trumped by any future international standards, such as the CPSS–IOSCO Consultative Report, ''Recovery of Financial Market Infrastructures.'' The Commission notes that regulation 39.40 requires consistency with both the CEA and with the PFMIs. Thus, ISDA's suggested language is not necessary because an international standard that is not consistent with the CEA would not trump a Commission regulation that implements or derives from the CEA.

Consistency between part 39 and the PFMIs would appear to promote international harmonization and is intended to allow the bank clearing members and bank customers of SIDCOs and Subpart C DCOs to receive the more favorable capital treatment under the Basel CCP Capital Requirements. For the reasons set forth above and in the Proposal, the Commission has decided to finalize regulation 39.40 as proposed.

M. Regulation 39.41 (Special enforcement authority for systemically important derivatives clearing organizations)

In August of 2013, the Commission adopted regulation 39.31, which implemented special enforcement authority over SIDCOs granted to the Commission under section 807(c) of the Dodd-Frank Act.[237] In the Proposal, the Commission renumbered regulation 39.31 as regulation 39.41 and did not propose any other changes. The Commission did not receive any comments on regulation 39.41 and thus, as part of this final rulemaking, the Commission is adopting regulation 39.41 as proposed.

N. Regulation 39.42 (Advance notice of material risk-related rule changes by systemically important derivatives clearing organizations)

The Commission proposed moving existing paragraph (c) of regulation 39.30 (Scope) to proposed regulation 39.42.[238] This paragraph instructs a SIDCO to provide advance notice to the Commission of any proposed change to its rules, procedures, or operations that could materially affect the nature or level of risks presented by the SIDCO, in accordance with regulation 40.10.[239] Because the other provisions of proposed revised regulation 39.28 (renumbered as regulation 39.30) pertain to the scope of Subpart C,[240] it would be appropriate for paragraph (d) to be codified in a separate regulation. The Proposal did not suggest any substantive amendments to this provision. The Commission did not receive any comments on regulation 39.41 and thus, as part of this final rulemaking, the Commission is moving the provision to regulation 39.42 as proposed.

O. Regulation 140.94 (Delegation of authority to the Director of the Division of Clearing and Risk)

The Commission proposed amending regulation 140.94 so that certain Commission functions contained in these proposed regulations would be delegated to the Director of the Division of Clearing and Risk and to such staff members as the Director may designate. Specifically, the Commission proposed to delegate all functions reserved to the Commission in proposed regulation 39.31 including, for example, the authority to request that a DCO provide information supplementing a Subpart C Election Form that it has filed with the Commission; to determine whether an election to be subject to Subpart C should be permitted to become effective, stayed or denied; and to provide any notices regarding the foregoing. The Commission also proposed to delegate to the Director of the Division of Clearing and Risk and to his or her designees the decision described in regulation 39.34(d) (whether to grant a SIDCO or a Subpart C DCO up to one year to comply with any provision of regulation 39.34).

[234] *Id.*

[235] As mentioned earlier in this section, the phrase ''funded by equity'' comes from Principle 15. *See* also *supra* Section I.E.1.

[236] *See* new paragraph (d) of regulation 39.39 and Section II.G. *supra* (discussing regulation 39.35).

[237] *See* SIDCO Final Rule.

[238] *See supra* Section II.B. and note 111.

[239] The Commission promulgated this provision as part of the SIDCO Final Rule.

[240] *See supra* Section II.B. (discussing proposed revised regulation 39.28, renumbered as regulation 39.30).

As discussed above, in response to comments from LCH, MGEX, and NYPC, the Commission has decided to permit a SIDCO or Subpart C DCO to request that the Commission grant the SIDCO or Subpart C DCO additional time of up to one year to comply with the requirements to establish default rules and procedures for uncovered losses or shortfalls pursuant to new regulation 39.35 and to establish recovery and wind-down plans pursuant to new regulation 39.39.[241] In this connection, just as proposed amended regulation 140.94 would delegate the disposition of such a request concerning compliance with regulation 39.34 to the Director of the Division of Clearing and Risk, the Commission has decided to delegate the disposition of a request for delayed compliance with regulation 39.39 to the Director of the Division of Clearing and Risk.[242] Otherwise, the Commission believes that the proposed amendments to regulation 140.94 provide appropriate delegations to the Director of the Division of Clearing and Risk. Therefore, the Commission has decided to finalize the other amendments as proposed.

P. Regulation 190.09 (Member property)

Certain of the proposed requirements for SIDCOs and Subpart C DCOs necessitated certain clarifications to part 190 of the Commission's regulations. Specifically, new regulation 39.35(a) requires a SIDCO or Subpart C DCO to ''adopt explicit rules and procedures that address fully any loss arising from any individual or combined default relating to any clearing members' obligations to the SIDCO or Subpart C DCO.'' New regulation 39.39(b) requires a SIDCO or Subpart C DCO to maintain viable plans for recovery and orderly wind-down. In addition, SIDCOs and Subpart C DCOs must comply with Core Principle R, which require all registered DCOs to ''have a well-founded, transparent, and enforceable legal framework for each aspect of the activities of the DCO.'' Recognizing the diversity of financial safeguard arrangements among DCOs, the Commission noted in the Proposal that it would appear to be prudent to clarify certain language in part 190 to materially aid compliance with Core Principle R and the proposed regulations specified above.

The Commission proposed amending paragraph (b) of regulation 190.09 to clarify that the scope of member property will be determined based on the by-laws and rules of the relevant DCO.

The Commission requested comment on all aspects of this proposal. The Commission did not receive any comments on the proposed amendments to regulation 190.09. The Commission believes that the proposed amendments to regulation 190.09(b) make appropriate clarifications, as described above. For the reasons set forth herein and in the Proposal, the Commission has decided to finalize the amendments to regulation 190.09(b) as proposed.

III. Effective Date

A. Congressional Review Act

This final rulemaking is a major rule for purposes of the Congressional Review Act (''CRA'').[243] Generally, under the CRA, a major rule takes effect 60 days after the date on which the rule is published in the **Federal Register**.[244] However, Section 808(2) of the CRA provides that any rule which an agency for good cause finds that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest (and incorporates the finding and a brief statement of reasons therefore in the rule issued), shall take effect at such time as the federal agency promulgating the rule determines.[245] For the regulations in this final rule, the Commission has determined that good cause exists to waive the CRA effective date requirement and make the regulations effective in less than 60 days.

For revised regulation 190.09, the Commission is making the regulation effective upon publication. In accordance with section 808(2), the Commission finds good cause to make this provision effective upon publication because the regulation does not impose any new, substantive obligations on regulated entities and only serves to clarify an existing regulation in order to aid DCOs in their compliance with Commission regulations, including the final rules adopted herein. Moreover, the final regulation is being adopted as proposed, including the effective date. Market participants are thus familiar with the clarification and the timing of its implementation. Furthermore, the Commission received no comments on any aspect of revised regulation 190.09. Therefore, the Commission has determined that good cause exists to make revised regulation 190.09 effective upon publication.

Regarding regulation 39.31, the Commission is making this regulation effective as of December 13, 2013. In accordance with section 808(2), the Commission finds that a 60 day effective date for this regulation is contrary to the public interest because such delay will cause public harm by significantly increasing (for the reasons discussed below) the costs for market participants to clear OTC and exchange-traded derivatives with DCOs. More broadly, the increase in costs will have an adverse effect on competition and may lead to a disruption in the financial markets. Regulation 39.31 does not impose any requirements on regulated entities; rather it is a permissive provision that gives DCOs that have not been designated as systemically important by the Council the opportunity to opt-into and become subject to the provisions of an enhanced regulatory scheme that is otherwise only applicable to SIDCOs.[246] Compliance with this enhanced regulatory scheme as well as existing Commission regulations is necessary for such DCOs to be subject to standards that are consistent with the PFMIs, and thus enable them to gain QCCP status.[247] Attaining QCCP status will increase a DCO's ability to compete in the global financial markets by allowing such DCO to offer lower capital charges to banks (including their subsidiaries and affiliates) that clear derivative transactions with the DCO.[248] Banks that transact with U.S. DCOs that do not have QCCP status will be charged substantially higher capital charges which they may pass along to their bank customers.[249] In order to benefit from QCCP status by December 31, 2013,[250]

[241] *See* Sections II.G. and II.K, *supra.*

[242] Regulation 140.94(c)(13), as finalized, replaces the term ''applications'' with ''requests'' to comport with the language used in final regulations 39.34 and 39.39.

[243] *See* 5 U.S.C. 804(2) (defining a ''major rule'' for purposes of the Congressional Review Act).

[244] *Id.* at 801(a)(3).

[245] *Id.* at 808(2).

[246] *See supra* Sections I.B. and I.C.

[247] *See supra* Section I.F.

[248] *Id.*

[249] *Id. See also* CME at 5, n. 18 (stating that the ''ramifications for failure to achieve QCCP status are onerous for banks' CCP exposures and can result in capital charges on trade exposures that are 10–20 times larger than capital charges for QCCP trade exposures.'').

[250] *See* CME at 5, n. 18 (stating that ''in order for banks to achieve preferential QCCP capital treatment for their exposures to given CCPs, the CCP's primary regulator, among other things, must have implemented the PFMIs by January 1, 2014.'' *See also* ''Basel III Counterparty Credit Risk and Exposures to Central Counterparties-Frequently Asked Questions'' (December 2012) available at *http://www.bis.org/publ/bcbs237.pdf* (stating that during 2013, if a CCP's primary regulator has publicly stated that it is working towards implementing regulations consistent with the PFMIs, then such CCP may be treated as a QCCP until the December 31, 2013. After December 31, 2013, the CCP's primary regulator must have implemented regulations consistent with the PFMIs

Continued

the Commission must receive a DCO's election form, as set out in regulation 39.31, by December 13, 2013. This date is necessary to allow the Commission a review period to stay, deny or permit the election by December 31, 2013. For those DCOs that wish to gain QCCP status, an effective date beyond December 13, 2013, would delay the election process and cause financial harm by adversely impacting the ability of these DCOs to compete with CCPs that have attained QCCP status by the end of 2013. Therefore the Commission has determined that good cause exists to make regulation 39.31 effective as of December 13, 2013.

The Commission is also making regulation 140.94 effective as of December 13, 2013. In accordance with section 804(3), the Commission finds that this provision is not covered by the CRA as it concerns agency management and procedures.[251] Nevertheless, in accordance with section 808(2), the Commission finds that a 60 day effective date for this regulation is not necessary because regulation 140.94 imposes no requirements on DCOs. Rather it amends the current regulation 140.94 to allow certain functions set forth in regulation 39.31 to be delegated to Commission staff, for which there is no need to provide for a delayed effective date. Therefore the Commission has determined that good cause exists to make regulation 140.94 effective as of December 13, 2013.

The remaining regulations, adopted herein,[252] require SIDCOs to establish additional enhanced standards, which along with existing Commission regulations, will enable SIDCOs to be compliant with the PFMIs and thus, be able to attain QCCP status and offer the lower capital charges to banks, their subsidiaries and/or affiliates. For these regulations, the Commission is making the effective date as of December 31, 2013. For SIDCOs, a delay in attaining QCCP status beyond that date could create significant business and operational losses which in turn, could constrain the availability of liquidity and credit, thereby destabilizing the US financial markets. In accordance with section 808(2), the Commission finds that a 60 day effective date for these regulations is contrary to the public interest because such delay in obtaining QCCP status will cause public harm by significantly increasing the costs for market participants to clear OTC and exchange-traded derivatives with SIDCOs and hindering the ability of SIDCOs to compete with internationally similarly situated CCPs, which would be contrary to public interest. Therefore the Commission has determined that good cause exists to make the remaining regulations effective as of December 31, 2013.

B. Administrative Procedure Act

The Administrative Procedure Act (''APA'') generally requires that the rules promulgated by an agency not be made effective less than 30 days after publication in the **Federal Register**, except for, inter alia, interpretative rules and statements of policy and as otherwise provided by the agency for good cause found.[253] For the same reasons cited above, the Commission also finds that good cause exists under the APA to make revised regulation 190.09, regulation 39.31 and regulation 140.94 effective on the dates set forth by the Commission.

Specifically, the Commission concludes that good cause exists to waive the 30 day effective date for revised regulation 190.09 because the regulation does not impose any new, substantive obligations on regulated entities and only clarifies the scope of an existing regulation. Thus, the Commission is of the view that this provision is not subject to the 30-day effective date requirement. Furthermore, because market participants are familiar with the regulation and no comments were received on the proposed change to the regulation, the Commission believes that a 30 day effective date is unnecessary and that good cause exists to make regulation 190.09 effective upon publication.

The Commission also concludes that good cause exists to waive the 30 day effective date for regulation 39.31 because a 30 day effective date would cause public financial harm by constraining the ability of certain DCOs to compete with other CCPs, particularly in global markets, which in turn, may substantially increase costs for market participants that transact in OTC and exchange traded derivatives. Moreover, as discussed above, regulation 39.31 does not impose any requirements on regulated entities or alter the status quo in any way; rather it is a permissive provision that gives DCOs that have not been designated as systemically important by the Council the opportunity to opt-into and become subject to the provisions of an enhanced regulatory scheme that is otherwise only applicable to SIDCOs. Compliance with this enhanced regulatory scheme as well as existing Commission regulations is necessary for such DCOs to be subject to standards that are consistent with the PFMIs, and thus enable them to gain QCCP status. Attaining QCCP status will increase a DCO's ability to compete in the global financial markets by allowing such DCO to offer lower capital charges to banks (including their subsidiaries and affiliates) that clear derivative transactions with the DCO. Banks that transact with U.S. DCOs that do not have QCCP status will be charged substantially higher capital charges which they may pass along to their bank customers. In order to benefit from QCCP status by December 31, 2013, the Commission must receive a DCO's election form, as set out in regulation 39.31, by December 13, 2013. This date is necessary to allow the Commission a review period to stay, deny or permit the election by December 31, 2013. For those DCOs that wish to gain QCCP status by December 31, 2013, an effective date beyond December 13, 2013, would delay the election process and cause financial harm by adversely impacting the ability of these DCOs to compete with CCPs that have attained QCCP status by the end of 2013. Therefore, the Commission has determined that good cause exists to make regulation 39.31 effective as of December 13, 2013.

Lastly, the Commission concludes that good cause exists to waive the 30 day effective date requirement for regulation 140.94 because the regulation pertains to agency management and procedures and imposes no duty on the Commission's regulated entities. Rather it amends the current regulation 140.94 to allow certain functions set forth in regulation 39.31 to be delegated to Commission staff, for which there is no need to provide for a delayed effective date. Therefore, the Commission has determined that good cause exists to make regulation 140.94 effective as of December 13, 2013. The effective date for the remaining regulations is December 31, 2013 in accordance with the APA.

and these regulations must be applied to the CCP on an ongoing basis in order for such CCP to be eligible for QCCP status).

[251] *See* 5 U.S.C. 804(3) (defining the term ''rule'' for purposes of the CRA not to include any rule relating to agency management or personnel or any rule of agency organization, procedure, or practice).

[252] These regulations set forth enhanced regulatory standards relating to governance, financial resources, system safeguards, risk management, special default rules and procedures for uncovered losses or shortfalls, additional disclosure requirements, efficiency, and recovery and wind-down procedures. Pursuant to Title VIII of the Dodd-Frank Act, the Commission prescribed these regulations in consultation with the Council and the Board. *See* Section 805 of the Dodd-Frank Act.

[253] *See generally* 5 U.S.C. 553(d).

IV. Related Matters

A. Paperwork Reduction Act

The Paperwork Reduction Act (''PRA''), 44 U.S.C. 3501 et seq., provides that an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number from the Office of Management and Budget (''OMB''). This rulemaking contains recordkeeping and reporting requirements that are collections of information within the meaning of the PRA. Although the Commission does not anticipate that more than ten persons will respond initially to this collection of information, the term ''ten or more persons,'' which triggers PRA compliance, has been deemed to apply to ''[a]ny recordkeeping, reporting, or disclosure requirement contained in a rule of general applicability.'' 5 C.F.R. 1320.3(c)(4). This rule amends existing OMB control number 3038–0081, titled ''General Regulations and Derivatives Clearing Organizations.'' Therefore, the Commission has submitted this notice of final rulemaking along with supporting documentation for OMB's review in accordance with 44 U.S.C. 3507(d) and 5 CFR 1320.11.

This rulemaking contains many provisions that would qualify as collections of information, for which the Commission has already sought and obtained a control number from OMB. The burden hours associated with those provisions are not replicated here because the Commission is obligated to account for PRA burden once, and the PRA encourages multiple applications of a single collection.[254] Accordingly, the burdens associated with the collections contained in this rulemaking, and the information collection request that has been submitted to OMB, have been estimated only to the extent that the rulemaking imposes collections of information that OMB has not yet reviewed and approved.

It should be noted that among the thirteen DCOs presently registered with the Commission, only two are SIDCOs. Moreover, not all remaining DCOs or all DCO Applicants are likely to elect to become Subpart C DCOs (for example, DCOs that are based outside of the U.S. may seek to obtain QCCP status through regulation by their home country regulator). Thus, the burden calculations herein are based on an estimate of how many DCOs are SIDCOs and how many DCOs and DCO Applicants are likely to elect to become Subpart C DCOs. Additionally, many of the collections herein, in particular those related to electing Subpart C DCO status, are expected to be one-time events for a DCO. It is anticipated that three DCOs will elect to become subject to Subpart C in the year following the adoption of these final rules, with possibly one or two additional elections thereafter.

Finally, it is not possible to precisely estimate the reporting and recordkeeping burden for the SIDCOs and Subpart C DCOs that will be affected by the collections contained in this rulemaking, as the actual burden will be dependent on the operations and staffing of each particular SIDCO and Subpart C DCO and the manner in which they choose to implement compliance with certain requirements. Therefore, the burden estimates below are meant to be a composite of the burdens that will be absorbed across all SIDCOs and Subpart C DCOs, to the extent that the provisions for which information collection burdens are applicable.

1. Collections Only Applicable to Subpart C DCOs

Regulations 39.31(b) and 39.31(c), as proposed and adopted, establish the process whereby DCO and DCO Applicants, respectively, may elect to become Subpart C DCOs subject to the provisions of Subpart C. The election involves filing the Subpart C Election Form that would be contained in appendix B to part 39 of the Commission's regulations. The Subpart C Election Form involves completing the certifications therein, providing exhibits A through G, and drafting and publishing the DCO's responses to the Disclosure Framework, and, when applicable, the DCO's Quantitative Information Disclosure. Additionally, regulation 39.31(b)(2) and (c)(3), as proposed and adopted, provide for Commission requests for supplemental information from those requesting Subpart C DCO status; regulation 39.31(b)(3) and (c)(4), as proposed and adopted, require amendments to the Subpart C Election Form in the event that a DCO or DCO Applicant, respectively, discovers a material omission or error in, or if there is a material change in, the information provided in the Subpart C Election Form; regulation 39.31 (b)(7) and (c)(5), as proposed and adopted, permit a DCO or DCO Applicant, respectively, to submit a notice of withdrawal to the Commission in the event the DCO or DCO Applicant determines not to seek Subpart C DCO status prior to such status becoming effective; and regulation 39.31(e), as proposed and adopted, establishes the procedures by which a Subpart C DCO may rescind its Subpart C DCO status after it has been permitted to take effect. Each of these requirements implies recordkeeping that would be produced by a DCO to the Commission on an occasional basis to demonstrate compliance with the rules. As noted above, the relevant final regulations were adopted as proposed and did not include any additional information collection requirements that would warrant a revision of the burden hour estimates.

The Proposal noted that, while it was is likely that only three DCOs will elect to become Subpart C DCOs, it was conservatively estimated that, collectively, five DCOs or DCO Applicants may elect to become Subpart C DCOs. The Proposal also noted that, while it is unlikely that any DCO or DCO Applicant will withdraw its election to become subject to Subpart C prior to such election becoming effective, an estimate of compliance with the withdrawal procedures by one DCO was included in the burden hours for the information collection. Finally, the Proposal estimated that, while it is likely that none of the Subpart C DCOs will elect to rescind its election, the Commission conservatively estimated that one Subpart C DCO may rescind its election.

The Commission received one comment that referenced the estimated burden hours of the collection of information in this rulemaking. Specifically, MGEX referenced the ''Commission's estimate'' of the ''1,020 hours'' that ''would be required to complete the Subpart C Election Form'' and the ''1,125 hours estimated for responding to requests for supplemental information.'' [255] MGEX did not, however, indicate that it disagreed with the burden hour assessments set forth in the Proposal. Accordingly, the Commission has not altered its calculations. The Commission did not receive any additional comments on its original hour burden estimates and believes that those estimates, as set forth below, remain appropriate for PRA purposes:

Reporting—Certifications—Subpart C Election Form

Estimated number of reporters: 5

Estimated number of reports per reporter: 1

Average number of hours per report: 25

Estimated gross annual reporting burden: 125

Reporting—Exhibits A through G—Subpart C Election Form

[254] *See* 35 U.S.C. 3501(2) and (3).

[255] *MGEX at 2.*

Estimated number of reporters: 5
Estimated number of reports per reporter: 1
Average number of hours per report: 155
Estimated gross annual reporting burden: 775

Reporting—Preparing and Publishing Disclosure Framework Responses
Estimated number of reporters: 5
Estimated number of reports per reporter: 1
Average number of hours per report: 200
Estimated gross annual reporting burden: 1,000

Reporting—Preparing Quantitative Information Disclosures
Estimated number of reporters: 5
Estimated number of reports per reporter: 1
Average number of hours per report: 80
Estimated gross annual reporting burden: 400

Reporting—Requests for Supplemental Information
Estimated number of reporters: 5
Estimated number of reports per reporter: 5
Average number of hours per report: 45
Estimated gross annual reporting burden: 1,125

Reporting—Amendments to Subpart C Election Form
Estimated number of reporters: 5
Estimated number of reports per reporter: 3
Average number of hours per report: 8
Estimated gross annual reporting burden: 120

Reporting—Withdrawal Notices
Estimated number of reporters: 1
Estimated number of reports per reporter: 1
Average number of hours per report: 2
Estimated gross annual reporting burden: 2

Reporting—Rescission Notices
Estimated number of reporters: 1
Estimated number of reports per reporter: 75
Average number of hours per report: 3
Estimated gross annual reporting burden: 225

Recordkeeping
Estimated number of recordkeepers: 5
Estimated number of records per recordkeeper: 82
Average number of hours per record: 1
Estimated gross annual recordkeeping burden: 410

2. Collections Applicable Both to SIDCOs and Subpart C DCOs

Regulations 39.32(a) and (b), as proposed and adopted, establish governance requirements applicable to each SIDCO and Subpart C DCO, including specific provisions requiring written and disclosed governance arrangements and the disclosure of certain decisions on particular, not regularly scheduled, occasions, to the Commission, the SIDCO or Subpart C DCO's clearing members, other relevant stakeholders and/or the public. Regulation 39.33(d), as proposed and adopted, requires a SIDCO or Subpart C DCO to conduct due diligence on its liquidity providers and to conduct periodic testing with respect to its access to liquidity resources. Regulation 39.33(e), as proposed and adopted, establishes documentation requirements with respect to the supporting rationale for the financial and liquidity resources it maintains pursuant to regulations 39.33(a) and 39.33(c), respectively.

Regulation 39.36(c)(6), as proposed and adopted, requires each SIDCO and Subpart C DCO to report stress test results to its risk management committee or board of directors. Regulation 39.37(a), as proposed and adopted, requires each SIDCO and Subpart C DCO to complete and to publicly disclose its responses to the Disclosure Framework and, when applicable, to complete and disclose a Quantitative Information Disclosure. As described above and as accounted for in the previous portion of this PRA burden estimate, these tasks will be conducted by Subpart C DCOs as part of their election to become subject to Subpart C. SIDCOs and DCOs also are required to update their Disclosure Framework responses and Quantitative Information Disclosure every two years. Regulations 39.37(c) and (d), as proposed and adopted, require each SIDCO or Subpart C DCO to disclose, publicly and to the Commission, certain data on transaction volume and values and their rules, policies, and procedures related to the segregation and the portability of customers' positions and funds.

Regulation 39.38, as proposed and adopted, requires each SIDCO or Subpart C DCO to establish a process to review the efficiency and effectiveness of its clearing and settlement arrangements, operating structure and procedures, scope of products cleared and use of technology. Finally, regulations 39.39(b) and (c), as proposed and adopted, require each SIDCO and Subpart C DCO to develop and maintain viable plans for the recovery or wind-down of the SIDCO or Subpart C DCO necessitated by certain circumstances. Each of these requirements implies recordkeeping that would be produced by the SIDCO or Subpart C DCO to the Commission on an occasional basis to demonstrate compliance with the proposed rules.

It is not possible to estimate with precision how many DCOs may, in the future, be determined to be SIDCOs and how many may elect to become Subpart C DCOs, but it was conservatively estimated in the Proposal that, collectively, a total of seven DCOs may be determined to be SIDCOs or may opt to become Subpart C DCOs. Presently, there are two SIDCOs and it has been estimated that five DCOs will elect to become Subpart C DCOs.

The Commission did not receive any comments on the estimated costs or burden hours of this collection of information and the Commission believes that its original estimates, as set forth below and in the Proposal,[256] remain appropriate for PRA purposes:

Reporting—Governance Requirements—Written Governance Arrangements
Estimated number of reporters: 7
Estimated number of reports per recordkeeper: 1
Average number of hours per report: 200
Estimated gross annual reporting burden: 1,400

Reporting—Governance Requirements—Required Disclosures
Estimated number of reporters: 7
Estimated number of reports per recordkeeper: 6
Average number of hours per report: 3
Estimated gross annual reporting burden: 126

Reporting—Financial and Liquidity Resource Documentation
Estimated number of reporters: 7
Estimated number of reports per recordkeeper: 1
Average number of hours per report: 120
Estimated gross annual reporting burden: 840

Reporting—Stress Test Results
Estimated number of reporters: 7
Estimated number of reports per recordkeeper: 16
Average number of hours per report: 14
Estimated gross annual reporting burden: 1,568

Reporting—Preparing and Publishing Disclosure Framework Responses (SIDCOs only)
Estimated number of reporters: 2
Estimated number of reports per recordkeeper: 1
Average number of hours per report: 200
Estimated gross annual reporting burden: 400

Reporting—Updating and Republishing Disclosure Framework Responses (SIDCOs and Subpart C DCOs)
Estimated number of reporters: 7
Estimated number of reports per recordkeeper: 1
Average number of hours per report: 80
Estimated gross annual reporting burden: 560

Reporting—Preparing and Publishing Quantitative Information Disclosures (SIDCOs only)
Estimated number of reporters: 2
Estimated number of reports per reporter: 1
Average number of hours per report: 80
Estimated gross annual reporting burden: 160

Reporting—Updating and Republishing Quantitative Information Disclosures (SIDCOs and Subpart C DCOs)
Estimated number of reporters: 7
Estimated number of reports per recordkeeper: 1

[256] 78 FR 50285–86.

Average number of hours per report: 35
Estimated gross annual reporting burden: 245
Reporting—Transaction, Segregation, Portability Disclosures
Estimated number of reporters: 7
Estimated number of reports per recordkeeper: 2
Average number of hours per report: 35
Estimated gross annual reporting burden: 490
Reporting—Efficiency and Effectiveness Review
Estimated number of reporters: 7
Estimated number of reports per recordkeeper: 1
Average number of hours per report: 3
Estimated gross annual reporting burden: 21
Reporting—Recovery and Wind-Down Plan
Estimated number of reporters: 7
Estimated number of reports per recordkeeper: 1
Average number of hours per report: 480
Estimated gross annual reporting burden: 3,360
Recordkeeping—Liquidity Resource Due Diligence and Testing
Estimated number of recordkeepers: 7
Estimated number of records per recordkeeper: 4
Average number of hours per record: 10
Estimated gross annual recordkeeping burden: 280
Recordkeeping—Financial and Liquidity Resources, Excluding Due Diligence and Testing
Estimated number of recordkeepers: 7
Estimated number of records per recordkeeper: 4
Average number of hours per record: 10
Estimated gross annual recordkeeping burden: 280
Recordkeeping—Generally
Estimated number of recordkeepers: 7
Estimated number of records per recordkeeper: 28
Average number of hours per record: 10
Estimated gross annual recordkeeping burden: 1960

B. Regulatory Flexibility Act

The Regulatory Flexibility Act (''RFA'') requires that agencies consider whether the rules they propose will have a significant economic impact on a substantial number of small entities and, if so, provide a regulatory flexibility analysis respecting the impact.[257] The rules adopted herein will only affect DCOs. The Commission has previously established certain definitions of ''small entities'' to be used by the Commission in evaluating the impact of its regulations on small entities in accordance with the RFA.[258] The Commission has previously determined that DCOs are not small entities for the purpose of the RFA.[259] Accordingly, the Chairman, on behalf of the Commission, hereby certifies pursuant to 5 U.S.C. 605(b) that the rules adopted herein will not have a significant economic impact on a substantial number of small entities. The Chairman made the same certification in the proposed rulemaking, and the Commission did not receive any comments on the RFA.

C. Consideration of Costs and Benefits

1. Introduction

Section 15(a) requires the Commission to consider the costs and benefits of its actions before promulgating a regulation under the CEA or issuing certain orders.[260] Section 15(a) further specifies that the costs and benefits shall be evaluated in light of five broad areas of market and public concern: (1) protection of market participants and the public; (2) efficiency, competitiveness, and financial integrity of futures markets; (3) price discovery; (4) sound risk management practices; and (5) other public interest considerations. The Commission's cost and benefit considerations in accordance with Section 15(a) are discussed below.

2. Background

In this final rulemaking, the Commission is adopting regulations to (1) address gaps between part 39 of the Commission's regulations and the standards set forth in the PFMIs, (2) provide a mechanism for DCOs to elect to opt-in the SIDCO enhanced regulatory framework set out in the provisions of Subpart C; and (3) make related technical amendments to regulations 140.94 and 190.09. As finalized herein, revised Subpart C, together with Subpart A and Subpart B, will establish regulations that are consistent with the PFMIs [261] and provide SIDCOs and Subpart C DCOs with the opportunity to become QCCPs for purposes of the Basel CCP Capital Requirements.[262]

In promulgating the final rule, the Commission considered the following alternatives: (1) not to adopt any of the proposed additional standards for SIDCOs, (2) to adopt the proposed additional standards for SIDCOs only, (3) to adopt the proposed additional standards for SIDCOs and also for DCOs that have not been designated as systemically important by the Council but that seek adherence to the enhanced regulatory framework for purposes of gaining QCCP status, or (4) to adopt the proposed additional standards for all DCOs. As detailed above, the Commission has concluded it is necessary and appropriate to adopt regulations which set forth enhanced regulatory standards for SIDCOs and also to extend this framework to DCOs that have not been designated systemically important in order to provide the opportunity to for all DCOs to become QCCPs.

The Commission invited public comment on all aspects of the proposed rulemaking, including (1) the competitive impact, the costs as well as benefits, resulting from, or arising out of, requiring SIDCOs to comply with the provisions set forth in Subpart C, while permitting other registered DCOs to elect to become subject to these requirements (or to forego such election), (2) the potential costs and benefits to a SIDCO or Subpart C DCO to comply with all aspects of the proposed rule, (3) alternative means to establish, for Subpart C DCOs, requirements consistent with the PFMIs and the costs (or cost savings) and benefits associated with such alternatives, and (4) any costs that would be imposed on and any benefits that would be conferred on other market participants or the financial system more broadly. As discussed above in more detail, the Commission received comment letters which generally supported the proposed rule and the Commission's objective to harmonize U.S. regulations with the international standards set forth by the PFMIs.[263] However, the Commission received only one comment that provided quantitative data from which the Commission could calculate the costs and benefits of the proposed regulations.[264] The remainder of the comment letters provided qualitative comments on the Commission's proposed consideration of costs and benefits, generally, as well as specifically with regard to certain proposed regulations. These comments are summarized below in connection with the Commission's consideration of costs and benefits on the final rules being promulgated herein pursuant to section 15(a) of the CEA.

3. Costs and Benefits of the Final Rule

a. Costs

The Commission requested quantitative data or specific cost

[257] 5 U.S.C 601 *et seq.*

[258] Policy Statement and Establishment of Definitions of ''Small Entities'' for Purposes of the Regulatory Flexibility Act, 47 FR 18618 (Apr. 30, 1982).

[259] *See* 66 FR 45609.

[260] 7 U.S.C. 19(a).

[261] *See supra* Section I.G.

[262] *See supra* Section I.F. (discussion of the Basel CCP Capital Requirements).

[263] *See* generally Chris Barnard, NYPC, FIA, ICE, ISDA, European Commission, CME, LCH and MGEX comment letters.

[264] *See* generally CME comment letter.

estimates associated with the proposed regulations but commenters, other than CME, did not provide this information. Commenters did address the costs and benefits of the proposed rule in qualitative terms, as described below.[265]

As noted in the cost-benefit discussion in the Proposal,[266] the Commission recognizes that the regulations in this final rulemaking are comprehensive and that, compared against the status quo (the DCO regulatory framework set forth in Subpart A and B of part 39 of the Commission's regulations), these regulations may impose important costs on SIDCOs and Subpart C DCOs depending, in particular, on the SIDCO's or Subpart C DCO's current financial and liquid resources, and risk management framework. In particular, these regulations may require SIDCOs and Subpart C DCOs to undertake a comprehensive review and analysis of their current policies, procedures, and systems in order to determine where it may be necessary to design and implement additional or alternative policies, procedures, and systems. Such costs are likely to increase operational, administrative, and compliance costs for SIDCOs or Subpart C DCOs.

In addition to the costs for SIDCOs and Subpart C DCOs, the Commission has considered the costs these regulations may impose upon market participants and the public. To the extent costs increase, the Commission notes that higher trading prices for market participants (*i.e.,* increased clearing fees, guaranty fund contributions, margin fees, etc.) may discourage market participation and result in decreased liquidity and reduced price discovery. However, the Commission has also considered the costs to market participants and the public if the regulations in this final rulemaking are not adopted. Significantly, without these regulations to ensure that SIDCOs operate under certain enhanced risk management standards, in a manner consistent with internationally accepted standards, the security of the U.S. financial markets would be at a greater risk relative to international markets. This could affect the attractiveness of the U.S. financial markets subject to the Commission's jurisdiction as compared to foreign competitors. Moreover, SIDCOS and DCOs that wish to opt-into the enhanced regulatory framework would not have the opportunity to gain QCCP status, thereby putting them at a significant competitive disadvantage in the global financial markets which, again, would be to the detriment of their clearing members and their customers.

i. Regulation 39.31 (Election to become subject to the provisions of subpart C)

Regulation 39.31 sets forth the procedures a DCO will be required to follow to elect to become subject to the provisions of Subpart C.[267] Specifically, paragraph (b) requires a registered DCO to file a completed Subpart C Election Form with the Commission. The form appears in Appendix B to Subpart C and is modeled after Form DCO, which the Commission promulgated in 2011 as part of the DCO General Provisions and Core Principles final rule.[268] Paragraph (c) requires the same of a DCO that applies for registration with the Commission and that wants to be subject to the provisions of Subpart C as of the date the DCO is registered with the Commission. The Subpart C Election Form includes disclosures and exhibits wherein the DCO is required to provide the following: a regulatory compliance chart; citations to the relevant rules, policies, and procedures of the DCO that addresses each Subpart C regulation; and a summary of the manner in which the DCO will comply with each regulation. In addition, the DCO is required to provide, in separate exhibits, all documents that demonstrate the DCO's compliance with regulations 39.32 through 39.36 and regulation 39.39, as finalized herein. A DCO is also required to complete responses to the Disclosure Framework and publish a copy of its responses on its Web site.

The Commission notes that regulation 39.31 only applies to a DCO that the Council has not designated to be systemically important and that *elects* to become subject to the provisions of Subpart C. By providing an opt-in procedure and a procedure to rescind such election, regulation 39.31, as adopted, offers the benefit of permitting a DCO that is not systemically important to compare the benefit of attaining QCCP status with the costs of preparing a comprehensive and complete Subpart C Election Form (in accordance with the requirements set forth in regulation 39.31) and complying with the requirements set forth in Subpart C and, thus, to decide for itself whether to become subject to Subpart C.

As discussed above in more detail, the Commission received 4 comment letters addressing the costs associated with specific regulations in the proposed rule.[269] All of the commenters expressed support for the Commission's efforts to provide DCOs with the opportunity to become eligible for QCCP status by adhering to an enhanced regulatory scheme.[270] However, MGEX referred to the application process set forth in proposed regulation 39.31 as ''burdensome'' and ''discriminatory'' towards DCOs that have not been designated as systemically important.[271] In addition, MGEX suggested to the Commission two alternatives methods to more efficiently implement regulations that are consistent with the PFMIs: (1) require all DCOs to be subject to the enhanced regulatory requirements in Subpart C and grant an extended compliance schedule beyond December 31, 2013 or (2) provide an ''opt-out'' process for those DCOs that do not wish to be held to the higher regulatory standards and grant compliance extensions for those regulations that would be difficult for DCOs to implement by December 31, 2013.[272] LCH suggested that the Commission consider requiring the enhanced regulatory standards to apply to all DCOs and allow DCOs to petition the Commission for extended compliance with ''more complex rules.''[273] LCH also suggested an opt-out process for those DCOs that believe QCCP status is not important for their business.[274] As MGEX itself pointed out in its comment letter, requiring all DCOs to adhere to the enhanced requirements in Subpart C would impose considerable costs on DCOs that may not seek QCCP status.[275] The Commission believes a DCO should have the flexibility to determine what level of regulatory standard is appropriate for its particular business model. Regarding the suggested alternative opt-out provision, as stated previously, the Commission does not have quantitative data on the costs associated with implementing the regulations in this final rule but it is aware that costs may be significant. Further, the Commission is aware that imposing an enhanced regulatory framework on all DCOs even with an opt-out provision, without the necessary quantitative analysis, would be inappropriate and could result in financial harm to certain DCOs. Moreover, without a detailed quantitative analysis comparing the

[265] *See* generally MGEX and LCH comment letters.

[266] 78 FR 50287.

[267] *See supra* Section II.C. (discussing regulation 39.31).

[268] *See* 76 FR 69448.

[269] *See* generally MGEX, CME, LCH and European Commission comment letters.

[270] MGEX at 1–2; CME at 1, LCH at 2, and European Commission at 1.

[271] MGEX at 2.

[272] Id. at 3.

[273] LCH at 3.

[274] *Id.*

[275] MGEX at 3.

costs for each DCO that elects to opt-in (under the proposed rule) with the costs of each DCO that elects to opt-out of Subpart C compliance (under MGEX's alternative), the Commission cannot determine whether establishing an opt-out regime would be a more efficient means of implementing the PFMIs than the Commission's proposed opt-in regime. Hence, at this time, the Commission cannot justify the cost burden that would result for DCOs if every DCO were required to comply with the Subpart C regulations.

MGEX and LCH also both suggested that to alleviate the compressed timeline for compliance, the Commission should allow compliance extensions. Specifically, LCH requested that ''more complex rules, such as those governing financial resources, system safeguards, risk management, and recovery and wind-down plans'' be given additional time for compliance.[276] Similarly, MGEX suggested ''granting compliance extensions for those regulations that may be particularly difficult to implement by the December 31, 2013 deadline.''[277] As highlighted by both MGEX and LCH, the Commission has already proposed an extended deadline for regulation 39.34 regarding system safeguards. The Commission is also extending the deadline for compliance with regulation 39.35 regarding default rules and procedures and regulation 39.39 regarding recovery and wind-down by permitting a SIDCO or Subpart C DCO to request that the Commission grant the SIDCO or Subpart C DCO up to a one year extension to comply with these regulations. However, because the very purpose of this final rule is to align the Commission's regulations with the PFMIs and to provide DCOs the opportunity to become QCCPs, inherently a DCO must comply with all of the regulations. An extended compliance date for all the regulations or a large subset of the regulations, would call into the question whether the Commission has rules and regulations in place consistent with the PFMIs and is applying these rules to the DCO on an ongoing basis as of December 31, 2013. Extending the compliance date could delay the ability of a Subpart C DCO or SIDCO to gain QCCP status and thus, increase costs for the DCO's clearing member banks and the customers of these banks. While the Commission recognizes the concerns expressed by the commenters regarding the compliance deadline for purposes of achieving QCCP status, the Commission notes that for DCOs that are not SIDCOs, it is ultimately the decision of the DCO as to whether to elect to become a Subpart C DCO and if so, when to make such an election. Thus, the compliance dates proposed in this regulation are permissive and not mandatory for such DCOs.

The Commission requested comments regarding the costs associated with the actual opt-in process. However, although MGEX stated that the Subpart C Election Form would be overly burdensome, neither MGEX nor any other commenter provided comments quantifying the cost of opting-in, the costs associated with rescinding an opt-in (including the notices required), or the costs associated with the completion and publication of responses to the Disclosure Framework.

The Commission notes that pursuant to paragraph (e), a Subpart C DCO is permitted, subject to a 180 day notice period, to rescind its election to become subject to the provisions of Subpart C. As a result of the rescission, the DCO would no longer be considered a QCCP, which would likely create important costs for bank clearing members and the bank customers of the DCO's clearing members due to the higher capital costs that they would incur as a result of clearing transactions through the DCO that is no longer a QCCP.[278] Alternatively, clearing members and their customers may choose to end their clearing activities and transact through another DCO that is a QCCP. Either choice would impose costs on those clearing members and their customers.

As the Commission has previously noted, a Subpart C DCO's compliance with the provisions of Subpart C will cause the Subpart C DCO to incur certain costs. Some of these costs may then be incurred, indirectly, by the Subpart C DCO's clearing members and their customers. The Commission requested but did not receive any comments concerning how these costs may be mitigated. Nor did the Commission receive any comments about the extent to which a DCO's analysis of the costs and benefits of being a Subpart C DCO could be affected by the possibility that some of the costs may be incurred indirectly by clearing members and their customers.

In the absence of input from market participants, the Commission lacks critical information necessary to make a reasonable assessment or quantify dollar costs associated with regulation 39.31. Each DCO has its own internal cost structure, management system, and existing regulatory compliance framework. Thus, the way in which regulation 39.31 impacts each Subpart C DCO with respect to costs likely will vary. Accordingly, the Commission is unable to provide a reliable quantification of the costs associated with regulation 39.31, because, among other things, such a determination would require information concerning the business model and strategies of individual DCOs, about which the Commission did not receive information during the comment period. The Commission has no reason to believe, however, that the costs associated with the regulation would be unreasonable or inappropriate to achieve the regulatory objective of providing an opportunity for DCOs to opt-in to Subpart C. In addition, the Commission believes that the costs the regulation imposes would not, to any unnecessary extent, impede a DCO from electing to be subject to Subpart C.

ii. Regulation 39.32 (Governance for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

Regulation 39.32 establishes governance requirements for SIDCOs and Subpart C DCOs that are consistent with the PFMIs and establish rules and procedures concerning conflicts of interest, compensation policies, organizational structure, and fitness standards for directors and officers.[279] Specifically, SIDCOs and Subpart C DCOs are required to have written governance arrangements that are clear and transparent, that place a high priority on the safety and efficiency of SIDCOs or Subpart C DCOs, and that explicitly support the stability of the broader financial system and other relevant public interest considerations of clearing members, customers of clearing members, and other relevant stakeholders. In addition, these governance arrangements are required to reflect the legitimate interests of clearing members, customers of clearing members, and other relevant stakeholders. To an extent consistent with other statutory and regulatory requirements on confidentiality and disclosure, SIDCOs and Subpart C DCOs are also required to disclose major decisions of the board.[280] Regulation 39.32 requires the rules and procedures of SIDCOs and Subpart C DCOs to: (1) Describe the SIDCO's or Subpart C DCO's management structure; (2) clearly specify the roles and responsibilities of

[276] LCH at 3.

[277] MGEX at 3.

[278] *See supra* Section I.F. (discussing the treatment for non-QCCP clearing members under the Basel CCP Capital Requirements).

[279] *See supra* Section II.D. (discussing regulation 39.32).

[280] *Id.*

the board of directors and its committees, including the establishment of a clear and documented risk management framework; (3) clearly specify the roles and responsibilities of management; (4) establish appropriate compensation policies; (5) establish procedures for managing conflicts of interest among board members; and (6) assign responsibility and accountability for risk decisions and for implementing rules concerning default, recovery, and wind-down. Finally, regulation 39.32 requires that the board members and managers of SIDCOs and Subpart C DCOs have the appropriate experience, skills, incentives and integrity; risk management and internal control personnel have sufficient independence, authority, resources and access to the board of directors; and that the board of directors include members who are not executives, officers or employees of the SIDCO or Subpart C DCO or of their affiliates.

As noted in the cost benefit section of the Proposal,[281] to the extent these requirements affect the behavior of a DCO, costs could arise from additional hours a DCO's employees might need to spend analyzing the compliance of the DCO's rules and procedures with these requirements, designing and drafting new or amended rules and procedures where the analysis indicates that these are necessary, and implementing these new or amended rules and procedures. The Commission continues to believe that these categories accurately summarize the sources of material costs that may be incurred in complying with regulation 39.32.

In the Proposal, the Commission requested comment on the potential costs to a SIDCO or Subpart C DCO to comply with all aspects of proposed regulation 39.32, and any costs that would be imposed on other market participants or the financial system more broadly. The Commission specifically requested comment on any alternative means to satisfy the requirements of regulation 39.32 in a manner consistent with the PFMIs and for costs or cost savings associated with such alternatives.[282] The Commission did not receive any comments in response to these requests.

In the absence of input from market participants, the Commission lacks critical information necessary to make a reasonable assessment or quantify dollar costs associated with regulation 39.32. The Commission notes that regulation 39.32 grants a DCO a certain amount of discretion in determining the specifics of the rules and procedures that should be adopted to comply with the regulation. Moreover, each DCO has its own internal cost structure, management system, and existing regulatory compliance framework. Thus, the way in which regulation 39.32 impacts each DCO with respect to initial and ongoing costs likely will vary. For example, some DCOs may already have rules and processes that comply with the regulation, in whole or in part, while other DCOs may not.

Accordingly, the Commission is unable to provide a reliable quantification of the costs associated with regulation 39.32, because, among other things, such a determination would require information concerning the business model and strategies of individual DCOs, about which the Commission did not receive information during the comment period. The Commission has no reason to believe, however, that the costs associated with the regulation would be unreasonable or inappropriate to achieve the regulatory objective of implementing the PFMI standards for SIDCOs and Subpart C DCOs. In addition, the Commission believes that the costs the regulation imposes would not, to any unnecessary extent, impede a DCO from electing to be subject to Subpart C.

iii. Regulation 39.33 (Financial resources for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

a.) Regulation 39.33(a): Cover Two

As discussed above, regulation 39.33(a), as revised, requires a Subpart C DCO to comply with the Cover Two minimum financial resource standard for all of its activities if the Subpart C DCO: (1) is involved in activities with a more complex risk profile or (2) is systemically important in multiple jurisdictions. This regulation currently applies to SIDCOs.[283]

The cost of the Cover Two requirement for a Subpart C DCO that meets either or both of the two criteria described above[284] includes the opportunity cost[285] of the additional financial resources needed to satisfy the guaranty fund requirements for the risk of loss resulting from the default of the clearing member creating the second largest financial exposure.[286] In addition, the possibility exists that some market participants will transfer their positions from a Subpart C DCO that either (1) is deemed systemically important in multiple jurisdictions or (2) clears products of a more complex risk profile to another DCO for which neither (1) nor (2) applies, because the value of the Cover Two protection to these market participants is less than the price at which that protection is being offered. These market participants will transact with SIDCOs or Subpart C DCOs that operate under Cover One, which is a lower financial resources requirement, and thus, get the benefit of lower transactional fees and forego the enhanced protections associated with the SIDCOs and Subpart C DCOs that operate under Cover Two. However, the potential cost to a SIDCO or a Subpart C DCO subject to the Cover Two requirement and to the goal of systemic risk reduction would likely be mitigated because: (a) not every product offered by a SIDCO or Subpart C DCO would be available at other DCOs and (b) a SIDCO or Subpart C DCO may offer benefits not available to a DCO that operates under Cover One because it does not elect to become subject to the provisions of Subpart C, and is not designated as systemically important, and/or does not clear products with a more complex risk profile. This would therefore reduce the likelihood that market participants would transfer their positions to other DCOs.

b.) Regulation 39.33(b): Valuation of Financial Resources

As discussed above, regulation 39.33(b) prohibits SIDCOs and Subpart C DCOs from including assessments as part of their calculation of the financial resources available to cover the default of the clearing member creating the largest financial exposure and, where applicable, the default of the two clearing members creating the largest aggregate financial exposure, in extreme but plausible circumstances, *i.e.,* Cover One or Cover Two.[287] This prohibition currently applies to SIDCOs and would be expanded to include Subpart C DCOs. The costs associated with the prohibition on the use of assessments by a Subpart C DCO in calculating its obligations under regulation 39.33(a)

[281] 78 FR 50287.

[282] *Id.* at 50288.

[283] *See supra* Section II.E. (discussing revised regulation 39.33).

[284] All Subpart C DCOs would bear the administrative cost of determining whether they meet either of the criteria.

[285] For Subpart C DCOs that are not deemed systemically important in multiple jurisdictions or that do not clear products with a more complex risk profile, the Cover One financial resources requirement would continue to apply, and therefore, these Subpart C DCOs would not face increased opportunity costs associated with the regulation.

[286] In the event that these additional resources would need to be raised by the Subpart C DCO, as opposed to reallocated, this cost would be the funding cost for raising these additional resources.

[287] *See supra* Section II.E. (discussing revised regulation 39.33).

would include the opportunity cost of the additional pre-funded financial resources needed to replace the value of such assessments, which may require an infusion of additional capital. In addition, as with the Cover Two requirement, market participant demand may shift from a SIDCO or a Subpart C DCO subject to the Cover Two requirement to a DCO with a lower capitalization requirement.

c.) Regulation 39.33(c), (d) and (e): Liquidity

As discussed above, regulation 39.33(c) requires a SIDCO and a Subpart C DCO to maintain eligible liquidity resources that will enable it to meet its intraday, same-day and multiday settlement obligations, in all relevant currencies, with a high degree of confidence under a wide range of stress scenarios notwithstanding a default by the clearing member creating the largest aggregate liquidity obligation. Eligible resources are limited to cash in the currency of the requisite obligation, held at the central bank of issue or a creditworthy commercial bank, certain highly marketable collateral, including high quality, liquid, general obligations of a sovereign nation (subject to certain prearranged and highly reliable funding arrangements), and various committed liquidity arrangements. These arrangements must be reliable and enforceable in extreme but plausible market conditions, and must not contain material adverse change clauses.

In addition, a SIDCO or Subpart C DCO that is systemically important in multiple jurisdictions or that is involved in activities with a more complex risk profile is required to *consider* maintaining liquidity resources that would enable it to meet the default of the two clearing members creating the largest aggregate payment obligation. If a SIDCO or Subpart C DCO maintains liquid financial resources in addition to those required to satisfy the minimum financial resources requirement set forth in regulation 39.11(a)(1) and proposed regulation 39.33(a), then those resources should be in the form of assets that are likely to be saleable or acceptable as collateral for lines of credit, swaps, or repurchase agreements on an *ad hoc* basis.[288]

Regulation 39.33(d) imposes a duty on SIDCOs and Subpart C DCOs to perform due diligence on their liquidity providers in order to determine their ability to perform reliably their commitments to provide liquidity. Finally, regulation 39.33(e) requires SIDCOs and Subpart C DCOs to document their supporting rationale for the amount of financial resources they maintain pursuant to regulation 39.33(a) and the amount of liquidity resources they maintain pursuant to regulation 39.33(c).[289]

Regulations 39.33(c)–(e) may result in additional costs for a SIDCO or Subpart C DCO with respect to analyzing and measuring intra-day, same-day, and multiday liquidity requirements in all relevant currencies, developing plans to meet those requirements, obtaining eligible liquidity resources and making eligible liquidity arrangements, reviewing and monitoring each liquidity provider's risks and reliability (including through periodic testing of access to liquidity), and documenting the DCO's basis for conclusions with respect to its financial resources and liquidity resources requirements. These regulations also will require stress testing and other analysis of such resources as compared with the DCO's liquidity needs. Specifically, with regards to regulation 39.33(c), there may be costs involved in obtaining cash in the relevant currencies or arranging for qualifying liquidity commitments, such as a committed line of credit, to satisfy the minimum financial resources requirement set forth in regulation 39.11(a)(1) (*i.e.* Cover One). Obtaining these committed financial resources may involve administrative expenses such as the negotiation and drafting of committed arrangements, as well as costs arising from the payment of fees to liquidity providers. In addition, there may be operational costs involved in calculating the liquidity resources requirements at the Cover One level on an intraday, same-day, and multiday basis over the course of a default. This calculation may require undertaking a complex analysis of the SIDCO's or Subpart C DCO's exposures and processes, including various models. Where appropriate, this calculation may also require designing and implementing changes to either create or modify existing internal processes. The Commission notes that while this analysis may involve costs, it will improve the SIDCO's or Subpart C DCO's financial condition, as described below in section 2.b.iii. of the benefits section.

CME estimated that if it had to obtain committed funding arrangements to comply with regulation 39.33(c), its liquidity costs would approximately double.[290] This increase is based on their ''assumption that the cost of committed liquidity or committed repurchase facilities is approximately $3 million for every $1 billion of required committed facilities'' or 30 basis points.[291] Additionally, CME commented that given the global clearing mandate slated to take effect over the next two years, liquidity requirements will significantly increase, which could potentially result in CME's liquidity costs increasing to $120 to $160 million per year.[292]

Based on CME's 30 basis point estimate, their increase in liquidity costs would translate into a liquidity exposure from the default of a single participant, including affiliates, (*i.e.,* Cover One) of $40 billion to $53 billion. The size of this potential exposure highlights the systemic importance of SIDCOs, such as CME, and how critical it is for a SIDCO to meet all of its obligations promptly even in extreme but plausible conditions. Consequently, while there may be costs associated with obtaining prearranged, highly reliable funding, these costs must be weighed against the potential disruptions and damage to the U.S. financial system if, during extreme but plausible market conditions, a SIDCO does not maintain sufficient liquidity to meet its financial obligations to its non-defaulting members promptly.

Moreover, as discussed above in more detail, the standard SIDCOs and Subpart C DCOs must meet under regulation 39.33(c) is to demonstrate the reliability of the requisite liquidity arrangements, even in extreme but plausible conditions. To the extent that a DCO is able to meet this burden through tools other than the use of a committed funding arrangement, and chooses to so, then the DCO would bear the cost of such an alternative arrangement, which may be lower than the costs of a committed funding arrangement.

Regulation 39.33(d) may increase administrative costs to the extent that a SIDCO or a Subpart C DCO is required to review and monitor its liquidity provider's capacity and reliability to perform its liquidity obligations to the DCO. In addition, regulation 39.33(e) may impose an administrative cost to document the SIDCO or Subpart C DCO's rationale for the financial resources it maintains.

[288] *Id.*

[289] *Id.*

[290] CME at 13.

[291] *Id.* Current and historic returns available on high quality sovereign bonds suggest that the actual costs of liquidity service may be less than the 30 basis points that CME estimates and therefore, CME's total liquidity costs would be lower than $120 to $160 million.

[292] CME at 13.

iv. Regulation 39.34 (System safeguards for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

As discussed above regulation 39.34, as revised, expands the enhanced system safeguards requirements already applicable to SIDCOs to include Subpart C DCOs.[293] As noted in the cost benefit section of the Proposal,[294] the regulation may increase operational costs for Subpart C DCOs by requiring additional resources, including, technology (*e.g.,* hardware and software) and the purchase or rental of premises in order to achieve geographic dispersal of resources. Moreover, business continuity planning inherently requires that personnel be trained in their roles and responsibilities under the plan, and this training consumes time and related resources.

The costs of moving from a next-day RTO, the minimum standard established by the DCO core principles and current regulation 39.18, to a two-hour RTO as required by proposed regulation 39.34, may be significant. Additionally, the implementation of a two-hour RTO may impose one-time costs to establish the enhanced resources and recurring costs to operate the additional resources. The Commission continues to believe that these categories accurately summarize the sources of material costs that may be incurred in complying with regulation 39.34.

In the Proposal, the Commission requested comment on the potential costs to a Subpart C DCO to comply with all aspects of proposed regulation 39.34 and any costs that would be imposed on other market participants or the financial system more broadly. The Commission specifically requested comment on any alternative means to satisfy the requirements of regulation 39.34 in a manner consistent with the PFMIs and for costs or cost savings associated with such alternatives.[295] The Commission received one comment in response. MGEX stated that it would require three or four additional employees to comply with the geographic diversity requirements of this rule, unless MGEX were to engage outsourced personnel.

The Commission notes that MGEX could, alternatively, relocate existing positions (rather than increase its headcount). This would require MGEX to incur either relocation or hiring costs, as well as office space for the geographically diverse employees. MGEX provided no estimates of the costs it might incur.

In the absence of input from market participants, the Commission lacks critical information necessary to make a reasonable assessment or quantify dollar costs associated with regulation 39.34. The Commission notes that regulation 39.34 grants a DCO a significant amount of discretion in determining how to comply with the regulation. Moreover, it is possible that each DCO has its own internal cost structure, management system, and existing regulatory compliance framework. Thus, the way in which regulation 39.34 impacts each DCO with respect to initial and ongoing costs likely will vary. For example, some DCOs may already have resources in place that comply with the regulation, in whole or in part, while other DCOs may not.

Accordingly, the Commission is unable to provide a reliable quantification of the costs associated with regulation 39.34, because, among other things, such a determination would require information concerning the business model and strategies of individual DCOs, about which the Commission did not receive information during the comment period. The Commission has no reason to believe, however, that the costs associated with the regulation would be unreasonable or inappropriate to achieve the regulatory objective of implementing the PFMI standards for Subpart C DCOs. In addition, the Commission believes that the costs the regulation imposes would not, to any unnecessary extent, impede a DCO from electing to be subject to Subpart C.

v. Regulation 39.35 (Default rules and procedures for uncovered losses or shortfalls (recovery) for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

As discussed above, regulation 39.35 requires SIDCOs and Subpart C DCOs to adopt rules and procedures to address certain issues arising from extraordinary stress events, including the default of one or more clearing members.[296] Such default rules and procedures must sufficiently (1) allocate uncovered credit losses and (2) enable a SIDCO or Subpart C DCO promptly to meet all of its obligations in the event of a default by one or more clearing members or an unforeseen liquidity shortfall exceeding the financial resources of the SIDCO or Subpart C DCO. As noted in the cost benefit section of the Proposal,[297] the costs associated with these default rules and procedures may include administrative costs to: review and analyze current policies and procedures; design and draft new or amended policies and procedures; and implement the new or amended policies and procedures. The tools that a SIDCO or Subpart C DCO chooses to include in its default rules and procedures may involve capital costs. The Commission continues to believe that these categories accurately summarize the sources of material costs that may be incurred in complying with regulation 39.35.

In the Proposal, the Commission requested comment on the potential costs to a SIDCO or Subpart C DCO to comply with all aspects of proposed regulation 39.35, and any costs that would be imposed on other market participants or the financial system more broadly. The Commission specifically requested comment on any alternative means to satisfy the requirements of regulation 39.35 in a manner consistent with the PFMIs and for costs or cost savings associated with such alternatives.[298] The Commission did not receive any comments in response to these requests.

In the absence of input from market participants, the Commission lacks critical information necessary to make a reasonable assessment or quantify dollar costs associated with regulation 39.35. The Commission notes that regulation 39.35 grants a DCO a certain amount of discretion in determining the specifics of the rules and procedures that should be adopted to comply with the regulation. Moreover, each DCO has its own internal cost structure, management system, and existing regulatory compliance framework. Thus, the way in which regulation 39.35 impacts each DCO with respect to initial and ongoing costs likely will vary. For example, some DCOs may already have rules and procedures that comply with the regulation, in whole or in part, while other DCOs may not.

Accordingly, the Commission is unable to provide a reliable quantification of the costs associated with regulation 39.35, because, among other things, such a determination would require information concerning the business model and strategies of individual DCOs, about which the Commission did not receive information during the comment period. The Commission has no reason to believe, however, that the costs associated with

[293] *See supra* Section II.F. (discussing regulation 39.34).

[294] 78 FR 50290.

[295] *Id.*

[296] *See supra* Section II.G. (discussing regulation 39.35).

[297] 78 FR 50290.

[298] *Id.*

the regulation would be unreasonable or inappropriate to achieve the regulatory objective of implementing the PFMI standards for SIDCOs and Subpart C DCOs. In addition, the Commission believes that the costs the regulation imposes would not, to any unnecessary extent, impede a DCO from electing to be subject to Subpart C.

vi. Regulation 39.36 (Risk management for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

Regulation 39.36 sets forth enhanced risk management requirements for a SIDCO or Subpart C DCO, including, but not limited to, specific criteria for stress tests of financial resources, specific criteria for sensitivity analysis of margin models, specific criteria for stress tests of liquidity resources, requirements surrounding the monitoring and management of credit and liquidity risks arising out of settlement banks, and requirements surrounding the custody and investment of a SIDCO's or Subpart C DCO's own funds and assets.[299] As noted in the Proposal,[300] complying with this regulation may involve operational costs to perform the required testing, monitoring and analyses, which may include: a comprehensive analysis of existing stress testing scenarios; the design of new and/or alternative stress testing scenarios; and the design of a sensitivity analysis; the creation of a system for comprehensively monitoring, managing and limiting credit and liquidity risks arising out of settlement banks; and the implementation of controls surrounding the custody and investment of a SIDCO's or Subpart C DCO's own funds and assets. In addition, there may be costs associated with the modification and/or creation of processes necessary to support the enhanced risk management requirements in the proposed regulation. There will also be ongoing costs to conduct such risk management, analyze the results, and take action based on such results. In particular, to the extent that the analyses and monitoring reveal the need for additional financial or liquidity resources, there would be costs associated with obtaining such resources. In addition, there may be administrative and other costs associated with the management of a SIDCO's or Subpart C DCO's settlement bank exposure. The Commission continues to believe that these categories accurately summarize the sources of material costs that may be incurred in complying with regulation 39.36.

In the Proposal, the Commission requested comment on the potential costs to a SIDCO or Subpart C DCO to comply with all aspects of proposed regulation 39.36, and any costs that would be imposed on other market participants or the financial system more broadly. The Commission specifically requested comment on any alternative means to satisfy the requirements of regulation 39.36 in a manner consistent with the PFMIs and for costs or cost savings associated with such alternatives.[301] The Commission did not receive any comments in response to these requests.

In the absence of input from market participants, the Commission lacks critical information necessary to make a reasonable assessment or quantify dollar costs associated with regulation 39.36. The Commission notes that regulation 39.36 grants a DCO a certain amount of discretion in determining the specifics of the processes that should be adopted to comply with the regulation. Moreover, each DCO has its own internal cost structure, management system, and existing regulatory compliance framework. Thus, the way in which regulation 39.36 impacts each DCO with respect to initial and ongoing costs likely will vary. For example, some DCOs may already have processes that comply with regulation 39.36, in whole or in part, while other DCOs may not.

Accordingly, the Commission is unable to provide a reliable quantification of the costs associated with regulation 39.36, because, among other things, such a determination would require information concerning the operations of individual DCOs, about which the Commission did not receive information during the comment period. The Commission has no reason to believe, however, that the costs associated with the regulation would be unreasonable or inappropriate to achieve the regulatory objective of implementing the PFMI standards for SIDCOs and Subpart C DCOs. In addition, the Commission believes that the costs the regulation imposes would not, to any unnecessary extent, impede a DCO from electing to be subject to Subpart C.

vii. Regulation 39.37 (Additional disclosure for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

As discussed above, regulation 39.37 sets forth additional public disclosure requirements for a SIDCO and Subpart C DCO, including the disclosure of, and updates to, the DCO's responses to the Disclosure Framework for FMIs.[302] As noted in the Proposal,[303] complying with this regulation may impose administrative costs to conduct a comprehensive analysis of the SIDCO or Subpart C DCO's policies, procedures and systems as well as the costs associated with the design, drafting and implementation of any new or modified policies, procedures and systems that would be necessary to comply with the proposed regulation. The Commission continues to believe that these categories accurately summarize the sources of material costs that may be incurred in complying with regulation 39.37.

In the Proposal, the Commission requested comment on the potential costs to a SIDCO or Subpart C to comply with all aspects of proposed regulation 39.37, and any costs that would be imposed on other market participants or the financial system more broadly. The Commission specifically requested comment on any alternative means to satisfy the requirements of regulation 39.37 in a manner consistent with the PFMIs and for costs or cost savings associated with such alternatives.[304] The Commission did not receive any comments in response to these requests.

In the absence of input from market participants, the Commission lacks critical information necessary to make a reasonable assessment or quantify dollar costs associated with regulation 39.37. The Commission notes that regulation 39.37 grants a DCO a certain amount of discretion in determining the specifics of the procedures that should be adopted to comply with the regulation. Moreover, each DCO has its own internal cost structure, management system, and existing regulatory compliance framework. Thus, the way in which regulation 39.37 impacts each DCO with respect to initial and ongoing costs likely will vary. For example, some DCOs may already have rules and processes that comply with the regulation, in whole or in part, while other DCOs may not.

[299] *See supra* Section II.H. (discussing regulation 39.36).

[300] 78 FR 50290.

[301] *Id.*

[302] *See supra* Section II.I. (discussing regulation 39.37).

[303] 78 FR 50290–50291.

[304] *Id.*

Accordingly, the Commission is unable to provide a reliable quantification of the costs associated with regulation 39.37, because, among other things, such a determination would require information concerning the business model and strategies of individual DCOs, about which the Commission did not receive information during the comment period. The Commission has no reason to believe, however, that the costs associated with the regulation would be unreasonable or inappropriate to achieve the regulatory objective of implementing the PFMI standards for SIDCOs and Subpart C DCOs. In addition, the Commission believes that the costs the regulation imposes would not, to any unnecessary extent, impede a DCO from electing to be subject to Subpart C.

viii. Regulation 39.38 (Efficiency for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

As discussed above, regulation 39.38 requires a SIDCO or a Subpart C DCO to comply with certain efficiency standards regarding its clearing and settlement arrangements, operating structure and procedures, product scope, and use of technology. In addition, a SIDCO or Subpart C DCO is required to establish clearly defined goals and objectives that are measureable and achievable, including minimum service levels, risk management expectations, and business priorities.[305] SIDCOs and Subpart C DCOs are also required to facilitate efficient payment, clearing and settlement by accommodating internationally accepted communication procedures and standards. As outlined in the cost benefit section of the Proposal,[306] the costs associated with the regulation may include the administrative costs of conducting a comprehensive review and analysis of the SIDCO's or Subpart C DCO's policies, procedures and systems, and where appropriate, the design, drafting and implementation of new or modified policies, procedures and systems to establish the goals and objectives necessary to comply with this regulation. There may also be administrative costs associated with establishing a mechanism to review the DCO's compliance with the regulation, as well as operational costs associated with designing and implementing processes to accommodate internationally accepted communications standards. The Commission continues to believe that these categories accurately summarize the sources of material costs that may be incurred in complying with regulation 39.38.

In the Proposal, the Commission requested comment on the potential costs to a SIDCO or Subpart C DCO to comply with all aspects of proposed regulation 39.38, and any costs that would be imposed on other market participants or the financial system more broadly. The Commission specifically requested comment on any alternative means to satisfy the requirements of regulation 39.38 in a manner consistent with the PFMIs and for costs or cost savings associated with such alternatives.[307] The Commission did not receive any comments in response to those requests.

In the absence of input from market participants, the Commission lacks critical information necessary to make a reasonable assessment or quantify dollar costs associated with regulation 39.38. The Commission notes that efficiency is inherently difficult to measure.

The Commission also notes that regulation 39.38 grants a DCO a certain amount of discretion in determining the specifics of the processes that should be adopted to comply with the regulation. Moreover, each DCO has its own internal cost structure and management system. Thus, the way in which regulation 39.38 impacts each DCO with respect to initial and ongoing costs likely will vary.

Accordingly, the Commission is unable to provide a reliable quantification of the costs associated with regulation 39.38, because, among other things, such a determination would require information concerning the business model and strategies of individual DCOs, about which the Commission did not receive information during the comment period. The Commission has no reason to believe, however, that the costs associated with the regulation would be unreasonable or inappropriate to achieve the regulatory objective of implementing the PFMI standards for SIDCOs and Subpart C DCOs. In addition, the Commission believes that the costs the regulation imposes would not, to any unnecessary extent, impede a DCO from electing to be subject to Subpart C.

ix. Regulation 39.39 (Recovery and wind-down for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

As discussed above, regulation 39.39 requires a SIDCO or Subpart C DCO to maintain viable plans for recovery and orderly wind-down, in cases necessitated by (1) credit losses or liquidity shortfalls and (2) general business risk, operational risk, or any other risk that threatens the DCO's viability as a going concern. This requires the DCO to identify scenarios that may prevent a SIDCO or Subpart C DCO from being able to provide its critical operations and services as a going concern and to assess the effectiveness of a full range of options for recovery or orderly wind-down. The regulation also requires a SIDCO or Subpart C DCO to evaluate the resources available to meet the plan to cover credit losses and liquidity shortfalls, and to maintain sufficient unencumbered liquid financial assets to implement the plan to cover other risks. The latter point requires a SIDCO or Subpart C DCO to analyze whether its particular circumstances and risks require it to maintain liquid net assets to fund the plan that are in addition to those resources currently required by regulation 39.11(a)(2).

As noted in the Proposal,[308] regulation 39.39 may impose costs on a SIDCO or Subpart C DCO to the extent it will be necessary to undertake a comprehensive qualitative and quantitative analysis of the credit, liquidity, general business, operational and other risks that may threaten the DCO's ability to provide its critical operations and services as a going concern, to design and draft plans to mitigate and address those risks, to analyze whether the DCO's resources allocated to recovery and/or wind-down are sufficient to implement those plans. This analysis may lead to the design of alternative and/or additional scenarios to be included in stress testing, the drafting of new or revised policies for a recovery and/or wind-down plan, and potentially the necessity of maintaining additional resources or procedures to obtain such resources in the event they are needed. Moreover, the regulation prohibits the double counting of available resources—that is, resources considered as available to meet the recovery and orderly wind-down plan for credit losses and liquidity shortfalls cannot be considered as available to meet the recovery and orderly wind-

[305] *See supra* Section II.J. (discussing regulation 39.38).

[306] 78 FR 50291.

[307] *Id.*

[308] 78 FR 50291.

down plan for general business risk, operational risk, and other risks (or vice-versa). This may result in the need to maintain a larger quantum of total resources to meet both plans which, depending on the resources maintained, may involve costs arising from factors such as greater use of capital by the DCO, or greater capital charges for clearing members arising out of their commitments to contribute default resources. The Commission continues to believe that these categories accurately summarize the sources of material costs that may be incurred in complying with regulation 39.39.

In the Proposal, the Commission requested comment on the potential costs to a SIDCO or Subpart C DCO to comply with all aspects of proposed regulation 39.39, and any costs that would be imposed on other market participants or the financial system more broadly. The Commission specifically requested comment on any alternative means to satisfy the requirements of regulation 39.39 in a manner consistent with the PFMIs and for costs or cost savings associated with such alternatives.[309] The Commission did not receive any comments in response to these requests.

In the absence of input from market participants, the Commission lacks critical information necessary to make a reasonable assessment or quantify dollar costs associated with regulation 39.39. The Commission notes that regulation 39.39 grants a DCO a certain amount of discretion in determining the specifics of the rules, procedures, and arrangements that should be adopted to comply with the regulation. Moreover, each DCO has its own internal cost structure, management system, and existing regulatory compliance framework. Thus, the way in which regulation 39.39 impacts each DCO with respect to initial and ongoing costs likely will vary. For example, some DCOs may already have rules, processes, and arrangements that comply with the regulation, in whole or in part, while other DCOs may not.

Accordingly, the Commission is unable to provide a reliable quantification of the costs associated with regulation 39.39, because, among other things, such a determination would require information concerning the business model and strategies of individual DCOs, about which the Commission did not receive information during the comment period. The Commission has no reason to believe, however, that the costs associated with the regulation would be unreasonable or inappropriate to achieve the regulatory objective of implementing the PFMI standards for SIDCOs and Subpart C DCOs. In addition, the Commission believes that the costs the regulation imposes would not, to any unnecessary extent, impede a DCO from electing to be subject to Subpart C.

b. Benefits

As explained in the subsections that follow, this final rule holds SIDCOs and Subpart C DCOs to enhanced regulatory standards, which are designed to promote the financial strength, operational integrity, security, and reliability of these organizations and to reduce the likelihood of their disruption or failure. This, in turn, increases the overall stability of the U.S. financial markets. As the PFMIs note, FMIs, including CCPs (*i.e.* DCOs), play a critical role in fostering financial stability.[310] This is particularly the case with respect to SIDCOs. The Council has determined that the failure of or a disruption to the functioning of a SIDCO could create or increase the risk of significant liquidity or credit problems spreading among financial institutions or markets and thereby threaten the stability of the U.S. financial system.[311] Thus, the final rule offers a substantial benefit vis-à-vis the status quo.

In addition, the regulations adopted in this final rulemaking are consistent with the international standards set forth in the PFMIs and address the remaining divergences between part 39 of the Commission's regulations and the PFMIs. These regulations will help ensure that SIDCOs and Subpart C DCOs are held to international standards in order to provide them with the opportunity to gain QCCP status. As discussed above, attaining QCCP status will provide clearing members that are banks, as well as banks that are customers of clearing members, with the benefit of complying with less onerous capital requirements, pursuant to the Basel CCP Capital Requirements, than if the SIDCO or Subpart C DCO were not a QCCP.[312] In turn, this may increase a SIDCO or Subpart C DCO's competitiveness vis-à-vis non-US clearing organizations that demonstrate compliance with international standards and are QCCPs.

i. Regulation 39.31 (Election To Become Subject to the Provisions of Subpart C)

The procedures set forth in regulation 39.31, together with the Subpart C Election Form, are intended to promote the protection of market participants and the public. These procedures require the Commission's staff to conduct a review of a DCO that elects to become subject to the provisions of Subpart C. The Subpart C Election Form provides the Commission, clearing members, and customers (and, significantly, the regulators of such clearing members and customers) with assurance that the electing DCO will be held to and will be required to meet the standards set forth in Subpart C.[313] Without regulation 39.31, a DCO that is not designated by the Council as being systemically important will not have the opportunity to gain QCCP status, thereby potentially putting such a DCO at a significant competitive disadvantage compared to SIDCOs and non-U.S. clearing organizations. This would ultimately be to the detriment of such a DCO's clearing members and their customers.[314] The Commission also notes that by clearing through a Subpart C DCO, a clearing member and its customers will be afforded the benefits of clearing through a DCO subject to enhanced risk management, operational, and other standards.

Regulation 39.31, as adopted herein, provides a benefit to a Subpart C DCO by allowing the Subpart C DCO the opportunity to weigh for itself the costs and benefits and to determine whether to maintain QCCP status. The notice requirements set forth in the regulation provide important benefits to clearing members of the rescinding Subpart C DCO (and their customers), particularly those that are banks or bank affiliates, by providing them with advance notice to permit them to assess their options and take any actions they deem appropriate with respect to clearing at a DCO that has acted to rescind its election to be held to the standards of Subpart C (and thus to renounce status as a QCCP).

ii. Regulation 39.32 (Governance for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

The requirements set forth in regulation 39.32 are beneficial to the extent that they cause a SIDCO or Subpart C DCO to internalize and/or more appropriately allocate certain costs

[309] *Id.*

[310] PFMIs, E.N. 1.1.

[311] *See http://www.treasury.gov/initiatives/fsoc/designations/Pages/default.aspx* (describing the designations of CME and ICE Clear Credit to be systemically important financial market utilities) and *see supra* Section I.C.

[312] *See supra* Section I.F.

[313] *See* 78 FR 50269.

[314] *See supra* Section I.F. (discussing QCCP status and the Basel CCP Capital Requirements); *see also supra* Section II.C. (discussing regulation 39.31).

that would otherwise be borne by clearing members, customers of clearing members, and other relevant stakeholders. Such requirements also promote market stability because the governance arrangements of SIDCOs and Subpart C DCOs are required to explicitly support the stability of the financial system and other relevant public interest considerations of clearing members, customers of clearing members, and other relevant stakeholders,[315] and reflect the legitimate interests of clearing members, customers of clearing members, and other relevant stakeholders. Finally, the governance arrangements required by regulation 39.32 promote a more efficient, effective, and reliable DCO risk management and operating structure.

As noted above, the Commission did not receive any comments focused specifically on the cost and benefit considerations relevant to regulation 39.32.

iii. Regulation 39.33 (Financial resources for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

As described above, regulation 39.33(a), as revised, expands the Cover Two minimum financial resources requirement to include Subpart C DCOs that engage in an activity with a more complex risk profile (*e.g.,* clearing credit default swaps or credit default futures), or that are systemically important in multiple jurisdictions.[316] This proposed regulation currently applies to SIDCOs. Regulation 39.33(a), as finalized herein, increases the financial stability of Subpart C DCOs subject to this regulation by requiring compliance with enhanced minimum financial resource requirements. Compliance with such standards, in turn, increases the overall stability of the U.S. financial markets because enhancing a Subpart C DCO's financial resources requirements from the minimum of Cover One to a more stringent Cover Two standard helps to ensure the affected Subpart C DCO will have greater financial resources to meet its obligations to market participants, including in the case of defaults by multiple clearing members. These added financial resources lessen the likelihood of the Subpart C DCO's failure which, in times of market turmoil, could increase the risk to the stability of the U.S. financial system.[317] By bolstering certain Subpart C DCO's resources, regulation 39.33(a) contributes to the financial integrity of the financial markets and reduces the likelihood of systemic risk from spreading through the financial markets due to the Subpart C DCO's failure or disruption. In addition, the approach of obtaining resources in such low-stress periods avoids the need to call for additional resources from clearing members during less stable, more volatile times, which would have pro-cyclical effects on the U.S. financial markets.

As discussed above, regulation 39.33(a)(2) provides the Commission with the ability to determine whether a SIDCO or a Subpart C DCO is systemically important in multiple jurisdictions. In making such a determination, the Commission will consider whether the DCO is a SIDCO and whether the DCO has been determined to be systemically important by one or more foreign jurisdictions pursuant to a designation process that considers whether the foreseeable effects of a failure or disruption of the SIDCO or Subpart C DCO could threaten the stability of each relevant jurisdiction's financial system. Moreover, regulation 39.33(a)(3) also provides the Commission with the ability to expand the definition of ''activity with a more complex risk profile'' beyond clearing credit default swaps or credit default futures. These provisions give the Commission the flexibility to determine, under appropriate circumstances, what particular SIDCOs or Subpart C DCOs (or DCOs that engage in certain activities) would need to maintain Cover Two default resources. Such a decision would help to ensure that the affected SIDCO or Subpart C DCO would have greater financial resources to meet its obligations to market participants, including in the case of defaults by multiple clearing members. These added financial resources would decrease the likelihood that the SIDCO or Subpart C DCO would fail, thus contributing to the integrity and stability of the financial markets.

Regulation 39.33(b) prohibits a Subpart C DCO from using assessments to meets its default resource obligations, *i.e.,* those under regulations 39.11(a)(1) and 39.33(a). This prohibition currently applies to SIDCOs. Prohibiting the use of assessments by a Subpart C DCO in meeting its default resource requirement increases the financial stability of the Subpart C DCO, which in turn, will increase the overall stability of the U.S. financial markets.

Assessment powers are more likely to be exercised during periods of financial market stress. If, during such a period, a clearing member defaults and the loss to the Subpart C DCO is sufficiently large to deplete (1) the collateral posted by the defaulting clearing member, (2) the defaulting clearing member's guaranty fund contribution, and (3) the remaining pre-funded default fund contributions, a Subpart C DCO's exercise of assessment powers over the non-defaulting clearing members may exacerbate a presumably already weakened financial market. The demand by a Subpart C DCO for more capital from its clearing members could force one or more additional clearing members into default because they cannot meet the assessment. The inability to meet the assessment could lead clearing members and/or their customers to de-leverage (*i.e.,* sell off their positions) in falling asset markets, which further drives down asset prices and may result in clearing members and/or their customers defaulting on their obligations to each other and/or to the Subpart C DCO. In such extreme circumstances, assessments could trigger a downward spiral and lead to the destabilization of the financial markets. Prohibiting the use of assessments by a Subpart C DCO in meeting default resources requirements is intended to require the Subpart C DCO to retain more financial resources upfront, *i.e.,* to prefund its financial resources requirement to cover its potential exposure.

The increase in prefunding of financial resources by a Subpart C DCO may increase costs to clearing members of that Subpart C DCO (*e.g.,* requiring clearing members to post additional funds with the Subpart C DCO), but it also reduces the likelihood that the Subpart C DCO will require additional capital infusions during a time of financial stress when raising such additional capital is expensive relative to market norms. By increasing prefunded financial resources, a Subpart C DCO becomes less reliant on the ability of its clearing members to pay an assessment, more secure in its ability to meets its obligations, and more viable in any given situation, even in the case of multiple defaults of clearing members. Accordingly, regulation 39.33(b) increases the financial security and reliability of the Subpart C DCO, which will, therefore, further increase the overall stability of the U.S. financial markets.

As described above, regulations 39.33(c), (d) and (e) increase the likelihood that a SIDCO or Subpart C DCO will promptly meet its settlement

[315] *See supra* Section II.D. (discussing regulation 39.32).

[316] *See supra* Section II.E. (discussing revised regulation 39.33).

[317] *See supra* Section I.B.

obligations in a variety of market conditions. Liquidity arrangements that are highly reliable in stressed market conditions are important to enable the SIDCO or Subpart C DCO to promptly meet its cash obligations to its members. Ensuring that the SIDCO or Subpart C DCO can meet those obligations promptly, particularly in stressed market conditions, is an important firebreak to avoid loss of market confidence and cascading defaults.

Specifically, regulation 39.33(c) requires a SIDCO or Subpart C DCO to maintain a minimum level of eligible liquidity resources that would permit the DCO to satisfy its intraday, same-day, and multi-day settlement obligations in all relevant currencies. Regulation 39.33(d) requires a SIDCO or Subpart C DCO to undertake due diligence to confirm that each liquidity provider upon which the DCO relies has the capacity to perform its commitments to provide liquidity (and to regularly test its own procedures for accessing its liquidity resources). Proposed regulation 39.33(e) requires a SIDCO or Subpart C DCO to document its supporting rationale for, and to have adequate governance arrangements relating to, the amount of total financial resources it maintains and the amount of total liquidity resources it maintains.

In determining the resources that would be necessary to meet the qualifying liquid resources requirements, a SIDCO or Subpart C DCO may need to undertake a complex analysis of the SIDCO's or Subpart C DCO's exposures and processes, including various models, and, where appropriate, designing and implementing changes to either create or modify existing internal processes and documenting the rationale for the amount of total financial and total liquidity resources the SIDCO or Subpart C DCO maintains. These efforts are likely to contribute to a better *ex ante* understanding by the SIDCO's or Subpart C DCO's management of the liquidity risks the DCO is likely to face in a stress scenario, resources that are calculated to enable the DCO to completely meets its settlement obligations on a prompt basis despite the default of a clearing member, and better assurance of its ability to rely on the commitments of its liquidity providers. The result of this analysis and these enhanced resources is likely to be better preparation to meet liquidity challenges promptly, and a greater likelihood that the DCO would efficiently and effectively meet its obligations promptly in a default scenario. This improved preparation and enhanced likelihood of the SIDCO or Subpart C DCO's prompt meeting of its own obligations will benefit the DCO's clearing members and their customers by avoiding an inability to meet settlement obligations that might cause cascading liquidity problems to such clearing members and their customers. The harm to clearing members and customers from a failure of a SIDCO or Subpart C DCO to meet its obligations promptly would be especially serious in a time of general financial stress. The assurance of the DCO meeting its settlement obligations promptly would also redound to the benefit of the larger financial system by mitigating systemic risk.

iv. Regulation 39.34 (System safeguards for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

As discussed above, regulation 39.34, as revised, requires SIDCOs and Subpart C DCOs to comply with enhanced system safeguards requirements, including a two-hour RTO.[318] While SIDCOs are already subject to these requirements, the Commission expanded this regulation to include Subpart C DCOs. A two-hour RTO in a Subpart C DCO's BC–DR plan will increase the soundness and operating resiliency of the Subpart C DCO. The two-hour RTO ensures that even in the event of a wide-scale disruption, the potential negative effects upon U.S. financial markets would be minimized because the affected Subpart C DCO would recover rapidly and resume its critical market functions. This would allow other market participants to process their transactions, including those participants in locations not directly affected by the disruption. The two-hour RTO would increase a Subpart C DCO's resiliency by requiring the Subpart C DCO to have the resources and technology necessary to resume operations promptly. This resiliency, in turn, will increase the overall stability of the U.S. financial markets.

v. Regulation 39.35 (Default rules and procedures for uncovered losses or shortfalls (recovery) for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

Regulation 39.35, as detailed above, requires SIDCOs and Subpart C DCOs to adopt explicit rules and procedures for: i) allocating uncovered credit losses and ii) meeting all settlement obligations in a variety of market conditions. [319] The analysis SIDCOs and Subpart C DCOs will need to perform to create these rules and procedures are likely to contribute to a better ex ante understanding by the SIDCO or Subpart C DCO of the scenarios that would lead to uncovered credit losses or liquidity shortfalls. This analysis will also enable the SIDCO or Subpart C DCO to more effectively and efficiently meet its obligations promptly, thereby avoiding harm to clearing members and their customers from a default. In addition, requiring SIDCOs and Subpart C DCOs to have clear rules and procedures addressing such scenarios will be beneficial for clearing members and their customers in that these rules and procedures will provide clearing members with a better understanding of the members' own obligations, and the extent to which the SIDCO or Subpart C DCO would perform its obligations to its clearing members during periods of market stress. This understanding will, in turn, contribute to the ability of clearing members and their customers to tailor their own contingency plans to address those circumstances. Improved preparation by SIDCOs, Subpart C DCOs, and their clearing members will also redound to the benefit of the larger financial system by mitigating systemic risk.

vi. Regulation 39.36 (Risk management for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

As discussed above, Regulation 39.36 establishes enhanced risk management requirements designed to help SIDCOs and Subpart C DCOs manage their risk exposure.[320] These requirements include the stress testing of their financial resources, the stress testing of their liquidity resources, and conducting regular sensitivity analyses of their margin methodologies. The analyses performed to comply with this regulation will increase the DCO's ability to mitigate and address credit risks, and to create proper incentives for members with respect to the exposures they create to the SIDCO or Subpart C DCO by enabling the DCO to tie risk exposures to margin requirements. In addition, regulation 39.36 requires a SIDCO or Subpart C DCO to monitor, manage and limit its credit and liquidity risks arising from its settlement banks, as well invest its own funds and assets

[318] *See supra* Section II.F. (discussing regulation 39.34).

[319] *See supra* Section II.G. (discussing regulation 39.35).

[320] *See supra* Section II.H. (discussing regulation 39.36).

in instruments with minimal credit, market, and liquidity risks.

Regulation 39.36, as adopted herein, increases the SIDCO's or Subpart C DCO's ability to mitigate and address the probability of being exposed to a settlement bank's failure and the potential losses and liquidity pressures to which the SIDCO or Subpart C DCO would be exposed in the event of such a failure. This, in turn, will benefit members of such DCOs and their customers, as discussed above. By enhancing the reliability and stability of SIDCOs and Subpart C DCOs, regulation 39.36 strengthens the overall stability of the U.S. financial markets.

vii. Regulation 39.37 (Additional disclosure for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

The disclosure requirements set forth in regulation 39.37 [321] benefit clearing members of SIDCOs and Subpart C DCOs, as well as customers of clearing members, because they provide transparency and certainty concerning the processes, operations and exposures of these DCOs. In particular, paragraph (d) requires a SIDCO or Subpart C DCO to publicly disclose its policies and procedures concerning the segregation and portability of customers' positions and funds. These disclosures will enable clearing members and their customers to better understand their respective exposures to the SIDCO or Subpart C DCO, to better choose a DCO that fits their needs, and, in turn, to create incentives for safe and effective operations of SIDCOs and Subpart C DCOs.

viii. Regulation 39.38 (Efficiency for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

The efficiency requirements set forth in regulation 39.38 will be beneficial to clearing members of SIDCOs and Subpart C DCOs, as well as to customers of clearing members, because they will require these DCOs to regularly endeavor to improve their clearing and settlement arrangements, operating structures and procedures, product offerings, and use of technology. In addition, under this regulation, SIDCOs and Subpart C DCOs are required to facilitate efficient payment, clearing and settlement by accommodating internationally accepted communication procedures and standards, which may result in operational efficiency for market participants. Accordingly, members of such DCOs and their customers, as well as the marketplace more broadly, may be offered more efficient clearing services that may be easier to access at an operational level.

ix. Regulation 39.39 (Recovery and wind-down for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations)

Regulation 39.39, as described in detail above, requires a SIDCO and Subpart C DCO to maintain viable plans for recovery and orderly wind-down, in cases necessitated by (1) credit losses or liquidity shortfalls and (2) general business risk, operational risk, or any other risk that threatens the derivatives clearing organization's viability as a going concern. This requires the DCO to identify scenarios that may prevent a SIDCO or Subpart C DCO from being able to provide its critical operations and services as a going concern and to assess the effectiveness of a full range of options for recovery or orderly wind-down.

Regulation 39.39 also requires a SIDCO or Subpart C DCO to evaluate the resources available to meet the plan to cover credit losses and liquidity shortfalls, and to maintain sufficient unencumbered liquid financial assets to implement the plan to cover other risks. The latter point requires a SIDCO or Subpart C DCO to analyze whether its particular circumstances and risks require it to maintain liquid net assets to fund the plan that are in addition to those resources currently required by regulation 39.11(a)(2).[322]

The complex analysis and plan preparation that a SIDCO or Subpart C DCO will undertake to comply with this regulation, including designing and implementing changes to existing plans, are likely to contribute to a better *ex ante* understanding by the SIDCO's or Subpart C DCO's management of the challenges the DCO would face in a recovery or wind-down scenario, and thus better preparation to meet those challenges. This improved preparation will help reduce the possibility of market disruptions and financial losses to clearing members and their customers. By maintaining and regularly updating recovery and wind-down plans, and maintaining resources and arrangements designed to meet the requirements of such plans, the DCO will better be able to mitigate the impact that a threat to, or a disruption of, a SIDCO's or Subpart C DCO's operations would have on customers, clearing members, and, more broadly, the stability of the U.S. financial markets. By reducing the possibility that a DCO would default in a disorganized fashion, regulation 39.39, as adopted herein, also helps to reduce the likelihood of a failure by the DCO to meet its obligations to its members, thereby enhancing protection for members of such a DCO and their customers, as well as helping to avoid the systemic effects of DCO failure.

4. Section 15(a) Factors

a. Protection of Market Participants and the Public

The regulations finalized herein create additional standards for compliance with the CEA, which include governance standards, enhanced financial resources and liquidity resource requirements, system safeguard requirements, special default rules and procedures for uncovered losses or shortfalls, enhanced risk management requirements, additional disclosure requirements, efficiency standards, and standards for recovery and wind-down procedures. They also include procedures for Subpart C DCOs to elect to be held to such additional standards, and procedures to rescind such election. These standards and procedures will further the protection of members of SIDCOs and Subpart C DCOs, customers of such members, as well as other market participants and the public by increasing the financial stability and operational security of SIDCOs and Subpart C DCOs. Additionally, these regulations may, more broadly, increase the stability of the U.S. financial markets. A designation of systemic importance under Title VIII means the failure of a SIDCO or the disruption of its clearing and settlement activities could create or increase the risk of significant liquidity or credit problems spreading among financial institutions or markets, thereby threatening the stability of the U.S. financial markets. The regulations contained in this final rule are designed to help ensure that SIDCOs continue to function even in extreme circumstances, including multiple defaults by clearing members and wide-scale disruptions. While there may be increased costs associated with the implementation of these regulations, the increased costs associated with the implementation of the final rule for Subpart C DCOs would be borne only by those DCOs that have not been designated systemically important under Title VIII and that elect to become subject to the provisions of Subpart C. Some of those costs would ultimately be borne by clearing

[321] *See supra* Section II.I. (discussing regulation 39.37).

[322] *See supra* Section II.K. (discussing regulation 39.39).

members of such Subpart C DCOs, and by customers of such clearing members.

The costs of this final rulemaking will likely be mitigated by the countervailing benefits of stronger resources, improved design, more efficient and effective processes, and enhanced planning that would lead to increased safety and soundness of SIDCOs and the reduction of systemic risk, which protect market participants and the public from the adverse consequences, including loss of market confidence or potentially cascading defaults, that would result from a SIDCO's failure to promptly meet its obligations to its members, or a disruption in its functioning. Similarly, the regulations will increase the safety and soundness of Subpart C DCOs so that they may continue to operate even in extreme circumstances, which would, in turn, better protect members of such DCOs, their customers, and also market participants and the public, particularly during time of severe market stress.

b. Efficiency, Competitiveness, and Financial Integrity

The regulations set forth in this final rulemaking promote the financial strength and stability of SIDCOs and Subpart C DCOs, as well as, more broadly, efficiency and greater competition in the global markets. Regulation 39.38, as finalized herein, expressly promotes efficiency in the design of a SIDCO's or Subpart C DCO's settlement and clearing arrangements, operating structure and procedures, scope of products cleared, and use of technology. The regulation also requires SIDCOs and Subpart C DCOs to accommodate internationally accepted communication procedures and standards to facilitate efficient payment, clearing, and settlement. In addition, the regulations finalized herein promote efficiency insofar as SIDCOs and Subpart C DCOs that operate with enhanced financial and liquidity resources, enhanced risk management requirements, increased system safeguards, and wind-down or recovery plans are more secure and are less likely to fail.

These regulations also promote competition because they are consistent with the international standards set forth in the PFMIs and will help to ensure that SIDCOs are held to international standards and thus are enabled to gain QCCP status and accordingly avoid an important competitive disadvantage relative to similarly situated foreign CCPs that meet international standards and are QCCPs. Moreover, by allowing other DCOs to elect to become subject to the provisions of Subpart C and thus the opportunity to meet international standards and to gain QCCP status, these regulations promote competition among registered DCOs, and between registered DCOs and foreign CCPs that meet international standards and are QCCPs. Conversely, the Commission notes that these enhanced financial resources and risk management standards are also associated with additional costs and to the extent that SIDCOs and Subpart C DCOs pass along the additional costs to their clearing members and, indirectly, those clearing members' customers, participation in the affected markets may decrease and have a negative impact on price discovery. However, it would appear that such higher transactional costs should (at least in the case of clearing members and customers that are banks or bank affiliates) be offset by the lower capital charges granted to bank or bank affiliated clearing members and customers for exposures resulting from transactions that are cleared through SIDCOs and Subpart C DCOs that are also QCCPs.

Additionally, enhanced risk management and operational standards promote financial integrity by leading to SIDCOs and Subpart C DCOs to be more secure and less likely to fail. By increasing the stability and strength of the SIDCOs and Subpart C DCOs, the regulations in this final rulemaking will would help SIDCOs and Subpart C DCOs to meet their obligations in extreme circumstances and be able to resume operations even in the face of wide-scale disruption, which contributes to the financial integrity of the financial markets. Moreover, in requiring (1) more financial resources to be pre-funded by expanding the potential losses those resources are intended to cover and restricting the means for satisfying those resource requirements, and (2) requiring greater liquidity resources, the requirements of these regulations seek to lessen the incidence of pro-cyclical demands for additional resources and, in so doing, promote both financial integrity and market stability. By promoting the ability of SIDCOs and Subpart C DCOs to promptly meet their obligations to members, including in times of extreme market stress, they will mitigate the potential loss of market confidence, and the potential for cascading defaults. These efforts will redound to the benefit of clearing members and their customers, as well as the financial system more broadly.

c. Price Discovery

The regulations in this final rulemaking will enhance financial resources, liquidity resources, risk management standards, disclosure standards, and recovery planning for SIDCOs and Subpart C DCOs which may result in increased public confidence, which, in turn, might lead to expanded participation in the affected markets (including markets with products with a more complex risk profile). The expanded participation in these markets (*i.e.,* greater transactional volume) may have a positive impact on price discovery. Conversely, the Commission notes that these regulations are also associated with additional costs and to the extent that SIDCOs and Subpart C DCOs pass along the additional costs to their clearing members and, indirectly, to their clearing members' customers, participation in the affected markets may decrease and have a negative impact on price discovery. However, it is the Commission's belief that such higher transactional costs should be offset by the lower capital charges granted to clearing members and customers with exposures resulting from transactions cleared through SIDCOs and Subpart C DCOs that are deemed QCCPs.

d. Sound Risk Management Practices

The regulations in this final rulemaking contribute to the sound risk management practices of SIDCOs and Subpart C DCOs because the requirements promote the safety and soundness of SIDCOs and Subpart C DCOs by: (1) Enhancing the financial resources requirements and liquidity resource requirements; (2) enhancing understanding of credit and liquidity risks and related governance arrangements; (3) enhancing system safeguards to facilitate the continuous operation and rapid recovery of activities; [323] (4) enhancing risk management standards by creating new stress testing and sensitivity analysis requirements; (5) promoting the active management of credit and liquidity risks arising from settlement banks; [324] and (6) enhancing risk management by establishing rules and procedures addressing uncovered credit losses or liquidity shortfalls, and recovery and wind-down planning for credit risks and for business continuity and operational risks.[325] In addition, by strengthening

[323] As mentioned above, this rulemaking would extend to Subpart C DCOs the system safeguards requirements currently applicable to SIDCOs. *See supra* Section II.F. (discussing revised regulation 39.34 (system safeguards)).

[324] *See supra* Section II.H. (discussing regulation 39.36).

[325] *See supra* Section II.G. (discussing regulation 39.35); *see also supra* Section II.K. (discussing regulation 39.39).

financial and liquidity resource requirements, enhancing risk management standards, and enhancing disclosure and recovery planning requirements, the regulations in this final rule provide greater certainty for clearing members of such DCOs, their customers, and other market participants that obligations of the SIDCOs and Subpart C DCOs will be honored promptly (thereby facilitating market participants own management of risks, including mitigating the risk that participants will be faced, at a time of market stress, with a failure by the SIDCO or Subpart C DCO to promptly meet its obligations to them), and provide certainty and security to market participants that potential disruptions will be reduced and, by extension, the risk of loss of capital and liquidity will be reduced.

e. Other Public Interest Considerations

The Commission notes the strong public interest for jurisdictions to either adopt the PFMIs or establish standards consistent with the PFMIs in order to allow CCPs licensed in the relevant jurisdiction to gain QCCP status. As emphasized throughout this final rulemaking, SIDCOs and Subpart C DCOs that are held to international standards and that gain QCCP status might hold a competitive advantage in the financial markets by, *inter alia,* helping bank clearing members and bank customers avoid the much higher capital charges imposed by the Basel CCP Capital Requirements on exposures to non-QCCPs. Moreover, because ''enhancements to the regulation and supervision of systemically important financial market utilities * * * are necessary * * * to support the stability of the broader financial system,'' [326] adopting the regulations in this final rule will promote the public interest in a more stable broader financial system.

List of Subjects

17 CFR Part 39

Commodity futures, Consumer protection, Default rules and procedures, Reporting and recordkeeping requirements, Risk management, Settlement procedures, System safeguards.

17 CFR Part 140

Authority delegations (Government agencies), Conflict of interests, Organization and functions (Government agencies).

17 CFR Part 190

Bankruptcy, Brokers, Commodity futures, Reporting and recordkeeping requirements.

For the reasons stated in the preamble, the Commodity Futures Trading Commission amends 17 CFR parts 39, 140, and 190 as follows:

PART 39—DERIVATIVES CLEARING ORGANIZATIONS

■ 1. The authority citation for part 39 is revised to read as follows:

Authority: 7 U.S.C. 2, 7a–1, and 12a; 12 U.S.C. 5464; 15 U.S.C. 8325.

■ 2. Revise § 39.2 to read as follows:

§ 39.2 Definitions.

For the purposes of this part:

Activity with a more complex risk profile includes:

(1) Clearing credit default swaps, credit default futures, or derivatives that reference either credit default swaps or credit default futures and

(2) Any other activity designated as such by the Commission pursuant to § 39.33(a)(3).

Back test means a test that compares a derivatives clearing organization's initial margin requirements with historical price changes to determine the extent of actual margin coverage.

Customer means a person trading in any commodity named in the definition of commodity in section 1a(9) of the Act or in § 1.3 of this chapter, or in any swap as defined in section 1a(47) of the Act or in § 1.3 of this chapter; *Provided, however,* an owner or holder of a house account as defined in this section shall not be deemed to be a customer within the meaning of section 4d of the Act, the regulations that implement sections 4d and 4f of the Act and § 1.35 of this chapter, and such an owner or holder of such a house account shall otherwise be deemed to be a customer within the meaning of the Act and §§ 1.37 and 1.46 of this chapter and all other sections of these rules, regulations, and orders which do not implement sections 4d and 4f of the Act.

Customer account or *customer origin* means a clearing member account held on behalf of customers, as that term is defined in this section, and which is subject to section 4d(a) or section 4d(f) of the Act.

Depository institution has the meaning set forth in section 19(b)(1)(A) of the Federal Reserve Act (12 U.S.C. 461(b)(1)(A)).

House account or *house origin* means a clearing member account which is not subject to section 4d(a) or 4d(f) of the Act.

Key personnel means derivatives clearing organization personnel who play a significant role in the operations of the derivatives clearing organization, the provision of clearing and settlement services, risk management, or oversight of compliance with the Act and Commission regulations and orders. Key personnel include, but are not limited to, those persons who are or perform the functions of any of the following: chief executive officer; president; chief compliance officer; chief operating officer; chief risk officer; chief financial officer; chief technology officer; and emergency contacts or persons who are responsible for business continuity or disaster recovery planning or program execution.

Stress test means a test that compares the impact of potential extreme price moves, changes in option volatility, and/or changes in other inputs that affect the value of a position, to the financial resources of a derivatives clearing organization, clearing member, or large trader, to determine the adequacy of the financial resources of such entities.

Subpart C derivatives clearing organization means any derivatives clearing organization, as defined in section 1a(15) of the Act and § 1.3(d) of this chapter, which:

(1) Is registered as a derivatives clearing organization under section 5b of the Act;

(2) Is not a systemically important derivatives clearing organization; and

(3) Has become subject to the provisions of subpart C of this part, pursuant to § 39.31.

Systemically important derivatives clearing organization means a financial market utility that is a derivatives clearing organization registered under section 5b of the Act, which is currently designated by the Financial Stability Oversight Council to be systemically important and for which the Commission acts as the Supervisory Agency pursuant to 12 U.S.C. 5462(8).

U.S. branch or agency of a foreign banking organization means the U.S. branch or agency of a foreign banking organization as defined in section 1(b) of the International Banking Act of 1978 (12 U.S.C. 3101).

Trust company means a trust company that is a member of the Federal Reserve System, under section 1 of the Federal Reserve Act (12 U.S.C. 221), but that does not meet the definition of depository institution.

■ 3. Revise subpart C to read as follows:

[326] *See* Section 802(a)(4) of the Dodd-Frank Act (Congressional findings).

Subpart C—Provisions Applicable to Systemically Important Derivatives Clearing Organizations and Derivatives Clearing Organizations That Elect To Be Subject to the Provisions of This Subpart

Sec.
39.30 Scope.
39.31 Election to become subject to the provisions of this subpart.
39.32 Governance for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.
39.33 Financial resources for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.
39.34 System safeguards for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.
39.35 Default rules and procedures for uncovered credit losses or liquidity shortfalls (recovery) for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.
39.36 Risk management for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.
39.37 Additional disclosure for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.
39.38 Efficiency for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.
39.39 Recovery and wind-down for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.
39.40 Consistency with the Principles for Financial Market Infrastructures.
39.41 Special enforcement authority for systemically important derivatives clearing organizations.
39.42 Advance notice of material risk-related rule changes by systemically important derivatives clearing organizations.
Appendix A to Part 39—Form DCO Derivatives Clearing Organization Application for Registration
Appendix B to Part 39—Subpart C Election Form

§ 39.30 Scope.

(a) The provisions of this subpart apply to each of the following: a subpart C derivatives clearing organization, a systemically important derivatives clearing organization, and any derivatives clearing organization, as defined under section 1a(15) of the Act and § 1.3(d) of this chapter, seeking to become a subpart C derivatives clearing organization pursuant to § 39.31.

(b) A systemically important derivatives clearing organization is subject to the provisions of subparts A and B of this part in addition to the provisions of this subpart.

(c) A subpart C derivatives clearing organization is subject to the provisions of subparts A and B of this part in addition to the provisions of this subpart except for §§ 39.41 and 39.42.

§ 39.31 Election to become subject to the provisions of this subpart.

(a) *Election eligibility.* (1) A derivatives clearing organization that is registered with the Commission and that is not a systemically important derivatives clearing organization may elect to become a subpart C derivatives clearing organization subject to the provisions of this subpart, using the procedures set forth in paragraph (b) of this section.

(2) An applicant for registration as a derivatives clearing organization pursuant to § 39.3 may elect to become a subpart C derivatives clearing organization subject to the provisions of this subpart as part of its application for registration using the procedures set forth in paragraph (c) of this section.

(b) *Election and withdrawal procedures applicable to registered derivatives clearing organizations*—(1) *Election.* A derivatives clearing organization that is registered with the Commission and that is not a systemically important derivatives clearing organization may request that the Commission accept its election to become a subpart C derivatives clearing organization by filing with the Commission a completed Subpart C Election Form. The Subpart C Election Form shall include the election and all certifications, disclosures and exhibits, as provided in appendix B to this part and any amendments or supplements thereto filed with the Commission pursuant to paragraphs (b)(2) and (3) of this section.

(2) *Submission of supplemental information.* The filing of a Subpart C Election Form does not create a presumption that the Subpart C Election Form is materially complete or that supplemental information will not be required. The Commission, at any time prior to the effective date, as provided in paragraph (b)(4) of this section, may request that the derivatives clearing organization submit supplemental information in order for the Commission to process the Subpart C Election Form, and the derivatives clearing organization shall file such supplemental information with the Commission.

(3) *Amendments.* A derivatives clearing organization shall promptly amend its Subpart C Election Form if it discovers a material omission or error in, or if there is a material change in, the information provided to the Commission in the Subpart C Election Form or other information provided in connection with the Subpart C Election Form.

(4) *Effective date.* A derivatives clearing organization's election to become a subpart C derivatives clearing organization shall become effective:

(i) Upon the later of the following, provided the Commission has neither stayed nor denied such election as set forth in paragraph (b)(5) of this section.

(A) The effective date specified by the derivatives clearing organization in its Subpart C Election Form; or

(B) Ten business days after the derivatives clearing organization files its Subpart C Election Form with the Commission;

(ii) Or upon the effective date set forth in written notification from the Commission that it shall permit the election to take effect after a stay issued pursuant to paragraph (b)(5) of this section.

(5) *Stay or denial of election.* Prior to the effective date set forth in paragraph (b)(4)(i) of this section, the Commission may stay or deny a derivatives clearing organization's election to become a subpart C derivatives clearing organization by issuing a written notification thereof to the derivatives clearing organization.

(6) *Commission acknowledgement.* The Commission may acknowledge, in writing, that it has received a Subpart C Election Form filed by a derivatives clearing organization and that it has permitted the derivatives clearing organization's election to become subject to the provisions of this subpart to take effect, and the effective date of such election.

(7) *Withdrawal of election.* A derivatives clearing organization that has filed a Subpart C Election Form may withdraw an election to become subject to the provisions of this subpart at any time prior to the date that the election is permitted to take effect by filing with the Commission a notice of the withdrawal of election.

(c) *Election and withdrawal procedures applicable to applicants for registration as derivatives clearing organization*—(1) *Election.* An applicant for registration as a derivatives clearing organization that requests an election to become subject to the provisions of this subpart may make that request by attaching a completed Subpart C Election Form to the Form DCO that it files pursuant to § 39.3. The Subpart C Election Form shall include the election and all certifications, disclosures and exhibits, as provided in appendix B of

this part, and any amendments or supplements thereto filed with the Commission pursuant to paragraphs (c)(3) or (4) of this section.

(2) *Election review and effective date.* The Commission shall review the applicant's Subpart C Election Form as part of the Commission's review of its application for registration pursuant to § 39.3(a). The Commission may permit the applicant's election to take effect at the time it approves the applicant's application for registration by providing written notice thereof to the applicant. The Commission shall not approve any application for registration filed pursuant to § 39.3(a) for which a Subpart C Election Form is pending, if the Commission determines that the applicant's election to become subject to this subpart should not become effective because the applicant has not demonstrated its ability to comply with the applicable provisions of this subpart.

(3) *Submission of supplemental information.* The filing of a Subpart C Election Form does not create a presumption that the Subpart C Election Form is materially complete or that supplemental information will not be required. At any time during the Commission's review of the Subpart C Election Form, the Commission may request that the applicant submit supplemental information in order for the Commission to process the Subpart C Election Form and the applicant shall file such supplemental information with the Commission.

(4) *Amendments.* An applicant for registration as a derivatives clearing organization shall promptly amend its Subpart C Election Form if it discovers a material omission or error in, or if there is a material change in, the information provided to the Commission in the Subpart C Election Form or other information provided in connection with the Subpart C Election Form.

(5) *Withdrawal of election.* An applicant for registration as a derivatives clearing organization may withdraw an election to become subject to the provisions of this subpart by filing with the Commission a notice of the withdrawal of its Subpart C Election Form at any time prior to the date that the Commission approves its application for registration as a derivatives clearing organization. The applicant may withdraw its Subpart C Election Form without withdrawing its Form DCO.

(d) *Public information.* The following portions of the Subpart C Election Form will be public: The Elections and Certifications and Disclosures in the Subpart C Election Form, the rules of the derivatives clearing organization, the regulatory compliance chart, and any other portion of the Subpart C Election Form not covered by a request for confidential treatment complying with the requirements of § 145.9 of this chapter.

(e) *Rescission of election.* (1) *Notice of intent to rescind.* A subpart C derivatives clearing organization may rescind its election to be subject to the provisions of this subpart and terminate its status as a subpart C derivatives clearing organization by filing with the Commission a notice of its intent to rescind such election. The notice of intent to rescind the election shall include:

(i) The effective date of the rescission; and

(ii) A certification signed by the relevant duly authorized representative of the subpart C derivatives clearing organization, as specified in paragraph three of the General Instructions to the Subpart C Election Form, stating that the subpart C derivatives clearing organization:

(A) Has provided the notice to its clearing members required by paragraph (e)(3)(i)(A) of this section;

(B) Will provide the notice to its clearing members required by paragraph (e)(3)(i)(B) of this section;

(C) Has provided the notice to the general public required by paragraph (e)(3)(ii)(A) of this section;

(D) Will provide notice to the general public required by paragraph (e)(3)(ii)(B) of this section; and

(E) Has removed all references to the organization as a subpart C derivatives clearing organization and a qualifying central counterparty on its Web site and in all other material that it provides to its clearing members and customers, other market participants or members of the public, as required by paragraph (e)(3)(ii)(C) of this section.

(2) *Effective date.* The rescission of the election to be subject to the provisions of this subpart shall become effective on the date set forth in the notice of intent to rescind the election filed by the subpart C derivatives clearing organization pursuant to paragraph (e)(1) of this section, provided that the rescission may become effective no earlier than 180 days after the notice of intent to rescind the election is filed with the Commission. The subpart C derivatives clearing organization shall continue to comply with all of the provisions of this subpart until such effective date.

(3) *Additional notice requirements.* (i) A subpart C derivatives clearing organization shall provide the following notices, at the following times, to each of its clearing members and shall have rules in place requiring each of its clearing members to provide the following notices to each of the clearing member's customers:

(A) No later than the filing of a notice of its intent to rescind its election to be subject to the provisions of this subpart, written notice that it intends to file such notice with the Commission and the effective date thereof; and

(B) On the effective date of the rescission of its election to be subject to the provisions of this subpart, written notice that the rescission has become effective.

(ii) A subpart C derivatives clearing organization shall:

(A) No later than the filing of a notice of its intent to rescind its election to be subject to the provisions of this subpart, provide notice to the general public, displayed prominently on its Web site, of its intent to rescind its election to be subject to the provisions of this subpart;

(B) On and after the effective date of the rescission of its election to be subject to the provisions of this subpart, provide notice to the general public, displayed prominently on its Web site, that the rescission has become effective; and

(C) Prior to the filing of a notice of its intent to rescind its election to become subject to the provisions of this subpart, remove all references to the derivatives clearing organization's status as a subpart C derivatives clearing organization and a qualifying central counterparty on its Web site and in all other materials that it provides to its clearing members and customers, other market participants, or the general public.

(iii) The employees and representatives of a derivatives clearing organization that has filed a notice of its intent to rescind its election to be subject to the provisions of this subpart shall refrain from referring to the organization as a subpart C derivatives clearing organization and a qualifying central counterparty on and after the date that the notice of intent to rescind the election is filed.

(4) *Effect of rescission.* The rescission of a subpart C derivatives clearing organization's election to be subject to the provisions of this subpart shall not affect the authority of the Commission concerning any activities or events occurring during the time that the derivatives clearing organization maintained its status as a subpart C derivatives clearing organization.

(f) *Loss of designation as a systemically important derivatives clearing organization.* A systemically

important derivatives clearing organization whose designation of systemic importance is rescinded by the Financial Stability Oversight Council, shall immediately be deemed to be a subpart C derivatives clearing organization and shall continue to comply with the provisions of this subpart unless such derivatives clearing organization elects to rescind its status as a subpart C derivatives clearing organization in accordance with the requirements of paragraph (e) of this section.

(g) All forms and notices required by this section shall be filed electronically with the Secretary of the Commission in the format and manner specified by the Commission.

§ 39.32 Governance for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.

(a) *General rules.* (1) Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall have governance arrangements that:

(i) Are written;

(ii) Are clear and transparent;

(iii) Place a high priority on the safety and efficiency of the systemically important derivatives clearing organization or subpart C derivatives clearing organization; and

(iv) Explicitly support the stability of the broader financial system and other relevant public interest considerations of clearing members, customers of clearing members, and other relevant stakeholders.

(2) The board of directors shall make certain that the systemically important derivatives clearing organization's or subpart C derivatives clearing organization's design, rules, overall strategy, and major decisions appropriately reflect the legitimate interests of clearing members, customers of clearing members, and other relevant stakeholders.

(3) To an extent consistent with other statutory and regulatory requirements on confidentiality and disclosure:

(i) Major decisions of the board of directors should be clearly disclosed to clearing members, other relevant stakeholders, and to the Commission; and

(ii) Major decisions of the board of directors having a broad market impact should be clearly disclosed to the public;

(b) *Governance arrangements.* Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall have governance arrangements that:

(1) Are clear and documented;

(2) To an extent consistent with other statutory and regulatory requirements on confidentiality and disclosure, are disclosed, as appropriate, to the Commission and to other relevant authorities, to clearing members and to customers of clearing members, to the owners of the systemically important derivatives clearing organization or subpart C derivatives clearing organization, and to the public;

(3) Describe the structure pursuant to which the board of directors, committees, and management operate;

(4) Include clear and direct lines of responsibility and accountability;

(5) Clearly specify the roles and responsibilities of the board of directors and its committees, including the establishment of a clear and documented risk management framework;

(6) Clearly specify the roles and responsibilities of management;

(7) Describe procedures for identifying, addressing, and managing conflicts of interest involving members of the board of directors;

(8) Describe procedures pursuant to which the board of directors oversees the chief risk officer, risk management committee, and material risk decisions;

(9) Assign responsibility and accountability for risk decisions, including in crises and emergencies; and

(10) Assign responsibility for implementing the:

(i) Default rules and procedures required by §§ 39.16 and 39.35;

(ii) System safeguard rules and procedures required by §§ 39.18 and 39.34; and

(iii) Recovery and wind-down plans required by § 39.39.

(c) *Fitness standards for board of directors and management.* Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall maintain policies to make certain that:

(1) The board of directors consists of suitable individuals having appropriate skills and incentives;

(2) The board of directors includes individuals who are not executives, officers or employees of the systemically important derivatives clearing organization or subpart C derivatives clearing organization or an affiliate thereof;

(3) The performance of the board of directors and the performance of individual directors are reviewed on a regular basis;

(4) Managers have the appropriate experience, skills, and integrity necessary to discharge operational and risk management responsibilities; and

(5) Risk management and internal control personnel have sufficient independence, authority, resources, and access to the board of directors so that the operations of the systemically important derivatives clearing organization or subpart C derivatives clearing organization are consistent with the risk management framework established by the board of directors.

§ 39.33 Financial resources requirements for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.

(a) *General rule.* (1) Notwithstanding the requirements of § 39.11(a)(1), each systemically important derivatives clearing organization and subpart C derivatives clearing organization that, in either case, is systemically important in multiple jurisdictions or is involved in activities with a more complex risk profile shall maintain financial resources sufficient to enable it to meet its financial obligations to its clearing members notwithstanding a default by the two clearing members creating the largest combined loss to the derivatives clearing organization in extreme but plausible market conditions.

(2) The Commission shall, if it deems appropriate, determine whether a systemically important derivatives clearing organization or subpart C derivatives clearing organization is systemically important in multiple jurisdictions. In determining whether a systemically important derivatives clearing organization or subpart C derivatives clearing organization is systemically important in multiple jurisdictions, the Commission shall consider whether the derivatives clearing organization:

(i) Is a systemically important derivatives clearing organization, as defined by § 39.2; or

(ii) Has been determined to be systemically important by one or more jurisdictions other than the United States pursuant to a designation process that considers whether the foreseeable effects of a failure or disruption of the derivatives clearing organization could threaten the stability of each relevant jurisdiction's financial system.

(3) The Commission shall, if it deems appropriate, determine whether any of the activities of a systemically important derivatives clearing organization or a subpart C derivatives clearing organization, in addition to clearing credit default swaps, credit default futures, and any derivatives that reference either credit default swaps or credit default futures, has a more complex risk profile. In determining whether an activity has a more complex

risk profile, the Commission will consider characteristics such as discrete jump-to-default price changes or high correlations with potential participant defaults as factors supporting (though not necessary for) a finding of a more complex risk profile.

(4) For purposes of this section, if a clearing member controls another clearing member or is under common control with another clearing member, such affiliated clearing members shall be deemed to be a single clearing member.

(b) *Valuation of financial resources.* Notwithstanding the provisions of § 39.11(d)(2), assessments for additional guaranty fund contributions (*i.e.,* guaranty fund contributions that are not pre-funded) shall not be included in calculating the financial resources available to meet a systemically important derivatives clearing organization's or subpart C derivatives clearing organization's obligations under paragraph (a) of this section or § 39.11(a)(1).

(c) *Liquidity resources.* (1) *Minimum amount of liquidity resources.* (i) Notwithstanding the provisions of § 39.11(e)(1)(ii), each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall maintain eligible liquidity resources that, at a minimum, will enable it to meet its intraday, same-day, and multiday obligations to perform settlements, as defined in § 39.14(a)(1), with a high degree of confidence under a wide range of stress scenarios that should include, but not be limited to, a default by the clearing member creating the largest aggregate liquidity obligation for the systemically important derivatives clearing organization or subpart C derivatives clearing organization in extreme but plausible market conditions.

(ii) A systemically important derivatives clearing organization and subpart C derivatives clearing organization that is subject to § 39.33(a)(1) shall *consider* maintaining eligible liquidity resources that, at a minimum, will enable it to meet its intraday, same-day, and multiday obligations to perform settlements, as defined in § 39.14(a)(1), with a high degree of confidence under a wide range of stress scenarios that should include, but not be limited to, a default of the two clearing members creating the largest aggregate liquidity obligation for the systemically important derivatives clearing organization or subpart C derivatives clearing organization in extreme but plausible market conditions.

(2) *Satisfaction of settlement in all relevant currencies.* Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall maintain liquidity resources that are sufficient to satisfy the obligations required by paragraph (c)(1) of this section in all relevant currencies for which the systemically important derivatives clearing organization or subpart C derivatives clearing organization has obligations to perform settlements, as defined in § 39.14(a)(1), to its clearing members.

(3) *Qualifying liquidity resources.* (i) Only the following liquidity resources are eligible for the purpose of meeting the requirement of paragraph (c)(1) of this section:

(A) Cash in the currency of the requisite obligations, held either at the central bank of issue or at a creditworthy commercial bank;

(B) Committed lines of credit;

(C) Committed foreign exchange swaps;

(D) Committed repurchase agreements; or

(E) (*1*) Highly marketable collateral, including high quality, liquid, general obligations of a sovereign nation.

(*2*) The assets described in paragraph (c)(3)(i)(E)(*1*) of this section must be readily available and convertible into cash pursuant to prearranged and highly reliable funding arrangements, even in extreme but plausible market conditions.

(ii) With respect to the arrangements described in paragraph (c)(3)(i) of this section, the systemically important derivatives clearing organization or subpart C derivatives clearing organization must take appropriate steps to verify that such arrangements do not include material adverse change conditions and are enforceable, and will be highly reliable, in extreme but plausible market conditions.

(4) *Additional liquidity resources.* If a systemically important derivatives clearing organization or subpart C derivatives clearing organization maintains financial resources in addition to those required to satisfy paragraph (c)(1) of this section, then those resources should be in the form of assets that are likely to be saleable with proceeds available promptly or acceptable as collateral for lines of credit, swaps, or repurchase agreements on an *ad hoc* basis. A systemically important derivatives clearing organization or subpart C derivatives clearing organization should consider maintaining collateral with low credit, liquidity, and market risks that is typically accepted by a central bank of issue for any currency in which it may have settlement obligations, but shall not assume the availability of emergency central bank credit as a part of its liquidity plan.

(d) *Liquidity providers.* (1) For the purposes of this paragraph, a liquidity provider means:

(i) A depository institution, a U.S. branch or agency of a foreign banking organization, a trust company, or a syndicate of depository institutions, U.S. branches or agencies of foreign banking organizations, or trust companies providing a line of credit, foreign exchange swap facility or repurchase facility to a systemically important derivatives clearing organization or subpart C derivatives clearing organization;

(ii) Any other counterparty relied upon by a systemically important derivatives clearing organization or subpart C derivatives clearing organization to meet its minimum liquidity resources requirement under paragraph (c) of this section.

(2) In fulfilling its obligations under paragraph (c) of this section, each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall undertake due diligence to confirm that each of its liquidity providers, whether or not such liquidity provider is a clearing member, has:

(i) Sufficient information to understand and manage the liquidity provider's liquidity risks; and

(ii) The capacity to perform as required under its commitments to provide liquidity to the systemically important derivatives clearing organization or subpart C derivatives clearing organization.

(3) Where relevant to a liquidity provider's ability reliably to perform its commitments with respect to a particular currency, the systemically important derivatives clearing organization or subpart C derivatives clearing organization may take into account the liquidity provider's access to the central bank of issue of that currency.

(4) Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall regularly test its procedures for accessing its liquidity resources under paragraph (c)(3)(i) of this section, including testing its arrangements under paragraph (c)(3)(ii) and its relevant liquidity provider(s) under paragraph (d)(1) of this section.

(e) *Documentation of financial resources and liquidity resources.* Each systemically important derivatives clearing organization and subpart C

derivatives clearing organization shall document its supporting rationale for, and have appropriate governance arrangements relating to, the amount of total financial resources it maintains pursuant to paragraph (a) of this section and the amount of total liquidity resources it maintains pursuant to paragraph (c) of this section.

§ 39.34 System safeguards for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.

(a) Notwithstanding § 39.18(e)(3), the business continuity and disaster recovery plan described in § 39.18(e)(1) for each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall have the objective of enabling, and the physical, technological, and personnel resources described in § 39.18(e)(1) shall be sufficient to enable, the systemically important derivatives clearing organization or subpart C derivatives clearing organization to recover its operations and resume daily processing, clearing, and settlement no later than two hours following the disruption, for any disruption including a wide-scale disruption.

(b) To facilitate its ability to achieve the recovery time objective specified in paragraph (a) of this section in the event of a wide-scale disruption, each systemically important derivatives clearing organization and subpart C derivatives clearing organization must maintain a degree of geographic dispersal of physical, technological and personnel resources consistent with the following for each activity necessary for the daily processing, clearing, and settlement of existing and new contracts:

(1) Physical and technological resources (including a secondary site), sufficient to enable the entity to meet the recovery time objective after interruption of normal clearing by a wide-scale disruption, must be located outside the relevant area of the physical and technological resources the systemically important derivatives clearing organization or subpart C derivatives clearing organization normally relies upon to conduct that activity, and must not rely on the same critical transportation, telecommunications, power, water, or other critical infrastructure components the entity normally relies upon for such activities;

(2) Personnel, who live and work outside that relevant area, sufficient to enable the entity to meet the recovery time objective after interruption of normal clearing by a wide-scale disruption affecting the relevant area in which the personnel the entity normally relies upon to engage in such activities are located;

(3) The provisions of § 39.18(f) shall apply to these resource requirements.

(c) Each systemically important derivatives clearing organization and subpart C derivatives clearing organization must conduct regular, periodic tests of its business continuity and disaster recovery plans and resources and its capacity to achieve the required recovery time objective in the event of a wide-scale disruption. The provisions of § 39.18(j) apply to such testing.

(d) The Commission may, upon request, grant an entity, which has been designated as a systemically important derivatives clearing organization or that has elected to become subject to subpart C, up to one year to comply with any provision of this section.

§ 39.35 Default rules and procedures for uncovered credit losses or liquidity shortfalls (recovery) for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.

(a) *Allocation of uncovered credit losses.* Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall adopt explicit rules and procedures that address fully any loss arising from any individual or combined default relating to any clearing members' obligations to the systemically important derivatives clearing organization or subpart C derivatives clearing organization. Such rules and procedures shall address how the systemically important derivatives clearing organization or subpart C derivatives clearing organization would:

(1) Allocate losses exceeding the financial resources available to the systemically important derivatives clearing organization or subpart C derivatives clearing organization;

(2) Repay any funds it may borrow; and

(3) Replenish any financial resources it may employ during such a stress event, so that the systemically important derivatives clearing organization or subpart C derivatives clearing organization can continue to operate in a safe and sound manner.

(b) *Allocation of uncovered liquidity shortfalls.* (1) Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall establish rules and/or procedures that enable it promptly to meet all of its settlement obligations, on a same day and, as appropriate, intraday and multiday basis, in the context of the occurrence of either or both of the following scenarios:

(i) An individual or combined default involving one or more clearing members' obligations to the systemically important derivatives clearing organization or subpart C derivatives clearing organization; or

(ii) A liquidity shortfall exceeding the financial resources of the systemically important derivatives clearing organization or subpart C derivatives clearing organization.

(2) The rules and procedures described in paragraph (b)(1) of this section shall:

(i) Enable the systemically important derivatives clearing organization or subpart C derivatives clearing organization promptly to meet its payment obligations in all relevant currencies;

(ii) Be designed to enable the systemically important derivatives clearing organization or subpart C derivatives clearing organization to avoid unwinding, revoking, or delaying the same-day settlement of payment obligations; and

(iii) Address the systemically important derivatives clearing organization's or subpart C derivatives clearing organization's process to replenish any liquidity resources it may employ during a stress event so that it can continue to operate in a safe and sound manner.

§ 39.36 Risk management for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.

(a) *Stress tests of financial resources.* In addition to conducting stress tests pursuant to § 39.13(h)(3), each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall conduct stress tests of its financial resources in accordance with the following standards and practices:

(1) Perform, on a daily basis, stress testing of its financial resources using predetermined parameters and assumptions;

(2) Perform comprehensive analyses of stress testing scenarios and underlying parameters to ascertain their appropriateness for determining the systemically important derivatives clearing organization's or subpart C derivatives clearing organization's required level of financial resources in current and evolving market conditions;

(3) Perform the analyses required by paragraph (a)(2) of this section at least

monthly and when products cleared or markets served display high volatility or become less liquid, when the size or concentration of positions held by clearing members increases significantly, or as otherwise appropriate, evaluate the stress testing scenarios, models, and underlying parameters more frequently than once a month;

(4) For the analyses required by paragraphs (a)(1) and (2) of this section, include a range of relevant stress scenarios, in terms of both defaulting clearing members' positions and possible price changes in liquidation periods. The scenarios considered shall include, but are not limited to, the following:

(i) Relevant peak historic price volatilities;

(ii) Shifts in other market factors including, as appropriate, price determinants and yield curves;

(iii) Multiple defaults over various time horizons;

(iv) Simultaneous pressures in funding and asset markets; and

(v) A range of forward-looking stress scenarios in a variety of extreme but plausible market conditions.

(5) Establish procedures for:

(i) Reporting stress test results to its risk management committee or board of directors, as applicable; and

(ii) Using the results to assess the adequacy of, and to adjust, its total amount of financial resources; and

(6) Use the results of stress tests to support compliance with the minimum financial resources requirement set forth in § 39.33(a).

(b) *Sensitivity analysis of margin model.* (1) Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall, at least monthly and more frequently as appropriate, conduct a sensitivity analysis of its margin models to analyze and monitor model performance and overall margin coverage. Sensitivity analysis shall be conducted on both actual and hypothetical positions.

(2) For the purposes of this paragraph (b), a sensitivity analysis of a margin model includes:

(i) Reviewing a wide range of parameter settings and assumptions that reflect possible market conditions in order to understand how the level of margin coverage might be affected by highly stressed market conditions. The range of parameters and assumptions should capture a variety of historical and hypothetical conditions, including the most volatile periods that have been experienced by the markets served by the systemically important derivatives clearing organization or subpart C derivatives clearing organization and extreme changes in the correlations between prices. The parameters and assumptions should be appropriate in light of the specific characteristics, considered on a current basis, of particular products and portfolios cleared.

(ii) Testing of the ability of the models or model components to produce accurate results using actual or hypothetical datasets and assessing the impact of different model parameter settings.

(iii) Evaluating potential losses in clearing members' proprietary positions and, where appropriate, customer positions.

(3) A systemically important derivatives clearing organization or subpart C derivatives clearing organization involved in activities with a more complex risk profile shall take into consideration parameter settings that reflect the potential impact of the simultaneous default of clearing members and, where applicable, the underlying credit instruments.

(c) *Stress tests of liquidity resources.* Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall conduct stress tests of its liquidity resources in accordance with the following standards and practices:

(1) Perform, on a daily basis, stress testing of its liquidity resources using predetermined parameters and assumptions;

(2) Perform comprehensive analyses of stress testing scenarios and underlying parameters to ascertain their appropriateness for determining the systemically important derivatives clearing organization's or subpart C derivatives clearing organization's required level of liquidity resources in current and evolving market conditions;

(3) Perform the analyses required by paragraph (c)(2) of this section at least monthly and when products cleared or markets served display high volatility or become less liquid, when the size or concentration of positions held by clearing members increases significantly, or as otherwise appropriate, evaluate its stress testing scenarios, models, and underlying parameters more frequently than once a month;

(4) For the analyses required by paragraphs (c)(1) and (2) of this section, include a range of relevant stress scenarios, in terms of both defaulting clearing members' positions and possible price changes in liquidation periods. The scenarios considered shall include, but are not limited to, the following:

(i) Relevant peak historic price volatilities;

(ii) Shifts in other market factors including, as appropriate, price determinants and yield curves;

(iii) Multiple defaults over various time horizons;

(iv) Simultaneous pressures in funding and asset markets; and

(v) A range of forward-looking stress scenarios in a variety of extreme but plausible market conditions.

(5) For the scenarios enumerated in paragraph (c)(4) of this section, consider the following:

(i) All entities that might pose material liquidity risks to the systemically important derivatives clearing organization or subpart C derivatives clearing organization, including settlement banks, permitted depositories, liquidity providers, and other entities,

(ii) Multiday scenarios as appropriate,

(iii) Inter-linkages between its clearing members and the multiple roles that they may play in the systemically important derivatives clearing organization's or subpart C derivatives clearing organization's risk management; and

(iv) The probability of multiple failures and contagion effect among clearing members.

(6) Establish procedures for:

(i) Reporting stress test results to its risk management committee or board of directors, as applicable; and

(ii) Using the results to assess the adequacy of, and to adjust its total amount of liquidity resources.

(7) Use the results of stress tests to support compliance with the liquidity resources requirement set forth in § 39.33(c).

(d) Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall regularly conduct an assessment of the theoretical and empirical properties of its margin model for all products it clears.

(e) Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall perform, on an annual basis, a full validation of its financial risk management model and its liquidity risk management model.

(f) *Custody and investment risk.* Custody and investment arrangements of a systemically important derivatives clearing organization's and subpart C derivatives clearing organization's own funds and assets shall be subject to the same requirements as those specified in § 39.15 for the funds and assets of

clearing members, and shall apply to the derivatives clearing organization's own funds and assets to the same extent as if such funds and assets belonged to clearing members.

(g) *Settlement banks.* Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall:

(1) Monitor, manage, and limit its credit and liquidity risks arising from its settlement banks;

(2) Establish, and monitor adherence to, strict criteria for its settlement banks that take account of, among other things, their regulation and supervision, creditworthiness, capitalization, access to liquidity, and operational reliability; and

(3) Monitor and manage the concentration of credit and liquidity exposures to its settlement banks.

§ 39.37 Additional disclosure for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.

In addition to the requirements of § 39.21, each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall:

(a) Complete and publicly disclose its responses to the Disclosure Framework for Financial Market Infrastructures published by the Committee on Payment and Settlement Systems and the Board of the International Organization of Securities Commissions;

(b) Review and update its responses disclosed as required by paragraph (a) of this section at least every two years and following material changes to the systemically important derivatives clearing organization's or subpart C derivatives clearing organization's system or the environment in which it operates. A material change to the systemically important derivatives clearing organization's or subpart C derivatives clearing organization's system or the environment in which it operates is a change that would significantly change the accuracy and usefulness of the existing responses;

(c) Disclose, publicly and to the Commission, relevant basic data on transaction volume and values; and

(d) Disclose, publicly and to the Commission, rules, policies, and procedures concerning segregation and portability of customers' positions and funds, including whether each of:

(1) Futures customer funds, as defined in § 1.3(jjjj) of this chapter;

(2) Cleared Swaps Customer Collateral, as defined in § 22.1 of this chapter; or

(3) Foreign futures or foreign options secured amount, as defined in § 1.3(rr) of this chapter is:

(i) Protected on an individual or omnibus basis or

(ii) Subject to any constraints, including any legal or operational constraints that may impair the ability of the systemically important derivatives clearing organization or subpart C derivatives clearing organization to segregate or transfer the positions and related collateral of a clearing member's customers.

§ 39.38 Efficiency for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.

(a) *General rule.* In order to meet the needs of clearing members and markets, each systemically important derivatives clearing organization and subpart C derivatives clearing organization should efficiently and effectively design its:

(1) Clearing and settlement arrangements;

(2) Operating structure and procedures;

(3) Scope of products cleared; and

(4) Use of technology.

(b) *Review of efficiency.* Each systemically important derivatives clearing organization and subpart C derivatives clearing organization should establish a mechanism to review, on a regular basis, its compliance with paragraph (a) of this section.

(c) *Clear goals and objectives.* Each systemically important derivatives clearing organization and subpart C derivatives clearing organization should have clearly defined goals and objectives that are measurable and achievable, including in the areas of minimum service levels, risk management expectations, and business priorities.

(d) Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall facilitate efficient payment, clearing and settlement by accommodating internationally accepted communication procedures and standards.

§ 39.39 Recovery and wind-down for systemically important derivatives clearing organizations and subpart C derivatives clearing organizations.

(a) *Definitions.* For purposes of this section:

(1) *General business risk* means any potential impairment of a systemically important derivatives clearing organization's or subpart C derivatives clearing organization's financial position, as a business concern, as a consequence of a decline in its revenues or an increase in its expenses, such that expenses exceed revenues and result in a loss that the derivatives clearing organization must charge against capital.

(2) *Wind-down* means the actions of a systemically important derivatives clearing organization or subpart C derivatives clearing organization to effect the permanent cessation or sale or transfer or one or more services.

(3) *Recovery* means the actions of a systemically important derivatives clearing organization or subpart C derivatives clearing organization, consistent with its rules, procedures, and other *ex-ante* contractual arrangements, to address any uncovered credit loss, liquidity shortfall, capital inadequacy, or business, operational or other structural weakness, including the replenishment of any depleted pre-funded financial resources and liquidity arrangements, as necessary to maintain the systemically important derivatives clearing organization's or subpart C derivatives clearing organization's viability as a going concern.

(4) *Operational risk* means the risk that deficiencies in information systems or internal processes, human errors, management failures or disruptions from external events will result in the reduction, deterioration, or breakdown of services provided by a systemically important derivatives clearing organization or subpart C derivatives clearing organization.

(5) *Unencumbered liquid financial assets* include cash and highly liquid securities.

(b) *Recovery and wind-down plan.* Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall maintain viable plans for:

(1) Recovery or orderly wind-down, necessitated by uncovered credit losses or liquidity shortfalls; and, separately,

(2) Recovery or orderly wind-down necessitated by general business risk, operational risk, or any other risk that threatens the derivatives clearing organization's viability as a going concern.

(c)(1) In developing the plans specified in paragraph (b) of this section, the systemically important derivatives clearing organization or subpart C derivatives clearing organization shall identify scenarios that may potentially prevent it from being able to meet its obligations, provide its critical operations and services as a going concern and assess the effectiveness of a full range of options for recovery or orderly wind-down. The plans shall include procedures for informing the

Commission, as soon as practicable, when the recovery plan is initiated or wind-down is pending.

(2) A systemically important derivatives clearing organization or subpart C derivatives clearing organization shall have procedures for providing the Commission and the Federal Deposit Insurance Corporation with information needed for purposes of resolution planning.

(d) *Financial resources to support the recovery and wind-down plan.*

(1) In evaluating the resources available to cover an uncovered credit loss or liquidity shortfall as part of its recovery plans pursuant to paragraph (b)(1) of this section, a systemically important derivatives clearing organization or subpart C derivatives clearing organization may consider, among other things, assessments of additional resources provided for under its rules that it reasonably expects to collect from non-defaulting clearing members.

(2) Each systemically important derivatives clearing organization and subpart C derivatives clearing organization shall maintain sufficient unencumbered liquid financial assets, funded by the equity of its owners, to implement its recovery or wind-down plans pursuant to paragraph (b)(2) of this section. In general, the financial resources required by § 39.11(a)(2) may be sufficient, but the systemically important derivatives clearing organization or subpart C derivatives clearing organization shall analyze its particular circumstances and risks and maintain any additional resources that may be necessary to implement the plans. In allocating sufficient financial resources to implement the plans, the systemically important derivatives clearing organization or subpart C derivatives clearing organization shall comply with § 39.11(e)(2). The plan shall include evidence and analysis to support the conclusion that the amount considered necessary is, in fact, sufficient to implement the plans.

(3) Resources counted in meeting the requirements of §§ 39.11(a)(1) and 39.33 may not be allocated, in whole or in part, to the recovery plans required by paragraph (b)(2) of this section. Other resources may be allocated, in whole or in part, to the recovery plans required by either paragraphs (b)(1) or (2) of this section, but not both paragraphs, and only to the extent the use of such resources is not otherwise limited by the Act, Commission regulations, the systemically important derivatives clearing organization's or subpart C derivatives clearing organization's rules, or any contractual arrangements to which the systemically important derivatives clearing organization or subpart C derivatives clearing organization is a party.

(e) *Plan for raising additional financial resources.* All systemically important derivatives clearing organizations and subpart C derivatives clearing organizations shall maintain viable plans for raising additional financial resources, including, where appropriate, capital, in a scenario in which the systemically important derivatives clearing organization or subpart C derivatives clearing organization is unable, or virtually unable, to comply with any financial resources requirements set forth in this part. This plan shall be approved by the board of directors and be updated regularly.

(f) The Commission may, upon request, grant an entity, which has been designated as a systemically important derivatives clearing organization or that has elected to become subject to subpart C, up to one year to comply with any provision of this section or of § 39.35.

§ 39.40 Consistency with the Principles for Financial Market Infrastructures.

This subpart C is intended to establish standards which, together with subparts A and B of this part, are consistent with section 5b(c) of the Act and the Principles for Financial Market Infrastructures published by the Committee on Payment and Settlement Systems and the Board of the International Organization of Securities Commissions and should be interpreted in that context.

§ 39.41 Special enforcement authority for systemically important derivatives clearing organizations.

For purposes of enforcing the provisions of Title VIII of the Dodd-Frank Act, a systemically important derivatives clearing organization shall be subject to, and the Commission has authority under the provisions of subsections (b) through (n) of section 8 of the Federal Deposit Insurance Act (12 U.S.C. 1818) in the same manner and to the same extent as if the systemically important derivatives clearing organization were an insured depository institution and the Commission were the appropriate Federal banking agency for such insured depository institution.

§ 39.42 Advance notice of material risk-related rule changes by systemically important derivatives clearing organizations.

A systemically important derivatives clearing organization shall provide notice to the Commission in advance of any proposed change to its rules, procedures, or operations that could materially affect the nature or level of risks presented by the systemically important derivatives clearing organization, in accordance with the requirements of § 40.10 of this chapter.

§§ 39.28 and 39.29 [Added and Reserved]

■ 4. In subpart B, add reserved §§ 39.28 and 39.29.

Appendix to Part 39 [Redesignated as Appendix A to Part 39]

■ 5. Redesignate the Appendix to Part 39—Form DCO Derivatives Clearing Organization Application for Registrations as Appendix A to Part 39—Form DCO Derivatives Clearing Organization Application for Registrations.

■ 6. Add appendix B to part 39 to read as follows:

Appendix B to Part 39—Subpart C Election Form

COMMODITY FUTURES TRADING COMMISSION

SUBPART C ELECTION FORM

GENERAL INSTRUCTIONS

GENERAL INSTRUCTIONS: Intentional misstatements or omissions of fact may constitute federal criminal violations (7 U.S.C. 13 and 18 U.S.C. 1001).

DEFINITIONS

Unless the context requires otherwise, all terms used in this Subpart C Election Form have the same meaning as in the Commodity Exchange Act (''Act''), and in the General Rules and Regulations of the Commodity Futures Trading Commission (''Commission'') thereunder. All references to Commission regulations are found at 17 CFR Ch. 1.

For purposes of this Subpart C Election Form, the term ''Applicant'' shall mean a derivatives clearing organization that is filing this Subpart C Election Form with a Form DCO as part of an application for registration as a derivatives clearing organization pursuant to Section 5b of the Act and 17 CFR 39.3(a).

GENERAL INSTRUCTIONS

1. Any derivatives clearing organization requesting an election to become subject to subpart C of part 39 of the Commission's regulations must file this Subpart C Election Form. The Subpart C Election Form includes the election to be subject to the provisions of subpart C of part 39 of the Commission's regulations, certain required certifications, disclosures, and exhibits, and any supplements or amendments thereto filed pursuant to 17 CFR 39.31(b) or (c) (collectively, the ''Subpart C Election Form'').

2. Any derivatives clearing organization wishing to request an extension of up to one year to comply with any of the provisions of 17 CFR 39.34, 17 CFR 39.35 or 17 CFR 39.39, pursuant to 17 CFR 39.34(d) or 17 CFR 39.39(f) must do so prior to filing this

Subpart C Election Form. Such requests shall become part of this Subpart C Election Form.

3. Individuals' names, except the executing signature, shall be given in full (Last Name, First Name, Middle Name).

4. The signatures required in this Subpart C Election Form shall be the manual signatures of: a duly authorized representative of the derivatives clearing organization as follows: If the Subpart C Election Form is filed by a corporation, it must be signed in the name of the corporation by a principal officer duly authorized; if filed by a limited liability company, it must be signed in the name of the limited liability company by a manager or member duly authorized to sign on the limited liability company's behalf; if filed by a partnership, it must be signed in the name of the partnership by a general partner duly authorized; if filed by an unincorporated organization or association which is not a partnership, it must be signed in the name of such organization or association by the managing agent, i.e., a duly authorized person who directs or manages or who participates in the directing or managing of its affairs.

5. All applicable items must be answered in full.

6. Under Section 5b of the Act and the Commission's regulations thereunder, the Commission is authorized to solicit the information required to be supplied by this Subpart C Election Form from any Applicant seeking registration as a derivatives clearing organization and from any registered derivatives clearing organization.

7. Disclosure of the information specified in this Subpart C Election Form is mandatory prior to the processing of the election to become a derivatives clearing organization subject to the provisions of subpart C of part 39 of the Commission's regulations. The Commission may determine that additional information is required in order to process such election.

8. A Subpart C Election Form that is not prepared and executed in compliance with applicable requirements and instructions may be returned as not acceptable for filing. Acceptance of this Subpart C Election Form, however, shall not constitute a finding that the Subpart C Election Form is acceptable as filed or that the information is true, current or complete.

9. Except as provided in 17 CFR 39.31(d), in cases where a derivatives clearing organization submits a request for confidential treatment with the Secretary of the Commission pursuant to the Freedom of Information Act and 17 CFR 145.9, information supplied in this Subpart C Election Form will be included routinely in the public files of the Commission and will be made available for inspection by any interested person.

APPLICATION AMENDMENTS

17 CFR 39.31(b)(3) and (c)(4) require a derivatives clearing organization that has submitted a Subpart C Election Form to promptly amend its Subpart C Election Form if it discovers a material omission or error in, or if there is a material change in, the information provided to the Commission in the Subpart C Election Form or other information provided in connection with the Subpart C Election Form. When amending a Subpart C Election Form, a derivatives clearing organization must re-file the Election and Certifications page, amended if necessary, and including all required executing signatures, and attach thereto revised exhibits or other materials marked to show changes, as applicable.

WHERE TO FILE

This Subpart C Election Form must be filed electronically with the Secretary of the Commission in the format and manner specified by the Commission.

COMMODITY FUTURES TRADING COMMISSION

SUBPART C ELECTION FORM

ELECTION AND CERTIFICATIONS

_____

Exact Name of the Derivatives Clearing Organization (as set forth in its charter, if an Applicant, or as set forth in its most recent order of registration, if registered with the Commission)

☐ Check here and complete sections 1 and 3 below, if the organization is an Applicant.

☐ Check here and complete sections 2 and 3 below, if the organization currently is registered with the Commission as a derivatives clearing organization.

1. The derivatives clearing organization named above hereby elects to become subject to the provisions of subpart C of part 39 of the Commission's regulations in the event that the Commission approves its application for registration as a derivatives clearing organization.

The derivatives clearing organization and the undersigned each certify that, in the event that the Commission approves the derivatives clearing organization's application for registration and permits its election to become subject to subpart C of part 39 of the Commission's regulations:

a. The derivatives clearing organization will be in compliance with such regulations as of the date set forth in the notice thereof provided by the Commission pursuant to 17 CFR 39.31(c)(2), except to the limited extent that the Commission has granted the derivatives clearing organization an extension of time to comply with: (1) specified provisions of 17 CFR 39.34, pursuant to 17 CFR 39.34(d) and/or (2) specified provisions of 17 CFR 39.35 and/or 17 CFR 39.39, pursuant to 17 CFR 39.39(f);

b. The derivatives clearing organization will be in compliance with all provisions of 17 CFR 39.34, 39.35 and/or 39.39 for which the Commission, pursuant to 17 CFR 39.34(d) and/or 17 CFR 39.39(f), has granted an extension of time to comply in accordance with the terms of such extensions; and

c. The derivatives clearing organization will remain in compliance with the provisions contained in subpart C of part 39 of the Commission's regulations until this election is rescinded pursuant to 17 CFR 39.31(e).

_____

Name of Derivatives Clearing Organization

_____

Manual Signature of Duly Authorized Person

_____

Print Name and Title of Signatory

2. The derivatives clearing organization named above hereby elects to become subject to the provisions of subpart C of part 39 of the Commission's regulations as of: _____ (''Effective Date'') [insert date, which must be at least 10 business days after the date this Subpart C Election Form is filed with the Commission].

The derivatives clearing organization and the undersigned each certify that:

a. As of the Effective Date set forth above, the derivatives clearing organization shall be in compliance with subpart C of part 39 of the Commission's regulations, except to the limited extent that the Commission has granted the derivatives clearing organization an extension of time to comply with: (1) specified provisions of 17 CFR 39.34, pursuant to 17 CFR 39.34(d) and/or (2) specified provisions of 17 CFR 39.35 and/or 17 CFR 39.39, pursuant to 17 CFR 39.39(f);

b. The derivatives clearing organization will be in compliance with all provisions of 17 CFR 39.34, 39.35 and/or 39.39 for which the Commission, pursuant to 17 CFR 39.34(d) and/or 17 CFR 39.39(f), has granted an extension of time to comply in accordance with the terms of such extensions; and

c. The derivatives clearing organization will remain in compliance with provisions contained in subpart C of part 39 of the Commission's regulations until this election is rescinded pursuant to 17 CFR 39.31(e).

_____

Name of Derivatives Clearing Organization

_____

Manual Signature of Duly Authorized Person

_____

Print Name and Title of Signatory

3. The derivatives clearing organization named above has duly caused this Subpart C Election Form (which includes, as an integral part thereof, the Election and Certifications and all Disclosures and Exhibits) to be signed on its behalf by its duly authorized representative as of the ____ __ day of _____, 20____. The

derivatives clearing organization and the undersigned each represent hereby that, to the best of their knowledge, all information contained in this Subpart C Election Form is true, current and complete in all material respects. It is understood that all required items including, without limitation, the Election and Certifications and Disclosures and Exhibits, are considered integral parts of this Subpart C Election Form.

Name of Derivatives Clearing Organization

Manual Signature of Duly Authorized Person

Print Name and Title of Signatory

COMMODITY FUTURES TRADING COMMISSION

PART 39, SUBPART C ELECTION FORM

DISCLOSURES AND EXHIBITS

Each derivatives clearing organization that requests an election to become subject to the provisions set forth in subpart C of part 39 of the Commission's regulations shall provide the Disclosures and Exhibits set forth below:

DISCLOSURES:

The derivatives clearing organization shall:

1. Publish on its Web site in a readily identifiable location the derivatives clearing organization's responses to the Disclosure Framework for Financial Market Infrastructures (''Disclosure Framework''), published by the Committee on Payment and Settlement Systems (''CPSS'') and the Board of International Organization of Securities Commissions (''IOSCO'') that are required to be completed pursuant to 17 CFR 39.37. The derivatives clearing organization's responses must be completed in accordance with section 2.0 and Annex A of the Disclosure Framework and must fully explain how the derivatives clearing organization observes the Principles for Financial Market Infrastructures (''PFMIs'') published by CPSS and IOSCO.

Provide the URL to the specific page on the derivatives clearing organization's Web site where its responses to the Disclosure Framework may be found:

2. In the event that CPSS and IOSCO publish final criteria for the disclosure by a Financial Market Infrastructure (''FMI'') of quantitative information to enable stakeholders to evaluate FMIs and to make cross comparisons referenced in section 2.5 of the Disclosure Framework (''Quantitative Information Disclosure''), publish such Quantitative Information Disclosure in a readily identifiable location on the derivatives clearing organization's Web site.

If applicable, provide the URL to the specific page on the derivatives clearing organization's Web site where its Quantitative Information Disclosure may be found:

EXHIBITS:

EXHIBIT INSTRUCTIONS:

1. The derivatives clearing organization must include a Table of Contents listing each Exhibit required by this Subpart C Election Form.

2. If the derivatives clearing organization is an Applicant, in its Form DCO, the derivatives clearing organization may summarize such information and provide a cross-reference to the Exhibit in this Subpart C Election Form that contains the required information.

The derivatives clearing organization shall provide the following Exhibits to this Subpart C Election Form:

EXHIBIT A—COMPLIANCE WITH SUBPART C

Attach, as Exhibit A, a regulatory compliance chart that separately sets forth for §§ 39.32–39.39 of the Commission's regulations, citations to the relevant rules, policies, and procedures of the derivatives clearing organization that address each such regulation and a summary of the manner in which the derivatives clearing organization will comply with each regulation. All citations and compliance summaries shall be separated by individual regulation and shall be clearly labeled with the corresponding regulation.

EXHBIT B—GOVERNANCE

Attach, as Exhibit B, documents that demonstrate compliance with the governance requirements set forth in § 39.32 of the Commission's regulations.

EXHIBIT C—FINANCIAL RESOURCES

Attach, as Exhibit C, documents that demonstrate compliance with the financial resource requirements set forth in § 39.33 of the Commission's regulations.

EXHIBIT D—SYSTEM SAFEGUARDS

Attach, as Exhibit D, documents that demonstrate compliance with the system safeguard requirements set forth in § 39.34 of the Commission's regulations.

EXHIBIT E—DEFAULT RULES AND PROCEDURES FOR UNCOVERED LOSSES OR SHORTFALLS

Attach, as Exhibit E, documents that demonstrate compliance with the requirements for default rules and procedures for uncovered losses or shortfalls set forth in § 39.35 of the Commission's regulations.

EXHIBIT F—RISK MANAGEMENT

Attach, as Exhibit F, documents that demonstrate compliance with the risk management requirements set forth in § 39.36 of the Commission's regulations.

EXHIBIT G—RECOVERY AND WIND-DOWN

Attach, as Exhibit G, documents that demonstrate compliance with the recovery and wind-down requirements set forth in § 39.39 of the Commission's regulations.

PART 140—ORGANIZATION, FUNCTIONS AND PROCEDURES OF THE COMMISSION

■ 7. The authority citation for part 140 continues to read as follows:

Authority: 7 U.S.C. 2(a)(12), 12a, 13(c), 13(d), 13(e), and 16(b).

■ 8. Amend § 140.94 to add new paragraphs (c)(12) and (c)(13) to read as follows:

§ 140.94 Delegation of authority to the Director of the Division of Swap Dealer and Intermediary Oversight and the Director of the Division of Clearing and Risk.

* * * * *

(c) * * *

(12) All functions reserved to the Commission in § 39.31 of this chapter; and

(13) The authority to approve the requests described in §§ 39.34(d) and 39.39(f) of this chapter.

* * * * *

PART 190—BANKRUPTCY

■ 9. The authority citation for part 190 continues to read as follows:

Authority: 7 U.S.C. 1a, 2, 4a, 6c, 6d, 6g, 7a, 12, 19, and 24, and 11 U.S.C. 362, 546, 548, 556, and 761–766, unless otherwise noted.

■ 10. In § 190.09, revise paragraph (b) to read as follows:

§ 190.09 Member property.

* * * * *

(b) *Scope of member property.* Member property shall include all money, securities and property received, acquired, or held by a clearing organization to margin, guarantee or secure, on behalf of a clearing member, the proprietary account, as defined in § 1.3 of this chapter, any account not belonging to a foreign futures or foreign options customer pursuant to the proviso in § 30.1(c) of this chapter, and any Cleared Swaps Proprietary Account, as defined in § 22.1 of this chapter: *Provided, however,* that any guaranty deposit or similar payment or deposit made by such member and any capital stock, or membership of such member in the clearing organization shall also be included in member property after payment in full, in each case in accordance with the by-laws or rules of the clearing organization, of that portion of:

(1) The net equity claim of the member based on its customer account; and

(2) Any obligations due to the clearing organization which may be paid therefrom, including any obligations due from the clearing organization to the customers of other members.

Issued in Washington, DC, on November 15, 2013, by the Commission.

Melissa D. Jurgens,

Secretary of the Commission.

Note: The following appendices will not appear in the Code of Federal Regulations.

Appendices to Derivatives Clearing Organizations and International Standards—Commission Voting Summary and Statement of Chairman

Appendix 1—Commission Voting Summary

On this matter, Chairman Gensler and Commissioners Chilton, O'Malia, and Wetjen voted in the affirmative; no Commissioner voted in the negative.

Appendix 2—Statement of Chairman Gary Gensler

I support the final rule to complete the process of bringing clearinghouse risk management rules in line with international standards.

In the fall of 2011, the Commission adopted a comprehensive set of rules for the risk management of clearinghouses. These final rules were consistent with international standards, as evidenced by the Principles for Financial Market Infrastructures (PFMIs) consultative document that had been published by the Committee on Payment and Settlement Systems and the International Organization of Securities Commissions (CPSS–IOSCO).

In April of 2012, CPSS–IOSCO issued final principles. Based upon these final principles, it was appropriate to augment our rules in certain areas to meet those standards, particularly relating to systemically important clearinghouses.

These final rules will implement the remaining items from the PFMIs in our clearinghouse rules. They will enable clearinghouses designated by the Financial Stability Oversight Council as systemically important (SIDCOs) to be qualifying central counterparties for the purposes of international bank capital standards. This permits banks and bank affiliates that are members (or customers of members) of the SIDCOs to benefit from favorable capital treatment for their exposures to these SIDCOs. The final rules also implement an opt-in mechanism to permit other clearinghouses to elect to be held to these additional standards, and thus benefit from the same capital treatment.

[FR Doc. 2013–27849 Filed 11–29–13; 8:45 am]

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FEDERAL REGISTER

Vol. 78 Monday,

No. 231 December 2, 2013

Part VII

The President

Proclamation 9062—Minority Enterprise Development Week, 2013
Proclamation 9063—Thanksgiving Day, 2013

Federal Register
Vol. 78, No. 231
Monday, December 2, 2013

Presidential Documents

Title 3—

The President

Proclamation 9062 of November 26, 2013

Minority Enterprise Development Week, 2013

By the President of the United States of America

A Proclamation

This August, as we marked the 50th anniversary of the March on Washington, we were reminded that the measure of America's progress is not whether the doors of opportunity are cracked a little wider for a few, but whether our economic system provides a fair shot for the many. Minority-owned businesses play a crucial part in driving this progress—not only when their founders pursue their fullest measure of success, but also when they offer employees of all backgrounds a chance to enter the ranks of the American middle class. During Minority Enterprise Development Week, we recognize the strength of our diverse workforce and the many ways minority entrepreneurs contribute to our economy, our society, and our Nation's fundamental promise.

America's minority enterprises include everything from Main Street cornerstones that sustain communities to global firms that drive innovation in the industries of tomorrow. Together, these businesses employ almost 6 million Americans and contribute 1 trillion dollars to our economy every year. Minority entrepreneurs bring unique perspectives to every corner of our country, and their understanding of diverse cultures often gives them an advantage in the international marketplace.

As our economy continues to recover, our investments in minority owned and operated firms will help create jobs, strengthen families, and build ladders of opportunity in underserved communities. Over the past 5 years, my Administration has worked to empower minority entrepreneurs by connecting them with billions of dollars in contracts and access to capital. And to better serve America's business community, we launched www.Business.USA.gov, where any firm can seek out financing opportunities, navigate Federal bureaucracy, and cut through red tape.

This week, we celebrate America's minority enterprises, renew our commitment to helping them grow, and look with pride toward the promise of the future.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim December 1 through December 7, 2013, as Minority Enterprise Development Week. I call upon all Americans to celebrate this week with appropriate programs, ceremonies, and activities to recognize the many contributions of our Nation's minority enterprises.

IN WITNESS WHEREOF, I have hereunto set my hand this twenty-sixth day of November, in the year of our Lord two thousand thirteen, and of the Independence of the United States of America the two hundred and thirty-eighth.

[FR Doc. 2013–28992
Filed 11–29–13; 11:15 am]
Billing code 3295–F4

Presidential Documents

Proclamation 9063 of November 26, 2013

Thanksgiving Day, 2013

By the President of the United States of America

A Proclamation

Thanksgiving offers each of us the chance to count our many blessings—the freedoms we enjoy, the time we spend with loved ones, the brave men and women who defend our Nation at home and abroad. This tradition reminds us that no matter what our background or beliefs, no matter who we are or who we love, at our core we are first and foremost Americans.

Our annual celebration has roots in centuries-old colonial customs. When we gather around the table, we follow the example of the Pilgrims and Wampanoags, who shared the fruits of a successful harvest nearly 400 years ago. When we offer our thanks, we mirror those who set aside a day of prayer. And when we join with friends and neighbors to alleviate suffering and make our communities whole, we honor the spirit of President Abraham Lincoln, who called on his fellow citizens to ''fervently implore the interposition of the Almighty hand to heal the wounds of the nation, and to restore it, as soon as may be consistent with the Divine purposes, to the full enjoyment of peace, harmony, tranquility, and union.''

Our country has always been home to Americans who recognize the importance of giving back. Today, we honor all those serving our Nation far from home. We also thank the first responders and medical professionals who work through the holiday to keep us safe, and we acknowledge the volunteers who dedicate this day to those less fortunate.

This Thanksgiving Day, let us forge deeper connections with our loved ones. Let us extend our gratitude and our compassion. And let us lift each other up and recognize, in the oldest spirit of this tradition, that we rise or fall as one Nation, under God.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim Thursday, November 28, 2013, as a National Day of Thanksgiving. I encourage the people of the United States to join together—whether in our homes, places of worship, community centers, or any place of fellowship for friends and neighbors—and give thanks for all we have received in the past year, express appreciation to those whose lives enrich our own, and share our bounty with others.

IN WITNESS WHEREOF, I have hereunto set my hand this twenty-sixth day of November, in the year of our Lord two thousand thirteen, and of the Independence of the United States of America the two hundred and thirty-eighth.

[FR Doc. 2013–28993
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Federal Register

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FEDERAL REGISTER PAGES AND DATE, DECEMBER

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CFR PARTS AFFECTED DURING DECEMBER

At the end of each month the Office of the Federal Register publishes separately a List of CFR Sections Affected (LSA), which lists parts and sections affected by documents published since the revision date of each title.

LIST OF PUBLIC LAWS

Note: No public bills which have become law were received by the Office of the Federal Register for inclusion in today's **List of Public Laws**.

Last List November 25, 2013

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This table is used by the Office of the Federal Register to compute certain dates, such as effective dates and comment deadlines, which appear in agency documents. In computing these dates, the day after publication is counted as the first day.

When a date falls on a weekend or holiday, the next Federal business day is used. (See 1 CFR 18.17)

A new table will be published in the first issue of each month.

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December 24	Jan 8	Jan 14	Jan 23	Jan 28	Feb 7	Feb 24	Mar 24
December 26	Jan 10	Jan 16	Jan 27	Jan 30	Feb 10	Feb 24	Mar 26
December 27	Jan 13	Jan 17	Jan 27	Jan 31	Feb 10	Feb 25	Mar 27
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